GROUP LONG TERM DISABILITY CERTIFICATE OF COVERAGE

FOR

STATE OF NEBRASKA

POLICY NUMBER: 306147

EFFECTIVE DATE: July 1, 2019

NE–UHIC/2008

(5-19)

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut

(Home Office)

Policyholder: State of Nebraska

Effective Date: July 1, 2019

Policy Number: 306147

Beneficiary: As on file with the Administrator

We, UnitedHealthcare Insurance Company, issue this Certificate to the Covered Person as evidence of insurance under the Policy We issued to the Policyholder shown above. This Certificate describes the benefits and other important provisions of the Policy. Please read it carefully.

The Policy may be amended, changed, cancelled or discontinued without the consent of the Covered Person or the Covered Person's beneficiary.

The benefits described in this Certificate insure the Covered Person. This Certificate becomes effective at 12:01 A.M. Eastern Standard time on the Effective Date shown above.

Read the Group Certificate Carefully

This is a legal contract between the Policyholder and Us. If the Policyholder has any questions or problems with the Policy, We will be ready to help the Policyholder. The Policyholder may call upon his agent or Our Home Office for assistance at any time.

If the Policyholder or the Covered Person have questions, need information about their insurance, or need assistance in resolving complaints, call 1-866-615-8727.

It is signed at the Home Office of UnitedHealthcare Insurance Company as of the Effective Date shown above.

NOTICE OF NON-INSURANCE BENEFITS

Non-insurance Benefits: Non-insurance benefits are not part of Your Certificate and do not modify Your insurance benefits. We may offer or arrange for various entities or vendors to offer benefits or other considerations to You for the purpose of promoting Your general health and well-being. Non-insurance benefits may include, but are not limited to beneficiary services, legal services, travel assistance, Employee Assistance Programs (EAP), and plan administrative services. These benefits may be modified or terminated at any time. Such modification or termination may be made based on availability of services or other reasons at Our discretion or at the discretion of the entity providing such services.

NIB NOTICE

Thomas J McGuire

Secretary

President

Group Working Returns Long Term Disability Insurance Policy
Non-Participating

Administrative Office:
9900 Bren Road East
Minnetonka, MN 55343

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SCHEDULE OF BENEFITS

Class of Employees

This schedule covers the following class(es) of Employees of companies and affiliates controlled by the Policyholder:

All active full-time and regular part-time Employees residing in the United States, excluding temporary and seasonal employees

Description of Class:

Employees are considered eligible for benefits if they customarily work: 20 hours per week

For active military firefighters hired prior to 7/1/2015:

Employees are considered full-time if they customarily work at least 50 hours per week

For active military firefighters hired on or after 7/1/2015:

Employees are considered full-time if they customarily work at least 53 hours per week

Employee Waiting Period:

An Employee is eligible for insurance on the later of the following dates:

1. The Group Policy's Effective Date, July 1, 2019.
2. The first day of the month following the date the Employee completes 30 days of continuous employment with the Policyholder.

If the Covered Person's employment ends and the same employer rehires him within 14 days, We will apply his previous employment in an eligible class toward completing the Waiting Period.

Cost of Insurance: The Covered Person is required to contribute to the entire cost of his insurance.

Covered Person Insurance:

Long Term Disability Benefit:

The Long Term Disability Insurance included in this certificate applies only to employees who have elected, been accepted for, and paid premiums for the Long Term Disability Insurance.

Benefit Percent: 60% of the Covered Person's Pre-Disability Monthly Earnings. The Covered Person's benefit may be reduced by Other Income Benefits and Disability Earnings. Some Disabilities may not be insured under the Policy.

Pre-Disability Monthly Earnings Definition:
The average monthly earnings received from the Covered Person's Employer for the 12-month period ending just prior to the date of Disability. Pre-Disability Monthly Earnings includes commissions, averaged over the lesser of the most recent 24-month period or the Covered Person's period of employment. It does not include bonuses, overtime pay, and other extra compensation.

Maximum Monthly Benefit: $7,500

Minimum Monthly Benefit: $100

Elimination Period: 180 days - Benefits begin the day after completion of the Elimination Period.

Accumulation of Elimination Period: 30 days

SCHEDULE OF BENEFITS (continued)

Maximum Benefit Period:
Reducing Benefit Duration reflecting Social Security Normal Retirement Age

Age at Disability	**Maximum Benefit Period**
Less than age 60	Greater of SSNRA * or To age 65
Age 60	60 Months
Age 61	48 Months
Age 62	42 Months
Age 63	36 Months
Age 64	30 Months
Age 65	24 Months
Age 66	21 Months
Age 67	18 Months
Age 68	15 Months
69 and over	12 Months

*SSNRA means the Social Security Normal Retirement Age as figured by the 1983 amendment or any later amendment to the Social Security Act.

Premium contributions are waived while the Covered Person is receiving Long Term Disability payments.

GENERAL DEFINITIONS

The male pronoun, whenever used in the Policy, includes the female.

Active Work or Actively at Work: The Covered Person reports for work at his usual place of employment or any other business location where he is required to travel and is able to perform the material and substantial duties of his regular occupation for the entire normal workday. The Covered Person must be working at least the minimum number of hours per week in an Eligible Class, as shown in the Schedule of Benefits.

Unless Disabled on the prior workday or on the day of absence, a Covered Person will be considered Actively at Work on the following days:

1. a Saturday, Sunday or holiday which is not a scheduled workday;
2. a paid vacation day, or other scheduled or unscheduled non-workday; or
3. an excused or emergency leave of absence (except medical leave).

Contributory or Non-Contributory Insurance: Contributory Insurance is insurance for which the Covered Person must apply and agree to make the required premium contributions. Non-Contributory Insurance is insurance for which the Covered Person does not have to make any premium contributions.

Covered Person: The Employee insured under the Policy. References to "Covered Person," "Covered Persons" and "Covered Person's" throughout this Certificate are references to a Covered Person.

Employee: A person who is:

1. directly employed in the normal business of the Policyholder; and
2. paid for services by the Policyholder; and
3. Actively at Work for the Policyholder, or any subsidiary or affiliate insured under the Policy.

No director or officer of an Policyholder will be considered an Employee unless he meets the above conditions.

Employer: The Policyholder and includes any division, subsidiary, or affiliated company named in the Policy. Employer does not include Employers of other related areas of practice for which the Covered Person may also work.

Hospital or Medical Facility: A legally operated, accredited facility licensed to provide full-time care and Treatment for the condition for which benefits are payable under the Policy. It is operated by a full-time staff of licensed physicians and registered nurses. It does not include facilities that primarily provide custodial, education or rehabilitative care, or long-term institutional care on a residential basis.

Injury: A bodily Injury resulting directly from an accident and independently of all other causes.

Physician: A practitioner of the healing arts who is:

1. duly licensed in the state in which the Treatment is received; and
2. practicing within the scope of that license.

The term Physician does not include the Covered Person, the Covered Person's Spouse, children, parents, parents-in-law, or siblings.

GENERAL DEFINITIONS (continued)

Regular Care: The Covered Person personally visits a Physician as often as is medically required to effectively manage and treat his disabling condition(s), according to generally accepted medical standards. The Covered Person is receiving appropriate Treatment and care, according to generally accepted medical standards, by a Physician whose specialty or experience is appropriate for the disabling condition(s).

Sickness: An illness, disease, pregnancy or complication of pregnancy.

Treatment: consultation, advice, tests, attendance or observation, supplies or equipment, including the prescription or use of prescription drugs or medicines.

We, Our and Us: UnitedHealthcare Insurance Company.

CERTIFICATE GENERAL PROVISIONS

Conformity With State or Federal Statutes: If any provision of the Certificate conflicts with any applicable law, the provision will be deemed to conform to the minimum requirements of the law.

Discretionary Authority: When making a benefit determination under the Policy, We have the sole discretionary authority to determine the Covered Person's or Dependent's eligibility, if applicable, for benefits and to interpret the terms, conditions, limitations, and exclusions, and all other provisions of the Policy including the Certificate of Coverage and any riders or amendments. We may delegate this discretionary authority to other entities or persons who provide services in regard to the administration of the Policy. This provision does not prevent the bringing of a legal action under the time limit for Legal Action provision, nor does it serve to deprive any insurance department of its statutory rights and obligations.

Fraud*:* We will focus on all means necessary to support fraud detection, investigation, and prosecution. It may be a crime if the Covered Person or the Employer knowingly, and with intent to injure, defraud or deceive Us, files a claim containing any false, incomplete, or misleading information. These actions, as well as submission of false information, will result in denial of the Covered Person's claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. We will pursue all appropriate legal remedies in the event of insurance fraud.

Incontestability: We may not contest the validity of the Policy, except for the non-payment of premiums or fraudulent misrepresentations, after it has been in force for two years from its date of issue. No statement made by any Covered Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime, nor unless it is contained in a written instrument signed by him.

Information To Be Furnished: The Policyholder may be required to furnish any information needed to administer the Policy. Clerical error by the Policyholder will not:

1. affect the amount of insurance which would otherwise be in effect; or
2. continue insurance which otherwise would be terminated; or
3. result in the payment of benefits not otherwise payable.

Once an error is discovered, an equitable adjustment in premium will be made. If the premium adjustment involves the return of unearned premium, the amount of the return will be limited to the 12-month period, which precedes the date We receive proof such an adjustment should be made. We may inspect any of the Policyholder's records which relate to the Policy.

Misstatement of Age: If a Covered Person's age has been misstated, premiums will be subject to an equitable adjustment. If the amount of the benefit depends upon age, then the benefit will be that which would have been payable, based upon the person's correct age.

Workers' Compensation: The Policy is not to be construed to provide benefits required by Workers' Compensation laws.

COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Covered Person's Eligibility: Employees who work on a full-time basis for a Policyholder are eligible for insurance after completion of the required Employee Waiting Period, provided they are in a class of Employees who are included. Employees will be considered to work on a full-time basis if they customarily work at least the number of hours per week shown in the Schedule of Benefits.

An Employee will become eligible for insurance on the latest of the following dates:

1. the Effective Date of the Policy;
2. the end of the Employee Waiting Period shown in the Schedule of Benefits;
3. the date the Policy is changed to include the Employee's class; or
4. the date the Employee enters a class eligible for insurance.

Effective Date of Covered Person Insurance: If an Employee is not Actively at Work on the date his insurance is scheduled to take effect, it will take effect on the day after the date he returns to Active Work. If the Employee's insurance is scheduled to take effect on a non-working day, his Active Work status will be based on the last working day before the scheduled Effective Date of his insurance.

An Employee must use forms provided by Us when applying for insurance.

The Employee's insurance will be effective at 12:01 A.M. Eastern Standard time as follows:

1. if it is Non-contributory, on the date the Employee becomes eligible for insurance, regardless of when he applies, or
2. if it is Contributory, and the Employee makes application within 31 days after the date he first became eligible, on the later of:
   a. the date the Employee is eligible for insurance, regardless of when he applies; or
   b. the date the Employee's application is approved by Us if evidence of insurability is required.

Evidence of insurability is required if an Employee applying for Contributory Insurance:

1. does not apply for insurance within 31 days after the date he first became eligible; or
2. he has previously terminated his insurance while in an eligible class.

COVERED PERSON ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS (continued)

Family and Medical Leave of Absence: If the Covered Person is on a Family or Medical Leave of Absence, his insurance will be governed by his Employer's policy on Family and Medical Leaves of Absence.

We will continue the Covered Person's insurance if the cost of his insurance continues to be paid and his Leave of Absence is approved in advance and in writing by his Employer.

The Covered Person's insurance will continue for up to the greater of:

1. the leave period required by the Federal Family and Medical Leave Act of 1993; or
2. the leave period required by applicable state law.

While the Covered Person is on a Family or Medical Leave of Absence, We will use earnings from his Employer just prior to the date his Leave of Absence started to determine Our payments to him.

If the Covered Person's insurance does not continue during a Family or Medical Leave of Absence, then when he returns to Active Work:

1. he will not have to meet a new Employee Waiting Period including a Waiting Period for insurance of a Pre-Existing Condition, if applicable; and
2. he will not have to give Us evidence of insurability to reinstate the insurance he had in effect before his Leave of Absence began.

However, time spent on a Leave of Absence, without insurance, does not count toward satisfying his Employee Waiting Period.

Termination of Covered Person Insurance: The Covered Person's insurance will terminate at 12:00 midnight Eastern Standard time on the earliest of the following dates:

1. the last day of the period for which a premium payment is made, if the next payment is not made;
2. the date he ceases to be a member of a class eligible for insurance;
3. the date the Policy terminates, or a specific benefit terminates; or
4. the date he ceases to be Actively at Work. For a leave of absence governed by federal or any applicable state Family and Medical Leave of Absence law, insurance will be continued in accordance with the Family and Medical Leave of Absence provision.
5. the date he is no longer Actively at Work due to a labor dispute, including but not limited to a strike, work slow down or lock out.

WORKING RETURNS LONG TERM DISABILITY INSURANCE FOR COVERED PERSON

Definition of Disabled or Disability:

The Covered Person is Disabled or has a Disability when We determine that:

1. he is not Actively at Work and is unable to perform some or all of the Material and Substantial Duties of his Regular Occupation due to his Sickness or Injury; and
2. he has a 20% or more loss in Indexed Pre-Disability Monthly Earnings due solely to the same Sickness or Injury; and
3. he is under the Regular Care of a Physician.

After 24 months of payments, the Covered Person is Disabled when We determine that due to the same Sickness or Injury, he is unable to perform some or all of the material and substantial duties of any Gainful Occupation for which he is reasonably fitted by education, training or experience and he continues to suffer a 20% or more loss in his Indexed Pre-Disability Monthly Earnings due solely to the Sickness or Injury.

Disability must begin while the Covered Person is insured under the Policy.

Material and Substantial Duties: duties that

1. are normally required for the performance of the Covered Person's Regular Occupation; and
2. cannot be reasonably omitted or modified.

Regular Occupation means: the occupation which the Covered Person is routinely performing when his Disability occurs. We will look at the Covered Person's occupation as it is normally performed in the national economy instead of how the work tasks are performed for a specific Employer or at a specific location.

Gainful Occupation means: an occupation that can be expected to provide the Covered Person with an income at least equal to his Gross Disability Payment within 12 months of his return to work, considering:

1. his past training, as well as training he could receive;
2. his education and experience; and
3. his physical and mental capacity.

Gainful Occupation will be determined with the assistance of a licensed vocational or rehabilitation specialist.

The loss of a professional or occupational license or certification does not, in itself, mean the Covered Person is Disabled. Additionally, economic factors, such as recession, job obsolescence, pay-cuts and job sharing will not be considered in determining whether the Covered Person meets the definition of Disability/Disabled.

We require the Covered Person to be under the Regular Care of a Physician for the Sickness or Injury causing his disability in order to be eligible to receive payments from Us.

We may require the Covered Person to be examined by Physicians, other medical practitioners or vocational experts of Our choice. We will pay for these examinations. We can require examinations as often as it is reasonable to do so. We may also require the Covered Person to be interviewed by an authorized representative of Ours. Refusal to be examined or interviewed may result in denial or termination of his claim.

Transplant Benefit: If, while insured under the Policy, the Covered Person donates an organ for an Organ Transplant Procedure, and as a result he becomes Disabled, We will consider him to be Disabled as a result of Sickness and his Elimination Period will be waived. Disability resulting from an Organ Transplant Procedure will have a limited pay period of 12 months. This benefit will be payable only once in the Covered Person's lifetime. Benefit payments will be subject to all of the provisions contained in the Policy, except for those that are in conflict with the provisions of this Transplant Benefit.

Organ Transplant Procedure means: the Covered Person donates any of the following for transplantation into another person: kidney, liver, lung, skin or bone marrow.

Calculating the Monthly Payment:

The Benefit Percent and Maximum Monthly Benefit are shown in the Schedule of Benefits.

Calculate the Covered Person's Monthly Payment as follows:

1. Multiply the Covered Person's Pre-Disability Monthly Earnings by the Benefit Percent.
2. Compare the result in Step 1 with the Maximum Monthly Benefit.
3. The lesser of these two amounts is the Covered Person's monthly Gross Disability Payment.
4. Subtract from his monthly Gross Disability Payment all Other Income Benefit amounts that he receives or is eligible to receive. The result is the Covered Person's Monthly Payment.

In no event will the Covered Person's Monthly Payment exceed the Maximum Monthly Benefit.

If the Covered Person is Disabled and working, earning between 20% and 80% of his Indexed Pre-Disability Monthly Earnings calculate his benefit payment as follows:

Calculate the Covered Person's Gross Disability Payment as follows:

1. Multiply his Pre-Disability Monthly Earnings by the Benefit Percent.
2. Compare the result in Step 1 with the Maximum Monthly Benefit.
3. The lesser of these two amounts is the Covered Person's Gross Disability Payment, which is used in the benefit calculation below.

When the Covered Person first returns to work during a period of disability, the Work Incentive Benefit establishes that, for 12 months, his Monthly Payment, as determined above, will not be reduced as long as Payment does not exceed 100% of his Indexed Pre-Disability Monthly Earnings.

During the period of time that the Work Incentive Benefit applies:

1. Add the Covered Person's monthly Disability Earnings to his Gross Disability Payment, as calculated above.
2. Compare the result in Step 1 to his Indexed Pre-Disability Monthly Earnings.
3. If the result from Step 2 is less than or equal to 100% of the Covered Person's Indexed Pre-Disability Monthly Earnings, We will not further reduce his Monthly Payment, as calculated above.
4. If the result in Step 2 is greater than 100% of the Covered Person's Indexed Pre-Disability Monthly Earnings, We will subtract the amount over 100% from his Monthly Payment, as calculated above.

The result is the amount We will pay the Covered Person each month.

After the period of time that the Work Incentive Benefit applies:

1. Subtract the Covered Person's Disability Earnings from his Indexed Pre-Disability Monthly Earnings.
2. Divide the result in Step 1 by his Indexed Pre-Disability Monthly Earnings. This is his percentage of lost earnings.
3. Multiply the Covered Person's Monthly Payment, as calculated above, by the answer in Step 2.

The result is the amount We will pay the Covered Person each month.

After the Elimination Period, if the Covered Person is Disabled for only part of a month, We will send him 1/30th of his payment for each day of Disability.

Gross Disability Payment means: the payment amount before We subtract Other Income Benefits and Disability Earnings.

Monthly Payment means: the payment amount after We subtract any Other Income Benefits.

Elimination Period means: the length of time the Covered Person must be continuously Disabled before a benefit is payable. The Elimination Period begins on the first day of Disability. If the Covered Person returns to work for a period of time not to exceed the Accumulation of Elimination Period and cannot continue, he will not have to begin a new Elimination Period. However, We will count only those days he is Disabled toward satisfying the Elimination Period. The Elimination Period and the Accumulation of Elimination Period are shown in the Schedule of Benefits.

Disability Earnings mean: the earnings, which the Covered Person receives while Disabled, and working.

Indexed Pre-Disability Monthly Earnings: The Covered Person's Pre-Disability Monthly Earnings adjusted on each anniversary of benefit payments by the lesser of 5% or the current annual percentage increase in the Consumer Price Index (CPI-W). The Covered Person's Indexed Pre-Disability Monthly Earnings may increase or remain the same, but will never decrease. This manner of indexing is only used to determine the Covered Person's percentage of lost earnings while he is Disabled and working and in the determination of Gainful Occupation. Consumer Price Index (CPI-W) means**:** the index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. We reserve the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-W.

Receipt of Disability Payments: The Covered Person will begin to receive payments when We approve his claim, provided the Elimination Period has been met and he is Disabled. We will send him a payment each month for any period for which We are liable. If he is Disabled and working, proof of Disability Earnings will be required before benefits are paid.

Disability During a Covered Layoff or Leave of Absence: If the Covered Person becomes Disabled while he is on a covered Layoff or Leave of Absence, We will calculate his benefit using his Pre-Disability Monthly Earnings from his Employer in effect just prior to the date his absence begins.

Fluctuation of Disability Earnings: If the Covered Person's Disability Earnings fluctuate, We may average his Disability Earnings over the most recent 3 months to determine if his claim should continue subject to all other terms and conditions in the Policy.

If We average his Disability Earnings, We will not terminate his claim unless the average of his Disability Earnings from the last 3 months exceeds 80% of his Indexed Pre-Disability Monthly Earnings.

We will not pay the Covered Person for any month during which Disability Earnings exceed the amount allowable under the Policy.

Other Income Benefits: We will subtract from the Covered Person's Gross Disability Payment the following Other Income Benefits:

1. any benefits and awards he receives or is eligible to receive under:
   a. Workers' Compensation Law;
   b. occupational disease Law; or
   c. any other similar Act or Law.
2. any Disability income benefits he receives or is eligible to receive under:
   a. any compulsory benefit Act or Law;
   b. any other group insurance policy with the Employer or with an association;
   c. any other group insurance policy with another Employer under which he becomes insured while he is Disabled under the Policy; or
   d. any governmental retirement system as the result of his job with his Employer.
3. any benefits under the United States Social Security Act, The Canada Pension Plan, The Quebec Pension Plan, the Jones Act, and any other similar plan or Act. Benefits include:
   a. Disability benefits he is eligible to receive and any disability benefits his Spouse or his children receive or are eligible to receive as a result of his Disability.
   b. retirement benefits he receives and any retirement benefits his Spouse or his children receive as a result of his receipt of retirement benefits.

   If the Covered Person's Disability begins after his 70th birthday, and he was receiving Social Security retirement benefits before his Disability began, then We will not reduce Our payments to him by these retirement benefits.

   Pension Plan means: a plan that provides retirement benefits and which is not wholly funded by Employee contributions. The term does not include a profit sharing plan, a thrift plan, an individual retirement account (IRA), a tax sheltered annuity plan (TSA), a stock ownership plan or a non-qualified plan of deferred compensation.
4. any benefits he receives from the Employer's sick leave or salary continuation plan.
5. any benefits from the Employer's retirement plan, the Public Employees Retirement System and the State Teachers Retirement System he:
   a. receives as disability benefits;
   b. voluntarily chooses to receive as retirement benefits; or
   c. receives as retirement benefits once he reaches the greater of age 62 or normal retirement age, as defined in his Employer's Retirement Plan.

   Regardless of how the retirement funds from the plan are distributed, for the purposes of determining Our payment to the Covered Person, We consider Employee and Employer contributions to be distributed at the same time throughout the Covered Person's lifetime.

   We will not reduce payments the Covered Person receives from Us for his contributions to the Employer's retirement plan, or for amounts he rolls over or transfer to an eligible Retirement Plan.

Disability benefits under a retirement plan are benefits that are paid due to disability and which do not reduce the retirement benefits which would have been paid if the disability had not occurred.

Retirement benefits under a retirement plan are benefits that are paid based on the Covered Person's Employer's contribution to the retirement plan. Disability benefits that reduce the retirement benefits under the plan will also be considered a retirement benefit.

Eligible retirement plan is defined in Section 402 of the Internal Revenue Code of 1986 and includes future amendments to Section 402 affecting the definition.

6. any benefits for loss of time or lost wages he receives from the mandatory portion of a no-fault motor vehicle insurance plan, or automobile liability insurance policy.
7. any amount he receives under any unemployment compensation Law.
8. any amounts he receives from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise.

If the Covered Person receives any of the Other Income Benefits in a lump sum payment, We will pro-rate the lump sum on a monthly basis over the time period for which the sum was given. If no time period is stated, the sum will be pro-rated on a monthly basis to the end of the Covered Person's Maximum Benefit Period.

Other Income Benefits must be payable as a result of the same Disability for which the Covered Person is receiving a payment from Us, except for retirement benefits.

We will NOT subtract from the Covered Person's Gross Disability Payment any amounts he receives from the following sources:

1. 401(k) plans
2. profit sharing plans
3. thrift plans
4. tax sheltered annuities
5. stock ownership plans
6. non-qualified plans of deferred compensation
7. Pension plans for partners
8. military pension and military disability income plans
9. credit disability insurance
10. franchise disability income plans
11. a retirement plan from another Employer
12. Individual Retirement Accounts (IRA)
13. individual disability income plans

Affect of Other Income Benefits on Payment: If subtracting Other Income Benefits results in a zero benefit, We will pay the Covered Person the Minimum Monthly Benefit shown in the Schedule of Benefits. The Minimum Monthly Benefit, however, may be applied toward an outstanding overpayment.

Cost of Living Increases: After the first deduction for each of the Other Income Benefits, We will not further reduce the amount of the Covered Person's Monthly Payment under the Policy due to cost of living increases he receives from any of the sources described in the "Other Income Benefits" section.

Estimating Amounts of Other Income Benefits: We have the right to estimate the amount of benefits the Covered Person may be eligible to receive under the "Other Income Benefits" section. We can reduce Our payments to him by the estimated amount if:

1. he has not been awarded but have not been denied such benefits; or
2. he has been denied such benefits and the denial is being appealed; or
3. he is reapplying for such benefits.

We will NOT reduce Our payments to the Covered Person by the estimated amount if:

1. he applies or reapplies for the benefits and appeals his denial through all of the administrative levels We believe are necessary;
2. he signs Our reimbursement agreement form stating that he promises to pay Us any overpayment caused by an award.

If We reduce Our payments to the Covered Person by an estimated amount:

1. We will adjust Our payment to him when he provides proof of the amount awarded; or
2. We will issue a lump sum refund of the estimated amount if he was denied benefits and has completed all appeals (or reapplications) We believe are necessary.

Termination of Benefits: We will stop sending the Covered Person payments and his claim will end on the earliest of:

1. the date he is no longer Disabled according to the terms of the Policy;
2. the date he reaches the end of the Maximum Benefit Period;
3. the date he fails to provide proof of continuing Disability;
4. the date his Disability Earnings exceed the amount allowable under the Policy;
5. the date he is able to increase his Disability Earnings by increasing the number of hours he work or the number of duties he performs but he chooses not to do so;
6. the date he refuses to be examined by a Physician, if such an exam is requested by Us;
7. the date he refuses to be interviewed by one of Our representatives;
8. the date he ceases to be under the Regular Care of a Physician;
9. the date he dies.

If the Covered Person is a citizen of the United States and is receiving Treatment outside of the United States, We may require him to return to the United States for Treatment. Failure to do so when requested may result in termination of benefits.

Limitations:

Mental Illness and Substance Abuse Limitation
Disabilities due to Mental Illness or Substance Abuse have a limited pay period of 24 months per disability.

We will continue to send the Covered Person payments beyond the limited pay period if he is confined to a Hospital or Medical Facility. If he is still Disabled when he is discharged, We will send him payments for a recovery period of up to 90 days. If he becomes re-confined at any time during the recovery period and remains confined for at least 14 days in a row, We will send payments during that additional confinement and for one additional recovery period up to 90 more days.

In no case will benefits be paid beyond the Maximum Benefit Period.

Mental Illness means: any Sickness, disease or disorder, which is:

1. listed in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (or any successor diagnostic manual) published by the American Psychiatric Association; and
2. usually treated by a mental health provider or other qualified provider, using psychotherapy, psychotropic drugs or other similar methods of Treatment.

Mental Illness includes any such conditions whether or not related to an underlying physical, genetic, chemical, organic or biological cause, although it may be associated with physical symptoms, manifestations or expressions. Specific conditions include, but are not limited to:

1. bipolar disorder;
2. depression and depressive disorders;
3. psychoses;
4. mood disorders;
5. manic-depressive illness;
6. anxiety disorders;
7. stress disorders including post-traumatic stress disorders;
8. somatoform disorders;
9. factitious disorders;
10. eating disorders;
11. adjustment disorders; and
12. personality disorders.

For purposes of the Policy, Mental Illness does not include coma (unless a consequence of Substance Abuse), mental retardation or Alzheimer's disease and other forms of dementia with an objectifiable organic basis.

Substance Abuse means: alcoholism, or the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance, whether or not prescribed by a Physician.

General Exclusions: We will not cover a Disability under the Policy if it is due to:

1. an act or accident of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
2. intentionally self-inflicted Injuries;
3. active participation in a riot;
4. committing or attempting to commit a felony.

Pre-Existing Condition Exclusion: 3/12
We will not cover any Disability that begins during the first 12 months after the Covered Person's Effective Date of insurance that is caused or contributed to by a Pre-Existing Condition.

Pre-Existing Condition means: any Sickness or Injury including Mental Illness, Substance Abuse or Subjective Symptoms for which the Covered Person, within 3 months prior to his Effective Date of insurance:

1. was diagnosed by or received Treatment from a legally qualified Physician; or
2. had symptoms for which an ordinarily prudent person would have sought Treatment.

Continuity of Insurance Upon Transfer of Insurance Carriers: In order to prevent loss of insurance for a Covered Person because of a transfer of insurance carriers, We will provide insurance for certain Employees as follows:

Employees who are not Actively at Work due to Sickness or Injury:

We will insure the Employee under this Policy if the prior group insurance policy insured him and the cost of his insurance under the prior group insurance policy was paid.

Our payments to the Employee will be limited to the lesser of the Monthly Payment under the Policy or the monthly benefit the prior group insurance policy would have paid him, had that policy stayed in effect. Our payments will be reduced by any amount the prior group insurance policy is responsible for paying.

Employees who are Disabled due to a Pre-Existing Condition:

If the Employee was insured by the prior group insurance policy immediately prior to becoming eligible for insurance under this Policy, he is Actively at Work and he is insured under this Policy, then he may be eligible for payments under this Policy if his Disability is due to a Pre-Existing Condition.

In order to receive payments from Us, the Employee must satisfy the Pre-Existing Condition Exclusion test of:

1. this Policy; or
2. the prior group insurance policy, had that policy stayed in effect.

We will give credit toward continuous time insured under both policies. We will determine Our payments using the provisions of this Policy, but the Employees Monthly Payment will not be more than the maximum monthly payment of the prior group insurance policy.

The Employee's Monthly Payment will end on the earlier of the following:

1. the end of the Maximum Benefit Period;
2. the date benefits would have ended under the prior group insurance policy, if the policy had stayed in effect.

If the Employee cannot satisfy the Pre-Existing Condition Exclusion test of either policy, then he will not be eligible for a Monthly Payment.

WORKING RETURNS LONG TERM DISABILITY INSURANCE FOR COVERED PERSON (continued)

Recurrent Disability: If the Covered Person's current Disability is related or due to the same causes(s) as his prior Disability for which We made a payment, We will treat his current Disability as part of his prior claim and he will not have to complete another Elimination Period if he returns to Active Work for his Employer on a full time basis for 6 consecutive months or less. His Disability will be subject to all of the provisions as his prior claim and will be treated as a continuation of that Disability.

Any Disability which occurs after 6 consecutive months from the date the Covered Person's prior claim ended will be treated as a new claim. His new claim will be subject to all of the provisions, including the Elimination Period.

If the Covered Person returns to work for another Employer, We will treat a Recurrent Disability the same as established above for the first 6 months following his return to work. Any Recurrent Disability that occurs more than 6 months but less than 12 months after the end of the Covered Person's prior Disability will be treated as a continuation of the prior Disability, but the Covered Person will be required to complete a new Elimination Period.

If the Covered Person becomes entitled to benefits under any other Group Long Term Disability policy, he will not be eligible for payments under the Policy.

Recurrent Disability means: a Disability that is:

1. caused by a worsening in the Covered Person's condition; and
2. due to the same or related cause(s) as his prior Disability for which We made a payment.

Multiple Causes: If a period of Disability is extended by a new, unrelated cause while benefits are payable, benefits will continue while the Covered Person remains Disabled, subject to the following:

1. benefits will not continue beyond the end of the original Maximum Benefit Period; and
2. any Exclusions and Pre-existing Conditions Limitations will apply to the new cause of Disability.

Concurrent Disability: Benefits for a Concurrent Disability will be paid as if the Concurrent Disability were caused by one Injury or one Sickness. In no event will a Covered Person be considered to have more than one continuous period of Disability at the same time.

Concurrent Disability means: one continuous period of Disability that is caused by more than one Injury or Sickness.

Lump Sum Survivor Benefit: When We receive proof that the Covered Person died, We will pay his Spouse, if living, otherwise, his children under age 26, a lump sum benefit equal to 3 months of the Covered Person's monthly Gross Disability Payment if, on the date of the Covered Person's death:

1. his Disability had continued for 180 or more consecutive days; and
2. he was receiving or was entitled to receive a Monthly Payment under the Policy.

If the Covered Person has no living Spouse or children, payment will be made to his estate. However, We will first apply the survivor benefit to any overpayment which may exist on the Covered Person's claim.

Workplace Modification Benefit: A workplace modification benefit may be payable to the Covered Person's Employer if a change is made to the work environment or the way a job is performed to allow the Covered Person to be Actively at Work and to perform the Material and Substantial Duties of his Regular Occupation, or any Gainful Occupation.

To qualify for a benefit:

1. the Covered Person must be Disabled under the terms of the Policy;
2. the Employer must agree to make the necessary modifications so that the Covered Person can return to work; and
3. any proposed modifications to the work place must be in writing and approved by Us prior to implementation.
4. In considering any proposed modifications, We have the right to have the Covered Person evaluated by a Physician or other health care professional, or a vocational rehabilitation specialist of Our choice.

When the above qualifications are met, the Covered Person's Employer will be reimbursed for the cost of the modification up to a maximum amount for the Workplace Modification Benefit. This benefit is available to the Covered Person on a one-time-only basis, at Our discretion, and will be paid in addition to any other Disability benefits for which the Covered Person qualifies. The Workplace Modification Benefit maximum amount is $5,000.

Rehabilitation Services: A rehabilitation program is available to assist the Covered Person in his return to work. Participation in this program is voluntary on his part and will be offered at Our discretion.

Our vocational rehabilitation specialists will review the Covered Person's file to determine if rehabilitation services might help him return to a Gainful Occupation. Once the review is completed, We may offer and pay for a return to work program. We will work with the Covered Person's Physician and other appropriate specialists to develop a plan that best suits the Covered Person's needs.

The return to work program may include, but is not limited to, the following services:

1. coordination with the Covered Person's Employer to assist him in his return to work;
2. evaluation of adaptive equipment to allow the Covered Person to work;
3. vocational evaluation to determine how his Disability may impact his employment options;
4. job placement services;
5. resume preparation;
6. job seeking skills training;
7. retraining for a new occupation; or
8. assistance with relocation that may be part of an approved return to work program.

We reserve the right to make the final decision concerning the Covered Person's eligibility to take part in a rehabilitation program and the amount of any services he will be provided.

During the Covered Person's participation in an approved rehabilitation program, his Gross Disability Payment will be increased by 10% for Rehabilitation Services.

In addition, We will make monthly payments to the Covered Person for 3 months following the date his Disability ends if We determine he is no longer Disabled while:

1. he is participating in Our rehabilitation program; and
2. he is not able to find employment.

Employee Outreach Services: may provide Employee Outreach Services for a Covered Person who has a medical disability accompanied by psychosocial problems that may interfere with his recovery and return to work.

Employee Outreach Services will be provided at our discretion and may include, but are not limited to:

1. service provider referrals; and
2. identifying available community and state resources that may be helpful in the Covered Person's recovery and return to work.

Social Security Assistance: If the Covered Person is receiving a payment from Us, We can provide advice to him regarding his Social Security Disability benefits claim and assist him with his application or appeal.

We can assist the Covered Person in obtaining Social Security disability benefits by:

1. helping him find appropriate legal representation or other assistance;
2. obtaining medical and vocational evidence; and
3. reimbursing pre-approved case management expenses.

Claim Information:

Notice of Claim: Written notice of a claim must be given to Us at Our Home Office by the Covered Person within 30 days after the date his Disability begins. If it is not possible, written notice must be given as soon as it is reasonably possible to do so.

The claim form is available from the Covered Person's Employer, or can be requested from Us. If the Covered Person does not receive the form from Us within 15 days of his request, written proof of claim should be sent to Us without waiting for the form. Written proof should establish facts about the claim such as date of occurrence, nature and extent of the Disability.

The Covered Person must notify Us immediately when he returns to work in any capacity.

Filing a Claim: The Covered Person and his Employer must fill out their own section of the claim form and then give it to the Covered Person's attending Physician. The Physician should fill out his section of the form and send it directly to Us.

Proof of Claim: Written proof of claim must be filed within 90 days after the Covered Person's Elimination Period ends. However, if it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

Proof of claim must include:

1. the date the Covered Person's Disability began;
2. appropriate documentation of the Disabling disorder;
3. the extent of the Covered Person's Disability, including restrictions and limitations preventing him from being Actively at Work;
4. the appropriate documentation of the Covered Person's earnings;
5. the name and address of any Hospital or Medical Facility where the Covered Person received Treatment;
6. the name and address of all Physicians providing Regular Care or specialty care.

We may request that the Covered Person send proof of continuing Disability, satisfactory to Us, indicating that he is under the Regular Care of a Physician. This proof, provided at the Covered Person's expense, must be received within 30 days of a request by Us.

In some cases, the Covered Person will be required to give Us authorization to obtain additional medical information, and to provide non-medical information as part of his proof of claim, or proof of continuing Disability. We will deny a Covered Person's claim or stop sending him payments if the appropriate information is not submitted.

Payment of Claim: Except as otherwise noted for specified additional benefits that may be included in the Policy, all benefits are payable to the Covered Person. If a benefit is payable to the Covered Person's estate, to a minor or to someone who is not competent to give a valid release, We have the right to pay up to $1,000 to any of the Covered Person's relatives whom We consider entitled. Any amount We pay in good faith releases Us from further liability, but only for the amount paid.

Overpayment of Claim: We have the right to recover any overpayments due to:

1. fraud;
2. any error We make in processing a claim; and
3. the Covered Person's receipt of Other Income Benefits.

The Covered Person must reimburse Us in full. We will determine the method by which the repayment is to be made. We have the right to recover overpayment from the Covered Person and Covered Person's estate.

Legal Action: The Covered Person may not bring suit to recover under this section until 60 days after he has given Us written proof of loss. No suit may be brought more than three years after the date the proof of loss is required to be filed.

PORTABILITY UNDER THE WORKING RETURNS LONG TERM DISABILITY INSURANCE

If the Covered Person's insurance under the Policy ends because his employment with the Employer ends, then he may choose to continue his Group Long Term Disability Insurance without providing evidence of insurability.

The Covered Person must be insured under the Policy for at least 12 months prior to the date his employment ends.

The Covered Person is not eligible to continue his insurance if:

1. he is Disabled under the terms of the Policy; or
2. he has recovered from a Disability under the terms of the Policy, but did not choose to return to work with the Employer; or
3. he failed to pay premium for the cost of his insurance; or
4. he is on an approved Leave of Absence; or
5. he retires; or
6. he is or becomes insured under another group long term disability policy; or
7. the Policy terminates.

Retire means: for purposes of this Portability benefit, the Covered Person has concluded his working career on a full-time basis and:

1. he is receiving payments from a governmental retirement plan or any Employer;
2. he is receiving Social Security Retirement benefits; or
3. he is no longer seeking active, full-time employment.

To apply for Portability insurance, within 31 days of the date the Covered Person's insurance ends he must:

1. submit a written application to Us; and
2. pay the first month's premium.

If the above conditions are met, such insurance will:

1. be issued without evidence of insurability; and
2. continue in effect for 12 months provided the Covered Person continues to pay the cost of his insurance.

During the time Portability insurance is in effect, any benefits paid will be based on the Covered Person's Pre-Disability Monthly Earnings as calculated just prior to the time his employment with the Employer ended.

The Portability insurance will end on the earliest of:

1. the date the Covered Person fails to pay the required premium;
2. the date he retires;
3. the date he becomes insured under any other group long term disability policy;
4. the date the Policy terminates; or
5. the date following 12 months of Portability insurance.

Employees rehired after porting insurance must either lapse that insurance or provide evidence of insurability.

ACCELERATED BENEFIT UNDER THE WORKING RETURNS LONG TERM DISABILITY INSURANCE

We will pay a lump sum Accelerated Benefit to a Covered Person if he:

1. meets the definition of Disabled under the Policy;
2. is certified as having a life expectancy of less than 12 months; and
3. makes a written request for this benefit.

We may, at Our option, confirm the terminal illness diagnosis with a second medical exam performed by a Physician of Our choosing at Our own expense.

The Accelerated Benefit:

1. will be an amount equal to the Covered Person's Monthly Payment for 12 months;
2. is payable one time only for any one Covered Person insured under the Policy;
3. is payable to a Covered Person only while he is living; and
4. is payable in addition to the Monthly Payment otherwise payable under the Policy.

CHILD CARE EXPENSE BENEFIT UNDER THE WORKING RETURNS LONG TERM DISABILITY INSURANCE

While the Covered Person is participating in an approved Rehabilitation Program, We will pay a Child Care Expense Benefit when the Covered Person is Disabled and is incurring expenses to provide care to a Child under the age of 13 or to a child age 13 or older who needs ongoing personal care assistance.

The payment of the Child Care Expense Benefit will begin immediately after the Covered Person begins participating in the Rehabilitation Program.

The Child Care Expense Benefit will be paid monthly and determined as follows:

1. be $350 per month per Dependent; and
2. not to exceed $1,000 per month for all child care expenses combined.

To receive this benefit, the Covered Person must provide satisfactory proof that he is incurring expenses that entitle him to the Child Care Expense Benefit. Expenses must be charged by a child care provider who is licensed to provide such services in the jurisdiction in which the services are provided.

The Child Care Expense Benefit will end on the earlier of the following:

1. the date the Covered Person is no longer incurring child care expenses for dependents;
2. the date the Covered Person is no longer participating in an approved Rehabilitation program; or
3. the date benefits terminate under the Termination of Benefits provision of the Policy.

The Child Care Expense Benefit is paid in addition to any other payments the Covered Person receives under the Policy.

SPOUSE AND ELDER CARE EXPENSE BENEFIT UNDER THE WORKING RETURNS LONG TERM DISABILITY INSURANCE

While the Covered Person is participating in an approved Rehabilitation Program, We will pay a Spouse and Elder Care Expense Benefit when the Covered Person is Disabled and is incurring expenses to provide care to a Disabled Eligible Family Member.

The payment of the Spouse and Elder Care Expense Benefit will begin immediately after the Covered Person begins participating in the Rehabilitation Program.

Our payment of the Spouse and Elder Care Expense Benefit will:

1. be $500 per Eligible Family Member; and
2. not exceed $1,000 for all Eligible Family Member expenses combined.

To receive this benefit, the Covered Person must provide satisfactory proof that he is incurring expenses that entitle him to the Spouse and Elder Care Expense Benefit. Expenses must be charged by a licensed adult care provider who is licensed to provide such services in the jurisdiction in which the services are provided.

The Spouse and Elder Care Expense Benefit will end on the earliest of the following:

1. the date the Covered Person is no longer incurring expenses for his Disabled Eligible Family Member ;
2. the date the Covered Person is no longer participating in an approved Rehabilitation program; or
3. the date benefits terminate under the Termination of Benefits provision of the Policy.

Eligible Family Members means: for purposes of this Spouse and Elder Care Expense Benefit, the Covered Person's Spouse, parents or grandparents who live with the Covered Person, and his Spouse's parents and grandparents who live with him.

Disabled Eligible Family Member means: for purposes of this Spouse and Elder Care Expense Benefit, that due to his Sickness or Injury, the Eligible Family Member:

1. has lost the ability to safely and completely perform two or more Activities of Daily Living without another person's active assistance or verbal cueing; or
2. is Cognitively Impaired and needs another person's assistance or verbal cueing for his protection or for the protection of others; or
3. has a life expectancy of less than 12 months.

The Spouse and Elder Care Expense Benefit is paid in addition to any other payments the Covered Person receives under the Policy.

Activities of Daily Living means:

1. bathing – the ability to wash oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
2. dressing – the ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
3. toileting – the ability to get to and from the toilet, get on and off the toilet and perform associated personal hygiene.
4. transferring – the ability to move into or out of a bed, chair or wheelchair.
5. continence – the ability to maintain control of bowel and bladder functions; or, when unable to maintain control of bowel and bladder function, the ability to perform associated personal hygiene including caring for catheter or colostomy bag.
6. eating – the ability to feed oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

Cognitively Impaired means: the Covered Person suffers a deficiency in short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness. The impairment must be measurable according to generally accepted medical standards.

CERTIFICATE MODIFICATIONS RIDER

Certificate Modification(s) to the Certificate

Policyholder: State of Nebraska

Policy Number: 306147

It is agreed that the Certificate is amended as follows:

Effective July 1, 2019, with respect to residents of the states as shown on the subsequent pages, the following provisions amend, replace or are added, when applicable, to the Certificate:

Signed for the Company by:

Thomas J McGuire

Secretary

President

UnitedHealthcare Insurance Company
Hartford, Connecticut

STATUTORY PROVISIONS

ALASKA

Residents of the state of Alaska, the following provisions are included to bring your Certificate into conformity with Alaska state law:

Discretionary Authority

When a Discretionary Authority provision is shown in the CERTIFICATE GENERAL PROVISIONS section, it is hereby deleted in its entirety.

Overpayment of Claim

The Overpayment of Claim section as contained in the Certificate is hereby changed to read as follows:

Overpayment of Claim: Within 180 days of payment of a benefit, We have the right to recover any overpayments due to:

1. fraud;
2. any error We make in processing a claim; and
3. the Covered Person's receipt of Other Income Benefits.

The Covered Person must reimburse Us in full. We will determine the method by which the repayment is to be made. We have the right to recover overpayment from the Covered Person's Spouse if living, otherwise child under the age 26 or estate.

ARKANSAS

Residents of the state of Arkansas, the following provision is included to bring your Certificate into conformity with Arkansas state law:

Insurer Information Notice

Any questions regarding the Policy may be directed to:
UnitedHealthcare Insurance Company
Administrative Offices
9900 Bren Road East
Minnetonka, MN 55343
1-866-615-8727

If the question is not resolved, you may contact the Arkansas Insurance Department:
Arkansas Insurance Department
Consumer Services Division
400 University Tower Building
Little Rock, Arkansas 77204
Telephone: 1-800-852-5494

MINNESOTA

Minnesota has determined that its statutory requirements apply to Minnesota residence when non-Minnesota sitused Employers have 25 or more Employees residing in Minnesota.

Any questions regarding these statutory requirements may be directed in writing to:

UnitedHealthcare Specialty Benefits
Contract Services
MN017-E800
9900 Bren Road East
Minnetonka, MN 55343

MONTANA

Residents of the state of Montana, the following provision is included to bring your Certificate into conformity with Montana state law:

Conformity with Montana Statutes: For Montana residents, the provisions of this Policy are intended to conform to the minimum requirements of Montana law. If any provision of the Policy conflicts with any Montana statutes, the provision will be deemed to conform to the minimum requirements of the Montana law.

Discretionary Authority

When a Discretionary Authority provision is shown in the CERTIFICATE GENERAL PROVISIONS section it is hereby deleted in its entirety.

Disability Pre-Existing Exclusion

Any applicable Pre-Existing exclusion will not be applied to any disability that begins more than 12 months after the Covered Person's Effective Date of insurance.

NEW HAMPSHIRE

Residents of the state of New Hampshire, the following provision is included to bring your Certificate into conformity with New Hampshire state law:

Proof of Claim

The provision(s) entitled Proof of Claim as contained in the Certificate of Coverage is modified to include the following:

Failure to furnish such proof of claim within the Certificate of Coverage stated time limit will not invalidate nor reduce any claim if it is shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as it was reasonably possible.

Discretionary Authority

When a Discretionary Authority provision is shown in the Certificate of Coverage GENERAL PROVISIONS section it is hereby deleted in its entirety.

NORTH CAROLINA

Residents of the state of North Carolina, the following provision is included to bring your Certificate into conformity with North Carolina state law:

Proof of Claim

The provision(s) entitled Proof of Claim as contained in the Certificate is modified as follows:

Written proof of claim must be filed within 180 days of the loss. However, if it is not possible to give proof within 180 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

Occupational Injury or Sickness Exclusion

Any exclusion that applies to an Occupational Injury or Sickness is hereby replaced by the following:

An Occupational Injury or Sickness for treatments which are paid under the North Carolina Worker's Compensation Act only to extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier 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.

NORTH DAKOTA

Residents of the state of North Dakota, the following provision is included to bring your Certificate into conformity with North Dakota state law:

20 Day Right to Examine Certificate: There is a 20 day right to review this Certificate. If You decide not to keep it, it may be returned to Us within 20 days of the original Certificate Effective Date. In that event, We will consider it void from the Certificate Effective Date and refund all premium paid. Any claims paid during the initial 20 day period will be deducted from the refund.

OKLAHOMA

Residents of the state of Oklahoma, the following provision is included to bring your Certificate into conformity with Oklahoma state law:

Certificates delivered to residents of state of Oklahoma are subject to Oklahoma laws.

OKLAHOMA (continued)

Incontestability

The Incontestability provision shown in the Certificate GENERAL PROVISIONS section is replaced by the following:

Incontestability: We may not contest the validity of the Policy, except for the non-payment of premiums, after it has been in force for two years from its date of issue. No statement made by any Covered Person relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime, unless it is contained in a written instrument signed by him. This clause will not affect Our right to contest claims made for accidental death or accidental dismemberment benefits.

TEXAS

Residents of the state of Texas, the following provision is included to bring your Certificate into conformity with Texas state law:

Incontestability

The Incontestability provision under the CERTIFICATE GENERAL PROVISIONS section, is amended to remove the phrase "or fraudulent misrepresentations" from the first sentence.

TEXAS

IMPORTANT NOTICE	AVISO IMPORTANTE
To obtain information or make a complaint: You may call UnitedHealthcare Insurance Company's toll-free telephone number for information or to make a complaint at 1-866-615-8727 You may also write to UnitedHealthcare Insurance Company at: UnitedHealthcare Insurance Company Administrative Offices 9900 Bren Road East Minnetonka, MN 55343 You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at: **800-252-3439** You may write the Texas Department of Insurance at: P.O. Box 149104 Austin, TX 78714-9104 FAX #(512) 490-1007 Web: http://www.tdi.texas.gov E-Mail: ConsumerProtection@tdi.texas.gov **PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance. **ATTACH THIS NOTICE TO YOUR POLICY:** This notice is for information only and does not become a part or condition of the attached document. Form No. AA-2068 (Rev. 6/15)	Para obtener información o para presentar una queja: Usted puede llamar al número de teléfono gratuito de UnitedHealthcare Insurance Company's para obtener información o para presentar una queja al: 1-866-615-8727 Usted también puede escribir a UnitedHealthcare Insurance Company: UnitedHealthcare Insurance Company Administrative Offices 9900 Bren Road East Minnetonka, MN 55343 Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al: **1-800-252-3439** Usted puede escribir al Departamento de Seguros de Texas a: P.O. Box 149104 Austin, TX 78714-9104 Fax: (512) 490-1007 Sitio web: http://www.tdi.texas.gov E-mail: ConsumerProtection@tdi.texas.gov **DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:** Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con (el agente) (la compañía) (el agente o la compañía) primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas. **ADJUNTE ESTE AVISO A SU PÓLIZA:** Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

ACN-TX-MP (8/95)