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# YOUR GROUP SHORT-TERM DISABILITY BENEFITS

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**FOR EMPLOYEES OF:**

**First Light Technologies, Inc**

**CLASS(ES):**

All Eligible Employees

**EFFECTIVE DATE:**

January 1, 2019

**PUBLICATION DATE:**

January 14, 2019

## **NOTICE(S)**

**THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU. PLEASE READ YOUR CERTIFICATE CAREFULLY. BENEFITS ARE PROVIDED THROUGH A GROUP POLICY ISSUED IN THE STATE OF VERMONT.**

### **FRAUD WARNING**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

## **HOW TO OBTAIN PLAN BENEFITS**

To obtain benefits see the Payment of Claims provision.

Forward your completed claim form to:

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

## **CLAIM ASSISTANCE**

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

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

When contacting the Company please have your Policy number available. Your Policy number is GUG-BGX4.

# TABLE OF CONTENTS

## PAGE

CERTIFICATE OF INSURANCE.....	1
SCHEDULE.....	2
EMPLOYEE ELIGIBILITY.....	5
DEFINITIONS.....	5
ELIGIBLE EMPLOYEES.....	5
THE FIRST ENROLLMENT PERIOD.....	6
SUBSEQUENT ENROLLMENT PERIODS.....	6
EVIDENCE OF GOOD HEALTH.....	6
WHEN YOUR CLASSIFICATION OR AMOUNT OF INSURANCE CHANGES.....	6
REINSTATEMENT OF INSURANCE.....	6
WHEN YOUR INSURANCE ENDS.....	7
CONTINUATION OF INSURANCE DURING TOTAL OR PARTIAL DISABILITY.....	7
CONTINUATION OF INSURANCE UNDER FAMILY AND MEDICAL LEAVE.....	7
CONTINUITY OF COVERAGE UPON TRANSFER OF INSURANCE CARRIER.....	7
NOTICE VERMONT MANDATORY CIVIL UNION ENDORSEMENT.....	8
SHORT-TERM DISABILITY BENEFITS.....	9
VOCATIONAL REHABILITATION PROVISION.....	10
PAYMENT OF CLAIMS.....	11
CLAIM REVIEW AND APPEAL PROCEDURES.....	13
STANDARD PROVISIONS.....	15
SHORT-TERM DISABILITY DEFINITIONS.....	16

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# CERTIFICATE OF INSURANCE

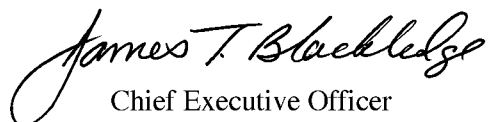
## UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:  
Mutual of Omaha Plaza  
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy No(s). GUG-BGX4 (Policy) has been issued to First Light Technologies, Inc (Policyholder).

Insurance is provided for certain Employees as described in the Policy.

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

  
Chief Executive Officer

  
Corporate Secretary

## SCHEDULE

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

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

### CLASSIFICATION

All Eligible Employees

### SHORT-TERM DISABILITY BENEFITS

#### ELIMINATION PERIOD

If Your Total or Partial Disability is a result of an Injury, there is no Elimination Period. Benefits will begin immediately.

If Your Total or Partial Disability is a result of a Sickness, Your Elimination Period is 7 calendar days.

#### DEFINITIONS

*Other Income Benefits* has the meaning set forth in the Other Income Benefits provision of this Schedule.

*Social Security Normal Retirement Age* means Your normal retirement age under the United States Social Security Act.

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

Weekly Earnings includes Employee contributions to Deferred Compensation plans and other extra compensation received from the Policyholder.

Weekly Earnings does not include commissions, bonuses, overtime pay, Policyholder contributions to Deferred Compensation plans, and shift differentials received from the Policyholder.

#### WEEKLY BENEFIT – TOTAL OR PARTIAL DISABILITY

If You are Totally Disabled, the Weekly Benefit is the lesser of:

- a) 66 2/3% of Your Weekly Earnings, less Other Income Benefits; or
- b) the Maximum Weekly Benefit. The Maximum Weekly Benefit is \$1,100, less any Other Income Benefits.

If You are Partially Disabled and unable to generate Current Earnings that exceed 99% of Your Weekly Earnings, the Weekly Benefit will be the Weekly Benefit payable while Partially Disabled, unless the sum of:

- a) the Gross Weekly Benefit while You are Totally Disabled; plus
- b) Other Income Benefits You receive or are eligible to receive; plus
- c) Current Earnings while You are Partially Disabled;

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

**Note:** Your Weekly Benefit, as calculated above, will be reduced by the amount of any formal salary continuance, sick leave benefits or severance pay for which You are eligible or that You are receiving from the Policyholder that, when combined with Your Gross Weekly Benefit, exceeds 100% of Your Weekly Earnings.

## **VOCATIONAL REHABILITATION INCENTIVE**

While You are participating in a plan of vocational rehabilitation approved by Us, Your Weekly Benefit, as calculated above, will be increased by 10%.

## **MAXIMUM BENEFIT PERIOD**

The maximum number of weeks that benefits are payable for a continuous period of Total or Partial Disability is 26 weeks.

## **OTHER INCOME BENEFITS**

If You receive income from any of the sources listed below, Your benefit will be reduced by such income. Your Other Income Benefits are any of the following amounts that You receive or are eligible to receive as compensation for the same loss claimed under the Policy as a result of Your Total or Partial Disability. Other Income Benefits also include family leave benefits received for any reason.

1. 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. Any benefits payable by a group short-term or long-term disability policy underwritten by United of Omaha Life Insurance Company will not be considered as Other Income Benefits.
2. Any amounts as disability income payments under any:
  - a) state compulsory benefit act or law;
  - b) government retirement system as a result of Your job with the Policyholder; or
  - c) any 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.
3. Any amount of Retirement Benefits under the Policyholder's Retirement Plan. Benefits payable before the plan's normal retirement age are considered Other Income Benefits only if You voluntarily elect to receive these benefits.
4. Any benefits for You or Your spouse and child(ren) under:
  - a) the Canada Pension Plan;
  - b) the Quebec Pension Plan;
  - c) the Railroad Retirement Act;
  - d) the Public Employee Retirement Plan;
  - e) the Teachers Employment Retirement Plan; or
  - f) any similar plan or act that provides:
    1. Disability benefits; or
    2. Retirement Benefits (except this will not apply if Your Total or Partial 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).
5. Any amount payable as:
  - a) salary continuance, except paid time off (PTO), vacation or any earned time off program;
  - b) sick leave; or
  - c) severance allowance.
6. Any amount from a third party (after subtracting attorneys' fees) by judgment, settlement or otherwise.
7. Any amounts from any unemployment insurance law or program.

## **EXPLANATION OF OTHER INCOME BENEFITS**

You must apply for Other Income Benefits for which You are or may become eligible and do what is needed to obtain them.

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

After the first reduction for each of the Other Income Benefits, We will not further reduce Your Weekly Benefit due to any cost of living increases payable under these Other Income Benefits.

Other Income Benefits 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 Benefits which are paid in a lump sum are paid on a retroactive basis, then we may adjust the Weekly Benefit to recover any overpayment.

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 Benefits, We may:

- a) estimate Your Other Income Benefits; 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 the reduced amounts to You in one payment.



# EMPLOYEE ELIGIBILITY

## Disability Insurance

### DEFINITIONS

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

*Active Employment or Actively Employed* means Actively Working on a regular and consistent basis for the Policyholder 30 or more hours each week. A Totally or Partially Disabled Employee will not be considered actively employed.

*Actively Working or Active Work* means performing the normal duties of a regular job for the Policyholder at:

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

An Employee will be considered actively working on any day that is:

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

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

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

#### *Confinement Rule*

1. If an eligible Employee is confined due to an Injury or Sickness:

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

insurance will begin on the day the Employee returns to Active Employment.

2. If an eligible Employee is Actively Employed and is not:

- a) confined; and
- b) available for work because of an Injury or Sickness;

insurance will begin on the day the Employee returns to Active Employment.

*Employee* means a person who receives compensation from the Policyholder for work performed for the Policyholder. An employee will not include a person who is unauthorized to work in the United States pursuant to the Immigration and Nationality Act and related rules and regulations.

The term Employee does not include any person performing services for the Policyholder:

- a) pursuant to an independent contractor relationship with the Policyholder;
- b) subject to the terms of a leasing agreement between the Policyholder and a leasing organization;
- c) who receives income which is reported by the Policyholder on IRS form 1099;
- d) while outside the United States for any period in excess of 12 consecutive months, unless approval has been received from the Home Office;
- e) on a seasonal basis; or
- f) on a temporary basis.

### ELIGIBLE EMPLOYEES

An Employee who is Actively Employed on January 1, 2019 becomes eligible for insurance under this Policy on January 1, 2019.

An Employee who is hired after January 1, 2019 becomes eligible for insurance under this Policy on the day the Employee begins Active Employment.

### **THE FIRST ENROLLMENT PERIOD**

An eligible Employee must request insurance by:

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

If an Employee's properly completed and signed enrollment form is received on or within 31 days following the day the Employee becomes eligible, the Employee will become insured on the first day of the Policy month which follows the later of:

- a) the day the Employee becomes eligible; or
- b) the date the enrollment form is properly completed and signed by the Employee;

provided the Employee is Actively Working on that day. If the Employee is not Actively Working on that day, insurance will begin on the day the Employee returns to Active Work.

### **SUBSEQUENT ENROLLMENT PERIODS**

Subsequent enrollment periods will be allowed in which an Employee may elect, drop or change insurance. A subsequent enrollment period is any period designated by the Policyholder and agreed to by Us, but in no event will any such period exceed 31 consecutive calendar days.

### **EVIDENCE OF GOOD HEALTH**

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

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

### **WHEN YOUR CLASSIFICATION OR AMOUNT OF INSURANCE CHANGES**

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

- a) If the change involves an increase in amount of insurance, the change will not take effect until the first day of the Policy month which follows the day You return to Active Work.
- b) If the change involves a decrease in amount of insurance, the change will take effect on the day of the change.

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

### **REINSTATEMENT OF INSURANCE**

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

- a) Rehire: If insurance ended because the Employee ceased to be eligible under this Policy and the Employee becomes eligible again within 90 days after insurance ended, the waiting period will be waived. All other Policy provisions, including Pre-existing Conditions, will apply.

- b) If insurance ended because the eligible Employee voluntarily let insurance lapse, the Employee must provide evidence of good health to Us. If such evidence is acceptable to Us, We will determine the day insurance is reinstated.

## **WHEN YOUR INSURANCE ENDS**

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

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

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

## **CONTINUATION OF INSURANCE DURING TOTAL OR PARTIAL DISABILITY**

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

## **CONTINUATION OF INSURANCE UNDER FAMILY AND MEDICAL LEAVE**

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

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

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

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

## **CONTINUITY OF COVERAGE UPON TRANSFER OF INSURANCE CARRIER**

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

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

## NOTICE VERMONT MANDATORY CIVIL UNION ENDORSEMENT

This Rider is made a part of Group Policy GUG-BGX4.

This Rider is effective the later of January 1, 2019, or the day You become insured under the Policy.

In the event of a conflict between this Rider and any other provision of the Policy, including the Certificate, this Rider shall control. This Rider shall be subject to all provisions of the Policy, including the Certificate, not in conflict with this Rider.

### PURPOSE

This endorsement is part of the policy, contract, certificate and/or riders and endorsements to which it is attached and is intended to provide benefits for parties to a civil union. Vermont law requires that insurance contracts and policies offered to married persons and their families be made available to parties to a civil union and their families. In order to receive benefits in accordance with this endorsement, the civil union must have been established in the state of Vermont according to Vermont law.

### DEFINITIONS, TERMS, CONDITIONS AND PROVISIONS

The definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

Terms that mean or refer to a marital relationship or that may be construed to mean or refer to a marital relationship: such as “marriage”, “spouse”, “husband”, “wife”, “dependent”, “next of kin”, “relative”, “beneficiary”, “survivor”, “immediate family” and any other such terms include the relationship created by a civil union.

Terms that mean or refer to a family relationship arising from a marriage such as “family”, “immediate family”, “dependent”, “children”, “next of kin”, “relative”, “beneficiary”, “survivor” and any other such terms include the family relationship created by a civil union.

Terms that mean or refer to the inception or dissolution of a marriage, such as “date of marriage”, “divorce decree”, “termination of marriage” and any other such terms include the inception or dissolution of a civil union.

“Dependent” means a spouse, a party to a civil union, and/or a child or children (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

“Child or covered child” means a child (natural, stepchild, legally adopted or a minor who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union.

### CAUTIONARY DISCLOSURE

**THIS ENDORSEMENT IS ISSUED TO MEET THE REQUIREMENTS OF VERMONT LAW AS EXPLAINED IN THE “PURPOSE” PARAGRAPH ABOVE. THE FEDERAL GOVERNMENT OR ANOTHER STATE GOVERNMENT MAY NOT RECOGNIZE THE BENEFITS GRANTED UNDER THIS ENDORSEMENT. YOU ARE ADVISED TO SEEK EXPERT ADVICE TO DETERMINE YOUR RIGHTS UNDER THIS CONTRACT.**

UNITED OF OMAHA LIFE INSURANCE COMPANY

  
Corporate Secretary

## SHORT-TERM DISABILITY BENEFITS

### BENEFITS

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

### RECURRENT DISABILITY

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

- a) You were continuously insured under the Policy for the period between Your prior claim and Your Recurrent Disability; and
- b) Your Recurrent Disability occurs within 180 days of the end of Your prior claim.

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

### WHEN BENEFITS END

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

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

### GENERAL EXCLUSIONS

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

- a) declared or undeclared war or any act of war;
- b) Your participation in a riot or insurrection;
- c) Your commission of a felony for which You have been charged under state or federal law;
- d) an intentionally self-inflicted Injury or Sickness;
- e) attempted suicide; or
- f) an occupational Sickness or Injury and You are eligible to receive benefits under Workers' Compensation or any other Act or law of like intent.

We also will not pay benefits for any Total or Partial Disability that is solely a result of a loss of a professional license, occupational license or certification.

## VOCATIONAL REHABILITATION PROVISION

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

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

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

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

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

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

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

### DEFINITIONS

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

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

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

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

## PAYMENT OF CLAIMS

### HOW TO FILE CLAIMS

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

### PROOF OF LOSS REQUIREMENTS

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

This request should be made:

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

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

Such statement should include:

- a) that You are under the Regular Care of a Physician;
- b) the appropriate documentation of Your job duties at Your regular job and Your Weekly Earnings;
- c) the date Your Disability began;
- d) the cause of Your Disability;
- e) any restrictions and limitations preventing You from performing Your regular job;
- f) the name and address of any Hospital or institution where You received treatment, including attending Physicians.

2. Next, You and Your employer must complete and sign Your sections of the claim form, and then give the claim form to the Physician. Your Physician should fill out his or her section of the form, sign it, and send it directly to Us.

3. The claim form should be sent to Us within 90 days after the end of Your Elimination Period. Failure to furnish proof within such time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish proof within such time, provided proof was furnished as soon as reasonably possible.

### HOW CLAIMS ARE PAID

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

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

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

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

### EXAMINATION

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

### OVERPAYMENTS

We have the right to recover any overpayments due to:

- a) fraud;
- b) any error We make in processing a claim; and
- c) Your receipt of Other Income Benefits.

Any other benefits will be paid to You except that benefits unpaid at Your death may be paid, at Our option to:

- a) Your beneficiary; or
- b) Your estate.

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

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

**AUTHORITY TO INTERPRET POLICY**



## CLAIM REVIEW AND APPEAL PROCEDURES

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

### DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

*Adverse Benefit Determination* means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, any such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

*Claimant* means the person who submits a claim for benefits under the Policy, including the authorized representative of such person.

### CLAIM REVIEW PROCEDURES

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except when the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant's failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

### INITIAL CLAIM DECISION

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

- a) initial claim decision period: 45 days unless additional information is requested as set forth below;
- b) extension period: 30 days; and
- c) maximum number of extensions: two.

If additional information is needed, We will notify the Claimant within 10 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 45 days to submit the additional information to Us. We will make Our determination within 15 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

### CLAIM DENIALS

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

- a) the specific reason(s) for the denial;
- b) reference to the specific Policy provisions on which the denial is based;
- c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 180 days and the right to bring a civil action following the appeal process; and
- d) any other information which may be required under state or federal laws and regulations.

Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

## **OPPORTUNITY TO REQUEST AN APPEAL**

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 180 days from the Claimant's receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

- a) the Claimant's name;
- b) the name of the person filing the appeal if different from the Claimant;
- c) the Policy number; and
- d) the nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

A document, record, or other information will be considered relevant to a claim if it:

- a) was relied upon in making the claim decision;
- b) was submitted, considered, or generated in the course of making the claim decision, without regard to whether it was relied upon in making the claim decision; or
- c) demonstrates compliance with administrative processes and safeguards designed to ensure and verify that claim decisions are made in accordance with the Policy and that, where appropriate, Policy provisions have been applied consistently with respect to similarly situated claimants.

## **RESPONSE TO APPEALS**

We will respond no later than 45 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 45 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

- a) information regarding the decision; and
- b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

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

## STANDARD PROVISIONS

### INSURANCE CONTRACT

The insurance contract consists of:

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

### CHANGES IN THE INSURANCE CONTRACT

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

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

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

### APPLICATIONS

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

### LEGAL ACTIONS

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

## SHORT-TERM DISABILITY DEFINITIONS

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

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

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

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

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

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

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

*Gross Weekly Benefit* means Your Weekly Benefit amount before any reduction for Other Income Benefits and Current Earnings.

*Hospital* means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing Your Total or Partial Disability. A hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

*Injury* means an accidental bodily injury sustained by the Insured Person and directly caused by an accident which is not the result of disease or bodily infirmity. Total or Partial Disability due to such injury must begin while You are insured under the Policy. Injury does not include elective or cosmetic surgery or procedures, or complications resulting therefrom. Cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part.

*Material Duties* means the essential tasks, functions, and operations relating to Your Regular Job that cannot be reasonably omitted or modified. In no event will We consider working an average of more than 40 hours per week in itself to be a part of material duties.

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

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

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

*Partial Disability* and *Partially Disabled* mean that because of an Injury or Sickness, a significant change in Your mental or physical functional capacity has occurred in which You, while unable to perform all of the Material Duties of Your Regular Job on a full-time basis, are:

- a) able to perform at least one of the Material Duties of Your Regular Job or another gainful job on a part-time or full-time basis; and
- b) unable to generate Current Earnings which exceed 99% of Your Weekly Earnings due to that same Injury or Sickness.

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

*Physician* means any of the following licensed practitioners:

- a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
- b) a licensed doctoral clinical psychologist; or
- c) where required by law, any other licensed practitioner who is acting within the scope of his/her license.

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

*Policyholder's Retirement Plan* means any retirement plan:

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

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

*Regular Care* means:

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

*Regular Job* means the occupation You are routinely performing when Your Total or Partial Disability begins.

*Retirement Benefit* means money which:

- a) is payable under a Retirement Plan either in a lump sum or in the form of periodic payments;
- b) does not represent contributions made by You; and
- c) is payable upon the later of:
  1. early or normal retirement as defined in the Policyholder's Retirement Plan or under the U.S. Social Security Act; or
  2. Total or Partial Disability, if the payment does not reduce the amount of money which would have been paid at the normal retirement age under the plan if the Total or Partial Disability had not occurred.

**Note:** Regardless of how the retirement funds from the Retirement Plan are distributed, We will consider Your contributions and Your employer's contributions to be distributed simultaneously during Your lifetime.

*Retirement Plan* means a plan which provides Your Retirement Benefits and which is not funded wholly by Your contributions. The term shall not include a profit-sharing plan or a plan such as a 401(k), a thrift plan, an individual retirement account (IRA), a tax sheltered annuity (TSA), a stock ownership plan, or a non-qualified plan of Deferred Compensation.

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

*Schedule* means the Schedule included in this Certificate.

*Sickness* means a disease, disorder or condition, including pregnancy, for which you are under the care of a Physician and which first manifests itself after the effective date of the Policy. Total or Partial Disability must begin while you are insured under the Policy. Sickness does not include elective or cosmetic surgery or procedures, or complications resulting therefrom. Cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part.

*Total Disability* and *Totally Disabled* mean that because of an Injury or Sickness, a significant change in Your mental or physical functional capacity has occurred in which You are prevented from performing all of the Material Duties of Your Regular Job on a full-time basis.

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

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

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



**Group Short-Term Disability Benefits**

**First Light Technologies, Inc**

**Group Number: G000BGX4**

**United of Omaha Life Insurance Company**

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



**Mutual of Omaha**