Employee Welfare Benefits Program

For the Employees of the

Killeen Independent School District

Wrap-Around

Plan Document

&

Summary Plan Description

Effective January 1, 2023

Employee Welfare Benefits Program

for the Employees of the

Killeen Independent School District

Wrap-Around Plan Document and Summary Plan Description

Table Contents

This document, together with the certificates of insurance, benefit description booklets, and summary plan description issued by Killeen Independent School District, or an insurance carrier, and attached hereto, constitutes the Wrap-Around Plan Document and Summary Plan Description for each of the Component Benefit Programs offered by Killeen Independent School District. If the certificates, booklets, or summaries are not attached, then this Wrap-Around Plan Document and Summary Plan Description is not complete, and you should contact Human Resources or the Killeen Independent School District for a complete copy.

Section One - Introduction

1.1 Introduction

The Killeen Independent School District (the "Employer") hereby establishes the Killeen Independent School District Flexible Benefits Plan (the "Plan") originally effective December 15, 1989 (the "Effective Date"). This Plan is effective January 1, 2023, for the exclusive benefit of its eligible employees and their eligible spouses and dependents.

Each of these Component Benefits Programs is summarized in a certificate, booklet, or summary issued by an insurance company, a summary plan description, the summary of benefits and coverage, enrollment documentation, or another governing document prepared by the Employer, and are incorporated as part of this Wrap-Around Plan Document. A copy of each certificate, booklet, summary, or other governing document, is attached hereto as Component Documents 1 through 13, as noted below in Section 1.3.

1.2 Purpose of Plan

The Employer is providing this Wrap-Around Plan Document and Summary Plan Description ("Wrap Document") to give you an overview of the Plan and to address certain information that may not be addressed in the Component Documents. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in the Glossary of this Wrap Document.

1.3 Component Benefits Programs

The Plan Provides the following Component Benefit Programs:

Health/Prescription Program Options: (Self-Funded Programs)

- Plan A – NexusACO OA Plan (Component Document 1)
- Plan B – NexusACO OA Plan (Component Document 2)
- Plan C – NexusACO OA Plan (Component Document 3)

- Plan D – NexusACO OA Plan (Component Document 4)

Dental Program Options: (Full Insured Programs)

- United Concordia Dental Base Plan (Component Document 5)
- United Concordia Buy-Up Plan (Component Document 6)

Vision Program Option: (Fully Insured Program)

- Avesis Advantage Vision Care (Component Document 7)

Flexible Benefits Plan Program Options:

- KISD Flexible Benefits Plan (Component Document 8)
  - ✓ Premium Payment Plan ("POP")
  - ✓ Health Flexible Spending Account ("Health FSA")
  - ✓ Health Savings Account Contribution Benefit ("HAS Contribution Benefit")
  - ✓ Dependent Care Flexible Spending Accounting ("Dependent Care FSA")

Life/AD&D Program Option: (Fully Insured Program)

- Mutual of Omaha Life and Accidental Death & Dismemberment Plan (Component Document 9)

Short Term Disability Program Options: (Fully Insured Program)

- Mutual of Omaha Short Term Disability Insurance (Component Document 10)

Long Term Disability Program Options: (Fully Insured Program)

- Mutual of Omaha Long Term Disability Insurance (Component Document 11)

Voluntary Accident Program Options: (Fully Insured Program)

- Mutual of Omaha Voluntary Accident Insurance (Component Document 12)

Voluntary Critical Illness Program Options: (Fully Insured Program)

- Mutual of Omaha Voluntary Group Critical Illness Insurance (Component Document 13)

Read All Documents. You must read this Wrap-Around Plan Document, Summary Plan Description, the Summary of Benefits and Coverage, and any enrollment documentation, along with the respective Component Document for each Component Benefit Program to understand your Benefits!

You must enroll to receive benefits. Enrollment requirements are explained in Section Three of Eligibility. Some of these Components Benefits Programs require you to make an annual election to enroll for coverage. The details of such annual elections are described in the Component Benefit Documents.

This document and the Component Documents constitute the Plan Document and SPD for the Component Benefit Programs.

Even though included in this document, the Life and AD&D, Short-Term Disability, and Long-Term Disability Component Benefit Programs are not subject to the requirements of HIPAA. The inclusion of Component Benefit Programs that are not subject to HIPAA as part of this Plan is not intended to subject the Component Benefit Programs to HIPAA.

Component Benefit Programs hereunder are provided pursuant to an insurance contract or pursuant to a governing plan document adopted by the Employer. If the terms of the Wrap-Around Plan Document and SPD conflict with the terms of the Component Documents, then the terms of the Component Documents will control, rather than the terms of this Wrap-Around Plan Document and SPD, unless otherwise required by law.

The terms of this Wrap-Around Plan Document and SPD are designed to incorporate important differences between the Fully Insured Component Benefit Programs and the Self-Funded Component Benefit Program. Nothing in this document or any of the Component Documents shall be construed as to change the funding nature of any Component Benefit Program, such as transferring a Fully Insured Component Benefit Program into a Self-Funded Component Benefit Program, or vice versa. For example, the use of Fully Insured language and terminology in a Self-Funded Component Document would not change the funding structure of that Component Benefit.

Section Two – General Plan Identifying Information

General Plan Identifying Information	
Name of the Plan	Killeen Independent School District Employee Welfare Benefits Plan
Type of Plan	Employee Welfare Benefits Plan
Address of Plan	Killeen Independent School District PO Box 967 2301 Atkinson Killeen, TX 76540-0967 Tel: (254) 336-0067
Plan Administrator	Killeen Independent School District Attn: Benefit Administrator for KISD PO Box 967 Killeen, TX 76540 Tel: (254) 336-0067

Agent for Service of Legal Process	Killeen Independent School District Attn: Benefit Administrator for KISD PO Box 967 Killeen, TX 76540 Tel: (254) 336-0067
Named Fiduciary	Killeen Independent School District PO Box 967 Killeen, TX 76540 Tel: (254) 336-0067
Plan Number	502 – Welfare Benefit Plan 501 – Flexible Benefits Plan
Plan Sponsor and its IRS Employer Identification Number	Killeen Independent School District PO Box 967 Killeen, TX 76540 Tel: (254) 336-0067 EIN: 74-6001505
Effective Date	January 1, 2023
Plan Year End	December 31, 2023
Health/Prescription Component Benefit Programs – Self Insured (Component Documents 1,2,3,4)	
Health/Prescription Plan Administrator	Killeen Independent School District Attn: Benefit Administrator for KISD PO Box 967 Killeen, TX 76540 Tel: (254) 336-0067
Health Program Claims Fiduciary	United Healthcare Services Inc. 9900 Bren Road East Minnetonka, MN 55343 Tel: (952)936-1300
Dental Component Benefit Programs – Fully Insured (Component Documents 5-6)	
Plan Administrator / Fiduciary	United Concordia Dental 4401 Deer Path Road Harrisburg, PA 17110 Tel: (888) 320-3316, option 4
Claims Fiduciary	United Concordia Dental PO Box 69421 Harrisburg, PA 17106-9421 Tel: (866) 357-3304

Vision Component Benefit Programs – Fully Insured (Component Documents 7)	
Plan Administrator / Fiduciary	Avesis Third Party Administrators, Inc. Corporate Headquarters 10400 N 25th Avenue, Suite 200 Phoenix, AZ 85021 Tel: (800) 522-0258 Customer Service: (800) 828-9341 Website: www.avesis.com
Claims Fiduciary	Avesis Third Party Administrators, Inc. Attn: Vision Claims Department PO Box 38300 Phoenix, AZ 85069-8300 Tel: (800) 828-9341
Flexible Benefits Plan Component Benefit Program (Component Documents 8)	
Plan Administrator / Fiduciary	Killeen Independent School District PO Box 967 Killeen, TX 76540 Tel: (254) 336-0070
Claims Fiduciary	WEX 4321 20th Ave S Fargo, ND 58103 Tel: (701) 492-7274
Life/AD&D Component Benefit Program – Fully Insured (Component Documents 9)	

Plan Administrator / Fiduciary	Benefit Administrator Killeen Independent School District 200 North W.S. Young Drive Killeen, TX 76543
Claims Fiduciary	United of Omaha Life Insurance Company Mutual of Omaha Plaza Omaha, Nebraska 68175 Tel: (800) 775-8805

Short Term Disability Component Benefit Program – Fully Insured (Component Documents 10)	
Plan Administrator / Fiduciary	Benefit Administrator Killeen Independent School District 200 North W.S. Young Drive Killeen, TX 76543
Claims Fiduciary	United of Omaha Life Insurance Company Group Disability Management Services Mutual of Omaha Plaza Omaha, Nebraska 68175 Tel: (800) 877-5176
Long Term Disability Component Benefit Program – Fully Insured (Component Documents 11)	
Plan Administrator / Fiduciary	Benefit Administrator Killeen Independent School District 200 North W.S. Young Drive Killeen, TX 76543
Claims Fiduciary	United of Omaha Life Insurance Company Group Disability Management Services Mutual of Omaha Plaza Omaha, Nebraska 68175 Tel: (800) 877-5176
Voluntary Accident Component Benefit Program – Fully Insured (Component Documents 12)	

Plan Administrator / Fiduciary	United of Omaha Life Insurance Company Mutual of Omaha Plaza Omaha, Nebraska 68175
Claims Fiduciary	United of Omaha Life Insurance Company Mutual of Omaha Plaza Omaha, Nebraska 68175 Tel: (800) 775-8805
Voluntary Critical Illness Component Benefit Program – Fully Insured (Component Documents 13)	
Plan Administrator / Fiduciary	United of Omaha Life Insurance Company Mutual of Omaha Plaza Omaha, Nebraska 68175
Claims Fiduciary	United of Omaha Life Insurance Company Mutual of Omaha Plaza Omaha, Nebraska 68175 Tel: (800) 775-8805
Benefit Program Effective Dates	The original effective date of the Self-Insured Health/Prescription program is January 1, 2022.
	The original effective date of the Fully Insured Dental program was January 1, 2020.
	The original effective date of the Fully Insured Vision program was January 1, 2020.
	The original effective date of the Flexible Benefits Plan program was December 15, 1989.
	The original effective date of the Fully Insured Life/AD&D program was June 1, 2014.
	The original effective date of the Fully Insured Short-Term Disability program was January 1, 2003.
	The original effective date of the Fully Insured Long Term Disability program was January 1, 1991.
	The original effective date of the Fully Insured Voluntary Accident program was January 1, 2014.
	The original effective date of the Fully Insured Voluntary Critical Illness program was January 1, 2014.

Funding Medium and Type of Plan Administration	Some Benefit Programs under the Plan may be Self-Funded by the Employer, and some may be Fully Insured under applicable insurance contracts. Insurance premiums for the Fully Insured Benefit Programs are paid in whole or in part by Killeen Independent School District contributions and by participants' payroll deductions (which may be pre-tax or post-tax). Contributions for the Self-Funded Benefit Programs are paid in whole or in part by Killeen Independent School District contributions and by participants' payroll deductions (which may be pre-tax or post-tax). The Plan Administrators for the various Benefit Programs will provide a schedule of the applicable contributions during the initial and subsequent open enrollment periods and upon request for each of the Benefits Programs, as applicable.

Funding Medium and Type of Plan Administration ***(continued…)***	The Self-Funded Plan A – NexusACO OA Plan, Plan B - NexusACO OA Plan, Plan C - NexusACO OA Plan, and Plan D - NexusACO OA Plan, programs are insured by Scott & White Care Plans, which are responsible for paying claims and administering the Health/Prescription benefit options.
	The United Concordia Dental Plans are Fully Insured by United Concordia Dental, which is responsible for paying claims and administering the United Concordia Dental Plan benefit options.
	The Vision Program Option is Fully Insured by Avesis Third Party Administrators, Inc., which is responsible for paying claims and administering the Avesis Advantage Vision Care benefit option.
	The Flexible Benefits Plan is adopted by Killeen Independent School District, which is responsible for administering the POP, Health FSA, HSA Contribution Benefit, and Dependent Care Flexible Spending Account benefit options.
	The Life/AD&D Program Option is Fully Insured by Mutual of Omaha, which is responsible for paying claims and administering the Mutual of Omaha Life and Accidental Death and Dismemberment Plan benefit option.

	The Short-term Disability Program Option is Fully Insured by Mutual of Omaha, which is responsible for paying claims and administering the Mutual of Omaha Short Term Disability Insurance benefit option.
	The Long-Term Disability Program Option is Fully Insured by Mutual of Omaha, which is responsible for paying claims and administering the Mutual of Omaha Long Term Disability Insurance benefit option.
	The Voluntary Accident Program Option is Fully Insured by Mutual of Omaha, which is responsible for paying claims and administering the Mutual of Omaha Voluntary Accident Insurance benefit option.
	The Voluntary Critical Illness Program Option is Fully Insured by Mutual of Omaha, which is responsible for paying claims and administering the Mutual of Omaha Critical Illness benefit option.

Section Three – Eligibility and Participation

3.1 Eligibility and Participation

An individual is eligible to be a Participant in the Plan if such individual meets the definition of an Eligible Employee as set forth in the Glossary.

The eligibility and participation requirements may vary depending on the particular Component Benefit Program. You must satisfy the eligibility requirements under a particular Component Benefit Program in order to receive benefits under that program. Certain individuals related to you, such as a spouse or your dependents, may be eligible for coverage under certain Component Benefit Programs. To determine whether you or your family members are eligible to participate in a Component Benefit Program, please read the eligibility information contained in the attached Component Documents for the applicable Component Benefits Programs.

Certain Component Benefit Programs require enrollment (either once or annually) for coverage. Information about enrollment procedures, including when the coverage begins and ends for the various Component Benefit Programs, is found in the Component Documents. Once eligible, you may begin participating in the Plan upon your election to participate in a Component Benefit Program in accordance with the terms and conditions established for that program or, if earlier, upon meeting the

eligibility criteria and becoming covered under a Component Benefit Program that does not require enrollment or an election.

3.2 Need for Enrollment: Time Limits

While some of the Component Benefit Programs may be provided automatically to Eligible Employees, other Component Benefit Programs require the completion of application forms, annual elections, or other administrative forms, as described in the Component Documents. For Component Benefits requiring enrollment, new employees must generally enroll within certain time periods after being hired or after first becoming eligible as described herein and in the Component Documents. Thereafter, enrollment for each Component Benefit Program is generally limited to the annual period that occurs before the beginning of each Plan Year, unless circumstances give rise to special enrollment rights as described immediately below, or unless other enrollment opportunities are available for a particular Component Benefit Program, as described in the Component Documents.

- New employees must complete enrollment forms within the first thirty (30) calendar days of employment.
- All current employees must complete benefits selections for the following plan year during the annual open enrollment period.

3.3 Special Enrollment Rights

In certain circumstances, enrollment may occur outside the open enrollment period, as explained in the Component Documents. The Plan's Special Enrollment Notice also contains important information about the special enrollment rights that you may have, a copy of which has been furnished to you. Contact Human Resources if you need another copy.

3.4 When Coverage Begins

An employee may commence participation in the Plan upon satisfaction of the eligibility requirements. The plan entry date is the later of the date the employee files a salary reduction agreement or the 1st of the month after the employees hire date.

As determined by the Employer, coverage may begin at different times for each of the Component Benefit Programs.

For additional information about when coverage begins, please read the eligibility information contained in the Component Documents.

3.5 Termination of Participation

Coverage under a particular Component Benefit Program will terminate as set forth in the Component Documents. Depending upon which Component Benefit Programs you are participating in, other circumstances will also result in the termination of your benefits as specified in the Component Documents. Note that termination of coverage under a particular Component Benefit Program may not necessarily mean that all Plan coverage terminates. You (or your covered family member) may still have coverage under another Component Benefit Program.

Coverage for your spouse and dependents stops when your coverage stops and for other reasons specified in the Component Documents (for example, divorce, dependent's attaining age limit, and other reasons). Benefits will also cease for you, your spouse, and dependents upon termination of the Plan.

3.6 COBRA Continuation Coverage

If health, prescription, vision, or dental coverage for you, your eligible spouse, or your eligible dependents ceases because of certain "qualifying events" (e.g., termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the Plan's definition of dependent) specified in a federal law called COBRA, then you, your eligible spouse, or your eligible dependents may have the right to purchase continuing coverage under the Plan for a limited period of time. For more information, see the "COBRA" summary, a copy of which has been previously furnished to you. Please contact Human Resources if you need another copy.

If you or your eligible family members qualify for such continuation coverage, then the Health Flexible Spending Account will be treated as a separate plan from the KISD Flexible Benefits Plan, and its Dependent Care, Health Savings Account, and Insurance Premium Payment Plan Component Benefit Programs, according to the provisions of the applicable Component Documents.

3.7 USERRA Continuation Coverage

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the Uniformed Services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage available pursuant to USERRA is included in the Component Documents.

For some Component Benefit Programs, You May Have Rights Under COBRA and USERRA. For Component Benefit Programs to which COBRA and USERRA apply, your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA. COBRA and USERRA may both apply with respect to the continuation coverage elected. If COBRA or USERRA give you or your covered dependents different rights or protections, the laws that provides that greater benefit will apply. The administrative policies and procedures for COBRA also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstance.

3.8 Qualified Medical Child Support Orders

The Plan will extend medical benefits to an Eligible Employee's non-custodial child as required by any qualified medical child support order (QMCSO) under ERISA §609(a), including a National Medical Support Notice. The Plan has procedures for determining whether an order qualifies as a QMCSO. You can obtain, without charge, a copy of such procedures from Human Resources.

3.9 Family and Medical Leave

As explained in the Component Documents issued by the Employer, if a Participant is on a Family or Medical Leave of Absence, the Participant may continue coverage in accordance with the Family and Medical Leave Act, and the Plan will continue coverage as if the Participant was Actively at Work if the following conditions are met:

- The required Contribution is paid; and
- The Participant has written approval of leave from the Employer.

Coverage will be continued for up to the greater of:

- The leave period required by the Family and Medical Leave Act of 1993 and any amendments thereto or regulations promulgated thereunder; or
- The leave period required by applicable state law.

If coverage is not continued during a family or medical leave of absence, when the Participant returns to Actively at Work status no new Waiting Period will apply.

Section Four – Plan Benefits Summary

4.1 Benefits

The Plan provides you and your eligible dependents with benefits under the Component Benefit Programs as set forth in Section One of this Wrap-Around Plan Document. A summary of each Component Benefit Program, describing the benefits provided under the program is set forth in the Component Documents.

4.2 Premiums and Contributions

The cost of the benefits provided through the Component Benefit Programs will be funded in part by Employer payments called premiums (for Fully Insured plans) and contributions (for Self-Funded plans) and in part by employee premiums and contributions (which may be pre-tax or after-tax, subject to the

terms of the KISD Flexible Benefits Plan and applicable Component Benefit Program 8). The Employer will determine and periodically communicate your share of the cost of the benefits provided through each Component Benefit Program, and it may change that determination at any time.

The Employer will make payment of its premiums or contributions in an amount that (in the Employer's sole discretion) is sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by employee premiums or contributions. With respect to Fully Insured Component Benefit Programs, The Employer will pay its own premiums and employee premiums to the insurance carrier specified above. With respect to benefits that are Self-Funded, the Employer will use its own contributions and employee contributions to pay benefits directly to or on behalf of you and your eligible family members from the Employer's general assets or from those assets held in trust (where applicable) for that purpose.

Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using Employer contributions to pay for the cost of the benefit.

4.3 Rebates, Refunds, and Similar Payments

Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be allocated consistent with applicable federal law.

The following three notices in Sections 4.4 through 4.6 apply to the Group Health Plan Component Benefit Programs (but only to the extent they provide applicable benefits).

4.4 Newborns and Mothers Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother of the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., your Physician, nurse, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans may not set the level of benefits for out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

4.5 Reconstructive Surgery Following Mastectomy

On January 1, 1999, a new federal law, the Women's Health and Cancer Rights Act of 1998, became effective for the Plan. The law requires group health plans to provide coverage for breast reconstruction, prostheses, and complications following a mastectomy. The law mandates that a Participant or Dependent who is receiving benefits for a mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of all stages of mastectomies, including lymphedemas.

This coverage will be provided in a manner determined in consultation with the attending Physician and the patient and will be subject to the same annual Deductible, Coinsurance, and/or Copayment provisions otherwise applicable under the Plan. If you have any questions about coverage for mastectomies and post-operative reconstructive surgery, please contact the applicable Plan Administrator.

4.6 Michelle's Law

A Dependent will not lose status as a Dependent while on a Medically Necessary Leave of Absence. A "Medically Necessary Leave of Absence" is a leave of absence from a post-secondary education institution that:

- Commences while the Dependent is suffering from a severe illness or injury;
- Is medically necessary (as certified by the Dependent's physician);
- Causes the dependent to lose full-time student status under the Plan.

Coverage may not terminate due to the Medically Necessary Leave of Absence until the earlier of:

- One year after the first day of the Medically Necessary Leave of Absence; or
- The date the coverage would otherwise terminate under the Plan.

(Section 4.6 may not be applicable due to ACA's age 26 dependent coverage mandate).

Section Five – Plan Administration

5.1 Plan Administrators

The Plan Administrators for the various Component Benefit Programs of the Plan are identified above in Section Two.

5.2 Power of Plan Administrators

Subject to the limitations of the Plan and any Component Documents, the Plan Administrators will from time to time establish rules for the administration of the various Component Programs of the Plan and transactions of its business. The Plan Administrators will rely on the records of the Employer with respect to any and all factual matters dealing with the employment and eligibility of any employee. The Plan Administrators will resolve any factual dispute, giving due weight to all evidence available to it. The Plan Administrators shall have such powers and duties as may be necessary to discharge its functions hereunder, including but not limited to, the sole and absolute discretion to:

- Construe and interpret the various Component Benefit Programs of the Plan;
- Decide questions of eligibility to participate in the various Component Benefit Programs of the Plan; and
- Determine the amount, manner, and time of payment of any benefit to any covered person.

The Plan Administrators will have final discretionary authority to make such decisions and all such determinations shall be final, conclusive, and legally binding.

Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious, or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan at the time it made the decision that is the subject or review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and further, constitutes agreement to the limited standard and scope of review described in this Section.

5.3 Outside Assistance

The Plan Administrators may employ such counsel, accountants, claims administrators, consultants, actuaries, and other person or persons as the Plan Administrators shall deem advisable. The various Component Benefit Programs of the Plan shall pay the compensation of such counsel, accountants, and other person or persons and any other reasonable expenses incurred by the Plan Administrators in the administration of the various Component Benefit Programs of the Plan.

5.4 Delegation of Powers

In accordance with the provisions hereof, the Plan Administrators have been delegated certain administrative functions relating to the various Component Benefit Programs of the Plan with all powers necessary to enable the Plan Administrators properly to carry out such duties. The Plan Administrators as such shall have no power in any way to modify, alter, add to, or subtract from any provisions of the various Component Benefit Programs of the Plan other than expressly provided in the Wrap-Around Plan Document and SPD or the Component Documents.

The Plan Administrator may delegate any of these administrative functions among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegates(s), and expressly describes the nature and scope of the delegated responsibility.

5.5 Power and Authority of Insurance Companies

The following list of benefits programs are Self Insured and provided under group insurance contracts entered into by the Employer and the applicable insurance companies:

Benefit Program	Insurance Company
Health/Prescription	United Health Care

The following list of benefits programs are Fully Insured and provided under group insurance contracts entered into by the Employer and the applicable insurance companies:

Benefit Program	Insurance Company
Dental	United Concordia
Vision	Avesis Third Party Administrators, Inc.
Life/AD&D	Mutual of Omaha
Short Term Disability	Mutual of Omaha
Long Term Disability	Mutual of Omaha
Voluntary Accident	Mutual of Omaha
Voluntary Critical Illness	Mutual of Omaha

You should send claims for benefits under these Component Benefit Programs to the insurance companies. The insurance companies are responsible for (a) determining eligibility for and the amount of any benefits under the applicable Component Benefit Program; (b) prescribing claims procedures to be followed and the claim forms you should use pursuant to the applicable Component Benefit Program. The Employer does not assume any responsibility for paying claims under these Component Benefit Programs. However, the insurance companies and the Employer share responsibility for administering the Plan.

5.6 Your Questions

If you have any general questions regarding the Plan or regarding your eligibility for, or the amount of, any benefit payable under the Self-Funded Component Benefit Programs, please contact Human Resources.

If you have questions regarding eligibility for, or the amount of, any benefits payable under a Fully Insured Component Benefit Program, please contact the applicable insurance company as provided in the Component Document.

Section Six – Circumstances That May Affect Benefits

6.1 Denial, Recovery, or Loss of Benefits

Your benefits (and, except in some cases in the event of your death, the benefits of your eligible spouse and eligible dependents) will cease when your participation in the Plan terminates. See Section Three. Your benefits will also cease upon termination of the Plan. Your benefits under any individual Component Benefit Program will cease upon termination of any such individual Component Benefit Program.

6.2 Rescission of Coverage

The Plan Administrator reserves the right to rescind coverage under the Plan if any employee, spouse, or a child becomes covered under this Plan or receives Plan benefits as a result of an act, practice, or omission that constitutes fraud or is due to the intentional misrepresentation of a material fact, both of which are prohibited by this Plan. Rescission is a cancellation and discontinuance of coverage, retroactive to the date the employee, spouse, or child became covered or received a Plan benefit as a result of fraud or the intentional misrepresentation of a material fact. The Plan Administrator will provide at least 30-days advance notice to an employee, spouse, or child of its intent to rescind coverage with an explanation of the reason for the intended rescission. The rescission shall not apply to benefits paid more than one year before the date of such advance notice. A cancellation or discontinuance of coverage is not a rescission if:

- The cancellation or discontinuance of coverage only has a prospective effect; or
- The cancellation or discontinuance of coverage is only retroactive to the extent it is attributable to the timely failure to pay Premiums (including COBRA Premiums) toward the cost of coverage. A rescission is subject to the claim's payment and appeal procedures.

6.3 Reimbursement and Subrogation

In certain circumstances, the Plan may recover overpaid benefits through its rights to subrogation and reimbursement. These Plan rights are described in detail in the Component Documents.

Section Seven – Amendment or Termination of the Plan

7.1 Right to Amend, Modify, Merge Consolidate, or Replace

The Employer reserves the right to merge, consolidate, or replace the Plan or any individual Component Benefit Program, and to make any amendment, modification, or restatement to the Plan or any individual Component Benefit Program from time to time, including those which are retroactive in effect. Such amendments may be applicable to any covered person. Terminating a Component Benefit Program (including terminating an insurance contract through which such benefits are provided) is not a termination of the Plan. Rather, it is an amendment to the Plan.

Any amendment, modification, or restatement shall be deemed to be duly executed by the Employer when adopted as part of the Employee Welfare Benefits Plan for the Employees of Killeen Independent School District Wrap-Around Plan Document and Summary Plan Description.

7.2 Right to Terminate

The Plan and its individual Component Benefit Programs are intended to be permanent, but the Employer may at any time and without notice terminate the Plan or any individual Component Benefit Program in whole or in part.

7.3 Effect on Benefits

Except as may otherwise be provided by applicable law or the Component Documents, if the Plan or any individual Component Benefit Program is amended or terminated, covered persons may not receive benefits described in the Plan or in any individual Component Benefit Program after the effective date of such amendment or termination. Any such amendment or termination shall not affect a covered person's right to benefits for claims incurred prior to such amendment or termination. If the Plan or any individual Component Benefit Program is amended, covered persons may be entitled to receive different benefits or benefits under different conditions. However, if the Plan is terminated, all benefit coverage will end, including COBRA or other continuation benefits. This may happen at any time. If the Plan is terminated, covered persons will not be entitled to any vested rights under the Plan.

Section Eight – No Contract of Employment

Nothing contained in the Plan, or the Component Benefit Programs shall be construed as a contract of employment with the Employer, or as a right to be continue in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of the participants, with or without cause.

Section Nine – Claims and Appeals Procedures

9.1 Claims and Appeals for Fully Insured Component Benefits Programs

For purposes of determining the amount of, and entitlement to, benefits of the Fully Insured Component Benefit Programs, the respective insurer is the Claims Fiduciary (as specified in Section Two) under the Plan. The Claims Fiduciary has the full power to interpret and apply the terms of the Plan to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a Component Benefit Program, you must follow the respective insurer's claims procedures. (See the Component Documents for more information).

The insurance company will decide your claim in accordance with its reasonable claim's procedures, as required by any applicable provisions of ERISA (if ERISA applies) and ACA. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide a claim. If the insurance company denies a claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide the appeal in accordance with its reasonable claim's procedures, as required by any applicable provisions of ERISA (if ERISA applies) and ACA. If you do not appeal on time, then you will lose your right to file suite in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). To the extent the Component Benefit Program is subject to provisions of ACA requiring external review, procedures to that effect will be available.

9.2 Claims and Appeals for Self-Funded Component Benefit Programs

For purposes of determining the amount of, and entitlement to, benefits under the Self-Funded Component Benefit Programs provided through the Employer's general assets, the Plan Administrator is the Named Fiduciary (as specified in Section Two) under the applicable Component Benefit Program. The Named Fiduciary has the full power to make factual determinations and to interpret and apply the terms of the applicable Component Benefit Program to the benefits provided through a Self-Funded Component Benefit Program.

To obtain benefits from a Self-Funded Component Benefit Program, you must submit to the Plan Administrator (or, if applicable to the Claims Administrator for that benefit) in accordance with the claim's procedure for the Component Benefit Program, set forth in the Component Document. The Plan

Administrator or Claims Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide a claim.

The Plan Administrator (or, if applicable to the Claims Administrator) will decide your claim in accordance with the Component Benefit Program's reasonable claims procedures, as required by any applicable provisions of ERISA (if ERISA applies) and ACA. If a claim is denied in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, you may appeal to the Plan Administrator (or, if applicable to the Claims Administrator) for a review of the denied claim. The Plan Administrator (or, if applicable to the Claims Administrator) will decide the appeal in accordance with reasonable claims procedures, as required by an applicable provision of ERISA (if ERISA applies) and ACA. If you do not appeal on time, then you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

See the certificate, booklet, summary, or other governing document among the applicable Component Documents for more information about how to file a claim and for details regarding the claim's procedures applicable to a claim.

9.3 Claims Deadline

Unless specifically provided otherwise in a Component Benefit Program or pursuant to applicable law, a claim for benefits under this Plan (including the Component Benefit Programs) must be made within 12 months after the date of service, except in the absence of legal capacity. It is your responsibility, or the responsibility of your designee to make sure this requirement is met.

9.4 Administrative Exhaustion Requirement

All claim review procedures provided for the Plan must be exhausted before any legal action is brought including a claim for benefits or for breach of fiduciary duty.

9.5 Limitation on Actions

To the extent not otherwise specified in the applicable Component Document, any legal action for the recovery of any benefits or breach of fiduciary duty must be commenced within one year after the Plan's claim review procedures have been exhausted.

9.6 Failure to File a Request

If you fail to file a request for review in accordance with the claim's procedures outlined herein and in the Component Documents, you shall have no right of review and shall have no right of review and shall

have no right to bring action in any court. The denial of the claim shall become final and binding on all persons for all purposes.

Section Ten – Plan Information

10.1 Fully Insured Component Benefit Contracts Control

Benefits under the Fully Insured Component Benefit Programs are provided solely pursuant to insurance contracts between the Plan Sponsor and the applicable insurance companies, as set forth in the Component Document for such Component Benefit Program. If the terms of this Wrap-Around Plan Document conflict with the terms of the Component Documents, the terms of the Component Document will control, unless superseded by applicable law. For this purpose, silence in an insurance contract (including the certificate of insurance) or booklet, plan document, or other governing document is not necessarily a conflict or inconsistency.

10.2 Self-Funded Component Benefit Plan Documents Control

Benefits under the Self-Funded Component Benefit Programs are provided solely pursuant to the Plan Document, SPD, or other governing document. If the terms of this Wrap-Around Plan Document and SPD conflict with the terms of the Plan Document, SPD or other governing document of any Self-Funded Component Benefit Program, the terms of the Plan Document, SPD or other governing document will control, unless superseded by applicable law. For this purpose, silence in a Plan Document, SPD, or other governing document is not necessarily a conflict or inconsistency.

10.3 Compliance with Federal Mandates

To the extent applicable, the Plan will provide benefits in accordance with the requirements of all applicable laws and as described in the certificate, booklet, or summary, including the following:

- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA);
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA);
- Health Insurance Portability and Accountability Act of 1996 (HIPPA);
- Newborns and Mothers' Health Protection Act of 1996 (NMHPA);
- Women's Health and Cancer Rights Act of 1998 (WHCRA);
- Genetic Information Nondiscrimination Act of 2008 (GINA);
- The Health Information Technology for Economic and Clinical Health Act (HITECH);
- Mental Health Parity and Addiction Equity Act (MHPAEA); and
- The Affordable Care Act (ACA).

10.4 Verification

The Plan Administrators for the various Component Benefit Programs shall be entitled to require reasonable information to verify any claim or the status of any person as an eligible employee or dependent. If the employee or dependent does not supply the requested information within the applicable time limits or provide a release for such information, such employee or dependent shall not be entitled to benefits under the Plan.

10.5 Limitation of Rights

Nothing appearing in or done pursuant to the Plan shall be held or construed:

- To give any person any legal or equitable right against the Employer, any of its employees, or persons connected therewith, except as provided by law; or
- To give any person any legal or equitable right to any assets of the Plan or any related trust, except as expressly provided herein or as provided by law.

10.6 Governing Law

The Plan is intended to be construed, and all rights and duties hereunder are to be governed, in accordance with the laws of the State of Texas, except to the extent such laws are preempted by federal law.

10.7 Severability

If any provision of the Plan is held invalid or unenforceable, its validity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

10.8 Caption

The captions contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope of intent of the Plan nor in any way shall affect the Plan or the construction of any provision thereof.

10.9 Federal Tax Disclaimer

To ensure compliance with requirements imposed by the Internal Revenue Service, we inform you that to the extent this communication (including any of the Component Documents) contains advice relating

to a Federal tax issue, it is not intended or written to be used, and it may not be used, for the purpose of (a) avoiding any penalties that may be imposed on your or any other person or entity under the Internal Revenue Code or (b) promoting, marketing or recommending to another party any transaction or matter addressed herein. If you are not the original addressee of this communication, you should seek advice from an independent advisor based on your particular circumstances.

Glossary

Capitalized terms used in the Plan have the following meanings:

Code means the Internal Revenue Code of 1986, as amended.

Component Benefit means the specific benefit(s) contained within a certificate, booklet, summary, or other governing document in which an Eligible Employee participates.

Component Benefit Program means the program under which the specific Component Benefit(s) are held.

Component Benefit Program Effective Date means the individual dates listed in Section 2.

Component Document means the certificate, booklet or summary issued by an insurance company, a summary plan description, or another governing document prepared by the Employer summarizing the Component Benefit Programs.

Plan Effective Date means January 1, 2023.

Eligible Employee means an Employee who becomes an Eligible Employee on the first day of the month following date of employment with the Employer.

Employee means an individual who is common-law employee of the Employer, regularly scheduled to work 17.5 hours or more per week with the Employer.

The following classes of employees are eligible to participate in the Killeen Independent School District Welfare Benefits Plan:

- Union member.

The following classes of employees cannot participate in the Killeen Independent School District Welfare Benefits Plan:

- Leased employee (as defined by §414 (n) of the Code);
- Contract workers and independent contractors;
- Temporary employee, casual employees, and employees hired short-term to meet specific needs to the Employer whether or not such persons are on the Employer's W-2 payroll; and
- Individuals paid by a temporary or other employment or staffing agency.

Employer means Killeen Independent School District, and any wholly owned subsidiary specifically identified in Section One, and any successor thereto.

KISD Flexible Benefits Plan means the Cafeteria Plan established by the Employer under the Plan. It allows you to use pre-tax dollars to pay for qualifying medical expenses, for the care of your eligible Dependents while you are at work, and for certain insurance premiums.

Participant means a person who is an Eligible Employee and who is participating in the Plan in accordance with the provisions of Section Three.

Plan means this Killeen Independent School District Employee Welfare Benefits Plan.

Plan Administrator means, with respect to the Killeen Independent School District Employee Welfare Benefits Plan for the Employees of Killeen Independent School District, the Employer. With respect to Component Benefit Programs, Plan Administrator means the entity identified as the Plan Administrator in Section Two.

Component Documents

The Plan provides the following Component Benefit Programs:

Health/Prescription Program Options: (Self Insured Programs)

- Plan A - NexusACO OA Plan (Component Document 1)
- Plan B - NexusACO OA Plan (Component Document 2)
- Plan C - NexusACO OA Plan (Component Document 3)
- Plan D - NexusACO OA Plan (Component Document 4)

Dental Program Options: (Fully Insured Programs)

- United Concordia Dental Base Plan (Component Document 5)
- United Concordia Buy-Up Plan (Component Document 6)

Vision Program Option: (Fully Insured Program)

- Avesis Advantage Vision Care (Component Document 7)

Flexible Benefits Plan Program Options:

- KISD Flexible Benefits Plan (Component Document 8)
    - Premium Payment Plan (“POP”)
    - Health Flexible Spending Account (“Health FSA”)
    - Health Saving Account Contribution Benefit (“HSA Contribution Benefit”)
    - Dependent Care Flexible Spending Account (“Dependent Care FSA”)

Life/AD&D Program Option: (Fully Insured Program)

- Mutual of Omaha Life and Accidental Death and Dismemberment Plan (Component Document 9)

Short Term Disability Program Option: (Fully Insured Program)

- Mutual of Omaha Short Term Disability Insurance (Component 10)

Long Term Disability Program Option: (Fully Insured Program)

- Mutual of Omaha Long Term Disability Insurance (Component Document 11)

Voluntary Accident Program Option: (Fully Insured Program)

- Mutual of Omaha Voluntary Accident Insurance (Component Document 12)

Voluntary Critical Illness Program Option: (Fully Insured Program)

- Mutual of Omaha Voluntary Group Critical Illness (Component Document13)

Component Document 1 – Plan A – NexusACO OA Plan

Payment Term and Description Table

Payment Term and Description	Amounts The Amount You Pay Designated Network, Network
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a health plan that was replaced by this Plan, any amount already applied to that annual deductible provision of the prior health plan will apply to the Annual Deductible provision under the Plan. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that	***Designated Network and Network*** $500 per Covered Person, not to exceed $1,000 for all Covered Persons in a family.

exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the Schedule of Benefits table.	
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of- Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • Charges that exceed Allowed Amounts, or the Recognized Amount when applicable. • Copayments or Coinsurance for any Covered Health Care Service shown in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Limit. • Copayments or Coinsurance for Covered Health Care Services provided under the *Outpatient Prescription Drug Plan*. Coupons: The Plan may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	***Designated Network and Network*** $7,350 per Covered Person, not to exceed $14,700 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Allowed Amount or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

Schedule of Benefits Table

When Benefit limits apply, the limit stated includes Covered Health Care Services provided at a Designated Network Benefit level unless otherwise specifically stated

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Services.

Covered Health Care Service	The Amount You Pay Designated Network, and Network	What are the Limitations & Exceptions?
Ambulance Services		
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation.		
Emergency Ambulance What is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance* – 20% *Air Ambulance* – 20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance* – Yes *Air Ambulance* – Yes	
Does the Annual Deductible Apply?	*Ground Ambulance* – Yes *Air Ambulance* – Yes	
Non-Emergency Ambulance What is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance* – 20% *Air Ambulance* – 20%	Ground or Air Ambulance, as the Claims Administrator determines appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of- Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance* – Yes *Air Ambulance* – Yes	
Does the Annual Deductible Apply?	*Ground Ambulance* – Yes *Air Ambulance* – Yes	
Acquired Brain Injury		
Hospital - Inpatient Stay and Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	
Outpatient Post-Acute Care, Transitional Services and Rehabilitative Services What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$35 per visit for a Primary Physician or $50 per visit for a Specialist Physician	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Cellular and Gene Therapy		

	Depending upon where the Covered Health Care Service is provided, Benefits will be the Same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Cellular or Gene Therapy services must be received from a Designated Provider.
Clinical Trials		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the Same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*
Congenital Heart Disease (CHD) Surgeries		
It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** – 20% ***Network*** – 40%	Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non- surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	
Does the Annual Deductible Apply?	***Designated Network*** – Yes ***Network*** – Yes	
Dental Services – Accident Only		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Diabetes Self-Management Items	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-	Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated

	management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Plan*.	under *Durable Medical Equipment (DME), Orthotics and Supplies*.
Durable Medical Equipment (DME), Orthotics and Supplies		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. Shoe orthotics are limited to one pair per year. Orthopedic shoes are limited to 1 pair per year. You must purchase, rent, or obtain the DME or orthotic from the vendor the Claims Administrator identifies or purchases it directly from the prescribing Network Physician.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Emergency Health Care Services - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20% after you pay $500 per visit.	**Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify the Claims Administrator within two business days or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Benefits will not be provided. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to

		pay the Emergency Health Care Services Copayment, Coinsurance and/or deductible. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Allowed Amounts for Emergency Health Care Services provided by an out- of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Enteral Nutrition		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Gender Dysphoria		
It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.		
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Plan*.	
Habilitative Services		
Inpatient	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Inpatient services limited per year as follows: • Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.
Outpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.		Outpatient therapies: • Physical therapy. • Occupational therapy. • Manipulative Treatment. • Speech therapy. • Post-cochlear implant

		aural therapy. For the above outpatient therapies: • Limits will be the same as, and combined with, those stated under Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Hearing Aids		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Benefits are limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase. Benefits are available for Covered Persons under age 19 only.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Home Health Care		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. For the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Hospice Care		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Hospital – Inpatient Stay		

What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** – 20% ***Network*** – 40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	
Does the Annual Deductible Apply?	***Designated Network*** – Yes ***Network*** – Yes	
Lab, X-Ray, and Diagnostic - Outpatient		
Lab Testing – Outpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
X-Ray and Other Diagnostic Testing - Outpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Major Diagnostic and Imaging - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Mental Health Care and Substance-Related and Addictive Disorders Services		
Inpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	

Outpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$35 per visit *Partial Hospitalization/Intensive Outpatient Treatment* 20% for Partial Hospitalization/ Intensive Outpatient Treatment	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes *Partial Hospitalization/ Intensive Outpatient Treatment* – Yes	
Does the Annual Deductible Apply?	No *Partial Hospitalization/ Intensive Outpatient Treatment* – Yes	
Virtual Behavioral Health Therapy and Coaching What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** AbleTo Therapy 360 None	There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Ostomy Supplies		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Pharmaceutical Products - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None in a Physician's Office 20% for all other places of service	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes, except when provided during a Physician office visit	
Physician Fees for Surgical and Medical Services		
What Is the Copayment, or Coinsurance You Pay? This May	***Designated Network*** None in a Physician's Office	Covered Health Care Services provided by an out- of-Network

Include a Copayment, Coinsurance or Both.	20% in all other places of service ***Network*** - 40%	Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however, Allowed Amounts will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	
Does the Annual Deductible Apply?	***Designated Network*** No, in a Physician's office Yes, in all other places of service ***Network*** – Yes	
Physician's Office Services – Sickness and Injury		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	For Covered Persons under the age of 19: *Designated Network: Child Visits covered 100%* *Network:* $55 per visit for a Primary Care Physician office visit or $70 per visit for a Specialist office visit For Covered Persons age 19 and older: *Designated Network:* $35 per visit for a Primary Care Physician office visit or $50 per visit for a Specialist office visit *Network:* $55 per visit for a Primary Care Physician office visit or $70 per visit for a Specialist office visit For all ages: None for allergy injections when no other service is provided during the office visit	Copayment/ Coinsurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic – Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*. • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment*. • Habilitative therapy
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	

		services described under *Habilitative Services*.
Pregnancy – Maternity Services		
It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.		
	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Preimplantation Genetic Testing (PGT) and Related Services		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to $10,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Preventative Care Services		
Physician office services What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Lab, X-Ray, or other preventive tests What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Breast pumps What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	

Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Prosthetic Devices		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase. Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998.*
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Reconstructive Procedures		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$50 per visit	Limited to 35 visits per year for physical therapy, occupational therapy, speech therapy and spinal manipulation combined. This visit limit does not apply for treatment of Autism Spectrum Disorder or developmental delay.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** None in a Physician's Office 20% in all other places of service ***Network*** - 40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	
Does the Annual Deductible Apply?	***Designated Network*** No, in a Physician's office Yes, in all other places of service ***Network*** – Yes	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to 60 days per year.

Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Surgery - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** – 20% ***Network*** – 40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	
Does the Annual Deductible Apply?	***Designated Network*** – Yes ***Network*** – Yes	
Temporomandibular Joint (TMJ) Services		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Therapeutic Treatments - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Transplantation Services		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Transplantation services must be received from a Designated Provider. The Claims Administrator does not require that cornea transplants be received from a Designated Provider.
Urgent Care Center Services		

What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$75 per visit	Copayments/Coinsurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments – Outpatient*
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Virtual Care Services		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Vision Exams		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$50 per visit	Limited to 1 exam every year.

Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Wigs		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to $500 every 36 months.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	

Outpatient Prescription Drug Schedule of Benefits Table

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits.

Outpatient Prescription Drug Benefits	What is the Amount You Pay? This May Include a Copayment, Coinsurance or Both.	Description and Supply Limits
Specialty Prescription Drug Products		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	*For a Tier 1 Specialty Prescription Drug Product:* $10.00 per Prescription Order or Refill. *For a Tier 2 Specialty Prescription Drug Product:* $50.00 per Prescription Order or Refill. *For a Tier 3 Specialty Prescription Drug Product:* $90.00 per Prescription Order or Refill.	The following supply limits apply. • As written by the provider, up to a consecutive 31- day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply , the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered.

		Supply limits apply to Specialty Prescription Drug Products obtained at Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.
Prescription Drugs from a Retail Network Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	***For a Tier 1 Prescription Drug Product:*** 1-31 days: $10.00 per Prescription Order or Refill. 32-62 days: $20.00 per Prescription Order or Refill. 63-90 days: $25.00 per Prescription Order or Refill. ***For a Tier 2 Prescription Drug Product:*** 1-31 days: $50.00 per Prescription Order or Refill. 32-62 days: $100.00 per Prescription Order or Refill. 63-90 days: $125.00 per Prescription Order or Refill. ***For a Tier 3 Prescription Drug Product:*** 1-31 days: $90.00 per Prescription Order or Refill. 32-62 days: $180.00 per Prescription Order or Refill. 63-90 days: $225.00 per Prescription Order or Refill.	The following supply limits apply: • As written by the provider, up to a consecutive 90- day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31- day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered.
Prescription Drug Products from a Mail Order Network Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.	For up to a 90-day supply at a mail order Network Pharmacy, you pay: *For a Tier 1 Prescription Drug Product:* $25.00 per Prescription Order or Refill. *For a Tier 2 Prescription Drug Product:* $125.00 per Prescription Order or Refill. *For a Tier 3 Prescription Drug Product:* 225.00 per Prescription	The following supply limits apply: • The Claims Administrator may allow a 31-day fill at the mail order Network Pharmacy for certain Prescription Drug Products for the Copayment and/or Coinsurance you would pay at a retail Network Pharmacy.

	Order or Refill.	You may find out whether a 31-day fill of Prescription Drug Product is available through the mail order Pharmacy for a retail Network Pharmacy Copayment and/or Coinsurance by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Copayment and/or Coinsurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.

Component Document 2 – Plan B – NexusACO OA Plan

Payment Term and Description Table

Payment Term and Description	Amounts The Amount You Pay Designated Network, Network
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will	***Designated Network and Network*** $1,000 per Covered Person, not to exceed $2,000 for all Covered Persons in a family.

be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a health plan that was replaced by this Plan, any amount already applied to that annual deductible provision of the prior health plan will apply to the Annual Deductible provision under the Plan. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the Schedule of Benefits table.	
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of- Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • Charges that exceed Allowed Amounts, or the Recognized Amount when applicable. • Copayments or Coinsurance for any Covered Health Care Service shown in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Limit. • Copayments or Coinsurance for Covered Health Care Services provided under the *Outpatient Prescription Drug Plan*. Coupons: The Plan may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	***Designated Network and Network*** $7,350 per Covered Person, not to exceed $14,700 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Allowed Amount or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	
Coinsurance	
Coinsurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.	

Schedule of Benefits Table

When Benefit limits apply, the limit stated includes Covered Health Care Services provided at a Designated Network Benefit level unless otherwise specifically stated

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Services.

Covered Health Care Service	The Amount You Pay Designated Network, and Network	What are the Limitations & Exceptions?
Ambulance Services		
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation.		
Emergency Ambulance What is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance* – 20% *Air Ambulance* – 20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance* – Yes *Air Ambulance* – Yes	
Does the Annual Deductible Apply?	*Ground Ambulance* – Yes *Air Ambulance* – Yes	
Non-Emergency Ambulance What is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance* – 20% *Air Ambulance* – 20%	Ground or Air Ambulance, as the Claims Administrator determines appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of- Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance* – Yes *Air Ambulance* – Yes	
Does the Annual Deductible Apply?	*Ground Ambulance* – Yes *Air Ambulance* – Yes	
Acquired Brain Injury		
Hospital - Inpatient Stay and Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	
Outpatient Post-Acute Care, Transitional Services and Rehabilitative Services What Is the Copayment, or Coinsurance You Pay? This May	$35 per visit for a Primary Physician or $80 per visit for a Specialist Physician	

Include a Copayment, Coinsurance or Both.		
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Cellular and Gene Therapy		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the Same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Cellular or Gene Therapy services must be received from a Designated Provider.
Clinical Trials		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the Same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*
Congenital Heart Disease (CHD) Surgeries		
It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** – 20% ***Network*** – 40%	Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non- surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	
Does the Annual Deductible Apply?	***Designated Network*** – Yes ***Network*** – Yes	
Dental Services – Accident Only		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic	

	eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Diabetes Self-Management Items	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Plan*.	Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.
Durable Medical Equipment (DME), Orthotics and Supplies		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. Shoe orthotics are limited to one pair per year. Orthopedic shoes are limited to 1 pair per year. You must purchase, rent, or obtain the DME or orthotic from the vendor the Claims Administrator identifies or purchases it directly from the prescribing Network Physician.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Emergency Health Care Services - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20% after you pay $500 per visit.	**Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify the Claims Administrator within two business days or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Benefits will not be provided.

		If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Copayment, Coinsurance and/or deductible. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Allowed Amounts for Emergency Health Care Services provided by an out- of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Enteral Nutrition		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Gender Dysphoria		
It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.		
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Plan*.	
Habilitative Services		
Inpatient	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Inpatient services limited per year as follows: • Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.

Outpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.		Outpatient therapies: • Physical therapy. • Occupational therapy. • Manipulative Treatment. • Speech therapy. • Post-cochlear implant aural therapy. For the above outpatient therapies: • Limits will be the same as, and combined with, those stated under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.*
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Hearing Aids		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Benefits are limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase. Benefits are available for Covered Persons under age 19 only.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Home Health Care		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. For the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Hospice Care		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	

Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Hospital – Inpatient Stay		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$1,500 per day, not to exceed $4,500 per admission	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Lab, X-Ray, and Diagnostic - Outpatient		
Lab Testing – Outpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
X-Ray and Other Diagnostic Testing - Outpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Major Diagnostic and Imaging - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$500	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Mental Health Care and Substance-Related and Addictive Disorders Services		
Inpatient What Is the Copayment, or Coinsurance You Pay? This May	$1,500 per day, not to exceed $4,500 per admission	

Include a Copayment, Coinsurance or Both.		
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Outpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$35 per visit *Partial Hospitalization/Intensive Outpatient Treatment* 20% for Partial Hospitalization/ Intensive Outpatient Treatment	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes *Partial Hospitalization/ Intensive Outpatient Treatment* – Yes	
Does the Annual Deductible Apply?	No *Partial Hospitalization/ Intensive Outpatient Treatment* – Yes	
Virtual Behavioral Health Therapy and Coaching What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** AbleTo Therapy 360 None	There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Ostomy Supplies		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Pharmaceutical Products - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None in a Physician's Office 20% for all other places of service	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	

Does the Annual Deductible Apply?	Yes, except when provided during a Physician office visit	
Physician Fees for Surgical and Medical Services		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** None in a Physician's Office 20% in all other places of service ***Network*** - 40%	Covered Health Care Services provided by an out- of-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance, and applicable deductible) as if those services were provided by a Network provider; however, Allowed Amounts will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	
Does the Annual Deductible Apply?	***Designated Network*** No, in a Physician's office Yes, in all other places of service ***Network*** – Yes	
Physician's Office Services – Sickness and Injury		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	For Covered Persons under the age of 19: *Designated Network: Child Visits covered 100%* *Network:* $55 per visit for a Primary Care Physician office visit or $100 per visit for a Specialist office visit For Covered Persons age 19 and older: *Designated Network:* $35 per visit for a Primary Care Physician office visit or $80 per visit for a Specialist office visit *Network:* $55 per visit for a Primary Care Physician office visit or $100 per visit for a Specialist office visit For all ages: None for allergy injections when no other service is provided during the office visit	Copayment/ Coinsurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic – Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic*

		Treatments - Outpatient. • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment*. • Habilitative therapy services described under *Habilitative Services*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Pregnancy – Maternity Services		
It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.		
	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Preimplantation Genetic Testing (PGT) and Related Services		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to $10,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Preventative Care Services		
Physician office services What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Lab, X-Ray, or other preventive tests	None	

What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.		
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Breast pumps What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Prosthetic Devices		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase. Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998.*
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Reconstructive Procedures		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$80 per visit	Limited to 35 visits per year for physical therapy, occupational therapy, speech therapy and spinal manipulation combined. This visit limit does not apply for treatment of Autism Spectrum Disorder or developmental delay.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
What Is the Copayment, or Coinsurance You Pay? This May	***Designated Network*** None in a Physician's Office 20% in all other places of service	

Include a Copayment, Coinsurance or Both.	***Network*** - 40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	
Does the Annual Deductible Apply?	***Designated Network*** No, in a Physician's office Yes, in all other places of service ***Network*** – Yes	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to 60 days per year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Surgery - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** – 20% ***Network*** – 40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	
Does the Annual Deductible Apply?	***Designated Network*** – Yes ***Network*** – Yes	
Temporomandibular Joint (TMJ) Services		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Therapeutic Treatments - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Transplantation Services		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those	Transplantation services must be received from a Designated Provider. The Claims

	stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Administrator does not require that cornea transplants be received from a Designated Provider.
Urgent Care Center Services		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$100 per visit	Copayments/Coinsurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments – Outpatient*
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Virtual Care Services		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	

Vision Exams		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$50 per visit	Limited to 1 exam every year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Wigs		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to $500 every 36 months.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	

Outpatient Prescription Drug Schedule of Benefits Table

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits.

Outpatient Prescription Drug Benefits	What is the Amount You Pay? This May Include a Copayment, Coinsurance or Both.	Description and Supply Limits
Specialty Prescription Drug Products		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	*For a Tier 1 Specialty Prescription Drug Product:* $10.00 per Prescription Order or Refill. *For a Tier 2 Specialty Prescription Drug Product:* $50.00 per Prescription Order or Refill. *For a Tier 3 Specialty Prescription Drug Product:* $90.00 per Prescription Order or Refill.	The following supply limits apply. • As written by the provider, up to a consecutive 31- day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered. If a Specialty Prescription Drug Product is provided for less than or

		more than a 31-day supply , the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered. Supply limits apply to Specialty Prescription Drug Products obtained at Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.
Prescription Drugs from a Retail Network Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	***For a Tier 1 Prescription Drug Product:*** 1-31 days: $10.00 per Prescription Order or Refill. 32-62 days: $20.00 per Prescription Order or Refill. 63-90 days: $25.00 per Prescription Order or Refill. ***For a Tier 2 Prescription Drug Product:*** 1-31 days: $50.00 per Prescription Order or Refill. 32-62 days: $100.00 per Prescription Order or Refill. 63-90 days: $125.00 per Prescription Order or Refill. ***For a Tier 3 Prescription Drug Product:*** 1-31 days: $90.00 per Prescription Order or Refill. 32-62 days: $180.00 per Prescription Order or Refill. 63-90 days: $225.00 per Prescription Order or Refill.	The following supply limits apply: • As written by the provider, up to a consecutive 90- day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31- day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered.
Prescription Drug Products from a Mail Order Network Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or	For up to a 90-day supply at a mail order Network Pharmacy, you pay: *For a Tier 1 Prescription Drug Product:* $25.00 per Prescription Order or Refill.	The following supply limits apply: • The Claims Administrator may allow a 31-day fill at the mail order Network Pharmacy for certain Prescription Drug Products

Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.	*For a Tier 2 Prescription Drug Product:* $125.00 per Prescription Order or Refill. *For a Tier 3 Prescription Drug Product:* $225.00 per Prescription Order or Refill.	for the Copayment and/or Coinsurance you would pay at a retail Network Pharmacy. You may find out whether a 31-day fill of Prescription Drug Product is available through the mail order Pharmacy for a retail Network Pharmacy Copayment and/or Coinsurance by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Copayment and/or Coinsurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.

Component Document 3 – Plan C – NexusACO OA Plan

Payment Term and Description Table

Payment Term and Description	Amounts The Amount You Pay Designated Network, Network
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Care Services under the Plan as indicated in this *Schedule of Benefits*, including Covered Health Care Services provided under the *Outpatient Prescription Drug Plan*.	***Designated Network and Network*** $3,000 per Covered Person, not to exceed $6,000 for all Covered Persons in a family.

Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a health plan that was replaced by this Plan, any amount already applied to that annual deductible provision of the prior health plan will apply to the Annual Deductible provision under the Plan. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the Schedule of Benefits table.	
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of- Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • Charges that exceed Allowed Amounts, or the Recognized Amount when applicable. • Copayments or Coinsurance for any Covered Health Care Service shown in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Limit. • Copayments or Coinsurance for Covered Health Care Services provided under the *Outpatient Prescription Drug Plan*. Coupons: The Plan may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	***Designated Network and Network*** $6,650 per Covered Person, not to exceed $13,300 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.
Copayment	
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Allowed Amount or the Recognized Amount when applicable.	

Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.
Coinsurance
Coinsurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.

Schedule of Benefits Table

When Benefit limits apply, the limit stated includes Covered Health Care Services provided at a Designated Network Benefit level unless otherwise specifically stated

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Services.

Covered Health Care Service	The Amount You Pay Designated Network, and Network	What are the Limitations & Exceptions?
Ambulance Services		
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation.		
Emergency Ambulance What is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance* – 20% *Air Ambulance* – 20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance* – Yes *Air Ambulance* – Yes	
Does the Annual Deductible Apply?	*Ground Ambulance* – Yes *Air Ambulance* – Yes	
Non-Emergency Ambulance What is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance* – 20% *Air Ambulance* – 20%	Ground or Air Ambulance, as the Claims Administrator determines appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of- Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance* – Yes *Air Ambulance* – Yes	
Does the Annual Deductible Apply?	*Ground Ambulance* – Yes *Air Ambulance* – Yes	
Acquired Brain Injury		
Hospital - Inpatient Stay and Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	20%	

Outpatient Post-Acute Care, Transitional Services and Rehabilitative Services What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Cellular and Gene Therapy		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the Same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Cellular or Gene Therapy services must be received from a Designated Provider.
Clinical Trials		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the Same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*
Congenital Heart Disease (CHD) Surgeries		
It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** – 20% ***Network*** – 40%	Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non- surgical management of CHD will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	
Does the Annual Deductible Apply?	***Designated Network*** – Yes ***Network*** – Yes	
Dental Services – Accident Only		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Diabetes Services		

Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Diabetes Self-Management Items	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Plan*.	Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies.*
Durable Medical Equipment (DME), Orthotics and Supplies		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. Shoe orthotics are limited to one pair per year. Orthopedic shoes are limited to 1 pair per year. You must purchase, rent, or obtain the DME or orthotic from the vendor the Claims Administrator identifies or purchases it directly from the prescribing Network Physician.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Emergency Health Care Services - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	**Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify the Claims Administrator within two business days or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the

		date the Claims Administrator decides a transfer is medically appropriate, Benefits will not be provided. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Copayment, Coinsurance and/or deductible. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Allowed Amounts for Emergency Health Care Services provided by an out- of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits.*
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Enteral Nutrition		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Gender Dysphoria		
It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.		
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Plan*.	
Habilitative Services		
Inpatient	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health	Inpatient services limited per year as follows: • Limit will be the same as, and combined with,

	Care Service category in this *Schedule of Benefits*.	those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.
Outpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.		Outpatient therapies: • Physical therapy. • Occupational therapy. • Manipulative Treatment. • Speech therapy. • Post-cochlear implant aural therapy. For the above outpatient therapies: • Limits will be the same as, and combined with, those stated under Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Hearing Aids		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Benefits are limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase. Benefits are available for Covered Persons under age 19 only.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Home Health Care		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. For the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Hospice Care		
What Is the Copayment, or Coinsurance You Pay? This May	20%	

Include a Copayment, Coinsurance or Both.		
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Hospital – Inpatient Stay		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** – 20% ***Network*** – 40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	
Does the Annual Deductible Apply?	***Designated Network*** – Yes ***Network*** – Yes	
Lab, X-Ray, and Diagnostic - Outpatient		
Lab Testing – Outpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
X-Ray and Other Diagnostic Testing - Outpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Major Diagnostic and Imaging - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Mental Health Care and Substance-Related and Addictive Disorders Services		
Inpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	

Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Outpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20% *Partial Hospitalization/Intensive Outpatient Treatment* 20% for Partial Hospitalization/ Intensive Outpatient Treatment	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes *Partial Hospitalization/ Intensive Outpatient Treatment* – Yes	
Does the Annual Deductible Apply?	Yes *Partial Hospitalization/ Intensive Outpatient Treatment* – Yes	
Virtual Behavioral Health Therapy and Coaching What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** AbleTo Therapy 360 None	There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Ostomy Supplies		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Pharmaceutical Products - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Physician Fees for Surgical and Medical Services		
What Is the Copayment, or Coinsurance You Pay? This May	***Designated Network*** -20% ***Network*** - 40%	Covered Health Care Services provided by an out- of-Network

Include a Copayment, Coinsurance or Both.		Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however, Allowed Amounts will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	
Does the Annual Deductible Apply?	***Designated Network*** - Yes ***Network*** – Yes	
Physician's Office Services – Sickness and Injury		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None for allergy injections when no other service is provided during the office visit ***Designated Network****: - 20%* ***Network*** *– 40%*	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** - Yes ***Network*** – Yes	
Does the Annual Deductible Apply?	***Designated Network*** - Yes ***Network*** – Yes	
Pregnancy – Maternity Services		
It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.		
	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Preimplantation Genetic Testing (PGT) and Related Services		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to $10,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Preventative Care Services		
Physician office services What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	

Does the Annual Deductible Apply?	No	
Lab, X-Ray, or other preventive tests What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Breast pumps What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Prosthetic Devices		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit in the same manner as a purchase. Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998.*
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Reconstructive Procedures		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to 35 visits per year for physical therapy, occupational therapy, speech therapy and spinal manipulation combined. This visit limit does not apply for treatment of Autism Spectrum Disorder or developmental delay.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
What Is the Copayment, or Coinsurance You Pay? This May	***Designated Network*** - 20% ***Network*** - 40%	

Include a Copayment, Coinsurance or Both.		
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	
Does the Annual Deductible Apply?	***Designated Network*** - Yes ***Network*** – Yes	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to 60 days per year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Surgery - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** – 20% ***Network*** – 40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	
Does the Annual Deductible Apply?	***Designated Network*** – Yes ***Network*** – Yes	
Temporomandibular Joint (TMJ) Services		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Therapeutic Treatments - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Transplantation Services		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Transplantation services must be received from a Designated Provider. The Claims Administrator does not require that cornea transplants be received from a Designated Provider.
Urgent Care Center Services		
What Is the Copayment, or Coinsurance You Pay? This May	20%	

Include a Copayment, Coinsurance or Both.		
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Virtual Care Services		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Vision Exams		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to 1 exam every year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Wigs		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to $500 every 36 months.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	

Outpatient Prescription Drug Schedule of Benefits Table

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits.

Outpatient Prescription Drug Benefits	What is the Amount You Pay? This May Include a Copayment, Coinsurance or Both.	Description and Supply Limits
Specialty Prescription Drug Products		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All	For a Tier 1 Specialty Prescription Drug Product: 20% of the Prescription Drug Charge. For a Tier 2 Specialty	The following supply limits apply. • As written by the provider, up to a consecutive 31- day supply of a Specialty

Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	Prescription Drug Product: 20% of the Prescription Drug Charge. For a Tier 3 Specialty Prescription Drug Product: 20% of the Prescription Drug Charge.	Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply , the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered. Supply limits apply to Specialty Prescription Drug Products obtained at Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.
Prescription Drugs from a Retail Network Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	*For a Tier 1 Prescription Drug Product:* 20% of the Prescription Drug Charge. *For a Tier 2 Prescription Drug Product:* 20% of the Prescription Drug Charge. *For a Tier 3 Prescription Drug Product:* 20% of the Prescription Drug Charge.	The following supply limits apply: • As written by the provider, up to a consecutive 90- day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31- day supply, the Copayment and/or Coinsurance that applies will reflect

		the number of days dispensed or days the drug will be delivered.
Prescription Drug Products from a Mail Order Network Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.	For up to a 90-day supply at a mail order Network Pharmacy, you pay: *For a Tier 1 Prescription Drug Product:* 20% of the Prescription Drug Charge. *For a Tier 2 Prescription Drug Product:* 20% of the Prescription Drug Charge. *For a Tier 3 Prescription Drug Product:* 20% of the Prescription Drug Charge.	The following supply limits apply: • The Claims Administrator may allow a 31-day fill at the mail order Network Pharmacy for certain Prescription Drug Products for the Copayment and/or Coinsurance you would pay at a retail Network Pharmacy. You may find out whether a 31-day fill of Prescription Drug Product is available through the mail order Pharmacy for a retail Network Pharmacy Copayment and/or Coinsurance by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Copayment and/or Coinsurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.

Component Document 4 – Plan D – NexusACO OA Plan

Payment Term and Description Table

Payment Term and Description	Amounts The Amount You Pay Designated Network, Network
Annual Deductible	
The amount you pay for Covered Health Care Services per year before you are eligible to receive Benefits. Coupons: The Plan Sponsor may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Annual Deductible. Amounts paid toward the Annual Deductible for Covered Health Care Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. When a Covered Person was previously covered under a health plan that was replaced by this Plan, any amount already applied to that annual deductible provision of the prior health plan will apply to the Annual Deductible provision under the Plan. The amount that is applied to the Annual Deductible is calculated on the basis of the Allowed Amount or the Recognized Amount when applicable. The Annual Deductible does not include any amount that exceeds the Allowed Amount. Details about the way in which Allowed Amounts are determined appear at the end of the Schedule of Benefits table.	***Designated Network and Network*** $5,000 per Covered Person, not to exceed $10,000 for all Covered Persons in a family.
Out-of-Pocket Limit	
The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of- Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that year. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table. The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following: • Any charges for non-Covered Health Care Services. • Charges that exceed Allowed Amounts, or the Recognized Amount when applicable. • Copayments or Coinsurance for any Covered Health Care Service shown in the *Schedule of Benefits* table that does not apply to the Out-of-Pocket Limit. • Copayments or Coinsurance for Covered Health Care Services provided under the *Outpatient Prescription Drug Plan*. Coupons: The Plan may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.	***Designated Network and Network*** $7,350 per Covered Person, not to exceed $14,700 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.

Copayment
Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Care Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Care Service. Please note that for Covered Health Care Services, you are responsible for paying the lesser of: • The applicable Copayment. • The Allowed Amount or the Recognized Amount when applicable. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.
Coinsurance
Coinsurance is the amount you pay (calculated as a percentage of the Allowed Amount or the Recognized Amount when applicable) each time you receive certain Covered Health Care Services. Details about the way in which Allowed Amounts are determined appear at the end of the *Schedule of Benefits* table.

Schedule of Benefits Table

When Benefit limits apply, the limit stated includes Covered Health Care Services provided at a Designated Network Benefit level unless otherwise specifically stated

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on Allowed Amounts or, for specific Covered Health Services.

Covered Health Care Service	The Amount You Pay Designated Network, and Network	What are the Limitations & Exceptions?
Ambulance Services		
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation.		
Emergency Ambulance What is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance* – 20% *Air Ambulance* – 20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance* – Yes *Air Ambulance* – Yes	
Does the Annual Deductible Apply?	*Ground Ambulance* – Yes *Air Ambulance* – Yes	
Non-Emergency Ambulance What is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	*Ground Ambulance* – 20% *Air Ambulance* – 20%	Ground or Air Ambulance, as the Claims Administrator determines appropriate. Allowed Amounts for Air Ambulance transport provided by an out-of- Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.

Does the Amount You Pay Apply to the Out-of-Pocket Limit?	*Ground Ambulance* – Yes *Air Ambulance* – Yes	
Does the Annual Deductible Apply?	*Ground Ambulance* – Yes *Air Ambulance* – Yes	
Acquired Brain Injury		
Hospital - Inpatient Stay and Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	
Outpatient Post-Acute Care, Transitional Services and Rehabilitative Services What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$35 per visit for a Primary Physician or $80 per visit for a Specialist Physician	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Cellular and Gene Therapy		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the Same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Cellular or Gene Therapy services must be received from a Designated Provider.
Clinical Trials		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	Depending upon the Covered Health Care Service, Benefit limits are the same as those stated under the specific Benefit category in this *Schedule of Benefits.*
Congenital Heart Disease (CHD) Surgeries		
It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** – 20% ***Network*** – 40%	Benefits under this section include only the inpatient facility charges for the CHD surgery. Depending upon where the Covered Health Care Service is provided, Benefits for diagnostic services, cardiac catheterization and non- surgical management of CHD will be the

Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.
Does the Annual Deductible Apply?	***Designated Network*** – Yes ***Network*** – Yes	
Dental Services – Accident Only		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Diabetes Services		
Diabetes Self-Management and Training/Diabetic Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management and training/diabetic eye exams/foot care will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Diabetes Self-Management Items	Depending upon where the Covered Health Care Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment (DME), Orthotics and Supplies* and in the *Outpatient Prescription Drug Plan*.	Benefits for diabetes equipment that meets the definition of DME are subject to the limit stated under *Durable Medical Equipment (DME), Orthotics and Supplies*.
Durable Medical Equipment (DME), Orthotics and Supplies		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Benefits are limited to a single purchase of a type of DME or orthotic every three years. Repair and/or replacement of DME or orthotics would apply to this limit in the same manner as a purchase. Shoe orthotics are limited to one pair per year. Orthopedic shoes are limited to 1 pair per year. You must purchase, rent, or obtain the DME or orthotic from the vendor the Claims Administrator identifies or purchases it directly from the prescribing Network Physician.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Emergency Health Care Services - Outpatient		

What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance, or Both.	20% after you pay $500 per visit.	**Note:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must notify the Claims Administrator within two business days or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the out-of-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Benefits will not be provided. If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits provided as described under *Hospital - Inpatient Stay* will apply. You will not have to pay the Emergency Health Care Services Copayment, Coinsurance and/or deductible. This does not apply to services provided to stabilize an Emergency after admission to a Hospital. Allowed Amounts for Emergency Health Care Services provided by an out- of-Network provider will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Enteral Nutrition		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Gender Dysphoria		

It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.		
	Network Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* and in the *Outpatient Prescription Drug Plan*.	
Habilitative Services		
Inpatient	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Inpatient services limited per year as follows: • Limit will be the same as, and combined with, those stated under *Skilled Nursing Facility/Inpatient Rehabilitation Services*.
Outpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.		Outpatient therapies: • Physical therapy. • Occupational therapy. • Manipulative Treatment. • Speech therapy. • Post-cochlear implant aural therapy. For the above outpatient therapies: • Limits will be the same as, and combined with, those stated under Rehabilitation Services – Outpatient Therapy and Manipulative Treatment.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Hearing Aids		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Benefits are limited to a single purchase per hearing impaired ear every three years. Repair and/or replacement of a hearing aid would apply to this limit in the same manner as a purchase. Benefits are available for Covered Persons under age 19 only.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Home Health Care		

What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to 60 visits per year. One visit equals up to four hours of skilled care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion. For the administration of intravenous infusion, you must receive services from a provider the Claims Administrator identifies.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Hospice Care		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Hospital – Inpatient Stay		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$1,500 per day, not to exceed $4,500 per admission	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Lab, X-Ray, and Diagnostic - Outpatient		
Lab Testing – Outpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Limited to 18 Presumptive Drug Tests per year. Limited to 18 Definitive Drug Tests per year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
X-Ray and Other Diagnostic Testing - Outpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	

Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Major Diagnostic and Imaging - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$500	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Mental Health Care and Substance-Related and Addictive Disorders Services		
Inpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$1,500 per day, not to exceed $4,500 per admission	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Outpatient What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$35 per visit *Partial Hospitalization/Intensive Outpatient Treatment* 20% for Partial Hospitalization/ Intensive Outpatient Treatment	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes *Partial Hospitalization/ Intensive Outpatient Treatment* – Yes	
Does the Annual Deductible Apply?	No *Partial Hospitalization/ Intensive Outpatient Treatment* – Yes	
Virtual Behavioral Health Therapy and Coaching What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** AbleTo Therapy 360 None	There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	

Does the Annual Deductible Apply?	No	
Ostomy Supplies		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Pharmaceutical Products - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None in a Physician's Office 20% for all other places of service	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes, except when provided during a Physician office visit	
Physician Fees for Surgical and Medical Services		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** None in a Physician's Office 20% in all other places of service ***Network*** - 40%	Covered Health Care Services provided by an out- of-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however, Allowed Amounts will be determined as described below under *Allowed Amounts* in this *Schedule of Benefits*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	
Does the Annual Deductible Apply?	***Designated Network*** No, in a Physician's office Yes, in all other places of service ***Network*** – Yes	
Physician's Office Services – Sickness and Injury		

What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	For Covered Persons under the age of 19: *Designated Network: Child Visits covered 100%* *Network:* $55 per visit for a Primary Care Physician office visit or $100 per visit for a Specialist office visit For Covered Persons age 19 and older: *Designated Network:* $35 per visit for a Primary Care Physician office visit or $80 per visit for a Specialist office visit *Network:* $55 per visit for a Primary Care Physician office visit or $100 per visit for a Specialist office visit For all ages: None for allergy injections when no other service is provided during the office visit	Copayment/ Coinsurance and any deductible for the following services also apply when the Covered Health Care Service is performed in a Physician's office: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic – Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient.* • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments - Outpatient*. • Rehabilitation therapy procedures described under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment*. • Habilitative therapy services described under *Habilitative Services*.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Pregnancy – Maternity Services		
It is important that you notify the Claims Administrator regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.		
	Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits* except that an Annual Deductible will not apply for a	

	newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Preimplantation Genetic Testing (PGT) and Related Services		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to $10,000 per Covered Person during the entire period of time he or she is enrolled for coverage under the Plan. This limit does not include Preimplantation Genetic Testing (PGT) for the specific genetic disorder.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Preventative Care Services		
Physician office services What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Lab, X-Ray, or other preventive tests What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Breast pumps What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	No	
Does the Annual Deductible Apply?	No	
Prosthetic Devices		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Benefits are limited to a single purchase of each type of prosthetic device every three years. Repair and/or replacement of a prosthetic device would apply to this limit

		in the same manner as a purchase. Once this limit is reached, Benefits continue to be available for items required by the *Women's Health and Cancer Rights Act of 1998.*
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Reconstructive Procedures		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits.*	
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$80 per visit	Limited to 35 visits per year for physical therapy, occupational therapy, speech therapy and spinal manipulation combined. This visit limit does not apply for treatment of Autism Spectrum Disorder or developmental delay.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** None in a Physician's Office 20% in all other places of service ***Network*** - 40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	
Does the Annual Deductible Apply?	***Designated Network*** No, in a Physician's office Yes, in all other places of service ***Network*** – Yes	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to 60 days per year.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Surgery - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	***Designated Network*** – 20% ***Network*** – 40%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	***Designated Network*** – Yes ***Network*** – Yes	

Does the Annual Deductible Apply?	***Designated Network*** – Yes ***Network*** – Yes	
Temporomandibular Joint (TMJ) Services		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	
Therapeutic Treatments - Outpatient		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	
Transplantation Services		
	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Transplantation services must be received from a Designated Provider. The Claims Administrator does not require that cornea transplants be received from a Designated Provider.
Urgent Care Center Services		

What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$100 per visit	Copayments/Coinsurance and any deductible for the following services also apply when the Covered Health Care Service is performed at an Urgent Care Center: • Lab, radiology/X-rays and other diagnostic services described under *Lab, X-Ray and Diagnostic - Outpatient*. • Major diagnostic and nuclear medicine described under *Major Diagnostic and Imaging - Outpatient*. • Outpatient Pharmaceutical Products described under *Pharmaceutical Products - Outpatient*. • Diagnostic and therapeutic scopic procedures described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic*. • Outpatient surgery procedures described under *Surgery - Outpatient*. • Outpatient therapeutic procedures described under *Therapeutic Treatments – Outpatient*
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Virtual Care Services		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	None	Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Vision Exams		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	$50 per visit	Limited to 1 exam every year.

Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	No	
Wigs		
What Is the Copayment, or Coinsurance You Pay? This May Include a Copayment, Coinsurance or Both.	20%	Limited to $500 every 36 months.
Does the Amount You Pay Apply to the Out-of-Pocket Limit?	Yes	
Does the Annual Deductible Apply?	Yes	

Outpatient Prescription Drug Schedule of Benefits Table

The amounts you are required to pay as shown below in the *Outpatient Prescription Drug Schedule of Benefits* are based on the Prescription Drug Charge for Network Benefits.

Outpatient Prescription Drug Benefits	What is the Amount You Pay? This May Include a Copayment, Coinsurance or Both.	Description and Supply Limits
Specialty Prescription Drug Products		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	*For a Tier 1 Specialty Prescription Drug Product:* $10.00 per Prescription Order or Refill. *For a Tier 2 Specialty Prescription Drug Product:* $50.00 per Prescription Order or Refill. *For a Tier 3 Specialty Prescription Drug Product:* $90.00 per Prescription Order or Refill.	The following supply limits apply. • As written by the provider, up to a consecutive 31- day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered. If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply , the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered.

		Supply limits apply to Specialty Prescription Drug Products obtained at Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.
Prescription Drugs from a Retail Network Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact the Claims Administrator at www.myuhc.com or the telephone number on your ID card to find out tier placement.	***For a Tier 1 Prescription Drug Product:*** 1-31 days: $10.00 per Prescription Order or Refill. 32-62 days: $20.00 per Prescription Order or Refill. 63-90 days: $25.00 per Prescription Order or Refill. ***For a Tier 2 Prescription Drug Product:*** 1-31 days: $50.00 per Prescription Order or Refill. 32-62 days: $100.00 per Prescription Order or Refill. 63-90 days: $125.00 per Prescription Order or Refill. ***For a Tier 3 Prescription Drug Product:*** 1-31 days: $90.00 per Prescription Order or Refill. 32-62 days: $180.00 per Prescription Order or Refill. 63-90 days: $225.00 per Prescription Order or Refill.	The following supply limits apply: • As written by the provider, up to a consecutive 90- day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. • A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31- day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered.
Prescription Drug Products from a Mail Order Network Pharmacy		
Your Copayment and/or Coinsurance is determined by the PDL Management Committee's tier placement of the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are placed on Tier 1, Tier 2 or Tier 3. Please contact us at www.myuhc.com or the telephone number on your ID card to find out tier status.	For up to a 90-day supply at a mail order Network Pharmacy, you pay: *For a Tier 1 Prescription Drug Product:* $25.00 per Prescription Order or Refill. *For a Tier 2 Prescription Drug Product:* $125.00 per Prescription Order or Refill. *For a Tier 3 Prescription Drug Product:* 225.00 per Prescription	The following supply limits apply: • The Claims Administrator may allow a 31-day fill at the mail order Network Pharmacy for certain Prescription Drug Products for the Copayment and/or Coinsurance you would pay at a retail Network Pharmacy.

	Order or Refill.	You may find out whether a 31-day fill of Prescription Drug Product is available through the mail order Pharmacy for a retail Network Pharmacy Copayment and/or Coinsurance by contacting the Claims Administrator at www.myuhc.com or the telephone number on your ID card. You may be required to fill the first Prescription Drug Product order and obtain 2 refills through a retail pharmacy before using a mail order Network Pharmacy. To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a Copayment and/or Coinsurance based on the day supply dispensed for any Prescription Orders or Refills sent to the mail order pharmacy. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.

Component Document 5 and 6 – Dental Program

United Concordia

Covered Services
Benefits and any applicable Coinsurance, Deductibles, Annual Maximums, Lifetime Maximums, Out-of-Pocket Maximums and Waiting Periods are shown on the attached Schedule of Benefits. Covered Services shown on the Schedule of Benefits must be Dentally Necessary unless otherwise specified in a Rider to this Group Policy and are subject to frequency or age Limitations detailed on the attached Schedule of Exclusions and Limitations.

No benefits will be paid for services, supplies or charges detailed under the Exclusions on the Schedule of Exclusions and Limitations, and no benefits will be paid for services on the Schedule of Benefits with a Coinsurance of zero (0).

If your plan includes coverage for Medically Necessary Orthodontic services , You or Your Dentist must submit a claim for Orthodontic services prior to the date of service in order to determine Medical

Necessity. Plans that include coverage for the pediatric dental Essential Health Benefits include coverage for Medically Necessary Orthodontics. Notice of the determination will be sent no later than two working days after the date of request and all necessary information is received to complete the review.

Base Plan

The grid below provides information related to Covered Services under this Plan. If a service is a Covered Service, a percentage greater than zero in the column titled "Plan Pays" will be indicated. If a Covered Service has a Waiting Period, the Waiting Period will be listed in the column titled "Waiting Period". Some services will be covered in full prior to the Deductible being met. If this is the case, the "Deductible Application" column will indicate "no". If the Deductible must be met prior to a service being covered at the indicated coinsurance, then "yes" will appear in the "Deductible Application column. Only Covered Services are subject to reimbursement. All services on this Schedule of Benefits are subject to the Schedule of Exclusions and Limitations. Consult Your Certificate for more details on the services listed. Riders may affect coverage levels. Participating Dentists accept the Maximum Allowable Charge as payment in full.

Service Category	Waiting Period	Plan Pays	Deductible Application
Diagnostic Services			
Oral Evaluations (Exams)	None	100%	No
Radiographs (x-Rays)			
Bitewings	None	100%	No
Full Mouth	None	100%	No
Occlusal Films	None	100%	No
Preventive Services			
Prophylaxis (Cleanings)	None	100%	No
Fluoride Varnish	None	100%	No
Topical Fluoride	None	100%	No
Sealants	None	100%	No
Space Maintainers	None	100%	No
Restorative Services			
Amalgam Restorations	None	80%	Yes
Resin-Based Composite – Anterior (White Fillings)	None	80%	Yes
Resin-Based Composite – Posterior (White Filling)	None	80%	Yes
Single Crowns	None	50%	Yes
Stainless Steel Crowns	None	50%	Yes
Inlays	None	50%	Yes
Onlays	None	50%	Yes
Inlay Repairs	None	50%	Yes
Onlay Repairs	None	50%	Yes
Crown Repair	None	50%	Yes
Gold Foil Restorations	None	50%	Yes
Labial Veneer Restorations (Resin Laminate)	None	50%	Yes
Labial Veneer Restoration (Porcelain Laminate)	None	50%	Yes

Labial Veneer Repair	None	50%	Yes
Endodontic Services			
Endodontic Therapy (Root Canals, etc.)	None	50%	Yes
Root Canal Retreatment	None	50%	Yes
Apicoectomy/Periradicular (Root Surgery)	None	50%	Yes
Periodontal Services			
Surgical Periodontics	None	50%	Yes
Non-Surgical Periodontics	None	50%	Yes
Periodontal Maintenance	None	50%	Yes
Prosthodontic Services			
Removable Complete and Partial Dentures	None	50%	Yes
Fixed Partial Dentures (Bridges)	None	50%	Yes
Adjustments and Repairs of Complete and Partial Dentures	None	50%	Yes
Tissue Conditioning	None	50%	Yes
Removal of Teeth			
Simple Extractions	None	80%	Yes
Surgical Removal	None	80%	Yes
Adjunctive General Services			
Consultations	None	100%	No
General Anesthesia, Nitrous Oxide and/or IV Sedation	None	80%	Yes
Palliative Treatment (Emergency)	None	100%	No

Deductibles & Maximums
$100 per calendar year Deductible per Member not to exceed $200 per family.
$1,000 per calendar year Maximum per Member.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

THIS PLAN DOES NOT MEET THE MINIMUM ESSENTIAL HEALTH BENEFIT REQUIREMENTS FOR PEDIATRIC ORAL HEALTH AS REQUIRED UNDER THE FEDERAL AFFORDABLE CARE ACT.

Exclusions and limitations may differ by state as specified below. Only American Dental Association procedure codes are covered.

EXCLUSIONS - The following services, supplies or charges are excluded:

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under the Group Policy (for example but not limitation, multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
2. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).
3. That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third-party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.

For Group Policies issued and delivered in Georgia, Missouri and Virginia, only services that are the responsibility of Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

For Group Policies issued and delivered in North Carolina, services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act are excluded only to the extent such services or supplies are the liability of the employee according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

For Group Policies issued and delivered in Maryland, this exclusion does not apply.

4. For prescription and non-prescription drugs, vitamins or dietary supplements.
   For Group Policies issued and delivered in Arizona and New Mexico, this exclusion does not apply.
5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.
   For Group Policies issued and delivered in Washington, this exclusion does not apply when required dental services and procedures are performed in a dental office for covered persons under the age of seven (7) or physically or developmentally disabled.
   For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.
6. Which are Cosmetic in nature as determined by the Company (for example but not limitation, to bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).
   For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.
   For Group Policies issued and delivered in New Jersey, this exclusion does not apply for Cosmetic services for newly born children of Members.
   For Group Policies issued and delivered in Washington, this exclusion does not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.
7. Elective procedures (for example but not limitation, the prophylactic extraction of third molars).
8. For congenital mouth malformations or skeletal imbalances (e.g. treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).
   For Group Policies issued and delivered in Kentucky, Minnesota and Pennsylvania, this exclusion shall not apply to newly born children of Members including newly adoptive children, regardless of age.
   For Group Policies issued and delivered in Colorado, Hawaii, Indiana, Missouri, New Jersey and Virginia, this exclusion shall not apply to newly born children of Members.
   For Group Policies issued and delivered in Florida, this exclusion shall not apply for diagnostic or surgical dental (not medical) procedures rendered to a Member of any age.
   For Group Policies issued and delivered in Washington, this exclusion shall not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.
9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the Schedule of Benefits or a Rider.

10. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
    For Group Policies issued and delivered in New York, diagnostic services and treatment of jaw joint problems related to a medical condition are excluded unless specifically covered under the Certificate. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
    For Group Policies issued and delivered in Florida, this exclusion does not apply to diagnostic or surgical dental (not medical) procedures for treatment of temporomandibular joint disorder (TMD) rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease or injury and such procedures are covered under the Certificate or the Schedule of Benefits.
    For Group Policies issued and delivered in Minnesota, this exclusion does not apply.
11. For treatment of fractures and dislocations of the jaw.
    For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.
12. For treatment of malignancies or neoplasms.
13. Services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
14. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
15. Preventive restorations.
16. Periodontal splinting of teeth by any method.
17. For duplicate dentures, prosthetic devices or any other duplicative device.
18. For which in the absence of insurance the Member would incur no charge.
19. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
20. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.
    For Group Policies issued and delivered in Oklahoma, this exclusion does not apply.
21. For treatment and appliances for bruxism (night grinding of teeth).
22. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.
    For Group Policies issued and delivered in Maryland, failure to furnish the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the required time, if the claim is furnished as soon as reasonably possible, and, except in the absence of legal capacity of the Member, not later than one (1) year from the time the claim is otherwise required.
23. Incomplete treatment (for example but not limitation, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).
24. Procedures that are:
    - part of a service but are reported as separate services; or
    - reported in a treatment sequence that is not appropriate; or
    - misreported or that represent a procedure other than the one reported.

25. Specialized procedures and techniques (for example but not limitation, precision attachments, copings and intentional root canal treatment).
26. Fees for broken appointments.
27. Those specifically listed on the Schedule of Benefits as "Not Covered" or "Plan Pays 0%".
28. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Company will apply.
29. Orthodontic services, supplies, and appliances.

LIMITATIONS – Covered services are limited as detailed below. Services are covered until 12:01 a.m. of the birthday when the patient reaches any stated age:

1. Full mouth x-rays - one (1) every 36 month(s).
2. Bitewing x-rays - two (2) set(s) per 12 months.
3. Oral Evaluations:
    - Comprehensive and periodic - two (2) of these services per 12 months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
    - Detailed problem focused - one (1) per dentist per patient per 12 months per eligible diagnosis.
4. Prophylaxis - two (2) per 12 months. One (1) additional for Members under the care of a medical professional during pregnancy.
5. Fluoride treatment - two (2) per 12 months under age nineteen (19).
6. Space maintainers - one (1) per fifteen (15) year period for Members under age nineteen (19) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.
7. Sealants - one (1) per tooth per 15 year(s) under age sixteen (16) on permanent first and second molars.
8. Prefabricated stainless steel crowns - one (1) per tooth per 5 years for Members under age fourteen (14).
9. Periodontal Services:
    - Full mouth debridement - one (1) per 12 months.
    - Periodontal maintenance following active periodontal therapy - four (4) per 12 months.
    - Periodontal scaling and root planning - one (1) per 12 months per area of the mouth.
    - Surgical periodontal procedures - one (1) per 12 months per area of the mouth.
    - Guided tissue regeneration - one (1) per tooth per lifetime.
10. Replacement of restorative services only when they are not, and cannot be made, serviceable:
    - Basic restorations - not within 12 months of previous placement of any basic restoration.
    - Single crowns, inlays, onlays - not within 5 year(s) of previous placement of any of the procedures in this category.
    - Buildups and post and cores - not within 5 year(s) of previous placement of any of the procedures in this category.
    - Replacement of natural tooth/teeth in an arch - not within 5 year(s) of a fixed partial denture, full denture or partial removable denture.

11. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of insertion by the same dentist. Subsequent denture relining or rebasing limited to one (1) every 3 year(s) thereafter.
12. Pulpal therapy - one (1) per primary tooth per lifetime only when there is no permanent tooth to replace it.
13. Root canal retreatment - one (1) per tooth per lifetime.
14. Recementation - one (1) per 12 months. Recementation during the first 6 months following insertion any preventive, restorative or prosthodontic service by the same dentist is included in the preventive, restorative or prosthodontic service benefit.
15. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.
16. Intraoral Films:
    - Periapical - six (6) per 12 months per dentist if not performed in conjunction with definitive procedure(s).
    - Occlusal - two (2) per 24 months under age eight (8).
17. General anesthesia and IV sedation: a total of 60 minutes per session.

Buy-Up Plan

Service Category	Waiting Period	Plan Pays	Deductible Application
Diagnostic Services			
Oral Evaluations (Exams)	None	100%	No
Radiographs (x-Rays)			
Bitewings	None	100%	No
Full Mouth	None	100%	No
Occlusal Films	None	100%	No
Preventive Services			
Prophylaxis (Cleanings)	None	100%	No
Fluoride Varnish	None	100%	No
Topical Fluoride	None	100%	No
Sealants	None	100%	No
Space Maintainers	None	100%	No
Restorative Services			
Amalgam Restorations	None	80%	Yes
Resin-Based Composite – Anterior (White Fillings)	None	80%	Yes
Resin-Based Composite – Posterior (White Filling)	None	80%	Yes
Single Crowns	None	50%	Yes
Stainless Steel Crowns	None	50%	Yes
Inlays	None	50%	Yes
Onlays	None	50%	Yes
Inlay Repairs	None	50%	Yes

Onlay Repairs	None	50%	Yes
Crown Repair	None	50%	Yes
Gold Foil Restorations	None	50%	Yes
Labial Veneer Restorations (Resin Laminate)	None	50%	Yes
Labial Veneer Restoration (Porcelain Laminate)	None	50%	Yes
Labial Veneer Repair	None	50%	Yes
Endodontic Services			
Endodontic Therapy (Root Canals, etc.)	None	80%	Yes
Root Canal Retreatment	None	80%	Yes
Apicoectomy/Periradicular (Root Surgery)	None	80%	Yes
Periodontal Services			
Surgical Periodontics	None	80%	Yes
Non-Surgical Periodontics	None	80%	Yes
Periodontal Maintenance	None	80%	Yes
Prosthodontic Services			
Removable Complete and Partial Dentures	None	50%	Yes
Fixed Partial Dentures (Bridges)	None	50%	Yes
Adjustments and Repairs of Complete and Partial Dentures	None	50%	Yes
Tissue Conditioning	None	50%	Yes
Removal of Teeth			
Simple Extractions	None	80%	Yes
Surgical Removal	None	80%	Yes
Adjunctive General Services			
Consultations	None	100%	No
General Anesthesia, Nitrous Oxide and/or IV Sedation	None	80%	Yes
Palliative Treatment (Emergency)	None	100%	No
Orthodontic Services			
Orthodontic Services are covered for Dependents to age 26 and are covered for adult Dependents to age 30.			
Cosmetic Orthodontic Services	None	50%	No

Deductibles & Maximums

$100 per calendar year Deductible per Member not to exceed $200 per family.

$1,000 per calendar year Maximum per Member.

$1,000 lifetime Maximum per Member for Orthodontic Services.

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

THIS PLAN DOES NOT MEET THE MINIMUM ESSENTIAL HEALTH BENEFIT REQUIREMENTS FOR PEDIATRIC ORAL HEALTH AS REQUIRED UNDER THE FEDERAL AFFORDABLE CARE ACT.

Exclusions and limitations may differ by state as specified below. Only American Dental Association procedure codes are covered.

EXCLUSIONS - The following services, supplies, or charges are excluded:

1. Started prior to the Member's Effective Date or after the Termination Date of coverage under the Group Policy (for example but not limitation, multi-visit procedures such as endodontics, crowns, bridges, inlays, onlays, and dentures).
2. For house or hospital calls for dental services and for hospitalization costs (facility-use fees).
3. That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile-related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third-party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.

   For Group Policies issued and delivered in Georgia, Missouri, and Virginia, only services that are the responsibility of Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

   For Group Policies issued and delivered in North Carolina, services or supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act are excluded only to the extent such services or supplies are the liability of the employee according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.

   For Group Policies issued and delivered in Maryland, this exclusion does not apply.
4. For prescription and non-prescription drugs, vitamins, or dietary supplements.
   For Group Policies issued and delivered in Arizona and New Mexico, this exclusion does not apply.
5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the Schedule of Benefits.

   For Group Policies issued and delivered in Washington, this exclusion does not apply when required dental services and procedures are performed in a dental office for covered persons under the age of seven (7) or physically or developmentally disabled.

   For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.
6. Which are Cosmetic in nature as determined by the Company (for example but not limitation, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

   For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.

   For Group Policies issued and delivered in New Jersey, this exclusion does not apply for Cosmetic services for newly born children of Members.

   For Group Policies issued and delivered in Washington, this exclusion does not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.
7. Elective procedures (for example but not limitation, the prophylactic extraction of third molars).
8. For congenital mouth malformations or skeletal imbalances (e.g., treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment).

For Group Policies issued and delivered in Kentucky, Minnesota and Pennsylvania, this exclusion shall not apply to newly born children of Members including newly adoptive children, regardless of age.

For Group Policies issued and delivered in Colorado, Hawaii, Indiana, Missouri, New Jersey and Virginia, this exclusion shall not apply to newly born children of Members.

For Group Policies issued and delivered in Florida, this exclusion shall not apply for diagnostic or surgical dental (not medical) procedures rendered to a Member of any age.

For Group Policies issued and delivered in Washington, this exclusion shall not apply in the instance of congenital abnormalities for covered newly born children from the moment of birth.

9. For dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the Schedule of Benefits or a Rider.
10. Diagnostic services and treatment of jaw joint problems by any method unless specifically covered under the Certificate. Examples of these jaw joint problems are temporomandibular joint disorders (TMD) and craniomandibular disorders or other conditions of the joint linking the jawbone and the complex of muscles, nerves and other tissues related to the joint.

    For Group Policies issued and delivered in New York, diagnostic services and treatment of jaw joint problems related to a medical condition are excluded unless specifically covered under the Certificate. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jawbone and the complex of muscles, nerves and other tissues related to the joint.

    For Group Policies issued and delivered in Florida, this exclusion does not apply to diagnostic or surgical dental (not medical) procedures for treatment of temporomandibular joint disorder (TMD) rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease or injury and such procedures are covered under the Certificate or the Schedule of Benefits.

    For Group Policies issued and delivered in Minnesota, this exclusion does not apply.
11. For treatment of fractures and dislocations of the jaw.

    For Group Policies issued and delivered in New York, this exclusion does not apply if dental services are required for sound teeth as a result of accidental injury.
12. For treatment of malignancies or neoplasms.
13. Services and/or appliances that alter the vertical dimension (for example but not limitation, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances, or any other method.
14. Replacement or repair of lost, stolen, or damaged prosthetic or orthodontic appliances.
15. Preventive restorations.
16. Periodontal splinting of teeth by any method.
17. For duplicate dentures, prosthetic devices, or any other duplicative device.
18. For which in the absence of insurance the Member would incur no charge.
19. For plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
20. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.

For Group Policies issued and delivered in Oklahoma, this exclusion does not apply.

21. For treatment and appliances for bruxism (night grinding of teeth).
22. For any claims submitted to the Company by the Member or on behalf of the Member in excess of twelve (12) months after the date of service.
    For Group Policies issued and delivered in Maryland, failure to furnish the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the required time, if the claim is furnished as soon as reasonably possible, and, except in the absence of legal capacity of the Member, not later than one (1) year from the time the claim is otherwise required.
23. Incomplete treatment (for example but not limitation, patient does not return to complete treatment) and temporary services (for example but not limitation, temporary restorations).
24. Procedures that are:
    - part of a service but are reported as separate services; or
    - reported in a treatment sequence that is not appropriate; or
    - misreported or that represent a procedure other than the one reported.
25. Specialized procedures and techniques (for example but not limitation, precision attachments, copings and intentional root canal treatment).
26. Fees for broken appointments.
27. Those specifically listed on the Schedule of Benefits as "Not Covered" or "Plan Pays 0%".
28. Those not Dentally Necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standards exist, or there are varying positions within the professional community, the opinion of the Company will apply.

LIMITATIONS – Covered services are limited as detailed below. Services are covered until 12:01 a.m. of the birthday when the patient reaches any stated age:

1. Full mouth x-rays - one (1) every 36 month(s).
2. Bitewing x-rays - two (2) set(s) per 12 months.
3. Oral Evaluations:
    - Comprehensive and periodic - two (2) of these services per 12 months. Once paid, comprehensive evaluations are not eligible to the same office unless there is a significant change in health condition or the patient is absent from the office for three (3) or more year(s).
    - Detailed problem focused - one (1) per dentist per patient per 12 months per eligible diagnosis.
4. Prophylaxis - two (2) per 12 months. One (1) additional for Members under the care of a medical professional during pregnancy.
5. Fluoride treatment - two (2) per 12 months under age nineteen (19).
6. Space maintainers - one (1) per fifteen (15) year period for Members under age nineteen (19) when used to maintain space as a result of prematurely lost deciduous molars and permanent first molars, or deciduous molars and permanent first molars that have not, or will not, develop.
7. Sealants - one (1) per tooth per 15 year(s) under age sixteen (16) on permanent first and second molars.
8. Prefabricated stainless steel crowns - one (1) per tooth per 5 years for Members under age fourteen (14).

9. Periodontal Services:
    - Full mouth debridement - one (1) per 12 months.
    - Periodontal maintenance following active periodontal therapy - four (4) per 12 months.
    - Periodontal scaling and root planning - one (1) per 12 months per area of the mouth.
    - Surgical periodontal procedures - one (1) per 12 months per area of the mouth.
    - Guided tissue regeneration - one (1) per tooth per lifetime.
10. Replacement of restorative services only when they are not, and cannot be made, serviceable:
    - Basic restorations - not within 12 months of previous placement of any basic restoration.
    - Single crowns, inlays, onlays - not within 5 year(s) of previous placement of any of the procedures in this category.
    - Buildups and post and cores - not within 5 year(s) of previous placement of any of the procedures in this category.
    - Replacement of natural tooth/teeth in an arch - not within 5 year(s) of a fixed partial denture, full denture, or partial removable denture.
11. Denture relining, rebasing or adjustments are considered part of the denture charges if provided within 6 months of insertion by the same dentist. Subsequent denture relining or rebasing limited to one (1) every 3 year(s) thereafter.
12. Pulpal therapy - one (1) per primary tooth per lifetime only when there is no permanent tooth to replace it.
13. Root canal retreatment - one (1) per tooth per lifetime.
14. Recementation - one (1) per 12 months. Recementation during the first 6 months following insertion any preventive, restorative or prosthodontic service by the same dentist is included in the preventive, restorative or prosthodontic service benefit.
15. An alternate benefit provision (ABP) will be applied if a covered dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed under this ABP.
16. Payment for orthodontic services, if covered, shall cease at the end of the month after termination by the Company. This limitation does not apply to Group Policies issued and delivered in Maryland.
17. Intraoral Films:
    - Periapical - six (6) per 12 months per dentist if not performed in conjunction with definitive procedure(s).
    - Occlusal - two (2) per 24 months under age eight (8).
18. General anesthesia and IV sedation: a total of 60 minutes per session.

Component Document 7 – Vision Program

SCHEDULE OF BENEFITS

Covered Persons have the right to obtain vision care from the Provider of their choice. However, payment of the Benefit varies depending on the type of Provider chosen. Benefits are payable as shown in the following Schedule:

Benefit	**Preferred Provider**	**Non-Preferred Provider** (Up to a Maximum Dollar Amount of):	**Benefit Period**
Vision Examination	$10.00 copayment	$35.00	12 Months
Vision Materials	$10.00 copayment	N/A	
Standard Lenses			12 Months
Single	Paid in full after copayment		
Bifocal	Paid in full after copayment		
Trifocal	Paid in full after copayment		
Lenticular	Paid in full after copayment		
Standard Progressives	$50.00		
Frames	$130.00		24 Months
*Contact Lenses**			12 Months
Elective	$130.00	$110.00	
Medically Necessary *{Lens Options}*	Paid in Full	$250.00	
Level 2 Lens Options Package	{$0 - $70} copayment	{$0 - $50}	
Basic Polycarbonate	$0 copayment	$10.00	

**Contact Lenses* includes Materials.*

LIMITATION

Vision Examination and Vision Materials - Fees charged by a Provider for services other than a Vision Examination or covered Vision Materials must be paid in full by the Covered Person to the Provider. Such fees or materials are not covered under this Policy.

Benefit allowances provide no remaining balance for future use within the same Benefit Period, except Contact Lenses benefit.

EXCLUSIONS

No benefits will be paid for services or materials connected with or charges arising from: 1) Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes, or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear, required by an Employer as a condition of employment and safety eyewear, unless specifically covered under the Policy; 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether Federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; or 8) Services or materials provided by any other group benefit plans providing vision care.

Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit Period when Vision Materials would next become available.

Component Document 8 – Flexible Benefits Plan Program

Benefit Offered

Each Employee may elect to participate in one or more of the following Benefit Options:

- Premium Payment Plan (PPP)
- Health Flexible Spending Account (Health FSA)
- Health Savings Account Contribution Benefit (HSA Contributions Benefit)
- Dependent Care Flexible Spending Account (Dependent Care FSA)
- Cash in Lieu of Benefits ("Cash Out")

Legal Status

The Plan is intended to qualify as a "cafeteria plan" under the Code §125, and regulations issued thereunder and shall be interpreted to accomplish that objective.

The **Health FSA** is intended to qualify as self-insured health reimbursement plans under Code §105, and the Health Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code §105(b).

The **HSA Contribution Benefit** is intended to meet all requirements of §223 of the Code.

The **Dependent Care FSA** is intended to qualify as a **Dependent Care Flexible Spending Account** under Code §129, and the Dependent Care Expenses reimbursed are intended to be eligible for exclusion from participating Employees' gross income under Code §129(a).

Although reprinted within this document, the **Health FSA**, the **HSA Contribution Benefit**, and the **Dependent Care FSA** are separate plans for purposes of administration, and all reporting and nondiscrimination requirements are imposed by Code §§105 and 129. The **Health FSA** is also a separate plan for purposes of applicable provisions of COBRA and HIPAA. The **HSA Contribution Benefit** consists solely of the ability to make Contributions to the HSA on a pre-tax Salary Reduction basis.

Establishment of Account

The Plan Administrator will establish and maintain a **Health FSA** with respect to each Participant who has elected to participate in the **Health FSA**, but will not create a separate fund or otherwise segregate assets for this purpose. The account established hereto will merely be a record-keeping account with the purpose of keeping track of Contributions and determining forfeitures.

- **Crediting of Accounts.** A Participant's **Health FSA** will be credited following each Salary Reduction actually made during each Period of Coverage with an amount equal to the Salary Reduction actually made.
- **Debiting of Accounts.** A Participant's **Health FSA** will be debited during each Period of Coverage for any reimbursement of Health Care Expenses incurred during the Period of Coverage.
- **Available Amount Not Based on Credited Amount.** The amount available for reimbursement of Health Care Expenses is the amount as calculated according to the "Maximum Reimbursement Available" paragraph of this section above. It is not based on the amount credited to the **Health FSA** at a particular point in time.

Use It or Lose It Rule; Forfeiture Of Account Balance

- **Use It or Lose It Rule.** Except for any allowable Carryover as set forth below, if any Unused **Health FSA** Balance remains in the Participant's **Health FSA** for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then such balance shall not be carried over to reimburse the Participant for Health Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance.
- Use of Forfeitures. All forfeitures under this Plan shall be used as follows:
    - First, to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to any Participant in excess of the Contributions paid by such Participant through Salary Reductions.
    - Second, to reduce the cost of administering the **Health FSA** during the Plan Year or the subsequent Plan Year; and
    - Third, to provide increased Benefits or Compensation to all Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with prevailing IRS guidance.
- **Unclaimed Benefits.** Benefit payments that remain unclaimed by the close of the Plan Year following the Period of Coverage in which the Health Care Expense was incurred shall be forfeited and applied as described above.

Carryovers

Notwithstanding any other provision of the Plan to the contrary, any Unused **Health FSA** Balance of up to $650 remaining in a Participant's **Health FSA** Account at the end of a Plan Year can be carried over and used to reimburse the Participant for Medical Care Expenses that are incurred during the next Plan Year, subject to the following conditions:

- No more than $650 of the Participant's Unused Health FSA Balance for a Plan Year may be carried over for use in the next Plan Year. Carryover amounts may not be cashed out or

converted to any other taxable or nontaxable benefit and will not count toward the maximum dollar limit.

- A Participant who is otherwise eligible for the **Health FSA** for a Plan Year but does not make a **Health FSA** election for the Plan Year may use any Carryovers from the preceding Plan Year for Medical Care Expenses incurred in the current or preceding Plan Year (as further provided herein). However, an Employee or other individual must be a participant in the **Health FSA** as of the last day of a Plan Year in order to carry over unused amounts to the next Plan Year. Termination of employment and cessation of eligibility will result in a loss of Carryover eligibility unless a COBRA election is made.
- A Participant may elect prior to the beginning of a Plan Year to waive the Carryover from the preceding Plan Year in accordance with procedures established by the Plan Administrator. A Participant who waives the Carryover may continue to submit claims for Medical Care Expenses incurred during the preceding Plan Year until April 30 of the following Plan Year, to be reimbursed from the Participant's available **Health FSA** amounts.
- Medical Care Expenses incurred during a Plan Year will be reimbursed first from a Participant's unused amounts credited for the Plan Year and then from amounts carried over from the preceding Plan Year. Carryovers that are used to reimburse a current Plan Year expense will reduce the amount available to pay the Participant's preceding Plan Year expenses, cannot exceed $500, and will count against the $500 maximum Carryover amount.
- If any Unused **Health FSA** Balance remains for a Plan Year after all reimbursements have been made for the Plan Year in excess of the amount that can be carried over under this subsection, the Participant will forfeit all rights with respect to those amounts, which will be subject to the Plan's provisions regarding forfeitures.

Reimbursement Procedure

- **Timing.** Within 30 days after receipt of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Health Care Expenses, or WEX will notify the Participant that a claim has been denied. This time period may be extended for additional 15 days for matters beyond the control of WEX, including in cases where a reimbursement claim is incomplete. WEX will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days from receipt of the written notice in which to complete an incomplete reimbursement claim.
- **Claims Substantiation.** A Participant who has elected to received Health Care Reimbursement Benefits for a Period of Coverage may apply for reimbursement by submitting a claim to WEX within a runout period of 90 days of the Plan Year, setting forth:
    - The person or persons on whose behalf Health Care Expenses have been incurred;
    - The nature and date of the expenses incurred;
    - The amount of the requested reimbursement;
    - The name of the person, organization or entity to whom the Expense was or is to be paid;
    - A statement that such expenses have not otherwise been reimbursed and the Participant will not seek reimbursement through any other source; and
    - Other such details about the expenses that may be requested by WEX in the reimbursement request form or otherwise.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Health Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that WEX may request. Except for the final reimbursement claim for a Participant's **Health FSA** for a Plan Year or other Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claim for reimbursement is at least $10. If the **Health FSA** is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by WEX in accordance with the prevailing IRS guidance.

- **Claims Denied**. For appeal of claims that are denied, see the Appeals Procedure in the Plan Documents.
- **Claims Ordering; No Reprocessing.** All claims for reimbursement will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise recharacterized solely for the purpose of paying it from amounts attributable to a different Plan Year or Period of Coverage.
- **Cash in Lieu of Benefits** is a conditional opt out payment offered to employees who are covered by another qualified group health plan. The employee must provide evidence that the employee and members of their tax family have or are expected to have coverage for the plan year for which the opt-out payment is offered. Individual marketplace coverage is not considered group health care. The employee must also provide an attestation that they are covered and the documentation presented is true and accurate.

Component Document 9 – Life/AD&D Program

CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy Number GLUG-BZPL (the Policy) has been issued to Killeen Independent School District (the Policyholder).

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

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

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

This Certificate replaces any certificate previously issued under the Policy.

James T. Blackledge
Chief Executive Officer

Daryl Vankat
Corporate Secretary

LIFE INSURANCE FOR YOU (THE EMPLOYEE)

Your amount of life insurance is $25,000.

Your amount of life insurance is subject to any reductions indicated in the Benefit Reductions provision in this Schedule. If You have questions regarding the amount of Your life insurance, You may contact the Policyholder.

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

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

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

EVIDENCE OF INSURABILITY

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

BENEFIT REDUCTIONS

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

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

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

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

Component Document 10 – Short-Term Disability Program

Elimination Period of 14 Calendar Days

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 GUC-BZPL (the Policy) has been issued to Killeen Independent School District (the Policyholder).

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

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

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

This Certificate replaces any certificate previously issued under the Policy.

James T. Blackledge
Chief Executive Officer

Jayd Vanbeat
Corporate Secretary

SCHEDULE

This Schedule describes some of the terms and conditions of the Policy including, but not limited to, the maximum amounts of benefits payable under the Policy, exclusions, and limitations. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of this Certificate.

A person is not necessarily entitled to insurance under the Policy because he or she received this Schedule. A person is only entitled to insurance if he or she is eligible in accordance with the terms of this Certificate. Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

POLICY INFORMATION

Policyholder:	Killeen Independent School District
Policy Effective Date:	January 1, 2023
Policy Anniversary:	January 1
Policy Number:	GUC-BZPL
Group Number:	G000BZPL

Classification:	All Eligible Employees Enrolled in the 14-14-11 Plan
Minimum Work Hours Required:	17.5 hours per week
Eligibility Present Waiting Period:	30 days
Eligibility Future Waiting Period:	30 days
When Insurance Begins:	the first day of the month that coincides with or follows the day the Employee becomes eligible. Additional eligibility conditions apply as described in the Certificate.

Elimination Period	
Injury:	14 calendar days
Sickness:	14 calendar days

BENEFITS

Weekly Benefit Percentage:	60%
Maximum Weekly Benefit:	$2,500
Minimum Weekly Benefit:	$25
Maximum Benefit Period:	11 weeks
Portability:	Included
Vocational Rehabilitation Benefit:	Voluntary 10%

LIMITATION

Pre-existing Condition Exclusion:	3/6

If Your Disability is a result of a Sickness, the Elimination Period is 14 calendar days.

The Elimination Period begins on the first day of Disability. The Elimination Period can be satisfied if You are working.

RECURRENT DISABILITY

A Recurrent Disability will be treated as part of Your prior claim, and You will not be required to satisfy a new Elimination Period if:

a) You were continuously insured under the Policy from the date benefits ended for Your prior claim to the date Your Recurrent Disability begins; and
b) Your Recurrent Disability occurs within 90 days after the date benefits ended for 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 Policyholder sponsored group long-term disability income policy or plan.

WEEKLY BENEFIT

Total Disability

If You are Disabled and earning less than 20% of Your Basic Weekly Earnings, the Weekly Benefit while Disabled is the lesser of:

a) 60% of Your Basic Weekly Earnings, less Other Income Sources; or
b) the Maximum Weekly Benefit, less any Other Income Sources.

Partial Disability

If You are Disabled and You are able to generate Current Earnings of at least 20% and not more than 99% of Your Basic Weekly Earnings, the Weekly Benefit payable will be the Weekly Benefit for Total Disability, unless the sum of:

a) the Gross Weekly Benefit while You are Disabled; plus
b) Other Income Sources You receive or are eligible to receive; plus
c) Current Earnings while You are Disabled exceeds 100% of Your Basic Weekly Earnings. If this sum exceeds 100% of Your Basic Weekly Earnings, the Weekly Benefit will be reduced by the amount in excess of 100% of Your Basic Weekly Earnings.

INTEGRATION ABOVE 100% OF COMBINED EARNINGS

Your Weekly Benefit, as calculated above, will be reduced by the amount of salary continuance and sick leave benefits for which You are eligible or that You receive from the Policyholder that, when combined with Your Weekly Benefit, exceeds 100% of Your Basic Weekly Earnings. The Weekly Benefit will be reduced by such amount to the extent the Weekly Benefit exceeds 100% of Your Basic Weekly Earnings.

MINIMUM BENEFIT

If subtracting Other Income Sources from Your Gross Weekly Benefit results in a zero benefit, a Weekly Benefit of $25 will be paid, unless We reduce the Weekly Benefit to recover an overpayment. If We reduce the Weekly Benefit to recover an overpayment, Your Weekly Benefit may be reduced to zero until We fully recover the overpayment.

When less than one week of Disability benefits is due, a pro rata benefit will be paid for each day of Disability. This pro rata benefit will be equal to 1/7th of Your Weekly Benefit.

VOLUNTARY VOCATIONAL REHABILITATION BENEFIT

While You are participating in a plan of voluntary vocational rehabilitation approved by Us, Your Monthly Benefit will be increased by 10%.

MAXIMUM BENEFIT PERIOD

The maximum number of weeks that benefits are payable for a continuous period of Disability is 11 weeks.

OTHER INCOME SOURCES

We take into account the total of all Your income from other sources of income in determining the amount of Your Weekly Benefit. Your Other Income Sources are any of the following amounts that You

receive or are eligible to receive as a result of Your Disability or the Sickness and/or Injury that caused, in whole or in part, Your Disability:

a) Any amount under another group or individual short-term or long-term disability insurance policy or plan for which the Policyholder has paid any part of the cost, except any group short-term or long-term disability insurance policy or plan underwritten by United of Omaha Life Insurance Company.
b) Any amount as disability income payments under any:
    1. state compulsory benefit act or law;
    2. government retirement system as a result of Your job with the Policyholder; or
    3. work loss provision in a no-fault motor vehicle insurance plan, unless state law or regulation does not allow group disability income benefits to be reduced by benefits from no-fault motor vehicle coverage.
c) Any amount of benefits under the Policyholder's Retirement Plan. Benefits payable before the plan's normal retirement age are considered Other Income Sources only if You voluntarily elect to receive these benefits.
d) Any benefits for You or Your Spouse and Dependent Child under:
    1. the U.S. Social Security Act;
    2. the Canada Pension Plan;
    3. the Quebec Pension Plan;
    4. the Railroad Retirement Act;
    5. any public employee retirement plan;
    6. any teacher's employment retirement plan; or
    7. any similar plan or act that provides:
        a) Disability benefits; or
        b) retirement benefits (except this will not apply if Your Disability begins after Your Social Security Normal Retirement Age and You were already receiving Social Security retirement benefits. This exception only applies to U.S. Social Security Benefits).
e) Any amount payable as:
    1. salary continuance, except
        i. paid time off (PTO) that is not specified as sick leave;
        ii. vacation;
        iii. any earned time off program;
    2. sick leave; or
    3. severance allowance.
f) Any amount from a third party (after subtracting attorneys' fees) by judgment, settlement or otherwise.
g) Any amount from any unemployment insurance law or program.

EXPLANATION OF OTHER INCOME SOURCES

You must apply for and pursue Other Income Sources for which You are or may become eligible, including but not limited to Social Security disability and/or dependent benefits, and do what is needed to obtain them. If Your application or claim for Other Income Sources is denied, We may require that

You appeal the decision to a level that is satisfactory to Us and provide written proof of all levels of appeal.

As part of Your proof of Disability, We require that You furnish evidence to Us that You have applied for and pursued Other Income Sources for which You are or may become eligible.

After the initial reduction for each type of Other Income Source, We will not further reduce Your Weekly Benefit due to any cost of living increases payable under such type of Other Income Source.

Other Income Sources that are paid in a lump sum will be prorated on a weekly basis over a period for which the sum is given. If no time period is stated, the sum will be prorated on a weekly basis over the lesser of the following:

a) the Policy's Maximum Benefit Period; or
b) 12 equal payments.

If Other Income Sources are paid on a retroactive basis, We may reduce or suspend the Weekly Benefit to recover any overpayment.

Regardless of how funds from a Retirement Plan are distributed, We will consider Your contributions and the Policyholder's contributions to be distributed simultaneously during Your lifetime.

We will pay the full amount of the Weekly Benefit if You:

a) apply for Other Income Sources; and
b) sign Our Reimbursement Agreement.

Until You have signed Our Reimbursement Agreement and have given written proof to Us that application has been made or all available appeals have been exhausted for Other Income Sources, We may:

a) estimate Your Other Income Sources; and
b) reduce Your Weekly Benefit by that amount.

If We reduce Your benefit on this basis, and if all of Your appeals are denied, We will restore Your Weekly Benefit amount and refund any underpayment to You in a lump sum.

SHORT-TERM 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.

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

SHORT-TERM DISABILITY BENEFITS

If You become Disabled due to an Injury or Sickness, while insured under the Policy, We will pay the Weekly Benefit shown in the Schedule in accordance with the terms of the Policy. Benefits will begin after You satisfy the Elimination Period shown in the Schedule.

VOLUNTARY 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) worksite modification and/or special equipment;
b) job placement;
c) retraining; and
d) other services reasonably necessary to help You return to work.

While You are participating in a plan of voluntary vocational rehabilitation approved by Us, Your Weekly Benefit will be increased by a percentage as shown in the Schedule.

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 Job;
b) You must have the physical and mental capability to complete a rehabilitation program; and
c) there must be reasonable expectation that rehabilitation services will help You return to active employment.

We will develop an Individual Written Rehabilitation Plan (IWRP), which may include input from You, Your Physician and the Policyholder. The IWRP will describe:

a) the vocational rehabilitation goals and services;
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.

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

While You are a participant in an IWRP, Weekly Benefits will continue to be payable. Eligibility for continued Weekly Benefits will be assessed at the completion of the IWRP.

WHEN BENEFITS END

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

a) You are no longer Disabled;
b) You die;
c) on which the Maximum Benefit Period ends as shown in the Schedule;
d) You fail to provide Us satisfactory proof of continuous Disability;
e) You fail to provide Us satisfactory Proof of Earnings;
f) You have been incarcerated or imprisoned for 31 days or longer;
g) You fail to comply with Our request to be examined by a Physician and/or vocational rehabilitation expert of Our choice;

h) You are not under Regular and Appropriate Care and Treatment for the Injury or Sickness that caused the Disability; or
i) You are able to return to work with the Policyholder on a part-time or full-time basis and do not do so.

If You are eligible to receive Disability payments on the day the Policy ends, benefits will continue subject to all other Policy provisions.

PRE-EXISTING CONDITION EXCLUSION

A *Pre-existing Condition* means any Injury or Sickness for which You received medical treatment, advice or consultation, care or services, including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to the day You become insured under the Policy.

We will not provide benefits for any Disability caused by, attributable to, or resulting from a Pre-existing Condition which begins in the first 6 months after You are continuously insured under the Policy.

PRE-EXISTING CONDITION EXCLUSION FOR INCREASED MAXIMUM MONTHLY BENEFIT

Any amount of insurance in excess of $1,000 that becomes effective on January 1, 2023, will be excluded for any Disability:
a) caused by, attributable to, or resulting from a Pre-existing Condition; and
b) which begins in the first 12 months after January 1, 2023.

For purposes of this provision, a *Pre-existing Condition* means any Injury or Sickness for which You received medical treatment, advice or consultation, care or services, including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to January 1, 2023.

EXCLUSIONS

We will not pay benefits for any Disability which:
a) results from an act of declared or undeclared war or armed aggression;
b) results from Your Participation in a Riot or Your commission of or attempt to commit a felony or any type of assault or battery;
c) arises out of or in the course of employment with the Policyholder for which You are entitled to benefits under any workers' compensation or occupational disease law, or receives any settlement from the workers' compensation carrier;
d) results, whether You are sane or insane, from:
e) an intentionally self-inflicted Injury or Sickness; or
f) attempted suicide;
g) occurs while You are incarcerated or imprisoned for any period exceeding 31 days; or
h) is solely a result of a loss of a professional license, occupational license, or certification.

Elimination Period of 30 Calendar Days

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 GUC-BZPL (the Policy) has been issued to Killeen Independent School District (the Policyholder).

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

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

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

This Certificate replaces any certificate previously issued under the Policy.

James T. Blackledge
Chief Executive Officer

Corporate Secretary

SCHEDULE

This Schedule describes some of the terms and conditions of the Policy including, but not limited to, the maximum amounts of benefits payable under the Policy, exclusions, and limitations. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of this Certificate.

A person is not necessarily entitled to insurance under the Policy because he or she received this Schedule. A person is only entitled to insurance if he or she is eligible in accordance with the terms of this Certificate. Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

POLICY INFORMATION

Policyholder:	Killeen Independent School District
Policy Effective Date:	January 1, 2022

Policy Anniversary:	January 1
Policy Number:	GUC-BZPL
Group Number:	G000BZPL
Classification:	All Eligible Employees Enrolled in the 30-30-9 Plan
Minimum Work Hours Required:	17.5 hours per week
Eligibility Present Waiting Period:	30 days
Eligibility Future Waiting Period:	30 days
When Insurance Begins:	the first day of the month that coincides with or follows the day the Employee becomes eligible. Additional eligibility conditions apply as described in the Certificate.

Elimination Period

Injury:	30 calendar days
Sickness:	30 calendar days

BENEFITS

Weekly Benefit Percentage:	60%
Maximum Weekly Benefit:	$2,500
Minimum Weekly Benefit:	$25
Maximum Benefit Period:	9 weeks
Portability:	Included
Vocational Rehabilitation Benefit:	Voluntary 10%

LIMITATION

Pre-existing Condition Exclusion:	3/6

VOLUNTARY VOCATIONAL REHABILITATION BENEFIT

While You are participating in a plan of voluntary vocational rehabilitation approved by Us, Your Monthly Benefit will be increased by 10%.

MAXIMUM BENEFIT PERIOD

The maximum number of weeks that benefits are payable for a continuous period of Disability is 9 weeks.

OTHER INCOME SOURCES

We take into account the total of all Your income from other sources of income in determining the amount of Your Weekly Benefit. Your Other Income Sources are any of the following amounts that You

receive or are eligible to receive as a result of Your Disability or the Sickness and/or Injury that caused, in whole or in part, Your Disability:

a) Any amount under another group or individual short-term or long-term disability insurance policy or plan for which the Policyholder has paid any part of the cost, except any group short-term or long-term disability insurance policy or plan underwritten by United of Omaha Life Insurance Company.
b) Any amount as disability income payments under any:
    1. state compulsory benefit act or law;
    2. government retirement system as a result of Your job with the Policyholder; or
    3. work loss provision in a no-fault motor vehicle insurance plan, unless state law or regulation does not allow group disability income benefits to be reduced by benefits from no-fault motor vehicle coverage.
c) Any amount of benefits under the Policyholder's Retirement Plan. Benefits payable before the plan's normal retirement age are considered Other Income Sources only if You voluntarily elect to receive these benefits.
d) Any benefits for You or Your Spouse and Dependent Child under:
    1. the U.S. Social Security Act;
    2. the Canada Pension Plan;
    3. the Quebec Pension Plan;
    4. the Railroad Retirement Act;
    5. any public employee retirement plan;
    6. any teachers employment retirement plan; or
    7. any similar plan or act that provides:
        i. Disability benefits; or
        ii. retirement benefits (except this will not apply if Your Disability begins after Your Social Security Normal Retirement Age and You were already receiving Social Security retirement benefits. This exception only applies to U.S. Social Security Benefits).
e) Any amount payable as:
    1. salary continuance, except
        i. paid time off (PTO) that is not specified as sick leave;
        ii. vacation;
        iii. any earned time off program;
    2. sick leave; or
    3. severance allowance.
f) Any amount from a third party (after subtracting attorneys' fees) by judgment, settlement or otherwise.
g) Any amount from any unemployment insurance law or program.

EXPLANATION OF OTHER INCOME SOURCES

You must apply for and pursue Other Income Sources for which You are or may become eligible, including but not limited to Social Security disability and/or dependent benefits, and do what is needed to obtain them. If Your application or claim for Other Income Sources is denied, We may require that

You appeal the decision to a level that is satisfactory to Us and provide written proof of all levels of appeal.

As part of Your proof of Disability, We require that You furnish evidence to Us that You have applied for and pursued Other Income Sources for which You are or may become eligible.

After the initial reduction for each type of Other Income Source, We will not further reduce Your Weekly Benefit due to any cost of living increases payable under such type of Other Income Source.

Other Income Sources that are paid in a lump sum will be prorated on a weekly basis over a period for which the sum is given. If no time period is stated, the sum will be prorated on a weekly basis over the lesser of the following:

a) the Policy's Maximum Benefit Period; or
b) 12 equal payments.

If Other Income Sources are paid on a retroactive basis, We may reduce or suspend the Weekly Benefit to recover any overpayment.

Regardless of how funds from a Retirement Plan are distributed, We will consider Your contributions and the Policyholder's contributions to be distributed simultaneously during Your lifetime.

We will pay the full amount of the Weekly Benefit if You:

a) apply for Other Income Sources; and
b) sign Our Reimbursement Agreement.

Until You have signed Our Reimbursement Agreement and have given written proof to Us that application has been made or all available appeals have been exhausted for Other Income Sources, We may:

a) estimate Your Other Income Sources; and
b) reduce Your Weekly Benefit by that amount.

If We reduce Your benefit on this basis, and if all of Your appeals are denied, We will restore Your Weekly Benefit amount and refund any underpayment to You in a lump sum.

SHORT-TERM 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.

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

SHORT-TERM DISABILITY BENEFITS

If You become Disabled due to an Injury or Sickness, while insured under the Policy, We will pay the Weekly Benefit shown in the Schedule in accordance with the terms of the Policy. Benefits will begin after You satisfy the Elimination Period shown in the Schedule.

VOLUNTARY 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) worksite modification and/or special equipment;
b) job placement;
c) retraining; and
d) other services reasonably necessary to help You return to work.

While You are participating in a plan of voluntary vocational rehabilitation approved by Us, Your Weekly Benefit will be increased by a percentage as shown in the Schedule.

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 Job;
b) You must have the physical and mental capability to complete a rehabilitation program; and
c) there must be reasonable expectation that rehabilitation services will help You return to active employment.

We will develop an Individual Written Rehabilitation Plan (IWRP), which may include input from You, Your Physician and the Policyholder. The IWRP will describe:

a) the vocational rehabilitation goals and services;
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.

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

While You are a participant in an IWRP, Weekly Benefits will continue to be payable. Eligibility for continued Weekly Benefits will be assessed at the completion of the IWRP.

WHEN BENEFITS END

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

a) You are no longer Disabled;
b) You die;
c) on which the Maximum Benefit Period ends as shown in the Schedule;
d) You fail to provide Us satisfactory proof of continuous Disability;
e) You fail to provide Us satisfactory Proof of Earnings;
f) You have been incarcerated or imprisoned for 31 days or longer;
g) You fail to comply with Our request to be examined by a Physician and/or vocational rehabilitation expert of Our choice;

h) You are not under Regular and Appropriate Care and Treatment for the Injury or Sickness that caused the Disability; or
i) You are able to return to work with the Policyholder on a part-time or full-time basis and do not do so.

If You are eligible to receive Disability payments on the day the Policy ends, benefits will continue subject to all other Policy provisions.

PRE-EXISTING CONDITION EXCLUSION

A *Pre-existing Condition* means any Injury or Sickness for which You received medical treatment, advice or consultation, care or services, including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to the day You become insured under the Policy.

We will not provide benefits for any Disability caused by, attributable to, or resulting from a Pre-existing Condition which begins in the first 6 months after You are continuously insured under the Policy.

PRE-EXISTING CONDITION EXCLUSION FOR INCREASED MAXIMUM MONTHLY BENEFIT

Any amount of insurance in excess of $1,000 that becomes effective on January 1, 2023 will be excluded for any Disability:
a) caused by, attributable to, or resulting from a Pre-existing Condition; and
b) which begins in the first 12 months after January 1, 2023.

For purposes of this provision, a *Pre-existing Condition* means any Injury or Sickness for which You received medical treatment, advice or consultation, care or services, including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to January 1, 2023.

EXCLUSIONS

We will not pay benefits for any Disability which:
a) results from an act of declared or undeclared war or armed aggression;
b) results from Your Participation in a Riot or Your commission of or attempt to commit a felony or any type of assault or battery;
c) arises out of or in the course of employment with the Policyholder for which You are entitled to benefits under any workers' compensation or occupational disease law, or receives any settlement from the workers' compensation carrier;
d) results, whether You are sane or insane, from:
e) an intentionally self-inflicted Injury or Sickness; or
f) attempted suicide;
g) occurs while You are incarcerated or imprisoned for any period exceeding 31 days; or
h) is solely a result of a loss of a professional license, occupational license, or certification.

Component Document 11 – Long-Term Disability Program

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 GUPR-BZPL (the Policy) has been issued to Killeen Independent School District (the Policyholder).

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

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

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

This Certificate replaces any certificate previously issued under the Policy.

James T. Blackledge
Chief Executive Officer

Daryl Vanbeat
Corporate Secretary

SCHEDULE

This Schedule describes some of the terms and conditions of the Policy including, but not limited to, the maximum amounts of benefits payable under the Policy, exclusions, and limitations. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate.

A person is not necessarily entitled to insurance under the Policy because he or she received this Schedule. A person is only entitled to insurance if he or she is eligible in accordance with the terms of the Certificate. Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

POLICY INFORMATION

Policyholder:	Killeen Independent School District
Policy Effective Date:	January 1, 2023
Policy Anniversary:	January 1
Policy Number:	GUPR-BZPL
Group Number:	G000BZPL
Classification:	All Eligible Employees
Minimum Work Hours Required:	17.5 hours per week
Eligibility Present Waiting Period:	30 days
Eligibility Future Waiting Period:	30 days
When Insurance Begins:	The first day of the month following the date of hire

	day the Employee becomes eligible. Additional eligibility conditions apply as described in the Certificate.
Elimination Period:	The latter of: a) 90 calendar days; or b) the date Your short-term Disability ends.

BENEFITS

Monthly Benefit Percentage:	60%
Maximum Monthly Benefit:	$10,000
Minimum Monthly Benefit:	$100
Maximum Benefit Period:	Age at Disability — Maximum Benefit Period 61 or less……to age 65, Your SSNRA, or 3 years and 6 months, whichever is longest; 62……Your SSNRA, or 3 years and 6 months, whichever is longer; 63……Your SSNRA, or 3 years, Whichever is longer; 64……Your SSNRA, or 2 years and 6 Months, whichever is longer; 65……2 years; 66……1 year and 9 months; 67……1 year and 6 months; 68……1 year and 3 months; 69 or older……1 year.
Own Occupation Definition:	2 years
Family Care Benefit:	Included
Survivor Benefit:	3 months
Vocational Rehabilitation Benefit:	Voluntary 10%

LIMITATIONS/EXCLUSIONS

Alcohol/Drug Abuse/Substance Abuse limitation:	24 months
Mental Disorder Limitation:	24 months
Pre-existing Condition Exclusion:	12/12

LONG-TERM 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.

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

LONG-TERM DISABILITY BENEFITS

If You become Disabled due to an Injury or Sickness, while insured under the Policy, We will pay the Monthly Benefit shown in the Schedule in accordance with the terms of the Policy. Benefits will begin after You satisfy the Elimination Period shown in the Schedule.

FAMILY CARE BENEFIT

We will offer an additional benefit amount of up to $350 per month for each Qualifying Family Member. The additional benefit amount will be included in the Monthly Benefit for Partial Disability formula described in the Schedule if:

a) You have received a total of 12 months of Disability benefits;
b) You continue to be Disabled;
c) You incur expenses for Family Care services; and
d) We receive satisfactory proof of the Family Care expense incurred by You.

The Family Care benefit will not exceed 100% of Your Current Earnings.

SURVIVOR BENEFIT

We will pay a Survivor Benefit to Your Eligible Survivor when We receive proof that You died:

a) after being Disabled; and
b) while receiving or eligible to receive a Monthly Benefit under the Policy.

The Survivor Benefit will be payable as a lump sum amount equal to three times Your Monthly Benefit for the month immediately prior to Your death.

If a Survivor Benefit is payable to Your Dependent Child and, if there is more than one such Dependent Child, then the Survivor Benefit will be divided equally among such Dependent Children.

If payment becomes due to Your Dependent Child or Dependent Children, the payment will be made to:

a) Your Dependent Child; or
b) a person legally authorized to receive payments or the Dependent Child's or Dependent Children's behalf. This payment will be valid and effective against all claims by the Dependent Child or Dependent Children or by others representing or claiming to represent such Dependent Child or Dependent Children.

If there are no Eligible Survivors, the Survivor Benefit will be paid to Your estate.

Any payment made in good faith will fully discharge Us to the extent of the payment.

VOLUNTARY 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) worksite modification and/or special equipment;
b) job placement;

c) retraining; and
d) other services reasonably necessary to help You return to work.

While You are participating in a plan of voluntary vocational rehabilitation approved by Us, Your Monthly Benefit will be increased by a percentage as shown in the Schedule.

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 have the physical and mental capability to complete a rehabilitation program; and
c) there must be reasonable expectation that rehabilitation services will help You return to active employment.

We will develop an Individual Written Rehabilitation Plan (IWRP), which may include input from You, Your Physician and the Policyholder. The IWRP will describe:

a) the vocational rehabilitation goals and services;
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.

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

While You are a participant in an IWRP, Monthly Benefits will continue to be payable. Eligibility for continued Monthly Benefits will be assessed at the completion of the IWRP.

LIMITATIONS

Alcohol and Drug Abuse and/or Substance Abuse
If You are Disabled and Your Disability is a result of Alcohol or Drug Abuse and/or Substance Abuse, Your benefits will be limited to a total of 24 months while insured under the Policy, unless You are confined as resident inpatient in a Hospital due to Your dependency at the end of that 24-month period. The Monthly Benefit will continue to be paid during such confinement.

If You are still Disabled when You are discharged from a Hospital, the Monthly Benefit will be paid for a recovery period of up to 90 additional days. If You become re-confined as a resident inpatient in a Hospital during the recovery period for at least 14 consecutive days, benefits will be paid for the duration of the subsequent confinements.

Mental Disorder
If You are Disabled and Your Disability is a result of a Mental Disorder, Your benefits will be limited to a total of 24 months while insured under the Policy, unless You are confined as a resident inpatient in a Hospital due to Your Mental Disorder at the end of that 24-month period. The Monthly Benefit will continue to be paid during such confinement.

If You are still Disabled when You are discharged from a Hospital, the Monthly Benefit will be paid for a recovery period of up to 90 additional days. If You become re-confined as a resident inpatient in a Hospital during the recovery period for at least 14 consecutive days, benefits will be paid for the duration of the subsequent confinements.

WHEN DISABILITY BENEFITS END

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

a) You are no longer Disabled;
b) You die;
c) on which the Maximum Benefit Period ends as shown in the Schedule;
d) You fail to provide Us satisfactory proof of continuous Disability;
e) You fail to provide Us satisfactory Proof of Earnings;
f) You have been incarcerated or imprisoned for 31 days or longer;
g) You fail to comply with Our request to be examined by a Physician and/or vocational rehabilitation expert of Our choice;
h) You are not under Regular and Appropriate Care and Treatment for the Injury or Sickness that caused the Disability;
i) You are able to return to work with the Policyholder on a part-time or full-time basis and do not do so; or
j) We have paid You 12 Monthly Benefit payments, if You reside outside the U.S., its territories or possessions, or Canada. You will be considered to reside outside the U.S., its territories or possessions, or Canada if You have been outside the U.S., its territories or possessions, or Canada for a total of six months or more during any twelve consecutive month period during which You were continuously Disabled.

If You are eligible to receive Disability payments on the day the Policy ends, benefits will continue subject to all other Policy provisions.

PRE-EXISTING CONDITION EXCLUSION

A *Pre-existing Condition* means any Injury or Sickness for which You received medical treatment, advice or consultation, care or services, including diagnostic measures, or had drugs or medicines prescribed or taken in the 12 months prior to the day You become insured under the Policy.

We will not provide benefits for any Disability caused by, attributable to, or resulting from a Pre-existing Condition which begins in the first 12 months after You are continuously insured under the Policy.

PRE-EXISTING CONDITION EXCLUSION FOR INCREASED MAXIMUM MONTHLY BENEFIT

Any amount of insurance in excess of $5,000 that becomes effective on January 1, 2023 will be excluded for any Disability:

a) caused by, attributable to, or resulting from a Pre-existing Condition; and
b) which begins in the first 12 months after January 1, 2023.

For purposes of this provision, a *Pre-existing Condition* means any Injury or Sickness for which You received medical treatment, advice or consultation, care or services, including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to January 1, 2023.

EXCLUSIONS

We will not pay benefits for any Disability or loss which:

a) results from an act of declared or undeclared war or armed aggression;
b) results from Your Participation in a Riot or Your commission of or attempt to commit a felony or any type of assault or battery;

c) results, whether You are sane or insane, from:
   1. an intentionally self-inflicted Injury or Sickness; or
   2. attempted suicide;
d) results from Alcohol and Drug Abuse and/or Substance Abuse, except as specifically provided in the Limitations Section;
e) results from a Mental Disorder, except as specifically provided in the Limitations Section;
f) is caused by Alcohol and Drug Abuse and/or Substance Abuse, while You are not being actively supervised by and receiving continuing treatment from a rehabilitation center or designated institution approved for such treatment by an appropriate body in the governing jurisdiction, or if none, by Us;
g) occurs while You are incarcerated or imprisoned for any period exceeding 31 days; or
h) is solely a result of a loss of a professional license, occupational license, or certification.

Component Document 12 – Voluntary Accident Program

High Accident Plan

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

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

United of Omaha Life Insurance Company certifies that Group Policy Number GUDH-BZPL (the Policy) has been issued to Killeen Independent School District (the Policyholder). The Policy provides Group Accident Insurance.

Insurance is provided for Employees of the Policyholder subject to the terms and conditions of the Policy. This Certificate is made a part 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.

The Policy is nonparticipating, therefore it will pay no dividends. The Policy is non contributory.

James T. Blackledge
Chief Executive Officer

David Vanket
Corporate Secretary

SCHEDULE

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

CLASS(ES)

All Eligible Employees Enrolled in the High Plan

ACCIDENT INSURANCE

Accident insurance offers financial protection for You and Your insured Dependent(s) by paying a benefit if You or an insured Dependent are Injured in an Accident. The benefit amount(s) payable is/are based on the type and amount of insurance in effect on the date the Accident occurs, subject to the definitions, limitations, exclusions and other provisions of the Policy.

You may elect insurance for Yourself and Your Dependent(s) under this Certificate for one of the following coverage options:

a. Yourself only;
b. You and Your Spouse;
c. You and Your Dependent child(ren); or
d. You, Your Spouse and Your Dependent child(ren).

Unless otherwise stated in this Certificate, the benefit amount payable is the same for You and Your insured Dependent(s). If You have questions regarding who is insured for accident insurance, You may contact the Policyholder.

Plan Type
You may elect insurance for Yourself and Your Dependent(s) under Full Plan 1M (TX-CC-CAT-NABM) or Full Plan 1M (TX-CC-CAT-NABM) under the Policy. This Certificate represents the accident insurance available under Full Plan 1M (TX-CC-CAT-NABM), as selected by You at the time You enrolled for coverage. If You have questions regarding the plan type, You may contact the Policyholder.

Coverage Type
This Certificate provides insurance for Accidents that occur while You or Your insured Dependent(s) are not working for any employer. This is known as “non-occupational coverage” or “off-job only coverage.”

EXPRESS BENEFIT

If You or an insured Dependent are Injured as the result of an Accident, We will pay a benefit amount of $175 upon notification of the Accident. The benefit can be paid in a very short time frame and based on minimal information (compared to a typical Accident claim).

This benefit is payable once per Accident for each Insured Person that is Injured as a result of the Accident. This benefit is subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

BASIC BENEFITS

The basic benefits payable under this Certificate are organized into the following categories:

Category	Benefit Amount
Initial Care & Emergency	Up to $2,000
Specified Injuries	Up to $20,000
Hospital, Surgical & Diagnostic	Up to $800 per day and $2,000 for admission
Follow-Up Care	Up to $1,250

Within each category, benefits are payable up to the amount shown, depending on the type of Injury sustained or the type of medical Treatment that is received as the result of an Accident. The specific benefit amounts, conditions and limitations that are applicable to each Injury or Treatment are available in the applicable benefits section of this Certificate for each category. (For example, specific information for the Initial Care & Emergency category can be located in the section titled "Initial Care & Emergency Benefits").

ADDITIONAL BENEFIT(S)

In addition to Basic Benefits, family care benefits (benefits for transportation, Lodging and Childcare) are available under this Certificate.

The specific benefit amounts, conditions and limitations that are applicable to the additional benefit(s) are available in the Additional Benefit(s) section of this Certificate.

CATASTROPHIC INSURANCE

In addition to Basic Benefits, benefits for catastrophic losses and Injuries are available under this Certificate.

Catastrophic insurance pays a benefit if You or an insured Dependent are in an Accident and experience a serious loss or Injury, such as death or dismemberment. The benefit amount payable is based on the amount of insurance that is in effect for You or an insured Dependent on the date the Accident occurs, subject to the definitions, limitations, exclusions and other provisions of the Policy.

Provided You have elected accident insurance, Your amount of catastrophic insurance is $70,000.

Provided You have elected accident insurance for Your Spouse, Your Spouse's amount of catastrophic insurance is $35,000.

Provided You have elected accident insurance for Your Dependent child(ren), the amount of catastrophic insurance for Your Dependent child(ren) is $10,000.

The amount of catastrophic insurance is also referred to as the Principal Sum. The Principal Sum for You or Your Spouse reduces by 50% when You reach the Attained Age of 70. If You have questions regarding the amount of catastrophic insurance for You or Your Dependent(s), You may contact the Policyholder.

The specific conditions and limitations that are applicable to catastrophic insurance are available in the Catastrophic Benefits section of this Certificate.

GUARANTEE ISSUE AMOUNT(S) AND EVIDENCE OF INSURABILITY

All amounts of insurance under the Policy are guarantee issue. Evidence of insurability (proof of good health) is not required for any amount of insurance under the Policy.

Insurance under the Policy is only available if the total number of Employees insured under the Policy attains or remains above 10 Employees or 5% of the eligible Employees, whichever is greater. If the total number falls below the required level, insurance may be reduced, rescinded or terminated.

INITIAL CARE & EMERGENCY BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

INITIAL CARE

If more than one form of Initial Care is received by an Insured Person for the same Accident, We will only pay the highest of the following benefits for the Insured Person:

a. Emergency Room Benefit;
b. Urgent Care Center Benefit; or
c. Initial Physician Office Visit Benefit.

We will reduce the amount payable for Initial Care by the amount paid for the Express Benefit for an Accident for an Insured Person.

Emergency Room Benefit
We will pay a benefit amount of $300 if an Insured Person receives Treatment in an Emergency Room for one or more Injuries sustained as the result of an Accident within 72 hours after the Accident. This benefit is payable once per Accident for each Insured Person.

Urgent Care Center Benefit
We will pay a benefit amount of $175 if an Insured Person receives Treatment in an Urgent Care Center for one or more Injuries sustained as the result of an Accident within 5 days after the Accident. This benefit is payable once per Accident for each Insured Person.

Initial Physician Office Visit Benefit
We will pay a benefit amount of $175 if an Insured Person receives Treatment from a Physician or Medical Professional in *-+*such individual's office or clinic for one or more Injuries sustained as the result of an Accident within 30 days after the Accident. This benefit is payable once per Accident for each Insured Person.

EMERGENCY TRANSPORTATION

Ground Ambulance Benefit
We will pay a benefit amount of $400 if an Insured Person is transported by a licensed professional ambulance company to or from a Hospital or between medical facilities for Treatment of one or more Injuries sustained as the result of an Accident. The ambulance transportation must occur within 30 days after the Accident. This benefit is payable twice per Accident for each Insured Person.

Air Ambulance Benefit
We will pay a benefit amount of $2,000 if an Insured Person is transported by a licensed professional air ambulance company to or from a Hospital or between medical facilities for Treatment of one or more

Injuries sustained as the result of an Accident. The ambulance transportation must occur within 72 hours after the Accident. This benefit is payable once per Accident for each Insured Person.

SPECIFIED INJURY BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

If an Insured Person sustains both a Fracture and Dislocation (or multiple Fractures and Dislocations) as the result of the same Accident, the maximum amount payable for all Fractures and Dislocations under the Policy is up to 300% of the amount payable for the Fracture or Dislocation with the highest applicable Open Reduction or Closed Reduction benefit amount.

FRACTURES (BROKEN BONES)

Benefits
We will pay the applicable benefit amount shown in the Fracture Benefits Table if an Insured Person receives Closed Reduction (Non-surgical) or Open Reduction (Surgical) Treatment for a Fracture sustained as the result of an Accident. Treatment must occur by a Physician or Medical Professional within 90 days after the Accident.

If a Fracture is diagnosed as a Chip Fracture, We will pay 25% of the amount listed in the table for the Closed Reduction for the bone/bone group involved.

The maximum amount payable for all Fractures sustained by an Insured Person for the same Accident is up to 250% of the amount payable for the Fracture with the highest applicable Open Reduction or Closed Reduction benefit amount.

Fracture Benefits Table

Bone/Bone Group (From Head to Toe)	Open Reduction Amt	Closed Reduction Amt
Skull, depressed (Cranial bones)	$7,500	$3,750
Skull, non-depressed (Cranial bones)	$3,500	$1,750
Bones of face (Except nose and lower jaw)	$1,500	$750
Nose (Nasal bones)	$1,200	$600
Lower jaw (Mandible)	$1,500	$750
Shoulder blade (Scapula)	$1,500	$750
Collarbone (Clavicle)	$1,200	$600
Breastbone (Sternum)	$1,500	$750
Rib	$1,200	$600
Upper arm (Humerus)	$1,500	$750
Forearm (Radius and/or ulna)	$1,500	$750
Wrist (carpals)	$1,500	$750
Hand (Metacarpals, except fingers)	$1,500	$750
Fingers (Phalanges)	$600	$300
Vertebral body (Except vertebral processes)	$3,500	$1,750
Vertebral process	$1,500	$750
Tail bone (Coccyx)	$1,200	$600

Pelvis (Except tail bone and hip bones)	$4,000	$2,000
Hip bones (Illium, ischium and/or pubis)	$8,000	$4,000
Thigh (Femur)	$4,500	$2,250
Kneecap (Patella)	$1,500	$750
Lower leg (Tibia and/or fibia)	$3,500	$1,750
Ankle (Talus)	$1,500	$750
Foot (Metatarsals and calcaneus, except toes)	$1,500	$750
Toes (Phalanges)	$600	$300

Limitations

If an Insured Person sustains:

a) multiple Fractures to the same bone/bone group as a result of the same Accident, only the applicable Open Reduction or Closed Reduction benefit for the bone/bone group is payable; or

b) a Fracture:
    1. that is treated with both Open Reduction and Closed Reduction as a result of the same Accident, only the benefit for the Open Reduction of the Fracture is payable;
    2. to the bones of the face and the nose (Nasal bones) as a result of the same Accident, only the highest applicable Open Reduction or Closed Reduction benefit is payable;
    3. to a vertebral body and a vertebral process of the same vertebrae as a result of the same Accident, only the highest applicable Open Reduction or Closed Reduction benefit is payable; or
    4. to the tail bone (Coccyx), pelvis or hip bones (Illium, ischium and/or pubis) as a result of the same Accident, only the highest applicable Open Reduction or Closed reduction benefit is payable.

If We have paid a benefit for a Fracture previously sustained by an Insured Person, any new claim for that same Fracture will be payable only if the subsequent Fracture is the result of a separate and distinct Accident that occurred after the previous Fracture was completely healed.

DISLOCATIONS (SEPARATED JOINTS)

Benefits

We will pay the applicable benefit amount shown in the Dislocation Benefits Table if an Insured Person receives Closed Reduction (Non-surgical) or Open Reduction (Surgical) Treatment for a Dislocation sustained as the result of an Accident. Treatment must occur by a Physician or Medical Professional within 90 days after the Accident.

If a Dislocation is diagnosed as an Incomplete Dislocation, or if Treatment of a Dislocation occurs by a Physician or Medical Professional without the use of Anesthesia, We will pay 25% of the amount listed in the table for the Closed Reduction for the joint/joint group involved.

The maximum amount payable for all Dislocations sustained by an Insured Person for the same Accident is up to 250% of the amount payable for the Dislocation with the highest applicable Open Reduction or Closed Reduction benefit amount.

Dislocation Benefits Table

Joint/Joint Group (From Head to Toe)	Open Reduction Amt	Closed Reduction Amt
Lower jaw (Temporomandibular)	$2,100	$1,050
Shoulder (Glenohumeral)	$2,100	$1,050
Collarbone and breastbone (Sternoclavicular)	$2,100	$1,050
Elbow	$2,100	$1,050
Wrist (Radiocarpal and/or intercarpal)	$2,100	$1,050
Hand (Carpometacarpal and/or intermetacarpal)	$2,100	$1,050
Fingers (Interphalangeal and/or metacarpophalangeal)	$600	$300
Hip	$10,000	$5,000
Kneecap (Patella)	$5,500	$2,750
Ankle (Talocalcaneal and/or talocalcaneonavicular)	$3,600	$1,800
Foot (Tarsometatarsal and/or intermetatarsal)	$3,600	$1,800
Toes (Interphalangeal and/or metatarsophalangeal)	$600	$300

Limitations

If an Insured Person sustains a Dislocation:

a) that is treated with both Open Reduction and Closed Reduction as a result of the same Accident, only the benefit for the Open Reduction of the Dislocation is payable;
b) to the wrist (radiocarpal and/or intercarpal) and hand (carpometacarpal and/or intermetacarpal) joints/joint groups as a result of the same Accident, only the highest applicable Open Reduction or Closed Reduction benefit is payable; or
c) to the ankle (talocalcaneal and talocalcaneonavicular) and foot (tarsometatarsal and/or intermetatarsal) joints/joint groups as a result of the same Accident, only the highest applicable Open Reduction or Closed Reduction benefit is payable.

If We will pay/have paid a benefit for a Dislocation previously sustained by an Insured Person, any new claim for that same Dislocation will be payable only if the subsequent Dislocation is the result of a separate and distinct Accident that occurred after the previous Dislocation was completely healed.

LACERATION BENEFIT

We will pay the applicable benefit amount shown in the Laceration Benefits Table if an Insured Person receives Treatment to repair one or more Lacerations sustained as the result of an Accident with an appropriate Laceration Repair Method. The benefit amount is based on the total length of all Lacerations that require repair with a Laceration Repair Method.

Treatment must occur by a Physician or Medical Professional within 72 hours after the Accident. This benefit is payable once per Accident for each Insured Person.

Laceration Benefits Table

Total Length of All Lacerations	Benefit Amount
Less than 2 inches	$100
2 inches to 6 inches	$600

Greater than 6 inches	$1.000

If no Laceration is severe enough to require a Laceration Repair Method for repair, We will pay a benefit of 50% of the lowest benefit amount shown in the table above.

BURNS

Burn Benefit
We will pay the applicable benefit amount shown in the Burn Benefits Table if an Insured Person receives Treatment for burns sustained as the result of an Accident. The benefit amount is based on the severity of the Burn (Burn type), as diagnosed by a Physician or Medical Professional. If more than one type of Burn is sustained, only the highest applicable benefit amount is payable.

Treatment must occur by a Physician or Medical Professional within 72 hours after the Accident. This benefit is payable once per Accident for each Insured Person.

Burn Benefits Table

Severity of Burn (Burn Type)	Benefit Amt
2nd degree burns which cover less than or equal to 9% of the total body surface area	$400
2nd degree burns which cover 10% to 36% of the total body surface area	$750
2nd degree burns which cover greater than 36% of the total body surface area	$2,000
3rd degree burns which cover less than 18% of the total body surface area	$2,500
3rd degree burns which cover 18% to 36% of the total body surface area	$10,000
3rd degree burns which cover greater than 36% of the total body surface area	$20,000

Skin Graft Benefit
If an Insured Person receives a Skin Graft for a Burn for which a benefit is payable under the Policy, We will pay a Skin Graft benefit of 25% of the payable Burn benefit. This benefit is payable once per Accident for each Insured Person.

DENTAL CARE

Crown or Filling Repair Benefit
We will pay a benefit amount of $400 if an Insured Person sustains an Injury as the result of an Accident to one or more natural teeth which requires repair by placement of a crown or filling. Treatment must occur by a Dentist within 30 days after the Accident. This benefit is payable once per tooth per Accident for each Insured Person.

Extraction Benefit
We will pay a benefit amount of $125 if an Insured Person sustains an Injury as the result of an Accident to one or more natural teeth which results in extraction of the damaged tooth/teeth.

Treatment must occur by a Dentist within 30 days after the Accident. This benefit is payable once per Accident for each Insured Person.

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

HOSPITAL

Admission Benefit
We will pay a benefit amount of $2,000 for the first time an Insured Person is Confined to a Hospital for Treatment of one or more Injuries sustained as the result of an Accident. The Confinement must begin within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

We will not pay this benefit for Treatment in an Emergency Room, Outpatient Treatment, a stay of less than 20 hours in an Observation Unit or other observation area of a Hospital, or Treatment at a Rehabilitation Facility.

Daily Confinement Benefit
We will pay a benefit amount of $400 per day of Confinement if an Insured Person is Confined to a Hospital for Treatment of one or more Injuries sustained as the result of an Accident. The Confinement must begin within 365 days after the Accident. This benefit is payable for up to 365 days per Accident for each Insured Person. This benefit is only payable for one Hospital Confinement at a time, even if the Confinement is the result of more than one Accident.

We will not pay this benefit for Treatment in an Emergency Room, Outpatient Treatment, Treatment at a Rehabilitation Facility, or during the first 15 days of Confinement for an Insured Person Confined to an Intensive Care Unit.

Intensive Care Unit Confinement Benefit
We will pay a benefit amount of $800 per day of Confinement if an Insured Person is Confined to an Intensive Care Unit (ICU) for Treatment of one or more Injuries sustained as the result of an Accident. The Confinement must begin within 365 days after the Accident. This benefit is payable for up to 15 days per Accident for each Insured Person. This benefit is only payable for one ICU Confinement at a time, even if the Confinement is the result of more than one Accident.

This benefit is not payable if an Insured Person is Confined to any Hospital unit that does not meet the definition in the Policy of an Intensive Care Unit. We will not pay this benefit and the Daily Confinement Benefit concurrently.

Rehabilitation Facility Confinement Benefit
If an Insured Person is transferred to a Rehabilitation Facility for Treatment of one or more Injuries sustained as the result of an Accident immediately after a period of Confinement for which a Daily Confinement Benefit is payable, We will pay a benefit amount of $200 per day for the Insured Person's Confinement as a resident inpatient in a Rehabilitation Facility. The Insured Person's Confinement in the Rehabilitation Facility must begin within 365 days after the Accident. This benefit is payable for up to 30 days per Accident for each Insured Person.

This benefit is only payable for one Rehabilitation Facility Confinement at a time, even if the Confinement is the result of more than one Accident. We will not pay this benefit and the Daily Confinement Benefit concurrently.

SURGICAL

If any surgery listed below occurs concurrently with an Open Reduction for a Fracture or Dislocation of the same bone/bone group or joint/joint group as a result of the same Accident, only the highest applicable benefit is payable.

Exploratory Surgery or Arthroscopic Debridement Benefit
We will pay a benefit amount of $350 if an Insured Person undergoes Exploratory Surgery or Arthroscopic Debridement for one or more Injuries sustained as the result of an Accident. An Exploratory Surgery must occur by a Physician within 365 days after the Accident. An Arthroscopic Debridement must occur by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

We will reduce the benefit amount payable for any surgery listed below if this benefit was previously paid for the same Injury(ies) for an Accident for an Insured Person.

Abdominal, Cranial or Thoracic Surgery Benefit
We will pay a benefit amount of $2,500 if an Insured Person undergoes abdominal, cranial or thoracic surgery for the repair of one or more internal Injuries sustained as the result of an Accident. The surgery must occur by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

We will not pay this benefit for the repair of a hernia. No Exploratory Surgery Benefit, Arthroscopic Surgery Benefit or Brain Injury Diagnosis Benefit is payable if this benefit is payable for the same injury(ies). If abdominal, cranial or thoracic surgery occurs concurrently with an Open Reduction for a Fracture or Dislocation of the same bone/bone group or joint/joint group as a result of the same Accident, only the highest applicable benefit is payable.

Herniated Disc Surgery Benefit
We will pay a benefit amount of $1,200 if an Insured Person undergoes surgery to repair one or more Herniated Discs sustained as the result of an Accident. Initial Treatment must occur by a Physician or Medical Professional within 30 days after the Accident and surgery must occur by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

No Exploratory Surgery Benefit or Arthroscopic Surgery Benefit is payable if this benefit is payable for the same injury(ies).

Torn Knee Cartilage (Meniscus) Surgery Benefit
We will pay a benefit amount of $1,000 if an Insured Person undergoes surgery to repair torn knee cartilage (meniscus) sustained as the result of an Accident. Initial Treatment must occur by a Physician or Medical Professional within 30 days after the Accident and surgery must occur by a Physician within 365 days after the Accident. This benefit is payable once per knee per Accident for each Insured Person.

No Exploratory Surgery Benefit or Arthroscopic Surgery Benefit is payable if this benefit is payable for the same injury(ies). If an Insured Person undergoes surgery to repair torn knee cartilage (meniscus) and undergoes surgery to repair one or more ligaments, rotator cuffs or tendons as a result of the same Accident, the maximum amount payable for the surgeries is equal to 200% of the highest applicable benefit amount.

Ligament, Rotator Cuff or Tendon Surgery Benefit
We will pay a benefit amount of $1,000 if an Insured Person undergoes surgery to repair one or more torn, ruptured or severed ligaments, rotator cuffs or tendons sustained as the result of an Accident. Initial Treatment must occur by a Physician or Medical Professional within 30 days after the Accident and surgery must occur by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

No Exploratory Surgery Benefit or Arthroscopic Surgery Benefit is payable if this benefit is payable for the same injury(ies). If an Insured Person undergoes surgery to repair one or more ligaments, rotator cuffs or tendons and undergoes surgery to repair torn knee cartilage (meniscus) as a result of the same Accident, the maximum amount payable for the surgeries is equal to 200% of the highest applicable benefit amount.

Eye Procedure Benefit
We will pay a benefit amount of $450 if an Insured Person undergoes a procedure to remove a foreign object or surgery for an eye Injury sustained as the result of an Accident. The surgery or procedure must occur by a Physician or Medical Professional within 90 days after the Accident. This benefit is payable once per eye per Accident for each Insured Person.

We will not pay this benefit for an Injury that is limited to the Eyelid or for an eye examination (with or without Anesthesia). No Exploratory Surgery Benefit or Arthroscopic Surgery Benefit is payable if this benefit is payable for the same injury(ies).

Blood Products Benefit
We will pay a benefit amount of $550 if an Insured Person receives a transfusion of one or more Blood Products for Treatment of an Injury sustained as the result of an Accident. The transfusion must occur within 90 days after the Accident. This benefit is payable up to 3 times per Accident for each Insured Person.

We will not pay this benefit for platelet or plasma infusions.

Pain Management (Epidural Anesthesia) Benefit
We will pay a benefit amount of $200 if an Insured Person receives Epidural Anesthesia for Treatment of an Injury sustained as the result of an Accident. The Anesthesia must be administered within 90 days after the Accident. This benefit is payable up to 3 times per Accident for each Insured Person.

DIAGNOSTIC

X-Ray Benefit
We will pay a benefit amount of $100 if an Insured Person undergoes an X-Ray for Treatment of one or more Injuries sustained as the result of an Accident. The X-Ray must occur within 90 days after the Accident. This benefit is payable up to 2 times per Accident for each Insured Person.

Diagnostic Exam Benefit
We will pay a benefit amount of $400 if an Insured Person undergoes a Diagnostic Exam for Treatment of one or more Injuries sustained as the result of an Accident. The exam must occur within 90 days after the Accident. This benefit is payable once per Accident for each Insured Person.

Brain Injury Diagnosis Benefit
We will pay a benefit amount of $350 if an Insured Person is diagnosed with a Brain Injury sustained as the result of an Accident. The diagnosis must occur by a Physician or Medical Professional within 30 days after the Accident and be confirmed by a Diagnostic Exam. This benefit is payable once per Accident for each Insured Person.

We will reduce the benefit amount payable for cranial surgery if this benefit was previously paid for the same Injury(ies) for an Accident for an Insured Person.

FOLLOW-UP CARE BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

FOLLOW-UP TREATMENT

Physician Follow-Up Office Visit Benefit
We will pay a benefit amount of $125 if an Insured Person receives Follow-Up Treatment for one or more Injuries sustained as the result of an Accident from a Physician or Medical Professional in such individual's office or clinic. The first Follow- Up Treatment must occur within 60 days after the Accident or within 30 days after the Insured Person is no longer Confined as a result of the Accident.

All Follow-Up Treatment must occur within 365 days after the Accident. This benefit is payable up to 6 times per Accident for each Insured Person.

We will not pay this benefit:

a) if any form of Initial Care was not received by the Insured Person for the same Accident;
b) for Follow-Up Treatment received on the same day that an Insured Person received any form of Initial Care for the same Accident; or
c) while an Insured Person is Confined.

Therapy Services Benefit
We will pay a benefit amount of $75 if an Insured Person receives Therapy for one or more Injuries sustained as the result of an Accident from a Therapist in such individual's office or clinic. The first Therapy visit must occur within 365 days after the Accident or within 30 days after the Insured Person is no longer Confined as a result of the Accident.

All Therapy visits must occur within 365 days after the Accident. This benefit is payable up to 6 times per Accident for each Insured Person.

We will not pay this benefit:

a) if any form of Initial Care was not received by the Insured Person for the same Accident;

b) for Therapy received on the same day that an Insured Person received any form of Initial Care for the same Accident; or
c) while an Insured Person is Confined.

MEDICAL DEVICE BENEFIT

We will pay a benefit amount of $300 if an Insured Person sustains an Injury as the result of an Accident which requires a Medical Device to assist the Insured Person with personal locomotion or mobility. The Medical Device must be prescribed by a Physician or Medical Professional and be received within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

Proof of the expense incurred for the purchase of a Medical Device for an Insured Person must be submitted with the claim.

PROSTHETIC DEVICE(S) BENEFIT

We will pay a benefit amount of $1,250 if an Insured Person sustains an Injury as the result of an Accident and receives a Prosthetic Device after the Injury results in the loss of limb, hand, foot or sight of an eye. The Prosthetic Device must be prescribed by a Physician for functional use and be received within 365 days after the Accident. This benefit is payable up to 2 times per Accident for each Insured Person.

We will not pay this benefit for more than one Prosthetic Device for the same body part, or for the replacement of a Prosthetic Device for which We will pay/have paid a benefit for an Insured Person for the same Accident.

ADDITIONAL BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

FAMILY CARE

Transportation Benefit
We will pay a benefit amount of $500 per round trip for travel by an Insured Person to a Hospital or other medical facility more than 75 miles away from the Insured Person's primary residence for Treatment (including Follow-Up Treatment) of one or more Injuries sustained as the result of an Accident. Treatment must be prescribed by a Physician and the same or similar Treatment must not be available within 75 miles of the Insured Person's primary residence. This benefit is payable for up to 3 round trips per Accident within 365 days after the Accident.

We will also pay a benefit amount of $500 if an Insured Person is Confined for Treatment of one or more Injuries sustained as the result of an Accident that occurred more than 200 miles away from the Insured Person's primary residence and is brought home (to the Insured Person's primary residence). Transportation to the Insured Person's primary residence must occur within 48 hours following discharge from the Hospital or Rehabilitation Facility, within 365 days after an Accident. This benefit is payable once per Calendar Year per Insured Person.

Mileage is measured as the distance from the Insured Person's primary residence to the facility at which the Treatment occurs. We will not pay this benefit if either the Ground Ambulance Benefit or Air Ambulance Benefit is payable for the same trip.

Lodging Benefit
We will pay a benefit amount of $175 per night of Lodging for which an expense is incurred if an adult Family member or adult companion accompanies an Insured Person who is Confined more than 75 miles away from the Insured Person's primary residence for Treatment of one or more Injuries sustained as the result of an Accident. This benefit is payable for up to 30 nights of Lodging per Accident within 365 days after the Accident.

This benefit is only payable for a Confinement for which We will pay a Daily Confinement Benefit, Intensive Care Unit Confinement Benefit or Rehabilitation Facility Confinement Benefit for the Insured Person. Only one benefit is payable per night of Lodging. Proof of the expense incurred by the adult companion for Lodging must be submitted with the claim.

Mileage is measured as the distance from the Insured Person's primary residence to the Hospital or medical facility in which the Insured Person is Confined.

Childcare Benefit
We will pay a benefit amount of $30 per day for Childcare if an Insured Person is Confined for Treatment of one or more Injuries sustained as the result of an Accident and incurs expense for one or more Dependent children attending a Childcare Center. This benefit is payable for up to 30 days of Childcare per Dependent child per Accident within 365 days after the Accident.

A Dependent child does not have to be insured under the Policy for this benefit to be payable. This benefit is only payable for a Confinement for which We will pay a Daily Confinement Benefit or Intensive Care Unit Confinement Benefit for the Insured Person. Proof of the expense incurred by the Insured Person for Childcare must be submitted with the claim.

CATASTROPHIC BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

The Principal Sum is the amount of catastrophic insurance in effect for the Insured Person on the date of the Accident.

ACCIDENTAL DEATH

Basic Accidental Death Benefit
We will pay a benefit amount equal to 100% of the Principal Sum if an Insured Person dies as the result of an Accident. Death must occur within 365 days after the Accident. This benefit is payable once under the Policy for each Insured Person.

If one or more Catastrophic Benefits have been previously paid under the Policy for an Accident for an Insured Person, We will reduce the amount payable under this benefit by the amount paid for the

previous Catastrophic Benefit(s) unless otherwise indicated in a benefit provision included in this Catastrophic Benefits section of this Certificate.

Common Carrier Accidental Death Benefit
We will pay a benefit amount equal to 300% of the Principal Sum if an Insured Person dies as the result of an Accident that occurs while a fare-paying passenger on a Common Carrier. Death must occur within 365 days after the Accident. This benefit is payable once under the Policy for each Insured Person.

We will not pay this benefit if an Insured Person was an operator or member of the crew on the Common Carrier conveyance at the time of the Accident. If this benefit is payable under the Policy for an Insured Person, We will not pay the Basic Accidental Death Benefit for that Insured Person.

If one or more Catastrophic Benefits have been previously paid under the Policy for an Accident for an Insured Person, We will reduce the amount payable under this benefit by the amount paid for the previous Catastrophic Benefit(s) unless otherwise indicated in a benefit provision included in this Catastrophic Benefits section of this Certificate.

Exposure & Disappearance
An Insured Person will be presumed to have died, for the purposes of the Basic Accidental Death Benefit or Common Carrier Accidental Death Benefit, if after the forced landing, stranding, sinking or wrecking of a vehicle:

a) the Insured Person disappears;
b) the Insured Person's body is not found; and
c) a valid death certificate is issued by a court of appropriate jurisdiction.

Transportation of Remains Benefit
We will pay for expenses reasonably incurred for the preparation and transportation of remains, up to a maximum of $5,000, if an Insured Person dies as the result of an Accident and the death occurs more than 100 miles away from the Insured Person's primary residence. We must be contacted prior to the preparation and transportation of the remains to pre-authorize the services.

The Insured Person's bodily remains or ashes must be transported to a mortuary or funeral home within 30 miles of the Insured Person's primary residence by a duly licensed company that provides mortuary transport services. This benefit is payable once under the Policy for each Insured Person. This benefit amount is payable in addition to any other applicable benefits under the Policy.

Proof of the expenses incurred must be submitted with the claim. This benefit does not include the transportation expense of anyone accompanying the body or remains, visitation expenses or funeral expenses. In no event will the total amount paid under all group insurance policies issued by Us exceed the actual expense for the preparation and transportation of remains of an Insured Person. We will not pay this benefit if a same or similar benefit is payable under a third-party service contracted by Us.

DISMEMBERMENT & PARALYSIS

Benefits
We will pay the applicable benefit amount shown in the Dismemberment & Paralysis Benefits Table below if an Insured Person sustains one or more Injuries as the result of an Accident that results in

Dismemberment and/or Paralysis. The Dismemberment or Paralysis must occur within 365 days after the Accident.

The maximum amount payable for all losses shown in the table sustained by an Insured Person for the same Accident is 100% of the Principal Sum.

Dismemberment & Paralysis Benefits Table

Loss	Benefit
Loss of Both Hands, Loss of Both Feet, Loss of Entire Sight of Both Eyes or any combination of two or more of these losses	100% of the Principal Sum
Loss of Speech and Loss of Hearing (both ears)	100% of the Principal Sum
Loss of One Hand, Loss of One Foot, Loss of Entire Sight of One Eye or Loss of Hearing (both ears)	50% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of Multiple Fingers or Loss of Multiple Toes	10% of the Principal Sum
Quadriplegia (Paralysis of both upper and both lower limbs)	100% of the Principal Sum
Triplegia (Paralysis of both upper and both lower limbs)	75% of the Principal Sum
Hemiplegia (Paralysis of an upper and lower limb)	50% of the Principal Sum
Paraplegia (Paralysis of both lower limbs)	50% of the Principal Sum
Uniplegia (Paralysis of a limb)	25% of the Principal Sum

Limitations

If more than one loss shown in the Dismemberment & Paralysis Benefits Table is sustained by an Insured Person for the same Accident, We will pay only the highest applicable benefit. If a benefit was paid under the Policy for an Insured Person for any Dismemberment or Paralysis and the Insured Person later sustains a more severe loss shown in the table as a result of the same Accident, We will reduce the amount payable for the subsequent, more severe loss by the amount paid previously under this benefit.

REASONABLE MODIFICATION(S) BENEFIT

We will pay for expenses reasonably incurred for Home Alteration and/or Vehicle Modification, up to a maximum of 10% of the Principal Sum, if an Insured Person sustains one or more Injuries as the result of an Accident for which a Dismemberment or Paralysis benefit is payable under the Policy for:

a) Loss of Both Hands, Loss of Both Feet, Loss of Entire Sight of Both Eyes or any combination of 2 or more of these losses;
b) Loss of Speech and Loss of Hearing (Both ears);
c) Loss of One Hand, Loss of One Foot, Loss of Entire Sight of One Eye or Loss of Hearing (Both ears); or
d) Quadriplegia, triplegia, hemiplegia or paraplegia.

A Physician must certify that any modification is needed to accommodate a physical disability of the Insured Person. A modification must be made by someone experienced in such adaptations and must be in compliance with any requirements established by the appropriate government authority. The expense for any modification cannot exceed the usual level of charges for similar alterations and/or modifications in the location where the expense is incurred.

The expense for any modification must be incurred within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person. This benefit amount is payable in addition to any other applicable benefits under the Policy.

COMA BENEFIT

We will pay a benefit amount equal to 25% of the Principal Sum if an Insured Person sustains one or more Injuries as the result of an Accident that results in a Coma. The Insured Person must become Comatose within 30 days after the Accident and remain Comatose for 10 or more consecutive days. The Coma must be diagnosed by a Physician and be confirmed by an electroencephalogram (EEG). This benefit is payable once per Accident for each Insured Person.

EXCLUSIONS

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

We will not pay any benefits under the Policy for any loss or claim which does not result from an Accident or occurs more than 365 days after an Accident.

We will also not pay any benefits under the Policy for an Accident that:

a) occurs in the course of any occupation or employment for an Insured Person with any employer for wage or profit, or for which the Insured Person is entitled to benefits under any workers' compensation or occupational disease law or receives any settlement from a workers' compensation carrier;
b) results from any bodily infirmity, Sickness, or medical or surgical Treatment thereof;
c) results from cosmetic surgery or procedures;
d) results, whether an Insured Person is sane or insane, from:
    1. an intentionally self-inflicted Injury or Sickness; or
    2. suicide or attempted suicide;
e) occurs in consequence of an Insured Person's being voluntarily intoxicated or under the influence of any controlled substance or alcohol (as defined by the laws of the state in which the Accident occurred), unless administered on the advice of a Physician;
f) results from an Insured Person's intentional or voluntary use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption, including self-infliction of carbon monoxide poisoning emanating from a motor vehicle;
g) results from an Insured Person's voluntary participation in a riot, commission of a felony, participation in illegal activities or participation in an illegal occupation;
h) occurs while an Insured Person is incarcerated or imprisoned;
i) results from an act of declared or undeclared war or armed aggression;
j) occurs while an Insured Person is operating, learning to operate, riding as a passenger, boarding, departing or jumping from any aircraft (including those that are not motor driven, such as a hot air balloon), unless riding as a fare-paying passenger in a commercial aircraft on a regularly-scheduled flight or while Traveling on Business of the Policyholder;

k) occurs while an Insured Person is riding in or on any motor vehicle or aircraft engaged in racing, endurance tests, off-road activities (for motor vehicles), acrobatic tricks or stunts (for motor vehicles), or acrobatic or stunt flying (for aircraft);
l) occurs while an Insured Person is practicing for, participating in or officiating any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received by the Insured Person;
m) occurs while an Insured Person is engaged in skydiving, scuba diving, parachuting, hang gliding, bungee jumping, sail gliding, parasailing, parakiting, mountain climbing, base jumping, rock climbing or other similar high-risk activities or extreme sports; or
n) occurs while an Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable.

Low Accident Plan

CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

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

United of Omaha Life Insurance Company certifies that Group Policy Number GUDH-BZPL (the Policy) has been issued to Killeen Independent School District (the Policyholder). The Policy provides Group Accident Insurance.

Insurance is provided for Employees of the Policyholder subject to the terms and conditions of the Policy. This Certificate is made a part 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.

The Policy is nonparticipating, therefore it will pay no dividends. The Policy is non contributory.

James T. Blackledge
Chief Executive Officer

Daryl Vanbeat
Corporate Secretary

SCHEDULE

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

CLASS(ES)

All Eligible Employees in Low Plan

ACCIDENT INSURANCE

Accident insurance offers financial protection for You and Your insured Dependent(s) by paying a benefit if You or an insured Dependent are Injured in an Accident. The benefit amount(s) payable is/are based on the type and amount of insurance in effect on the date the Accident occurs, subject to the definitions, limitations, exclusions and other provisions of the Policy.

You may elect insurance for Yourself and Your Dependent(s) under this Certificate for one of the following coverage options:

a) Yourself only;
b) You and Your Spouse;
c) You and Your Dependent child(ren); or
d) You, Your Spouse and Your Dependent child(ren).

Unless otherwise stated in this Certificate, the benefit amount payable is the same for You and Your insured Dependent(s). If You have questions regarding who is insured for accident insurance, You may contact the Policyholder.

Plan Type
You may elect insurance for Yourself and Your Dependent(s) under Full Plan 1M (TX-CC-CAT-NABM) or Full Plan 1M (TX-CC-CAT-NABM) under the Policy. This Certificate represents the accident insurance available under Full Plan 1M (TX-CC-CAT-NABM), as selected by You at the time You enrolled for coverage. If You have questions regarding the plan type, You may contact the Policyholder.

Coverage Type
This Certificate provides insurance for Accidents that occur while You or Your insured Dependent(s) are not working for any employer. This is known as “non-occupational coverage” or “off-job only coverage.”

EXPRESS BENEFIT

If You or an insured Dependent are Injured as the result of an Accident, We will pay a benefit amount of $100 upon notification of the Accident. The benefit can be paid in a very short time frame and based on minimal information (compared to a typical Accident claim).

This benefit is payable once per Accident for each Insured Person that is Injured as a result of the Accident. This benefit is subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

BASIC BENEFITS

The basic benefits payable under this Certificate are organized into the following categories:

Category	Benefit Amount
Initial Care & Emergency	Up to $1,500
Specified Injuries	Up to $15,000
Hospital, Surgical & Diagnostic	Up to $600 per day and $1,500 for admission
Follow-Up Care	Up to $1,000

Within each category, benefits are payable up to the amount shown, depending on the type of Injury sustained or the type of medical Treatment that is received as the result of an Accident. The specific benefit amounts, conditions and limitations that are applicable to each Injury or Treatment are available in the applicable benefits section of this Certificate for each category. (For example, specific information for the Initial Care & Emergency category can be located in the section titled "Initial Care & Emergency Benefits.")

ADDITIONAL BENEFIT(S)

In addition to Basic Benefits, family care benefits (benefits for transportation, Lodging and Childcare) are available under this Certificate.

The specific benefit amounts, conditions and limitations that are applicable to the additional benefit(s) are available in the Additional Benefit(s) section of this Certificate.

CATASTROPHIC INSURANCE

In addition to Basic Benefits, benefits for catastrophic losses and Injuries are available under this Certificate. Catastrophic insurance pays a benefit if You or an insured Dependent are in an Accident and experience a serious loss or

Injury, such as death or dismemberment. The benefit amount payable is based on the amount of insurance that is in effect for

You or an insured Dependent on the date the Accident occurs, subject to the definitions, limitations, exclusions and other provisions of the Policy.

Provided You have elected accident insurance, Your amount of catastrophic insurance is $50,000.

Provided You have elected accident insurance for Your Spouse, Your Spouse's amount of catastrophic insurance is $25,000.

Provided You have elected accident insurance for Your Dependent child(ren), the amount of catastrophic insurance for Your Dependent child(ren) is $10,000.

The amount of catastrophic insurance is also referred to as the Principal Sum. The Principal Sum for You or Your Spouse reduces by 50% when You reach the Attained Age of 70. If You have questions regarding the amount of catastrophic insurance for You or Your Dependent(s), You may contact the Policyholder.

The specific conditions and limitations that are applicable to catastrophic insurance are available in the Catastrophic Benefits section of this Certificate.

GUARANTEE ISSUE AMOUNT(S) AND EVIDENCE OF INSURABILITY

All amounts of insurance under the Policy are guarantee issue. Evidence of insurability (proof of good health) is not required for any amount of insurance under the Policy.

Insurance under the Policy is only available if the total number of Employees insured under the Policy attains or remains above 10 Employees or 5% of the eligible Employees, whichever is greater. If the total number falls below the required level, insurance may be reduced, rescinded or terminated.

SPECIFIED INJURY BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

If an Insured Person sustains both a Fracture and Dislocation (or multiple Fractures and Dislocations) as the result of the same Accident, the maximum amount payable for all Fractures and Dislocations under the Policy is up to 300% of the amount payable for the Fracture or Dislocation with the highest applicable Open Reduction or Closed Reduction benefit amount.

FRACTURES (BROKEN BONES)

Benefits
We will pay the applicable benefit amount shown in the Fracture Benefits Table if an Insured Person receives Closed Reduction (Non-surgical) or Open Reduction (Surgical) Treatment for a Fracture sustained as the result of an Accident. Treatment must occur by a Physician or Medical Professional within 90 days after the Accident.

If a Fracture is diagnosed as a Chip Fracture, We will pay 25% of the amount listed in the table for the Closed Reduction for the bone/bone group involved.

The maximum amount payable for all Fractures sustained by an Insured Person for the same Accident is up to 250% of the amount payable for the Fracture with the highest applicable Open Reduction or Closed Reduction benefit amount.

Fracture Benefits Table

Bone/Bone Group (From Head to Toe)	Open Reduction Amt	Closed Reduction Amt
Skull, depressed (Cranial bones)	$6,000	$3,000
Skull, non-depressed (Cranial bones)	$3,000	$1,500
Bones of face (Except nose and lower jaw)	$1,200	$600
Nose (Nasal bones)	$900	$450
Lower jaw (Mandible)	$1,200	$600
Shoulder blade (Scapula)	$1,200	$600
Collarbone (Clavicle)	$900	$450
Breastbone (Sternum)	$1,200	$600
Rib	$900	$450
Upper arm (Humerus)	$1,200	$600
Forearm (Radius and/or ulna)	$1,200	$600
Wrist (Carpals)	$1,200	$600

Hand (Metacarpals, except fingers)	$1,200	$600
Fingers (Phalanges)	$400	$200
Vertebral body (Except vertebral processes)	$3,000	$1,500
Vertebral process	$1,200	$600
Tail bone (Coccyx)	$900	$450
Pelvis (Except tail bone and hip bones)	$3,000	$1,500
Hip bones (Illium, ischium and/or pubis)	$6,000	$3,000
Thigh (Femur)	$3,000	$1,500
Kneecap (Patella)	$1,200	$600
Lower leg (Tibia and/or fibia)	$3,000	$1,500
Ankle (Talus)	$1,200	$600
Foot (Metatarsals and calcaneus, except toes)	$1,200	$600
Toes (Phalanges)	$400	$200

Limitations

If an Insured Person sustains:

a) multiple Fractures to the same bone/bone group as a result of the same Accident, only the applicable Open Reduction or Closed Reduction benefit for the bone/bone group is payable; or

b) a Fracture:

1. that is treated with both Open Reduction and Closed Reduction as a result of the same Accident, only the benefit for the Open Reduction of the Fracture is payable;
2. to the bones of the face and the nose (Nasal bones) as a result of the same Accident, only the highest applicable Open Reduction or Closed Reduction benefit is payable;
3. to a vertebral body and a vertebral process of the same vertebrae as a result of the same Accident, only the highest applicable Open Reduction or Closed Reduction benefit is payable; or
4. to the tail bone (Coccyx), pelvis or hip bones (Illium, ischium and/or pubis) as a result of the same Accident, only the highest applicable Open Reduction or Closed reduction benefit is payable.

If We have paid a benefit for a Fracture previously sustained by an Insured Person, any new claim for that same Fracture will be payable only if the subsequent Fracture is the result of a separate and distinct Accident that occurred after the previous Fracture was completely healed.

DISLOCATIONS (SEPARATED JOINTS)

Benefits

We will pay the applicable benefit amount shown in the Dislocation Benefits Table if an Insured Person receives Closed Reduction (Non-surgical) or Open Reduction (Surgical) Treatment for a Dislocation sustained as the result of an Accident. Treatment must occur by a Physician or Medical Professional within 90 days after the Accident.

If a Dislocation is diagnosed as an Incomplete Dislocation, or if Treatment of a Dislocation occurs by a Physician or Medical Professional without the use of Anesthesia, We will pay 25% of the amount listed in the table for the Closed Reduction for the joint/joint group involved.

The maximum amount payable for all Dislocations sustained by an Insured Person for the same Accident is up to 250% of the amount payable for the Dislocation with the highest applicable Open Reduction or Closed Reduction benefit amount.

Dislocation Benefits Table

Joint/Joint Group (From Head to Toe)	Open Reduction Amt	Closed Reduction Amt
Lower jaw (Temporomandibular)	$1,800	$900
Shoulder (Glenohumeral)	$1,800	$900
Collarbone and breastbone (Sternoclavicular)	$1,800	$900
Elbow	$1,800	$900
Wrist (Radiocarpal and/or intercarpal)	$1,800	$900
Hand (Carpometacarpal and/or intermetacarpal)	$1,800	$900
Fingers (Interphalangeal and/or metacarpophalangeal)	$450	$225
Hip	$9,000	$4,500
Kneecap (Patella)	$4,500	$2,250
Ankle (Talocalcaneal and/or talocalcaneonavicular)	$2,700	$1,350
Foot (Tarsometatarsal and/or intermetatarsal)	$2,700	$1,350
Toes (Interphalangeal and/or metatarsophalangeal)	$450	$225

Limitations

If an Insured Person sustains a Dislocation:

a) that is treated with both Open Reduction and Closed Reduction as a result of the same Accident, only the benefit for the Open Reduction of the Dislocation is payable;
b) to the wrist (radiocarpal and/or intercarpal) and hand (carpometacarpal and/or intermetacarpal) joints/joint groups as a result of the same Accident, only the highest applicable Open Reduction or Closed Reduction benefit is payable; or
c) to the ankle (talocalcaneal and talocalcaneonavicular) and foot (tarsometatarsal and/or intermetatarsal) joints/joint groups as a result of the same Accident, only the highest applicable Open Reduction or Closed Reduction benefit is payable.

If We will pay/have paid a benefit for a Dislocation previously sustained by an Insured Person, any new claim for that same Dislocation will be payable only if the subsequent Dislocation is the result of a separate and distinct Accident that occurred after the previous Dislocation was completely healed.

LACERATION BENEFIT

We will pay the applicable benefit amount shown in the Laceration Benefits Table if an Insured Person receives Treatment to repair one or more Lacerations sustained as the result of an Accident with an appropriate Laceration Repair Method. The benefit amount is based on the total length of all Lacerations that require repair with a Laceration Repair Method.

Treatment must occur by a Physician or Medical Professional within 72 hours after the Accident. This benefit is payable once per Accident for each Insured Person.

Laceration Benefits Table

Category	Benefit Amount
Less than 2 inches	$100
2 inches to 6 inches	$450
Greater than 6 inches	$800

If no Laceration is severe enough to require a Laceration Repair Method for repair, We will pay a benefit of 50% of the lowest benefit amount shown in the table above.

BURNS

Burn Benefit

We will pay the applicable benefit amount shown in the Burn Benefits Table if an Insured Person receives Treatment for burns sustained as the result of an Accident. The benefit amount is based on the severity of the Burn (Burn type), as diagnosed by a Physician or Medical Professional. If more than one type of Burn is sustained, only the highest applicable benefit amount is payable.

Treatment must occur by a Physician or Medical Professional within 72 hours after the Accident. This benefit is payable once per Accident for each Insured Person.

Burn Benefits Table

Severity of Burn (Burn Type)	Benefit Amt
2nd degree burns which cover less than or equal to 9% of the total body surface area	$250
2nd degree burns which cover 10% to 36% of the total body surface area	$500
2nd degree burns which cover greater than 36% of the total body surface area	$1,500
3rd degree burns which cover less than 18% of the total body surface area	$2,000
3rd degree burns which cover 18% to 36% of the total body surface area	$7,500
3rd degree burns which cover greater than 36% of the total body surface area	$15,000

Skin Graft Benefit

If an Insured Person receives a Skin Graft for a Burn for which a benefit is payable under the Policy, We will pay a Skin Graft benefit of 25% of the payable Burn benefit. This benefit is payable once per Accident for each Insured Person.

DENTAL CARE

Crown or Filling Repair Benefit

We will pay a benefit amount of $300 if an Insured Person sustains an Injury as the result of an Accident to one or more natural teeth which requires repair by placement of a crown or filling. Treatment must occur by a Dentist within 30 days after the Accident. This benefit is payable once per tooth per Accident for each Insured Person.

Extraction Benefit

We will pay a benefit amount of $100 if an Insured Person sustains an Injury as the result of an Accident to one or more natural teeth which results in extraction of the damaged tooth/teeth.

Treatment must occur by a Dentist within 30 days after the Accident. This benefit is payable once per Accident for each Insured Person.

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

HOSPITAL

Admission Benefit
We will pay a benefit amount of $1,500 for the first time an Insured Person is Confined to a Hospital for Treatment of one or more Injuries sustained as the result of an Accident. The Confinement must begin within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

We will not pay this benefit for Treatment in an Emergency Room, Outpatient Treatment, a stay of less than 20 hours in an Observation Unit or other observation area of a Hospital, or Treatment at a Rehabilitation Facility.

Daily Confinement Benefit
We will pay a benefit amount of $300 per day of Confinement if an Insured Person is Confined to a Hospital for Treatment of one or more Injuries sustained as the result of an Accident. The Confinement must begin within 365 days after the Accident. This benefit is payable for up to 365 days per Accident for each Insured Person. This benefit is only payable for one Hospital Confinement at a time, even if the Confinement is the result of more than one Accident.

We will not pay this benefit for Treatment in an Emergency Room, Outpatient Treatment, Treatment at a Rehabilitation Facility, or during the first 15 days of Confinement for an Insured Person Confined to an Intensive Care Unit.

Intensive Care Unit Confinement Benefit
We will pay a benefit amount of $600 per day of Confinement if an Insured Person is Confined to an Intensive Care Unit (ICU) for Treatment of one or more Injuries sustained as the result of an Accident. The Confinement must begin within 365 days after the Accident. This benefit is payable for up to 15 days per Accident for each Insured Person. This benefit is only payable for one ICU Confinement at a time, even if the Confinement is the result of more than one Accident.

This benefit is not payable if an Insured Person is Confined to any Hospital unit that does not meet the definition in the Policy of an Intensive Care Unit. We will not pay this benefit and the Daily Confinement Benefit concurrently.

Rehabilitation Facility Confinement Benefit
If an Insured Person is transferred to a Rehabilitation Facility for Treatment of one or more Injuries sustained as the result of an Accident immediately after a period of Confinement for which a Daily Confinement Benefit is payable, We will pay a benefit amount of $150 per day for the Insured Person's Confinement as a resident inpatient in a Rehabilitation Facility. The Insured Person's Confinement in the Rehabilitation Facility must begin within 365 days after the Accident. This benefit is payable for up to 30 days per Accident for each Insured Person.

This benefit is only payable for one Rehabilitation Facility Confinement at a time, even if the Confinement is the result of more than one Accident. We will not pay this benefit and the Daily Confinement Benefit concurrently.

SURGICAL

If any surgery listed below occurs concurrently with an Open Reduction for a Fracture or Dislocation of the same bone/bone group or joint/joint group as a result of the same Accident, only the highest applicable benefit is payable.

Exploratory Surgery or Arthroscopic Debridement Benefit
We will pay a benefit amount of $200 if an Insured Person undergoes Exploratory Surgery or Arthroscopic Debridement for one or more Injuries sustained as the result of an Accident. An Exploratory Surgery must occur by a Physician within 365 days after the Accident. An Arthroscopic Debridement must occur by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

We will reduce the benefit amount payable for any surgery listed below if this benefit was previously paid for the same Injury(ies) for an Accident for an Insured Person.

Abdominal, Cranial or Thoracic Surgery Benefit
We will pay a benefit amount of $2,000 if an Insured Person undergoes abdominal, cranial or thoracic surgery for the repair of one or more internal Injuries sustained as the result of an Accident. The surgery must occur by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

We will not pay this benefit for the repair of a hernia. No Exploratory Surgery Benefit, Arthroscopic Surgery Benefit or Brain Injury Diagnosis Benefit is payable if this benefit is payable for the same injury(ies). If abdominal, cranial or thoracic surgery occurs concurrently with an Open Reduction for a Fracture or Dislocation of the same bone/bone group or joint/joint group as a result of the same Accident, only the highest applicable benefit is payable.

Herniated Disc Surgery Benefit
We will pay a benefit amount of $900 if an Insured Person undergoes surgery to repair one or more Herniated Discs sustained as the result of an Accident. Initial Treatment must occur by a Physician or Medical Professional within 30 days after the Accident and surgery must occur by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

No Exploratory Surgery Benefit or Arthroscopic Surgery Benefit is payable if this benefit is payable for the same injury(ies).

Torn Knee Cartilage (Meniscus) Surgery Benefit
We will pay a benefit amount of $750 if an Insured Person undergoes surgery to repair torn knee cartilage (meniscus) sustained as the result of an Accident. Initial Treatment must occur by a Physician or Medical Professional within 30 days after the Accident and surgery must occur by a Physician within 365 days after the Accident. This benefit is payable once per knee per Accident for each Insured Person.

No Exploratory Surgery Benefit or Arthroscopic Surgery Benefit is payable if this benefit is payable for the same injury(ies). If an Insured Person undergoes surgery to repair torn knee cartilage (meniscus) and undergoes surgery to repair one or more ligaments, rotator cuffs or tendons as a result of the same Accident, the maximum amount payable for the surgeries is equal to 200% of the highest applicable benefit amount.

Ligament, Rotator Cuff or Tendon Surgery Benefit
We will pay a benefit amount of $750 if an Insured Person undergoes surgery to repair one or more torn, ruptured or severed ligaments, rotator cuffs or tendons sustained as the result of an Accident. Initial Treatment must occur by a Physician or Medical Professional within 30 days after the Accident and surgery must occur by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

No Exploratory Surgery Benefit or Arthroscopic Surgery Benefit is payable if this benefit is payable for the same injury(ies). If an Insured Person undergoes surgery to repair one or more ligaments, rotator cuffs or tendons and undergoes surgery to repair torn knee cartilage (meniscus) as a result of the same Accident, the maximum amount payable for the surgeries is equal to 200% of the highest applicable benefit amount.

Eye Procedure Benefit
We will pay a benefit amount of $400 if an Insured Person undergoes a procedure to remove a foreign object or surgery for an eye Injury sustained as the result of an Accident. The surgery or procedure must occur by a Physician or Medical Professional within 90 days after the Accident. This benefit is payable once per eye per Accident for each Insured Person.

We will not pay this benefit for an Injury that is limited to the Eyelid or for an eye examination (with or without Anesthesia). No Exploratory Surgery Benefit or Arthroscopic Surgery Benefit is payable if this benefit is payable for the same injury(ies).

Blood Products Benefit
We will pay a benefit amount of $450 if an Insured Person receives a transfusion of one or more Blood Products for Treatment of an Injury sustained as the result of an Accident. The transfusion must occur within 90 days after the Accident. This benefit is payable up to 3 times per Accident for each Insured Person.

We will not pay this benefit for platelet or plasma infusions.

Pain Management (Epidural Anesthesia) Benefit
We will pay a benefit amount of $150 if an Insured Person receives Epidural Anesthesia for Treatment of an Injury sustained as the result of an Accident. The Anesthesia must be administered within 90 days after the Accident. This benefit is payable up to 3 times per Accident for each Insured Person.

DIAGNOSTIC

X-Ray Benefit
We will pay a benefit amount of $75 if an Insured Person undergoes an X-Ray for Treatment of one or more Injuries sustained as the result of an Accident. The X-Ray must occur within 90 days after the Accident. This benefit is payable up to 2 times per Accident for each Insured Person.

Diagnostic Exam Benefit
We will pay a benefit amount of $300 if an Insured Person undergoes a Diagnostic Exam for Treatment of one or more Injuries sustained as the result of an Accident. The exam must occur within 90 days after the Accident. This benefit is payable once per Accident for each Insured Person.

Brain Injury Diagnosis Benefit
We will pay a benefit amount of $200 if an Insured Person is diagnosed with a Brain Injury sustained as the result of an Accident. The diagnosis must occur by a Physician or Medical Professional within 30 days after the Accident and be confirmed by a Diagnostic Exam. This benefit is payable once per Accident for each Insured Person.

We will reduce the benefit amount payable for cranial surgery if this benefit was previously paid for the same Injury(ies) for an Accident for an Insured Person.

FOLLOW-UP CARE BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

FOLLOW-UP TREATMENT

Physician Follow-Up Office Visit Benefit
We will pay a benefit amount of $100 if an Insured Person receives Follow-Up Treatment for one or more Injuries sustained as the result of an Accident from a Physician or Medical Professional in such individual's office or clinic. The first Follow- Up Treatment must occur within 60 days after the Accident or within 30 days after the Insured Person is no longer Confined as a result of the Accident.

All Follow-Up Treatment must occur within 365 days after the Accident. This benefit is payable up to 6 times per Accident for each Insured Person.

We will not pay this benefit:

a) if any form of Initial Care was not received by the Insured Person for the same Accident;
b) for Follow-Up Treatment received on the same day that an Insured Person received any form of Initial Care for the same Accident; or
c) while an Insured Person is Confined.

Therapy Services Benefit
We will pay a benefit amount of $50 if an Insured Person receives Therapy for one or more Injuries sustained as the result of an Accident from a Therapist in such individual's office or clinic. The first Therapy visit must occur within 365 days after the Accident or within 30 days after the Insured Person is no longer Confined as a result of the Accident.

All Therapy visits must occur within 365 days after the Accident. This benefit is payable up to 6 times per Accident for each Insured Person.

We will not pay this benefit:

a) if any form of Initial Care was not received by the Insured Person for the same Accident;

b) for Therapy received on the same day that an Insured Person received any form of Initial Care for the same Accident; or
c) while an Insured Person is Confined.

MEDICAL DEVICE BENEFIT

We will pay a benefit amount of $200 if an Insured Person sustains an Injury as the result of an Accident which requires a Medical Device to assist the Insured Person with personal locomotion or mobility. The Medical Device must be prescribed by a Physician or Medical Professional and be received within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

Proof of the expense incurred for the purchase of a Medical Device for an Insured Person must be submitted with the claim.

PROSTHETIC DEVICE(S) BENEFIT

We will pay a benefit amount of $1,000 if an Insured Person sustains an Injury as the result of an Accident and receives a Prosthetic Device after the Injury results in the loss of limb, hand, foot or sight of an eye. The Prosthetic Device must be prescribed by a Physician for functional use and be received within 365 days after the Accident. This benefit is payable up to 2 times per Accident for each Insured Person.

We will not pay this benefit for more than one Prosthetic Device for the same body part, or for the replacement of a Prosthetic Device for which We will pay/have paid a benefit for an Insured Person for the same Accident.

ADDITIONAL BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

FAMILY CARE

Transportation Benefit
We will pay a benefit amount of $450 per round trip for travel by an Insured Person to a Hospital or other medical facility more than 75 miles away from the Insured Person's primary residence for Treatment (including Follow-Up Treatment) of one or more Injuries sustained as the result of an Accident. Treatment must be prescribed by a Physician and the same or similar Treatment must not be available within 75 miles of the Insured Person's primary residence. This benefit is payable for up to 3 round trips per Accident within 365 days after the Accident.

We will also pay a benefit amount of $450 if an Insured Person is Confined for Treatment of one or more Injuries sustained as the result of an Accident that occurred more than 200 miles away from the Insured Person's primary residence and is brought home (to the Insured Person's primary residence). Transportation to the Insured Person's primary residence must occur within 48 hours following discharge from the Hospital or Rehabilitation Facility, within 365 days after an Accident. This benefit is payable once per Calendar Year per Insured Person.

Mileage is measured as the distance from the Insured Person's primary residence to the facility at which the Treatment occurs. We will not pay this benefit if either the Ground Ambulance Benefit or Air Ambulance Benefit is payable for the same trip.

Lodging Benefit
We will pay a benefit amount of $150 per night of Lodging for which an expense is incurred if an adult Family member or adult companion accompanies an Insured Person who is Confined more than 75 miles away from the Insured Person's primary residence for Treatment of one or more Injuries sustained as the result of an Accident. This benefit is payable for up to 30 nights of Lodging per Accident within 365 days after the Accident.

This benefit is only payable for a Confinement for which We will pay a Daily Confinement Benefit, Intensive Care Unit Confinement Benefit or Rehabilitation Facility Confinement Benefit for the Insured Person. Only one benefit is payable per night of Lodging. Proof of the expense incurred by the adult companion for Lodging must be submitted with the claim.

Mileage is measured as the distance from the Insured Person's primary residence to the Hospital or medical facility in which the Insured Person is Confined.

Childcare Benefit
We will pay a benefit amount of $30 per day for Childcare if an Insured Person is Confined for Treatment of one or more Injuries sustained as the result of an Accident and incurs expense for one or more Dependent children attending a Childcare Center. This benefit is payable for up to 30 days of Childcare per Dependent child per Accident within 365 days after the Accident.

A Dependent child does not have to be insured under the Policy for this benefit to be payable. This benefit is only payable for a Confinement for which We will pay a Daily Confinement Benefit or Intensive Care Unit Confinement Benefit for the Insured Person. Proof of the expense incurred by the Insured Person for Childcare must be submitted with the claim.

CATASTROPHIC BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

The Principal Sum is the amount of catastrophic insurance in effect for the Insured Person on the date of the Accident.

ACCIDENTAL DEATH

Basic Accidental Death Benefit
We will pay a benefit amount equal to 100% of the Principal Sum if an Insured Person dies as the result of an Accident. Death must occur within 365 days after the Accident. This benefit is payable once under the Policy for each Insured Person.

If one or more Catastrophic Benefits have been previously paid under the Policy for an Accident for an Insured Person, We will reduce the amount payable under this benefit by the amount paid for the

previous Catastrophic Benefit(s) unless otherwise indicated in a benefit provision included in this Catastrophic Benefits section of this Certificate.

Common Carrier Accidental Death Benefit
We will pay a benefit amount equal to 300% of the Principal Sum if an Insured Person dies as the result of an Accident that occurs while a fare-paying passenger on a Common Carrier. Death must occur within 365 days after the Accident. This benefit is payable once under the Policy for each Insured Person.

We will not pay this benefit if an Insured Person was an operator or member of the crew on the Common Carrier conveyance at the time of the Accident. If this benefit is payable under the Policy for an Insured Person, We will not pay the Basic Accidental Death Benefit for that Insured Person.

If one or more Catastrophic Benefits have been previously paid under the Policy for an Accident for an Insured Person, We will reduce the amount payable under this benefit by the amount paid for the previous Catastrophic Benefit(s) unless otherwise indicated in a benefit provision included in this Catastrophic Benefits section of this Certificate.

Exposure & Disappearance
An Insured Person will be presumed to have died, for the purposes of the Basic Accidental Death Benefit or Common Carrier Accidental Death Benefit, if after the forced landing, stranding, sinking or wrecking of a vehicle:

a) the Insured Person disappears;
b) the Insured Person's body is not found; and
c) a valid death certificate is issued by a court of appropriate jurisdiction.

Transportation of Remains Benefit
We will pay for expenses reasonably incurred for the preparation and transportation of remains, up to a maximum of $5,000, if an Insured Person dies as the result of an Accident and the death occurs more than 100 miles away from the Insured Person's primary residence. We must be contacted prior to the preparation and transportation of the remains to pre-authorize the services.

The Insured Person's bodily remains or ashes must be transported to a mortuary or funeral home within 30 miles of the Insured Person's primary residence by a duly licensed company that provides mortuary transport services. This benefit is payable once under the Policy for each Insured Person. This benefit amount is payable in addition to any other applicable benefits under the Policy.

Proof of the expenses incurred must be submitted with the claim. This benefit does not include the transportation expense of anyone accompanying the body or remains, visitation expenses or funeral expenses. In no event will the total amount paid under all group insurance policies issued by Us exceed the actual expense for the preparation and transportation of remains of an Insured Person. We will not pay this benefit if a same or similar benefit is payable under a third-party service contracted by Us.

DISMEMBERMENT & PARALYSIS

Benefits
We will pay the applicable benefit amount shown in the Dismemberment & Paralysis Benefits Table below if an Insured Person sustains one or more Injuries as the result of an Accident that results in

Dismemberment and/or Paralysis. The Dismemberment or Paralysis must occur within 365 days after the Accident.

The maximum amount payable for all losses shown in the table sustained by an Insured Person for the same Accident is 100% of the Principal Sum.

Dismemberment & Paralysis Benefits Table

Loss	Benefit
Loss of Both Hands, Loss of Both Feet, Loss of Entire Sight of Both Eyes or any combination of two or more of these losses	100% of the Principal Sum
Loss of Speech and Loss of Hearing (both ears)	100% of the Principal Sum
Loss of One Hand, Loss of One Foot, Loss of Entire Sight of One Eye or Loss of Hearing (both ears)	50% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of Multiple Fingers or Loss of Multiple Toes	10% of the Principal Sum
Quadriplegia (Paralysis of both upper and both lower limbs)	100% of the Principal Sum
Triplegia (Paralysis of both upper and both lower limbs)	75% of the Principal Sum
Hemiplegia (Paralysis of an upper and lower limb)	50% of the Principal Sum
Paraplegia (Paralysis of both lower limbs)	50% of the Principal Sum
Uniplegia (Paralysis of a limb)	25% of the Principal Sum

Limitations

If more than one loss shown in the Dismemberment & Paralysis Benefits Table is sustained by an Insured Person for the same Accident, We will pay only the highest applicable benefit. If a benefit was paid under the Policy for an Insured Person for any Dismemberment or Paralysis and the Insured Person later sustains a more severe loss shown in the table as a result of the same Accident, We will reduce the amount payable for the subsequent, more severe loss by the amount paid previously under this benefit.

REASONABLE MODIFICATION(S) BENEFIT

We will pay for expenses reasonably incurred for Home Alteration and/or Vehicle Modification, up to a maximum of 10% of the Principal Sum, if an Insured Person sustains one or more Injuries as the result of an Accident for which a Dismemberment or Paralysis benefit is payable under the Policy for:

a) Loss of Both Hands, Loss of Both Feet, Loss of Entire Sight of Both Eyes or any combination of 2 or more of these losses;
b) Loss of Speech and Loss of Hearing (Both ears);
c) Loss of One Hand, Loss of One Foot, Loss of Entire Sight of One Eye or Loss of Hearing (Both ears); or
d) Quadriplegia, triplegia, hemiplegia or paraplegia.

A Physician must certify that any modification is needed to accommodate a physical disability of the Insured Person. A modification must be made by someone experienced in such adaptations and must be in compliance with any requirements established by the appropriate government authority. The expense for any modification cannot exceed the usual level of charges for similar alterations and/or modifications in the location where the expense is incurred.

The expense for any modification must be incurred within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person. This benefit amount is payable in addition to any other applicable benefits under the Policy.

COMA BENEFIT

We will pay a benefit amount equal to 25% of the Principal Sum if an Insured Person sustains one or more Injuries as the result of an Accident that results in a Coma. The Insured Person must become Comatose within 30 days after the Accident and remain Comatose for 10 or more consecutive days. The Coma must be diagnosed by a Physician and be confirmed by an electroencephalogram (EEG). This benefit is payable once per Accident for each Insured Person.

EXCLUSIONS

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

We will not pay any benefits under the Policy for any loss or claim which does not result from an Accident or occurs more than 365 days after an Accident.

We will also not pay any benefits under the Policy for an Accident that:

a) occurs in the course of any occupation or employment for an Insured Person with any employer for wage or profit, or for which the Insured Person is entitled to benefits under any workers' compensation or occupational disease law or receives any settlement from a workers' compensation carrier;
b) results from any bodily infirmity, Sickness, or medical or surgical Treatment thereof;
c) results from cosmetic surgery or procedures;
d) results, whether an Insured Person is sane or insane, from:
    1. an intentionally self-inflicted Injury or Sickness; or
    2. suicide or attempted suicide;
e) occurs in consequence of an Insured Person's being voluntarily intoxicated or under the influence of any controlled substance or alcohol (as defined by the laws of the state in which the Accident occurred), unless administered on the advice of a Physician;
f) results from an Insured Person's intentional or voluntary use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption, including self-infliction of carbon monoxide poisoning emanating from a motor vehicle;
g) results from an Insured Person's voluntary participation in a riot, commission of a felony, participation in illegal activities or participation in an illegal occupation;
h) occurs while an Insured Person is incarcerated or imprisoned;
i) results from an act of declared or undeclared war or armed aggression;
j) occurs while an Insured Person is operating, learning to operate, riding as a passenger, boarding, departing or jumping from any aircraft (including those that are not motor driven, such as a hot air balloon), unless riding as a fare-paying passenger in a commercial aircraft on a regularly-scheduled flight or while Traveling on Business of the Policyholder;
k) occurs while an Insured Person is riding in or on any motor vehicle or aircraft engaged in racing, endurance tests, off-road activities (for motor vehicles), acrobatic tricks or stunts (for motor vehicles), or acrobatic or stunt flying (for aircraft);

l) occurs while an Insured Person is practicing for, participating in or officiating any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received by the Insured Person;
m) occurs while an Insured Person is engaged in skydiving, scuba diving, parachuting, hang gliding, bungee jumping, sail gliding, parasailing, parakiting, mountain climbing, base jumping, rock climbing or other similar high-risk activities or extreme sports; or
n) occurs while an Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable.

Component Document 13 – Voluntary Critical Illness Program

CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

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

United of Omaha Life Insurance Company certifies that Group Policy Number GUDE-BZPL (the Policy) has been issued to Killeen Independent School District (the Policyholder). The Policy provides Group Critical Illness Insurance.

Insurance is provided for Employees of the Policyholder subject to the terms and conditions of the Policy. This Certificate is made a part 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.

The Policy is nonparticipating, therefore it will pay no dividends. The Policy is noncontributory.

James T. Blackledge
Chief Executive Officer

Corporate Secretary

SCHEDULE

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

CLASS(ES)

All Eligible Employees

CRITICAL ILLNESS INSURANCE FOR YOU (THE EMPLOYEE)

You may elect to be insured for an amount of critical illness (CI) insurance from $10,000 to $20,000 in increments of $10,000.

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

CRITICAL ILLNESS INSURANCE FOR YOUR DEPENDENT(S)

Provided You have elected some amount of insurance, You may elect to have Your Spouse insured for an amount of critical illness (CI) insurance equal to $5,000, provided the amount elected does not exceed 50% of Your CI Principal Sum.

Your Spouse's amount of CI insurance is subject to any reductions indicated in the Benefit Reductions provision in this Schedule.

Provided You have elected some amount of CI insurance, the amount of CI insurance for Your eligible Dependent child(ren) is 50% of Your CI Principal Sum, but in no event more than $5,000.

Any amount of CI insurance for Your Dependent(s) will be rounded to the next higher multiple of $1,000, if not already an even multiple of $1,000. Any amount of CI insurance for a Dependent is the Dependent's CI Principal Sum. If You have questions regarding the amount of CI insurance for Your Dependent(s), You may contact the Policyholder.

GUARANTEE ISSUE AMOUNT(S) AND EVIDENCE OF INSURABILITY

Guarantee Issue Amount(s) is/are subject to any reductions indicated in the Benefit Reductions provision of this Schedule. Guarantee issue is only available if the total number of Employees insured under the Policy attains or remains above 10 Employees or 20% of the eligible Employees, 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 Employee)
Your Guarantee Issue Amount is $20,000. Any amount of insurance in excess of this amount requires Evidence of Insurability, regardless of the amount of insurance You were insured for under a Prior Plan.

Guarantee Issue Amount For Your Spouse
The Guarantee Issue Amount for Your Spouse is $5,000. Any amount of insurance in excess of this amount requires Evidence of Insurability, regardless of the amount of insurance the Dependent was insured for under a Prior Plan.

Guarantee Issue Amount For Your Dependent Child(ren)
The Guarantee Issue Amount for Your Dependent child(ren) is $5,000. Any amount of insurance in excess of this amount requires Evidence of Insurability, regardless of the amount of insurance the Dependent was insured for under a Prior Plan.

Insurance 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 Employee or Dependent becomes eligible;

b) any amount of insurance elected in excess of a Guarantee Issue Amount for the Employee or Dependent;
c) any increase in the amount of insurance after the initial election of insurance for the Employee or Dependent, unless during a Subsequent Enrollment Period or as otherwise stated or allowed in the Policy;
d) an Employee or Dependent who was eligible for insurance under a Prior Plan but did not elect such insurance; or
e) an Employee or Dependent 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 elected 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.

Evidence of Insurability will be waived for any Dependent child(ren) for whom insurance is elected within 31 days after the date a Dependent child(ren) become(s) eligible, if Dependent child insurance requires an election and Dependent child insurance for any other child(ren) is not already in effect under the Policy.

Evidence of Insurability will be waived for any Dependent child(ren) for whom insurance is elected within 31 days after the date a Dependent child(ren) become(s) eligible, if Dependent child insurance requires an election and Dependent child insurance for any other child(ren) is not already in effect under the Policy.

BENEFIT REDUCTIONS

As You grow older, the Principal Sum for critical illness (CI) for You or Your Spouse will be reduced according to the following schedule:

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

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

If You are age 70 or older on the date insurance becomes effective, the Principal Sum for CI for You and Your Spouse will be reduced as shown above.

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

CRITICAL ILLNESS INSURANCE BENEFITS

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

BENEFITS

Basic Benefits

In the event an Insured Person is Diagnosed with a Critical Illness while insured under the Policy, We will pay a critical illness (CI) benefit. The benefit amounts payable are shown in the following Critical Illness Benefits Table (the "CI Table"). The amount of CI insurance for each Insured Person, also referred to as the CI Principal Sum, is provided in the Schedule.

Once benefits have been paid for a Critical Illness for an Insured Person, no additional benefits are payable under this Basic Benefits section of the Policy for the Insured Person:

a) for that same Critical Illness; or
b) for any other Critical Illness in that same Benefit Category if 100% of the CI Principal Sum has been paid for the Insured Person in that category.

Once benefits have been paid for a Critical Illness for an Insured Person, benefits remain payable under the Policy for:

a) any other Critical Illness in that same Benefit Category for the Insured Person until 100% of the CI Principal Sum has been paid in the category, if a Partial Benefit was paid for a previous Critical Illness for the Insured Person; or
b) a Critical Illness in a different Benefit Category for the Insured Person if the date of Diagnosis for a subsequent Critical Illness occurs at least 3 months from the date of Diagnosis of a previous Critical Illness for the Insured Person.

If more than one Critical Illness is incurred by an Insured Person at the same time, only the highest applicable benefit is payable. Benefit payments are subject to any policy benefit maximum stated in this Critical Illness Insurance Benefits section of the Policy. Benefit payment is also subject to the definitions, limitations, exclusions and other provisions of the Policy.

Critical Illness Benefits Table (the "CI Table")

Benefit Category/Critical Illness Benefit	
Heart/Circulatory/Motor Function Category	
Heart Attack (Myocardial Infarction)	100% of the CI Principal Sum
Heart Transplant/Placement on UNOS List	100% of the CI Principal Sum
Heart Valve Surgery	25% of the CI Principal Sum
Coronary Artery Bypass	25% of the CI Principal Sum
Aortic Surgery	25% of the CI Principal Sum
Stroke	100% of the CI Principal Sum
ALS (Lou Gehrig's) Disease*	100% of the CI Principal Sum
Advanced Alzheimer's Disease*	100% of the CI Principal Sum
Advanced Parkinson's Disease*	100% of the CI Principal Sum
Organ Category	
Major Organ Transplant/Placement on UNOS List	100% of the CI Principal Sum
End Stage Renal Failure	100% of the CI Principal Sum
Acute Respiratory Distress Syndrome (ARDS)	25% of the CI Principal Sum
Childhood/Developmental Category (These benefits are available to children only)	
Cerebral Palsy*	100% of the CI Principal Sum

Structural Congenital Defects*	100% of the CI Principal Sum
Genetic Disorders*	100% of the CI Principal Sum
Congenital Metabolic Disorders*	100% of the CI Principal Sum
Type 1 Diabetes*	100% of the CI Principal Sum
Cancer Category	
Cancer (Invasive)	100% of the CI Principal Sum
Bone Marrow Transplant	50% of the CI Principal Sum
Carcinoma in Situ (Non-Invasive Cancer)	25% of the CI Principal Sum
Benign Brain Tumor	25% of the CI Principal Sum

To demonstrate how payment for a Partial Benefit works, assume that a person is insured under the Policy for a CI Principal Sum of $5,000. This person is Diagnosed with ductal breast cancer that has not spread outside of the breast. Under the Policy, this would be considered Carcinoma in Situ (Non-Invasive Cancer), which offers a benefit of 25% of the CI Principal Sum. Since the CI Principal Sum is $5,000, the benefit payable under the Policy is $1,250.

Additional Category Occurrence Benefit
Once benefits have been paid for a Critical Illness for an Insured Person, no additional benefits are payable under the Policy for that same Critical Illness for the Insured Person, but with the additional category occurrence benefit, benefits are still payable for any other Critical Illness for the Insured Person in that same Benefit Category. This benefit allows an Insured Person to receive up to 200% of the CI Principal Sum in the Heart/Circulatory/Motor Function Category and the Organ Category.

An additional category occurrence benefit for an Insured Person is only payable if the date of Diagnosis for an additional Critical Illness occurs at least 6 months after the date of Diagnosis of a previous Critical Illness for the Insured Person in the same Benefit Category for which benefits were paid under the Policy. This benefit does not apply to the Cancer Category or the Childhood/Developmental Category. Additional benefit payments are subject to any policy benefit maximum stated in this Critical Illness Insurance Benefits section of the Policy. Benefit payment is also subject to the definitions, limitations, exclusions and other provisions of the Policy.

To demonstrate how this benefit works, assume that a person is insured under the Policy for a CI Principal Sum of $5,000. This person is Diagnosed with a Heart Attack and receives a benefit of 100% of the Principal Sum ($5,000). 12 months or more later, the same person is Diagnosed with a Stroke, and because the Additional Category Occurrence Benefit is included in the Policy, the person receives another benefit of 100% of the CI Principal Sum ($5,000) for a total of 200% of the CI Principal Sum in the Heart/Circulatory/Motor Function Category.

Reoccurrence Benefit
Once benefits have been paid for a Critical Illness for an Insured Person, a reoccurrence benefit is payable one time for a subsequent Diagnosis of that same Critical Illness. Benefits for some illnesses are only payable once per Insured Person under the Policy, as indicated in the CI Table. The amount of the reoccurrence benefit is the benefit shown in the CI Table for the reoccurring Critical Illness.

A reoccurrence benefit for an Insured Person is only payable if the initial and subsequent dates of Diagnosis for the same Critical Illness under the Policy occur at least 12 months apart without Treatment. Additional benefit payments are subject to any policy benefit maximum stated in this Critical Illness Insurance Benefits section of the Policy. Benefit payment is subject to the definitions, limitations, exclusions and other provisions of the Policy.

To demonstrate how this benefit works, assume that a person is insured under the Policy for a CI Principal Sum of $5,000. This person is Diagnosed with a Heart Attack and receives a benefit of 100% of the Principal Sum ($5,000). 12 months or more later, the same person is Diagnosed with another Heart Attack, and because the Reoccurrence Benefit is included in the Policy, the person receives another benefit of 100% of the CI Principal Sum ($5,000).

Health Screening Benefit
We will pay a health screening benefit of $50 for each Insured Person who has a Health Screening Test performed while insurance under the Policy is in force. This benefit is payable once per calendar year for each Insured Person. Payment of this benefit has no impact on any other benefits payable under this Policy. Benefit payment is subject to the definitions, limitations, exclusions and other provisions of the Policy.

Policy Benefit Maximum
For each Insured Person, the total amount of CI benefits payable under the Policy and any Prior Plan (if applicable) is subject to a benefit maximum of 300% of the CI Principal Sum in effect for the Insured Person. Any benefits paid for the health screening benefit are not applied toward the benefit maximum.

If the CI benefits paid for an Insured Person reach the benefit maximum, all insurance under the Policy for the Insured Person will terminate. Insurance for any other Insured Persons will remain in effect, subject to this maximum. If insurance terminates for You under this provision, Your Dependent(s), if applicable, may remain insured provided You continue to satisfy the eligibility requirements of the Policy.

LIMITATIONS AND EXCLUSIONS

Pre-Existing Condition Limitation
We will not provide benefits for any Critical Illness caused by, attributable to or resulting from a Pre-existing Condition until 12 months after an Insured Person is continuously insured under the Policy and any Prior Plan (if applicable).

In addition, We will not provide benefits for:

a) any increase in the CI Principal Sum for any Insured Person;
b) the addition by amendment of a benefit or category of benefits under the Policy for any Insured Person; or
c) the election after initial enrollment of any benefit provided by an amendment to the Policy for any Insured Person; for any Critical Illness caused by, attributable to, or resulting from a Pre-Existing Condition until 12 months after the date of the increase or change for any Insured Person.

This Pre-existing Condition limitation will not apply to newborn child(ren) as they are automatically eligible for insurance upon birth.

Exclusions

We will not pay benefits for any Critical Illness that:

a) results, whether the Insured Person is sane or insane, from:
    1. an intentionally self-inflicted Injury or Illness; or
    2. suicide or attempted suicide;
b) results from an act of declared or undeclared war or armed aggression;
c) is incurred while the Insured Person is on active duty or training in the Armed Forces, National Guard, or Reserves of any state or country and for which any governmental body or its agencies are liable;
d) results from illegal activities, including participation in an illegal occupation;
e) is the result of:
    1. the voluntary use of illegal drugs by an Insured Person;
    2. the intentional misuse of over-the-counter medication or prescription drugs by an Insured Person that is not in accordance with the recommended dosage and/or warning instruction(s); or
    3. the excessive or harmful use of alcohol and/or alcoholic drinks by an Insured Person; or
f) is Diagnosed outside of the United States.