



**Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175**

**ACCIDENT & SICKNESS POLICY
POLICY NUMBER: G000181C
NON-PARTICIPATING**

We, the Mutual of Omaha Insurance Company, agree with the Policyholder,

**The Corps Network
666 Eleventh Street NW, Suite 1000
Washington, DC 20001**

to insure, in accordance with the terms of the policy, those Eligible Persons for whom required premium is paid.

The policy is issued in the state of the District of Columbia and shall be governed by its laws.

SCOPE OF COVERAGE: Insurance is provided for a covered loss which:

- is set forth in the DESCRIPTION OF BENEFITS provisions; and
- occurs while the person is an Insured Person under the policy.

EFFECTIVE DATE AND POLICY TERM: This policy takes effect on July 1, 2009, the Policy Effective Date, and expires on July 1, 2010. All periods of insurance begin and end at 12:01 A.M. Standard Time at the Policyholder's address. Coverage will continue as long as the premiums are paid according to the agreed terms. Coverage may be terminated by Us or the Policyholder in accordance with the GENERAL PROVISIONS called "POLICY TERMINATION". Anniversaries will be determined from the Policy Effective Date.

We have issued the policy in consideration of the application by the Policyholder and payment of the required premium. It is subject to all of the terms, conditions and limits set forth in the policy.

Signed by

Chairman of the Board and
Chief Executive Officer

Corporate Secretary

**THIS IS A LIMITED ACCIDENT AND SICKNESS POLICY.
READ IT CAREFULLY.**

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Section 3.

DEFINITIONS

The terms shown below shall have the meaning given in this section whenever they appear in the policy. Additional terms may be defined within the provision to which they apply.

"Accident" means a sudden, unexpected and unintended external event independent of Sickness and all other causes which

- causes Injury to an Insured Person; and
- occurs while insurance is in effect for the Insured Person and within the Scope Of Coverage.

"Air Ambulance Service" means the service provided by means of a fixed or roto-winged aircraft equipped with life support and medical apparatus.

"Ambulance Service" means the service provided by a commercial or municipal Ambulance Service.

"Benefit Period" means the period of time, as stated on the Schedule, within which benefits will be paid.

"Controlled Substance" means any drug or substance, other than alcohol, having the capacity to affect behavior and is regulated by law with regard to possession and use.

"Core Plan" means insurance:

- under the Core Plan described on the Schedule; and
- for which all premium is paid by the Sponsoring Organization.

"Deductible" means the amount of eligible Medical Expenses which must be satisfied for each covered loss before benefits are payable under the policy. It applies separately to each Insured Person.

"Elective Surgery and Elective Treatment" includes but is not limited to surgery and/or treatment for biofeedback-type services; circumcision; corns, calluses and bunions; deviated nasal septum, including sub-mucous resection and/or other surgical correction thereof, except for purulent sinusitis; family planning; fertility tests; impotence, organic or otherwise; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; learning disabilities; sleep disorders, including testing thereof; temporomandibular joint dysfunction; tubal ligation; vasectomy.

"He", "Him" and "His" includes "She", "Her" and "Hers."

"Health Care Plan" means any contract, policy or other arrangement for benefits or services for medical or dental care or treatment under:

- group or blanket insurance, whether on an insured or self-funded basis;
- hospital or medical service organizations on a group basis;
- Health Maintenance Organizations on a group basis;
- group lab or management plans;
- employee benefit organization plan;
- professional association plans on a group basis; or
- any other group employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974 as amended.

"Home Health Care" means nursing care and treatment in an Insured Person's home by a Hospital licensed or certified to provide Home Health Care services or by a licensed or certified Home Health Care agency. It includes, but is not limited to, daily living care services, such as cooking, feeding, bathing, dressing and personal hygiene, which the Insured Person is unable to perform for Himself.

"Hospital" means an institution which:

- is operated pursuant to law;
- is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis;
- is under the supervision of a staff of Physicians;
- provides 24-hour nursing service by or under the supervision of a graduate registered nurse (R.N.);
- has medical, diagnostic and treatment facilities, with major surgical facilities;
 - on its premises; or
 - available to it on a prearranged basis; and
- charges for its services.

Hospital does not include:

- a clinic or facility for:
 - convalescent, custodial, educational or nursing care;
 - the aged;
 - rehabilitation; or
- a military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless:
 - the services are rendered on an emergency basis; and
 - a legal liability exists for the charges made to the individual for the services given in the absence of insurance.

"Hospital Stay" means a Medically Necessary overnight confinement in a Hospital when room and board and general nursing care are provided for which a per diem charge is made by the Hospital.

"Immediate Family Member" means the lawful spouse, child, parent, grandparent, brother or sister of the Insured Person or step relatives in these same categories, or a person who reared the Insured Person, or a person whom the Insured Person reared.

"Injury" means bodily harm which results, directly and independently of Sickness and all other causes, to an Insured Person while coverage is in effect and within the Scope of Coverage.

"Insured Person" means an Insured, or other Eligible Person for whom proper premium has been paid, and therefore is covered under this policy.

"Intensive Care Unit" means a section, ward, or wing within a Hospital which is separated from other Hospital facilities and:

- is operated exclusively for the purpose of providing professional treatment for critically ill patients;
- has special supplies and equipment necessary for such treatment which is available on a standby basis for immediate use;
- provides room and board, and constant observation by registered graduate nurses or other specialty trained Hospital personnel; and
- is not maintained for the purpose of providing normal post-operative recovery treatment or service.

"Loss Period" means that period of time, as stated on the Schedule, from the date of a covered accident within which an Insured Person must seek initial treatment for an Injury or within which disability must commence.

"Maximum Benefit Amount" means the total benefits payable under an applicable benefit provision.

"Medical Expenses" means expenses incurred for Medically Necessary services and supplies. Not included are amounts in excess of Usual, Customary and Reasonable Charges. Medical Expenses are incurred on the date the service or supply is received.

"Medically Necessary" or **"Medical Necessity"** means the services or supplies provided by a Hospital, Physician, or other covered provider that are required to identify or treat a covered loss and which, as determined by Us, are:

- consistent with the diagnosis and treatment of the covered loss;
- appropriate with the standards of good medical practice;
- not solely for the convenience of an Insured Person;
- the most appropriate supply or level of service which can be safely provided; and
- not considered experimental or investigative.

"Nurse" means a professional, licensed, graduate registered nurse (R.N.), a professional, licensed practical nurse (L.P.N.) or a Certified Registered Nurse Anesthetist (CRNA).

"Orthopedic Appliances" means braces and appliances including durable medical equipment that

- is primarily and customarily used to serve a medical purpose, can withstand repeated use; and
- generally is not useful to the person in the absence of Injury or Sickness.

"Physician" means a legally qualified physician practicing within the scope of his license; and recognized as a physician in the state where services are rendered. Legally qualified physician does not include: the Insured Person; His spouse; His child; His parent; His brother; His sister; or a person living with Him ; or employed or retained by the Sponsoring Organization.

"Prescription Drugs" are drugs which:

- under Federal law may only be dispensed by written prescription; and
- are approved for general use by the Food and Drug Administration.

"Pre-existing Conditions" means any condition for which an Insured Person has received medical treatment, care, diagnosis or advice; or of which symptoms were manifested within 6 months before being covered by this policy.

"Sickness" means illness or disease which begins and for which Medical Expense is incurred while coverage is in force under the policy for the Insured Person. Sickness includes normal pregnancy and complications of pregnancy. All related conditions and recurring symptoms of sickness will be considered one sickness.

"Sponsoring Organization" means a legal entity to whom the policy is issued.

"Usual, Customary and Reasonable Charges" - **"Usual"** means those charges made by a provider for services and supplies rendered to all patients for the same or similar Injury or Sickness; **"Customary"** means those charges made by the majority of providers in the area for similar services or supplies. **"Reasonable"** means those charges that do not exceed the majority of prevailing fees in the geographic area for the same or similar services and supplies.

"We", **"Our"**, and **"Us"** means the Mutual of Omaha Insurance Company.

Section 4.

TERMS OF PAYMENTS

We will provide the benefits as set forth in the DESCRIPTION OF BENEFITS to all Insured Persons who suffer a covered loss due to Injury or Sickness.

Full Excess Medical Expense

If an Insured Person incurs expenses for covered services, We will pay the applicable benefit for the expenses incurred, subject to the Deductible Amount, Benefit Percentage and Benefit Period shown on the Schedule, that are in excess of expenses payable by any other Health Care Plan, regardless of any Coordination of Benefits provision contained in such Health Care Plan.

The first expense must be incurred within the Loss Period stated on the Schedule.

The Maximum Benefit Amount payable and sub-limits under the policy are shown on the Schedule.

Non-Duplication of Coverage - This Policy

If, for any one Injury or Sickness, the benefits above are payable under more than one provision in this policy, then benefits will be provided only under the provision providing the greater benefit.

Section 5.

INSURED PERSONS PROVISIONS

**CORE PLAN
PROVISIONS CONCERNING INSURED**

ELIGIBILITY

Persons eligible to be insured under the policy are described on the Schedule. This includes anyone who may become eligible while the policy is in force.

EFFECTIVE DATES

An Eligible Person will become an Insured under the policy, provided proper premium payment is made, on the latest of:

- the Policy Effective Date; or
- the day He becomes eligible.

TERMINATION

Insurance for an Insured will end on the earliest of:

- the date He is no longer in an Eligible Class; or
- full time active duty in any Armed Forces of any country. Send Us proof of service. We will refund any premium paid for this time. This does not include Reserve or National Guard duty for training unless it extends beyond 31 days.; or
- the date any premium for the Insured is due and unpaid, subject to the Grace Period; or
- the date the policy is terminated.

Termination will not affect a claim for a covered loss which occurred while coverage was in effect.

CHANGE IN COVERAGE

Any change in the Insured's coverage because of change of class will become effective on the date of change.

Section 6.

DESCRIPTION OF HAZARDS

SPECIFIED ACTIVITY COVERAGE

Subject to all other provisions of the policy, insurance is provided for an Insured Person while He is:

- attending or participating in a Specified Activity as shown on the Schedule.

24 HOUR COVERAGE

We will pay the benefits described in the policy for any Accident which happens to an Insured Person while He is covered by the policy.

Section 7.

DESCRIPTION OF BENEFITS

ACCIDENTAL DEATH, DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING

If an Insured Person suffers a Loss listed below, within the Loss Period stated on the Schedule, from an Accident, We will pay the Benefit Amount opposite such Loss. If the Insured Person sustains more than one such Loss as the result of one Accident, We will pay only one amount, the largest to which He is entitled. The Principal Sum is shown on the Schedule.

<u>LOSS</u>	<u>BENEFIT AMOUNT</u>
Loss of Life.....	100% of Principal Sum
Loss of Both Hands	100% of Principal Sum
Loss of Both Feet.....	100% of Principal Sum
Loss of Entire Sight of Both Eyes	100% of Principal Sum
Loss of One Hand and One Foot.....	100% of Principal Sum
Loss of One Hand and Entire Sight of One Eye.....	100% of Principal Sum
Loss of One Foot and Entire Sight of One Eye.....	100% of Principal Sum
Loss of Speech and Hearing (both ears).....	100% of Principal Sum
Loss of One Arm or One Leg	50% of Principal Sum
Loss of Entire Sight of One Eye.....	50% of Principal Sum
Loss of Speech or Hearing (both ears).....	50% of Principal Sum
Loss of One Hand or One Foot	50% of Principal Sum
Loss of Thumb and Index Finger of same Hand.....	25% of Principal Sum

Loss of a hand means complete Severance at or above the wrist. Loss of foot means complete Severance above the ankle. Loss of sight means the total, permanent loss of sight of the eye or eyes. The loss of sight must be irrecoverable by natural, surgical or artificial means. Loss of speech means total, permanent and irrecoverable loss of audible communication. Loss of hearing means total and permanent loss of hearing in both ears which cannot be corrected by any means. Loss of a thumb and index finger of the same hand means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand from the same accident).

MEDICAL EXPENSE

We will pay the Medical Expense incurred, subject to any sub-limits, for the following covered services:

- Hospital Room and Board charges, up to the average semi-private daily room rate, for each day in the Hospital.
- Intensive Care Unit Benefits. This payment is in lieu of payment for Hospital Room and Board charges for those days.
- Hospital Miscellaneous charges, during a Hospital Stay. Miscellaneous charges do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.
- Outpatient charges, by a Hospital for:
 - pre-admission testing, confinement must occur within 7 days of the testing; or
 - emergency room treatment;
 - use of surgical facilities.
- Surgical charges for:
 - Physician, for primary performance of a surgical procedure. Two or more surgical procedures through the same incision will be considered as one procedure;
 - a Physician, for assistant surgeon duties, a second surgical opinion, or consultation;
 - anesthesia and its administration.
- Charges by a Physician for other than pre- or post-operative care:
 - for in-Hospital visits;
 - for office visits.
- Charges for X-ray and Laboratory Tests.
- Charges for nursing services, other than routine Hospital care, by or under the supervision of a licensed graduate registered nurse.

- Charges for physiotherapy:
 - while Hospital confined; or
 - as an outpatient.
 Physiotherapy includes:
 - heat treatment;
 - diathermy;
 - microtherm;
 - ultrasonic;
 - adjustment;
 - manipulation;
 - massage therapy;
 - acupuncture.
- Surface Ambulance Service or Air Ambulance Service to a Hospital.
- Rental charges for medical equipment, not to exceed the purchase price, for:
 - a wheelchair;
 - an iron lung; or
 - other medical equipment for which prior approval by Us has been given.
- Charges for medical services and supplies for:
 - oxygen and its administration
 - blood and blood transfusions.
- Charges for dental treatment, for Injury to a tooth which was sound and natural at the time of Injury.
- Orthopedic Braces and Appliances, not including replacements.
- Prescription Drugs except as specifically provided.
- Home Health Care which is:
 - established and approved in writing by a Physician; and
 - commences within seven (7) days of Hospital confinement of five (5) days or more.
- Other Expense: if applicable and as noted on the Schedule.

The Medical Expense Maximum and any applicable sub-limit amounts are shown on the Schedule.

Section 8.

EXCLUSIONS

Benefits will not be paid for a loss due to:

- intentionally self-inflicted Injury, suicide while sane or insane or any attempt thereat (in Missouri this applies only while sane);
- an act of declared or undeclared war;
- dental treatment or dental X-rays, except as otherwise provided, and only when Injury occurs to sound natural teeth;
- services or treatment rendered by a Physician, Nurse or any other person who is:
 - employed or retained by the Sponsoring Organization; or
 - is the Insured Person or an Immediate Family Member;
- charges which the Insured Person would not have to pay if He did not have insurance;
- charges which are in excess of Usual, Customary and Reasonable charges;
- mental and nervous disorders (except as specifically provided);
- expenses incurred to the extent that they are paid or payable under any other valid and collectible Health Care Plan;
- treatment for alcoholism except as specifically provided;
- treatment for drug addiction except as specifically provided;
- any loss for which benefits are paid under state or federal worker's compensation, employers liability, or occupational disease law;
- eyeglasses, contact lenses, hearing aids, or examinations or prescriptions therefor; (this is the durable medical equipment)
- active duty service in any Armed Forces of any country and, in such event, the pro-rata unearned premium will be returned upon proof of service. This does not include Reserve or National Guard active duty or training unless it extends beyond 31 days.;
- Elective Treatment or Surgery, where no Injury or Sickness is involved;
- Pre-existing Conditions (except as specifically provided); or
- expenses incurred outside the United States.

Section 9.

PREMIUM PROVISIONS

REPORTING REQUIREMENTS

The Sponsoring Organization or its authorized agent must report to Us, by the premium due date, any additional information required, as agreed to by Us and the Sponsoring Organization.

GRACE PERIOD

A grace period of not less than 45 days is granted for each premium due after the first premium payment. Coverage will stay in force during this period unless notice has been sent, in accordance with the POLICY TERMINATION provision, of the intent to terminate coverage under the policy. Coverage will end if the premium is not paid by the end of the grace period or if the Sponsoring Organization selects replacement coverage on the termination date.

CHANGES IN RATES

We have the right to change the premium rates on any premium due date:

- (1) after the first 10 months insurance is in effect;
- (2) coinciding with a change in the coverage provided or classes eligible; or
- (3) coinciding with a change in the risks We have assumed.

New rates will take effect coincident with the effective date of such coverage or eligibility changes.

We will give 31 days written notice of any change under (1) above. Notice will be sent to the Sponsoring Organization's most recent address in Our records.

REINSTATEMENT or RE-ENROLLMENT

If an Insured Person's insurance is terminated for any reason, then again made effective through reinstatement or reenrollment, only covered loss due to an Injury that is received after the date of reinstatement or reenrollment or a Sickness that begins more than 10 days after the date of reinstatement or re-enrollment will be covered.

Section 10.

CLAIM PROVISIONS

NOTICE OF CLAIM

Written notice must be given to Us within 30 days after a covered loss occurs or begins or as soon as reasonably possible. Notice can be given at Our home office or to Our authorized representative. Notice should include the Sponsoring Organization's name and the policy number and the Insured Person's name, address and policy number.

CLAIM FORMS

When We or Our authorized representative receive the notice of claim, We or Our authorized representative will send forms for filing proof of loss. If claim forms are not sent within 15 days after notice is given, the proof requirements will be met by submitting, within the time required under PROOFS OF LOSS, written proof of the nature and extent of the loss.

PROOF OF LOSS

Written proof of loss must be furnished to Us at Our home office or to Our authorized representative within 90 days after the date of the loss or as soon as reasonably possible. Proof must, however, be furnished no later than twelve months from the time it is otherwise required, except in absence of legal capacity.

In case of claim for loss for which the policy provides periodic payment contingent upon continuing loss for which We are liable, written proof that the loss continues must be furnished to Us or to Our authorized representative at intervals required by Us.

TIME OF PAYMENT OF CLAIMS

Benefits due under the policy for a loss, other than a loss for which the policy provides installments, will be paid upon receipt of due written proof of such loss and completion of Our claim investigation.

PAYMENT OF CLAIMS

Benefits other than loss of life will be paid to the Insured, unless otherwise stated in the policy. Any other benefits unpaid at the Insured Person's death will be paid, at Our option, to the Insured Person's beneficiary or estate.

Subject to any written direction by the:

- Insured; or
- Parent, Parents or guardian of the Insured is a minor;

We will pay, at Our option, all or a portion of any MEDICAL EXPENSE benefit directly to the Hospital, Physician, or other health care provider who furnished the medical treatment, care, diagnosis or advice.

PHYSICAL EXAMINATION AND AUTOPSY

We have the right to have an Insured Person examined, at Our cost, as often as reasonably necessary while the claim is pending. We may require an autopsy at Our expense unless prohibited by law.

Section 11.

GENERAL POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES

The policy, the Schedule of the Sponsoring Organization (a copy of which is attached), endorsements, riders and attached papers constitute the entire contract between the parties. All statements made by the Sponsoring Organization will, in the absence of fraud, be deemed representations and not warranties.

No change in the policy will be valid until approved by one of Our executive officers. This approval must be endorsed on or attached to the policy. No agent may change the policy or waive any of its provisions.

WORKERS' COMPENSATION INSURANCE

The policy is not in lieu of and does not affect any requirement for coverage under any Workers' Compensation Insurance.

CLERICAL ERROR

Clerical error on Our or the Sponsoring Organization's part in keeping records or furnishing records shall not void insurance otherwise in force or continue insurance otherwise terminated under the terms of the policy.

RECORDS MAINTAINED

The Sponsoring Organization or its authorized administrator will maintain records of the essential features of each Insured Person's insurance under the policy.

We shall be permitted to examine the Sponsoring Organization's records relating to coverage under the policy. Examination may occur at any reasonable time up to the later of:

- the two year period after the expiration of the Sponsoring Organization's coverage; or
- the final adjustment and settlement of all claims under the Sponsoring Organization's coverage.

RIGHT OF REIMBURSEMENT

We are not obligated to pay for expenses due to an Injury for which a third party may be liable or legally responsible. A third party is any person or organization other than the Insured Person. We will ask the Insured to sign an agreement immediately after We pay benefits. This agreement will specify that the Insured will notify Us in writing whenever the Insured makes a claim or the Insured's legal representative makes a claim against a third party or a third party's insurer for damages due to the Insured Person's Injury and the Insured will reimburse Us for any benefits received which We paid when the Insured recovers money from the third party's insurer by settlement, judgment or in any other manner.

We will also require the Insured to sign an assignment of funds due Us from any funds the Insured recovers from the third party or its insurer.

The amount of reimbursement to Us will be the smaller of: (1) the actual amount paid by Us; or (2) the portion of the amount the Insured actually recovered from the judgment or settlement that exceeds the amount necessary to fully reimburse the Insured for out of pocket expenses. Out of pocket expenses include attorney fees.

This Right of Reimbursement does not apply in any state where prohibited by law.

POLICY TERMINATION

We may terminate coverage on or after the first anniversary as of any premium due date. The Sponsoring Organization may terminate its coverage on any premium due date. The pro rata unearned premium will be refunded. Written notice must be given at least 31 days prior to such premium due date. Failure by the Sponsoring Organization to pay premiums when due or within the Grace Period shall be deemed notice to Us to terminate coverage at the end of the period for which premium was paid.

CONFORMITY WITH STATE STATUTES

Any provision of the policy in conflict, on the Policy Effective Date, with the laws of the state where it is delivered, is amended to conform to the minimum requirements of such laws.

LEGAL ACTIONS

The Insured may not bring a legal action to recover under the policy for at least 60 days after the Insured has given Us written proof of loss. No such action may be brought after three years from the time written proof of loss is required to be given to us.

SELECTION OR CHANGE OF BENEFICIARY; ASSIGNMENT

The Insured has the right to select or change the beneficiary or to assign His rights or benefits. Unless the rights have been given up, He does not need the consent of the beneficiary to make such a change or to assign His rights or benefits. We will not be bound by any assignment, or any selection or change of beneficiary, until We receive and acknowledge a signed copy of it. When recorded and acknowledged, the selection, change or assignment will take effect as of the date of the request and will not apply to any payments or other action taken by Us before the request was acknowledged. We are not responsible for the validity or sufficiency of any assignment.

Section 12.

SCHEDULE

BASIC CORE PLAN (100% Participation): “Plan participation is required to be 100% unless a corpsmember provides to the plan a signed waiver form along with proof of other coverage.”

Corpsmember can only waive coverage if they have proof of other insurance. If a corpsmember waives coverage and then loses the other coverage, the group is required to enroll the individual on this plan. Once the corpsmember waives coverage, the individual will only be able to enroll in this plan if their other insurance has terminated.

A. Policy Term (Plan Year)

Effective Date: July 1, 2009 (12:01 a.m.)

Expiration Date: July 1, 2010 (12:01a.m.)

Term of Coverage: Coverage for an Insured Person begins on the latest of: 1) the Policy Effective Date; or 2) the day he or she becomes eligible. Coverage for an Insured Person will continue until the end of the Policy Term, subject to the Section 5 Termination provision.

If a member exits the program and returns, either to the same program or a different program, the corpsmember can enroll with an effective date matching the first day of service of their second term. If a member signs on for a second term and there is no break in service, the member will be allowed to enroll on the anniversary date of when their initial service started.

“Service Year” means, for an Insured Person, the period of time from the date his or her insurance begins until his or her one-year anniversary, subject to the Section 5 Termination provision.

B. Eligible Persons:

THIS POLICY PROVIDES INSURANCE FOR ACTIVE CORPSMEMBERS ONLY AS DESCRIBED BELOW AND DOES NOT PROVIDE ANY INSURANCE COVERAGE FOR DEPENDENTS.

Class 1 - Active Corpsmembers contracted with a service organization of the Policyholder, for a limited term of service (usually up to one year or 1,700 hours), and actively performing their assigned duties on a regular and consistent basis under the direction and instruction of the organization, at:

- a) an alternative work site at the direction of the organization;
- b) a location to which one must travel to perform the job; or
- c) a location in the United States, its territories and possessions,

provided that the appropriate premium has been paid.

Members are considered to be actively performing their assigned duties on any day that is

- a) a regular or scheduled non-working day; or
- b) a day on which the Member is on a qualified family or medical leave of absence as defined by the Family and Medical Leave Act of 1993;
- c) provided the Member was actively performing their assigned duties on the last preceding regular work day.

The corpsmember must have completed the probationary period outlined by the Participating Program Member as defined in its enrollment materials. An eligible corpsmember may be a foreign national but coverage is only for expense incurred in the United States.

An Extension of Coverage is available to corpsmembers that elect a second term of service if the Participating Program Member elects to provide it. The extension of coverage will last no more than 30 days, beginning on the first of the month following the member’s last day of active service in the first term.

An active Corpmember 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) on a seasonal basis; or
- (e) in a foreign country.

Exiting Corpmembers may be eligible for continued coverage under Class 2, subject to the specific The Corps Network program in which they are a member. Corpmembers should contact their program for more information regarding continued coverage.

Class 2 – Corpmembers that meet the requirements of Class 1 that have selected continued coverage.

C. Description of Hazards:

- Specified Activity Coverage
- 24 Hour Coverage

D. Description of Benefits:

Class 1 and 2

Optional Accidental Death and Dismemberment
Medical Expense

E. Benefit Amounts:

ACCIDENTAL DEATH AND DISMEMBERMENT

Principal Sum
Loss Period

Benefit Limits

\$10,000.00
365 Days

MEDICAL EXPENSE BENEFITS

(as shown below, unless otherwise specified)

Benefit Limits

Loss Period:

Not Applicable

Benefit Period:

During the Term of Coverage.

Deductible:

\$100.00 per Service Year (can be satisfied by a combination of eligible Medical Expenses for Sickness and Injury.) Once satisfied, no further Deductible will apply for Sickness or Injury for remainder of that Service Year.)

Coinsurance

The policy pays 80% of the first \$4,500.00 (after any Deductible applied) of Usual, Customary and Reasonable Charges per Injury or Sickness. Thereafter, 100% of Usual, Customary and Reasonable Charges up to the Maximum Benefit Amount per Injury or Sickness.

Out-of-Pocket Maximum

\$1,000.00 per Service Year (including the Deductible) for Injury and Sickness combined. This does not apply to the Right of Reimbursement.

Maximum Amount for Injury per Tooth

\$200.00 for dental treatment or x-rays

Maximum Amount – Inpatient Physiotherapy Outpatient Physiotherapy	Subject to maximum per Injury or Sickness \$500.00 maximum for all combined Benefit Periods
Maximum Benefit Amount (Medical Expense Maximum)	\$50,000.00 per Injury or Sickness for all combined Benefit Periods including any preceding coverage issued to the The Corps Network and rolled over to this policy.

MEDICAL EXPENSE BENEFITS – OTHER EXPENSE

(All following benefits are subject to Benefit Period, Deductible, Coinsurance and Maximum Benefit Amounts above unless otherwise specified below)

Abortion (if performed by a Physician)	Subject to Medical Expense Benefit Limits.
Outpatient Prescription Drug (Including hormone replacement therapy for treatment of Menopause)	Subject to Medical Expense Benefit Limits. Limited to 90-day supply.

Pre-existing Conditions: Subject to Medical Expense Benefit Limits except that there is a Maximum Benefit Amount of \$5,000.00 for the first 12 months of coverage then same as any other condition thereafter.

Preventive Care: Subject to Medical Expense Benefit Limits except:
Deductible Not applicable
Maximum Benefit Amount \$150.00 per Benefit Period
Preventive Care Includes:
Complete health assessments
Routine physicals
Blood pressure screening
Cholesterol screening
Glucose – blood level screening
Prostate – rectal examination for Insureds age 40 and over
Colorectal Cancer Screening Immunizations
Other similar type services when recommended by a Physician

Other Preventive Care: Subject to Medical Expense Benefit Limits except:
Deductible Not applicable
Coinsurance 100%
Other Preventive Care Includes
Annual pap smear
Annual cervical cytological screening
Baseline mammogram
Breast evaluation and screening mammogram

Treatment of Mental, Alcohol and Substance Abuse Disorders: Subject to Medical Expense Benefit Limits except as shown below.

Mental Disorders:
Inpatient and Residential Care Coinsurance - up to 60 days per year payable in the same manner and subject to the same conditions and limitations as for any other sickness
Outpatient visit Coinsurance - 75% for the first 40 visits per year
Coinsurance - 60% each visit thereafter per year

Alcohol or Controlled Substance Abuse:

Detoxification Treatment

Inpatient/residential care

Outpatient visits

Coinsurance - up to 12 days per year payable in the same manner and subject to the same conditions and limitations as for any other sickness.

Coinsurance - up to 60 days per year payable in the same manner and subject to the same conditions and limitations as for any other sickness.

Coinsurance - 80% for the first 40 visits per year

Coinsurance - 60% each visit thereafter per year

F. Mandated Coverage for residents of Maine

Prosthetic devices must be included as Medical Expenses, subject to Medical Expense Benefit Limits. The device must replace, in whole or in part, an arm or a leg. The Maximum Prosthetic Benefit while the Insured Person is covered under the Policy is the greater of:

(a) \$5,000.00; or

(b) the maximum benefit for prosthetics as provided under Medicare.

G. Monthly Premium Rates:

Core Plan

\$142.78 per Member

H. The following riders are attached to and made a part of this policy for all Insured Persons (subject to the Medical Expense Benefit Limits):

Diabetes Treatment Rider

0JH9M

Post Mastectomy Benefit Rider

0GX8M

Prostate Cancer Screening Rider

0KT5M

Amendment Rider

335MS-NN

I. The following riders/notices apply only to residents of states as follows (subject to the Medical Expense Benefit Limits):

Alabama Residents

Payment of Claims

0CA3M

Arizona Residents

Appeals Information

0GV3M

Appeals Information Packet

MLU20794

California Residents

Independent Medical Review

M20828

Connecticut Residents

Ambulance Benefit Rider

M20828

Dental Benefits

0JC1M

Cancer Clinical Trials

0JY1M

Mandated Benefits Amendment Rider

0FA4M

Delaware Residents

Surgical Benefits

0HR6M

Maryland Residents

Mastectomy Prosthesis 0HR3M

Massachusetts Residents

Human Leukocyte Antigen Testing Benefits Rider 0JN4M
Speech, Hearing and Language Disorders 0KW1M
Clinical Trials 0KM8M

New Mexico Residents

Temporomandibular Joint Dysfunction Limitation 0GG0M
Clinical Trials 0JT0M Rev.

North Carolina Residents

Clinical Trials Benefits Rider 0KD3M

Texas Residents

Acquired Brain Injury 0KT0M

Virginia Residents

Off Label Prescription Drugs 0HE9M
Virginia Insurance Department 8312M-3

060509:bd



DIABETES BENEFITS RIDER

This rider is made a part of your policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider.

Rider Date (October 25, 2000 or the Policy or Certificate Date, whichever is later)

If your policy or certificate provides hospital, medical or surgical coverage, the following is added.

BENEFITS

We will pay the expense incurred for equipment, supplies and other outpatient self-management training and education, including medical nutritional therapy for:

- (a) insulin dependent diabetes;
- (b) insulin using diabetes;
- (c) gestational diabetes; and
- (d) non-insulin using diabetes

if prescribed by a health care professional legally authorized to prescribe treatment.

Benefits are subject to policy or certificate maximums, deductible and coinsurance provision

NONDUPLICATION OF BENEFITS

No benefits are payable under this rider for that portion of expense for which benefits are payable under the policy or certificate or another rider attached to it. If benefits are payable under more than one provision, then benefits will be provided only under the provision providing the greater benefit.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



**NOTIFICATION REGARDING WOMEN'S HEALTH
AND CANCER RIGHTS ACT OF 1998**

Effective October 21, 1998, the federal government passed the Women's Health and Cancer Rights Act of 1998. One of the provisions of this act requires that Individual Health Insurance Carriers notify you of your rights under this law.

If your policy or certificate provides surgical or medical benefits on an expense incurred basis for a mastectomy and you are currently receiving benefits in connection with a mastectomy; we will provide coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Any benefits are subject to all policy, certificate or rider deductibles, coinsurance provisions, benefit maximums, terms and conditions.

No benefits are payable for those expenses for which benefits are provided under your policy, certificate, or previously added by rider. We will pay the greater of your policy, certificate or rider benefits or those required under the Women's Health and Cancer Rights Act of 1998.

"Reconstruction" means any initial and subsequent reconstructive surgeries or prosthetic devices, and follow-up care determined necessary by the physician.

"Prostheses" means and includes the initial and subsequent prosthetic devices pursuant to an order of your physician.

"Symmetrical Appearance" means that, in addition to prosthetic devices and reconstructive surgery for the diseased breast that the mastectomy was performed, prosthetic devices and reconstructive surgery for a healthy breast is also covered if, in the opinion of the physician, this surgery is necessary to achieve normal symmetrical appearance.

MUTUAL OF OMAHA INSURANCE COMPANY



Corporate Secretary



PROSTATE CANCER SCREENING BENEFITS RIDER

This rider is made a part of your policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider. In the event of a conflict between this rider and any other provision of the policy or certificate, this rider shall control.

Rider Date (February 20, 2003, or the Policy Date or Certificate Date, whichever is later)

If your policy or certificate provides hospital-medical-surgical benefits on an expense incurred basis, then the following applies.

BENEFITS

If an insured person incurs expense for prostate cancer screening, benefits will be paid the same as any other covered service.

CONDITIONS

The prostate cancer screening must be in accordance with the latest screening guidelines issued by the American Cancer Society for the ages, family histories and frequencies referenced in such guidelines.

NONDUPLICATION OF BENEFITS

No benefits are payable under this rider for that portion of expense for which benefits are payable under the policy or certificate or another rider attached to it. If benefits are payable under more than one provision, then benefits will be provided only under the provision providing the greater benefit.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



AMENDMENT RIDER

This rider is attached to and made a part of Policy No. G000181C and is subject to the provisions and conditions contained therein.

The effective date of this rider is the same as the Policy Date.

The policy to which this rider is attached is hereby amended as follows:

1. The Medical Expense Deductible will be administered other than as defined in the policy. A Deductible will not be required for each Injury or Sickness as defined. Instead, a Deductible will only need to be met once for each Insured Person during a Service Year. The Deductible can be satisfied by a combination of Medical Expenses for Sickness or Injury. When satisfied, no further Deductible will apply for Injury or Sickness for remainder of that Service Year.
2. The limitation and exclusion applicable to Pre-existing Conditions will not apply if the Insured Person:
 - did not receive treatment, care, diagnosis or advice for 12 consecutive months while insured under this policy or its predecessor issued to the The Corps Network; or
 - has been covered under another policy with similar benefits for one full year immediately prior to becoming insured under this policy.

The Pre-existing Condition waiting period of 12 months will be reduced by the aggregate of the periods of prior creditable coverage applicable to the Insured as of his enrollment date under the Policy. Creditable coverage is coverage that the Insured had from: a group or blanket plan, Medicare, Medicaid, Indian Health Service, state risk pool, public health plan, Peace Corps service, an individual plan or any other health coverage considered to be creditable coverage under state/federal law or regulations. Prior creditable coverage does not apply if there was a break in coverage of 63 days or more, prior to enrolling under this Policy.

3. The exclusion for treatment outside of the United States is amended. The term United States includes territories and possessions of the United States.
4. The "Elective Surgery and Elective Treatment" definition also includes, but is not limited to, Gender Identity disorders and Erectile Dysfunction. These conditions are not covered under the policy.
5. Within Section 3. The definition of "Pre-existing Conitions" is amended. The following phrase is deleted: "; or of which symptoms were manifested".
6. The first item in the Section 5. Termination provision is amended to read:
 - When an Insured is no longer in an Eligible Class, insurance for that person will end on the last day of the month in which the Insured ceases to be actively performing His duties of the service organization; or

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary

The Corps Network (DC)
062206:bdt



PAYMENT OF CLAIMS AMENDMENT RIDER

This rider is made a part of the policy or certificate to which it is attached. It is subject to all provisions of the policy or certificate which are not in conflict with this rider.

Rider Date (April 26, 1994 or the Policy Date or Certificate Date, which is later)

AMENDMENT

The Payment of Claims provision contained in your policy or certificate is deleted. The following is added.

PAYMENT OF CLAIMS. All benefits will be paid as soon as we receive acceptable proof of loss.

Benefits for loss of life, if any, will be paid to your beneficiary (your estate if no beneficiary is named).

Benefits for services which you have assigned will be paid to the hospital or the provider of services within 25 working days of receipt of a proper claim or invoice by us. If we do not make payment within 25 working days to the provider of service, an interest of 1.5% per month, or any part of the month, will be payable to the provider, beginning on the 26th day of receipt of the claim until the claim has been paid.

This does not apply if there is a dispute regarding the legitimacy of the claim, or if your policy or certificate is in its contestable period, and we do both of the following: (a) notify the provider of service within two weeks of the receipt of the claim that it is being contested or investigated, and specify which items of the claim are in question; and (b) we pay any portion of the claim that is payable within 30 days of receipt of the claim and make a timely, good faith effort to resolve the differences.

If any benefits are payable to your estate, to a minor or to any person not legally able to give a valid release, we may pay up to \$1,000.00 to any relative of yours who we find entitled to the payment. Payment made in good faith shall fully discharge us to the extent of the payment.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



APPEALS INFORMATION RIDER

This rider is made a part of your policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider.

Rider Date (June 30, 1998, or the Policy Date or Certificate Date, whichever is later)

APPEALS INFORMATION

A replacement Health Care Insurer Appeals Information Packet that explains the appeals process may be obtained by contacting the following:

Mutual of Omaha Companies
S3- Health Care Management
Mutual of Omaha Plaza
Omaha, NE 68175-5820

Telephone : 1-800-228-0286
Fax: 402-351-5848

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary

Health Care Insurer Appeals Information Packet-State of Arizona

Please read this notice carefully. This notice contains important information about how to appeal decisions made by your insurer.

I. Levels of Review

You may ask your insurer to review its decisions involving your requests for service or your requests to have your claims paid. In general, the following four levels of review will be available to you:

Expedited Review
First Level Appeal (Informal Reconsideration)
Second Level Appeal (Formal Appeal)
External, Independent Review

These levels of review are discussed more fully below.

A. Expedited Review

1. An Expedited Review will be provided for a denied service not yet provided at any level of appeal if the treating provider certifies in writing that the time required to process your request through the standard appeal process would cause a significant negative change in your medical condition. Documentation must be provided by the treating physician or provider to indicate this. This type of review is not available if the services have already been provided prior to the denial.
2. The Expedited Review will be completed and notification of the decision will be forwarded within one business day receipt of the necessary information to complete the review. The notice will include a description of the criteria used, the clinical reasons for that decision, and references to supporting documentation.

a. Denial upheld

If we agree that the service should have been denied, you may ask for further review through the Second Level Appeal process discussed below.

b. Denial overturned

If we agree that the service should have been authorized, we will do so.

B. First Level Appeal (Informal Reconsideration)

1. A First Level Appeal will be provided for a service that has been denied. This review will be provided for both services that have been provided but not yet paid, or have not yet been provided.
2. A request for appeal relating to medical or surgical services may be made by fax, telephone or in writing to the following:

Mutual of Omaha Companies
Health Care Management S-3
Mutual of Omaha Plaza
Omaha, NE 68175-5820
Telephone: (800) 228-0286 Fax: (402) 351-5848

A request for appeal relating to mental health or substance abuse services may be made by fax, telephone or in writing to the following:

Mutual of Omaha Companies'
Integrated Behavioral Services S-3
Mutual of Omaha Plaza
Omaha, NE 68175-5820
Telephone: (800)995-6002 Fax: (402) 351-2880

You must provide us with any material justification or documentation for the appeal at the time of the request. There is no time limit for filing the request for First Level Appeal.

3. Within five business days after receiving your request for First Level Appeal, we will send you a notice stating that your request was received. You will also receive another copy of this information packet with the notice.
4. We are required to make a decision regarding this First Level Appeal and to notify you and your treating provider within 30 days after receipt of the request for appeal.

a. Denial upheld

If we continue to agree that the service or claim for a service should have been denied, your written notice will state that. The notice will contain a description of the criteria used, the clinical reasons for that decision, references to supporting documentation and the instructions for requesting a Second Level Appeal.

b. Denial overturned

If we agree that the service should have been provided, or that your claim should have been paid, your written notice will state this.

c. External, Independent Review Option

During the First Level Appeal Process we may ask the Director of Insurance to immediately start the External, Independent Review Process.

If we elect this option, we will send you the written decision, a description of the criteria used, the clinical reasons for that decision and any references to supporting documentation. We will also send a copy of this information to your physician or treating provider and the Director of Insurance.

C. Second Level Appeal (Formal Appeal)

1. If we have denied your request for a service or claim after either the Expedited Medical Review or First Level Appeal you may send a written request for a Second Level Appeal relating to medical or surgical services to:

Mutual of Omaha Companies
Health Care Management S-3
Mutual of Omaha Plaza
Omaha, NE 68175-5820
Telephone: (800) 228-0286 Fax: (402) 351-5848

If we have denied your request for a service or claim after either the Expedited Medical Review or First Level Appeal you may send a written request for a Second Level Appeal relating to mental health or substance abuse services to:

Mutual of Omaha Companies'
Integrated Behavioral Services S-3
Mutual of Omaha Plaza
Omaha, NE 68175-5820
Telephone: (800) 995-6002 Fax: (402) 351-2880

If you elect this option, you or your physician or treating provider must give us any material justification or documentation to support your request for the service.

At any time during the Second Level Appeal process, we may send your case directly to External, Independent Review. There is no time limit for filing your request for Second Level Appeal.

2. Within five business days after receiving your request for Second Level Appeal, we will send you a notice stating that your request was received. You will also receive another copy of this information packet with the notice.
3. A decision will be made and communicated in writing within 30 days of receipt of the request for reconsideration and all of the necessary medical and supporting documentation. If services have already been provided, such notice will be sent within 60 days of receipt of the request.

a. Denial upheld

If we continue to agree that the service or claim for a service should have been denied, your written notice will state that. The notice will include a description of the criteria used, the clinical reasons for that decision, and references to supporting documentation. You will also receive a notice of your option to proceed to External, Independent Review.

b. Denial overturned

If we agree that the service should have been provided, or that your claim should have been paid, your written notice will state this.

D. External, Independent Review

1. Eligibility

You may obtain an External, Independent Review only after you have sought any available Expedited Review, First and Second Level Reviews as discussed above. You have 30 days after you receive written notice from us that your Second Level Appeal has been denied to request an External, Independent Review.

You must send your request for External, Independent Review relating to medical or surgical services in writing to:

Mutual of Omaha Companies
Health Care Management S-3
Mutual of Omaha Plaza
Omaha, NE 68175-5820
Telephone: (800) 228-0286 Fax: (402) 351-5848

You must send your request for External, Independent Review relating to mental health or substance abuse services in writing to:

Mutual of Omaha Companies'
Integrated Behavioral Services S-3
Mutual of Omaha Plaza
Omaha, NE 68175-5820
Telephone: (800) 995-6002 Fax: (402) 351-2880

2. Deadlines Applicable to the External, Independent Review Process:

a. Medical Necessity Issues

If the request for External, Independent Review involves an issue of medical necessity:

1. We must, within five business days of the request, mail a written notice to the Director of Insurance, you and your physician or treating provider of the request for External, Independent Review.
2. We must, within five business days of the request, choose one or more independent reviewers and forward notice of that choice to the Director of Insurance.
3. We must, within 30 days of the request, send the external independent reviewer(s) all relevant medical records and a description of the criteria used, the clinical reasons for that decision and any references to supporting documentation used to make the decision.
4. We must, within 30 days of the request, send the Director of Insurance, you and your physician or treating provider a notice of the decision of the external independent reviewer(s).

b. Coverage Issues

If your appeal involves an issue or question of whether your policy covers your request for a service or for the payment of a claim:

1. We must, within five business days of the request, mail a written notice to the Director of Insurance, you and your physician or treating provider of the request for External, Independent Review.
2. We must, within five business days of the request, send the Director of Insurance your policy, evidence of coverage or similar document, all relevant medical records, a description of the criteria used, clinical reasons for that decision and any references to supporting documentation used to make the decision.
3. The Director of Insurance must, within five business days of receiving information about your request from us, determine if the service or claim is covered. If the Director is unable to determine issues of coverage, the Director of Insurance will direct that your case be submitted to External, Independent Review. If the Director of Insurance determines that no coverage exists, the request will not be sent to External, Independent Review.
4. If the Director of Insurance refers the request to External, Independent Review, we must within 30 days after this referral, send the Director of Insurance, you and your physician or treating provider a notice of the external, independent reviewer(s) decision.

3. Decision

We must provide any covered service or pay any covered claim determined to be medically necessary by the external, independent reviewer(s) regardless of whether we elect to seek judicial review of the decision of the external independent reviewer(s).

4. Judicial Review

If you disagree with the final decision of the external independent reviewer(s), you may seek judicial review. If we disagree with the final decision of the external, independent reviewer(s), we may seek judicial review. However, we must provide any covered service or pay any covered claim determined to be medically necessary by the external independent reviewer(s) regardless of whether we elect to seek judicial review.

II. Obtaining Medical Records

A. Requesting Medical Records

Arizona law A.R.S. § 12-2293 permits you to ask for a copy of your medical records. Your request must be in writing. Your request must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

B. Designated Health Care Decision Maker

If you have a designated health care decision maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision maker or a person designated in writing by your health care decision maker unless you limit access to your medical records only to yourself or your health care decision maker.

C. Confidentiality

Medical Records disclosed under A.R.S. §12-2293 remain confidential.

III. Contacts

All correspondence relating to medical or surgical services should be directed to:

Mutual of Omaha Companies
Health Care Management S-3
Mutual of Omaha Plaza
Omaha, NE 68175-5820
Telephone: (800) 228-0286 Fax: (402) 351-5848

All correspondence relating to mental health or substance abuse services should be directed to:

Mutual of Omaha Companies'
Integrated Behavioral Services S-3
Mutual of Omaha Plaza
Omaha, NE 68175-5820
Telephone: (800) 995-6002 Fax: (402) 351-2880

IV. Documentation for an Appeal

If you decide to file an appeal, you must give us authorization to obtain any material justification or documentation for the appeal at the time the appeal is filed. You must also give us the address and phone number where you can be contacted. There is a "Release of Information" on the back of the denial letter you received from us that must be signed and sent to the address on the back of the letter. This will give us the authorization to contact your physician or treating provider for medical information needed to complete your request.

V. Medical Review Criteria

The Mutual of Omaha Companies' Care Review Unit references a commercially produced criteria source by Milliman & Robertson, Inc. titled Healthcare Management Guidelines. In addition, we use Company developed criteria. Bibliography review and input by our panel of medical experts support the criteria. All review criteria are subject to annual review and approval by the Medical Director staff members, consulting physician reviewers and the Criteria Committee. The Mutual of Omaha Companies' Integrated Behavioral Services, which manages your mental health and substance abuse benefits, developed five sets of Utilization Management Criteria designed to match patient need, level of functioning, and/or status with the characteristics of each level of care to determine appropriateness of treatment.

VI. The Role of the Director of Insurance

The law requires "any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed" by law A.R.S. §20-2533(E).

The appeal process requires the Director to:

1. Oversee the appeals process.
2. Publish a list of independent reviewers.
3. Maintain copies of each utilization review plan submitted by insurers.
4. Receive, process, and act on request from an insurer for External, Independent Review of a claim.
5. Enforce the decisions of insurers.
6. Review decisions of insurers.
7. Report to the Legislature.

VII. Confidentiality

If you participate in the review process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

VIII. Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. As discussed above in Section IV, "properly addressed" means your last known address.

IX. Complaints to the Arizona Department of Insurance

The Director of Insurance requires any member who files a complaint with the Arizona Department of Insurance relating to an adverse decision to pursue the review process established by the Legislature and your insurer.

INDEPENDENT MEDICAL REVIEW

If an insured person's proposed covered services are denied on the basis that the treatment is investigational or experimental, he or she may request an independent medical review process. We will provide the necessary information at the time the insured person requests such independent medical review, subject to the following conditions. We will pay for the cost of such review.

Conditions

1. The independent medical review process is available only when:
 - (a) the insured person has a terminal condition that, as diagnosed by a physician, has a high probability of causing death within two years from the date of the request for such review;
 - (b) the physician determines that such condition has not improved by using standard therapies, or for which standard therapies would be inappropriate, or for which there is no other standard therapy other than as described in item (c);
 - (c) Either:
 - (1) the physician has recommended a drug, device, procedure, or other therapy that he or she has certified in writing that is likely to be more beneficial than any available standard therapies; or
 - (2) the insured person or the physician who specializes in the insured person's condition has requested a therapy that, based on two documents from the Medical and Scientific Evidence, is likely to be more beneficial than any available standard therapy; and
 - (d) services as described in item (c) are denied by us; unless specifically excluded under the policy, or would be covered except for our determination that such services are considered experimental or under investigation.
2. Benefits will be payable under the terms of the policy if the majority of the panel of experts who conduct the independent medical review recommend providing the therapy.

Definition

Medical and Scientific Evidence means the following sources:

- (a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- (b) Peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR);
- (c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861 (t) (2) of the Social Security Act;
- (d) The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics and The United States Pharmacopoeia-Drug Information;
- (e) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognize federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
- (f) Peer-reviewed abstracts accepted for presentation at major medical association meetings.



AMBULANCE BENEFIT RIDER

This rider is made a part of your policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider. In the event of a conflict between this rider and any other provision of the policy or certificate, this rider shall control.

Rider Date (October 1, 2002, or the Policy or Certificate Date, whichever is later)

BENEFIT

If an Insured Person incurs expense due to a medically necessary ambulance trip to the hospital, benefits are payable under the policy or certificate for the ambulance expense incurred by such person not to exceed the maximum allowable rate as established by the Department of Public Health in accordance with Public Act 02124 or other applicable law.

CONDITIONS

1. The above benefit is payable only if:
 - (a) the ambulance services are required because of a medical emergency; and
 - (b) the Insured Person is transported to a local hospital (or to the nearest hospital equipped to furnish the required services).
2. Any ambulance benefits will be paid directly to the provider of the services when:
 - (a) we have not received notice that payment has been made by some other source; and
 - (b) the provider submits a bill with the following statement stamped on the face of each bill:

NOTICE -- This bill is subject to mandatory assignment pursuant to Connecticut General Statutes.

EXCEPTIONS

We will not pay for:

- (a) transportation by taxi, limousine or other nonemergency vehicle;
- (b) expense which is paid under any other provision of the policy or certificate; or
- (c) anything excluded under the Exclusions or Limitations.

NONDUPLICATION OF BENEFITS

No benefits are payable under this rider for that portion of expense for which benefits are payable under the policy or certificate or another rider attached to it. If benefits are payable under more than one provision, then benefits will be provided only under the provision providing the greater benefit.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



DENTAL BENEFITS RIDER

This rider is made a part of your policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider.

Rider Date (May 26, 2000 or the Policy or Certificate Date, whichever is later)

If your policy or certificate provides benefits on an expense incurred basis, then the following applies.

BENEFITS

If you or your insured dependent requires in-patient, outpatient or one day dental services, we will provide benefits for:

- (a) general anesthesia; and
- (b) nursing and related hospital services.

Benefits are subject to any policy or certificate maximums, deductible and coinsurance provisions.

CONDITIONS

1. The general anesthesia, nursing and related services are deemed medically necessary by the treating dentist or oral surgeon and the insured person's physician;
2. The patient is either:
 - (a) an insured dependent child under the age of four who is determined by a dentist in conjunction with a physician to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a hospital; or
 - (b) an insured person who has a developmental disability, as determined by a physician, that places that person at serious risk.

NONDUPLICATION OF BENEFITS

No benefits are payable under this rider for that portion of expense for which benefits are payable under the policy or certificate or another rider attached to it. If benefits are payable under more than one provision, then benefits will be provided only under the provision providing the greater benefit.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



CANCER CLINICAL TRIAL BENEFITS RIDER

This rider is made a part of your policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider. In the event of a conflict between this rider and any other provision of the policy or certificate, this rider shall control.

Rider Date (January 1, 2002, or the Policy Date or Certificate Date, whichever is later)

If your policy or certificate provides hospital, surgical or medical benefits on an expense incurred basis, then the following applies.

DEFINITION

Cancer Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer in human beings, except that a clinical trial for the prevention of cancer is eligible for coverage only if it involves a therapeutic intervention and is a phase III clinical trial approved by:

- (a) one of the National Institutes of Health;
- (b) a National Cancer Institute affiliated cooperative group;
- (c) the Federal Food and Drug Administration as part of an investigational new drug or device exemption; or
- (d) the Federal Department of Defense or Veterans Affairs.

BENEFITS

Benefits will be provided for expenses associated with Cancer Clinical Trials in the same manner and subject to the same conditions and limitations as any other covered service.

EXCEPTIONS

Benefits will not be provided for:

- (a) the cost of an investigational new drug or device that has not been approved for market for any indication by the Federal Food and Drug Administration;
- (b) the cost of a nonhealth care service that an insured person may be required to receive as a result of the treatment being provided for the purposes of the Cancer Clinical Trial;
- (c) facility, ancillary, professional services and drug costs that are paid for by grants or funding for the Cancer Clinical Trial;
- (d) costs of services that:
 - (1) are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis; or
 - (2) are performed specifically to meet the requirements of the Cancer Clinical Trial;
- (e) costs that would not be covered under your policy or certificate for noninvestigational treatments, including, but not limited to, items excluded from coverage; and
- (f) transportation, lodging, food or any other expenses associated with travel to or from a facility providing the Cancer Clinical Trial, for the insured person or any family member or companion.

NONDUPLICATION OF BENEFITS

No benefits are payable under this rider for that portion of expense for which benefits are payable under the policy or certificate or another rider attached to it. If benefits are payable under more than one provision, then benefits will be provided only under the provision providing the greater benefit.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



MANDATED BENEFITS AMENDMENT RIDER

This rider is made a part of the policy or certificate to which it is attached. All provisions of the policy or certificate not in conflict with the provisions of this rider apply to this rider.

PART A. DEFINITIONS

The definitions in the policy or certificate apply to this rider. In applying them, substitute "rider" for "policy" or "certificate." In addition, the following definitions will also apply.

"Eligible Expense," for the purpose of this rider, will include expense for services and supplies specified in the definition of Home Health Care. It may not be in amounts in excess of the Usual and Customary charges for such services and supplies in the geographic area concerned. Eligible Expense for any service and supply will be considered incurred on the date such service or supply is received.

"Home Health Agency" means an agency or organization which meets each of the following requirements: (a) is primarily engaged in and federally certified as a Home Health Agency; (b) is duly licensed, if required, by the state in which it is located to provide nursing and other therapeutic services; (c) its policies are established and the services provided are governed by a professional group associated with such agency or organization (such group must include at least one Doctor and one registered nurse); (d) it provides for the full-time supervision of the services provided by a Doctor or registered nurse; (e) maintains a complete medical record on each patient; and (f) has an administrator.

"Home Health Care" means the continued care and treatment of a Covered Person, but only, if: (a) continued hospitalization would otherwise have been required in the absence of such care (except in the case of a Terminally Ill Person); (b) the plan covering such care is established and approved in writing by the attending Doctor within seven days following termination of Hospital Stay (such plan must be the same for a Terminally Ill Person and may be established and approved at any time without a prior Hospital Stay and, if hospitalized, without regard to the seven-day period); and (c) such care must begin within seven days (except in the case of a Terminally Ill Person).

Home Health Care coverage shall consist of, but not be limited to, the following: (a) Part-time or intermittent nursing care by, or under the supervision of a registered graduate nurse (RN); (b) Part-time or intermittent home health aid services. Such services consist primarily of patient care of a medical or therapeutic nature by other than a registered graduate nurse (RN) or a licensed practical nurse (LPN); (c) Physical, occupational or speech therapy; (d) Medical supplies, drugs and medicines prescribed by a Doctor and laboratory services by or on behalf of a Hospital; but only to the extent and up to the maximums provided under this policy or certificate and any attached riders, if the Covered Person had remained or been confined in a Hospital; or (e) Medical Social Services provided to or on behalf of the Terminally Ill Person. The Medical Social Services benefit shall not exceed \$200.00 in one plan year.

"Medical Social Services" means services rendered under the direction of a Doctor by a qualified social worker. Such worker must hold a master's degree from an accredited school of social work. The services may include, but are not limited to: (a) Assessment of the social, psychological and family problems related to or arising out of such Covered Person's illness and treatment; (b) Appropriate action and utilization of community resources to assist in resolving such problems; and (c) Participation in the development of the overall plan of treatment for such Covered Person.

"Terminally Ill Person" means the Insured or a Dependent, if covered, diagnosed by a Doctor as having six months or less to live.

PART B.

EXCLUSIONS AND LIMITATIONS

The Exclusions and Limitations in the policy or certificate apply to this rider.

PART C.

BENEFITS

ACCIDENTAL INGESTION OR CONSUMPTION OF A CONTROLLED DRUG BENEFIT

We will pay the following for expense incurred for emergency medical care due to the accidental ingestion or consumption of a controlled drug. Only accidental ingestion or consumption which occurs on or after the Policy Date or Certificate Date and while the coverage is in force is covered. A "controlled drug" is defined by subsection (8) of section 19-443 of the general statutes of Connecticut.

Benefits shall not exceed thirty days in any one plan year based upon confinement as a hospital inpatient, whether or not the hospital is operated by the State of Connecticut and \$500.00 in any one plan year for expense incurred while other than a hospital inpatient.

Only Eligible Expenses for treatment deemed Medically Necessary under generally accepted medical standards are covered.

HYPODERMIC NEEDLES OR SYRINGES BENEFIT

Benefits are payable for hypodermic needles or syringes prescribed by a Doctor for the purpose of administering medications for medical conditions, provided such medications are covered under the policy or certificate.

MAMMOGRAPHY EXPENSE BENEFIT

When a female Insured incurs expense for mammography upon referral of a Doctor for breast cancer screening or for diagnostic purposes, We will pay the following benefits on the same basis as any other Sickness:

- (a) one baseline mammogram for a female Insured age 35 through 39;
- (b) one mammogram every two years (or more frequently based on the female Insured's Doctor's recommendation) for a female Insured age 40 through 49; and
- (c) one mammogram each plan year for a female Insured age 50 and over.

TUMOR OR LEUKEMIA BENEFIT

If an Insured is treated for tumors or leukemia, We will pay the greater of the expense incurred for the services and supplies, in accordance with the other benefit provisions of the policy or certificate or up to the amounts shown below during each plan year;

	Amount
Removal of any breast implant which was implanted on or before July 1, 1994	\$1,000.00
Surgical removal of one or more tumors	500.00
Reconstructive surgery due to tumor surgery for which the Insured person was paid benefits under the policy	500.00
Outpatient chemotherapy for tumors or leukemia	500.00
Nondental prosthesis and appliance to support a prosthesis (This includes any maxillo-facial prosthesis replacing structures lost due to head or neck tumors)	300.00

Except for purposes of the surgical removal of breasts due to tumors, the yearly benefit for prosthesis, shall be \$300.00 for each breast removed.

OCCUPATIONAL THERAPY EXPENSE BENEFIT

We will pay the expense incurred for occupational therapy furnished by a health care facility, a private practice, or a partial hospitalization program on the same basis as benefits are paid for expense incurred for physical therapy.

The number of days payable under the policy or certificate for a partial hospitalization program will be determined on an exchange basis. One day of inpatient services reduces the available number of partial hospitalization days by two. Two days of partial hospitalization services reduces the number of inpatient days by one.

HOME HEALTH CARE BENEFIT

Benefits are payable for Home Health Care as follows: 75% of the expense incurred in excess of \$50.00. The Deductible, if any, does not apply. However, benefits will be limited to 80 Home Health Care visits in any one plan year (this 80 visit limitation does not apply to a Terminally Ill Person). A Home Health Care visit includes each visit by a representative of a Home Health Agency, four hours of home health aide services or each occupational or speech therapy session.

NONDUPLICATION OF BENEFITS. No benefits are payable under this rider for that portion of expense for which benefits are payable under the policy, certificate or another attached rider.

MUTUAL OF OMAHA INSURANCE COMPANY



Corporate Secretary



SURGICAL BENEFIT AMENDMENT RIDER

This rider is made part of your policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider.

Rider Date (January 1, 2000, or the Policy or Certificate Date, whichever is later)

If your policy or certificate provide benefits for surgery and you have two or more surgical procedures performed at the same time then the following applies.

DEFINITIONS

Fee Schedule means the monetary allowance payable to a healthcare provider for services rendered as provided for in your policy or certificate.

BENEFITS

Any paragraph regarding two or more surgical operations or procedures in your policy or certificate is hereby deleted and replaced with the following.

When more than one surgical service is performed on the same patient, by the same physician and on the same day, we will pay as follows:

- (a) One hundred per cent (100%) of the fee schedule for the procedure which has the highest regular fee schedule amount; and not less than fifty (50%) of the fee schedule for each additional procedure performed through the same incision; and
- (b) One hundred per cent (100%) of the fee schedule for each procedure performed through separate incisions.

Benefits are subject to any policy or certificate maximums, deductible and coinsurance provisions.

NONDUPLICATION OF BENEFITS

No benefits are payable under this rider for that portion of expense for which benefits are payable under the policy or certificate or another rider attached to it. If benefits are payable under more than one provision, then benefits will be provided only under the provision providing the greater benefit.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



MASTECTOMY PROSTHESIS BENEFITS RIDER

This rider is made a part of your policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider.

Rider Date (October 1, 1999, or the Policy or Certificate Date, whichever is later)

If your policy or certificate provides hospital, surgical or medical benefits on an expense incurred basis, then the following applies.

BENEFITS

We will provide coverage for a prosthesis prescribed by a physician for an insured person who has undergone a mastectomy and has not had breast reconstruction.

Benefits are subject to any policy or certificate maximums, deductible and coinsurance provisions.

NONDUPLICATION OF BENEFITS

No benefits are payable under this rider for that portion of expense for which benefits are payable under the policy or certificate or another rider attached to it. If benefits are payable under more than one provision, then benefits will be provided only under the provision providing the greater benefit.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



HUMAN LEUKOCYTE ANTIGEN TESTING BENEFITS RIDER

This rider is made a part of your policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider.

Rider Date (December 28, 2000 or the Policy or Certificate Date, whichever is later)

If your policy or certificate provides benefits on an expense incurred basis, then the following is added.

BENEFITS

We will pay the expense incurred by you or your insured dependent for:

- (a) human leukocyte antigen testing; or
- (b) histocompatibility locus antigen testing

necessary to establish bone marrow transplant donor compatibility. Coverage shall include the costs of testing for A, B or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the Department of Public Health.

Benefits are subject to any policy or certificate maximum, deductible and coinsurance provisions.

LIMITATIONS

Benefits are limited to:

- (a) test expenses incurred by an insured person; and
- (b) one antigen test per person while covered under this rider.

NONDUPLICATION OF BENEFITS

No benefits are payable under this rider for that portion of expense for which benefits are payable under the policy or certificate or another rider attached to it. If benefits are payable under more than one provision, then benefits will be provided only under the provision providing the greater benefit.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



Mutual of Omaha

SPEECH, HEARING AND LANGUAGE DISORDERS SERVICES RIDER

This rider is made part of your policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider. In the event of a conflict between this rider and any other provision of the policy or certificate this rider shall control.

Rider Date (April 1, 2003, or the Policy Date or Certificate Date, whichever is later).

If your policy or certificate provides hospital, medical or surgical benefits on an expense incurred basis, then the following applies.

BENEFITS

If an insured person is diagnosed or treated for a speech, hearing or language disorder by a licensed speech pathologist or audiologist in a: (a) hospital; (b) clinic; or (c) private office, we will pay benefits for such services in the same manner and subject to the same conditions as any other covered service. We will not pay benefits for speech, hearing or language disorder diagnosis or treatment received in a school-based setting.

NONDUPLICATION OF BENEFITS

No benefits are payable under this rider for that portion of expense for which benefits are payable under the policy or certificate or another rider attached to it. If benefits are payable under more than one provision, then benefits will be provided only under the provision providing the greatest benefit.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



CLINICAL TRIAL BENEFITS RIDER

This rider is made a part of your policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider. In the event of a conflict between this rider and any other provision of the policy or certificate, this rider shall control.

Rider Date (January 1, 2003 or the Policy Date or Certificate Date, whichever is later)

If your policy or certificate provides hospital, medical and/or surgical benefits on an expense incurred basis, then the following applies.

DEFINITIONS

Cooperative Group means a formal network of facilities that collaborate on research projects and have an established peer review program approved by the National Institutes of Health operating within the group. A cooperative group includes a National Cancer Institute-sanctioned Clinical Cooperative Group and the National Cancer Institute Community Clinical Oncology Program.

Patient Care Service means a healthcare item or service that is furnished to an individual enrolled in a qualified clinical trial, which is consistent with the usual and customary standard of care for someone with the patient's diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the clinical trial. Patient care services include drugs and devices that have been approved for use in the trial, whether or not the Food and Drug Administration (FDA) has approved the drug or device for use in treating the patient's particular condition.

BENEFITS

If an insured person incurs expense for Patient Care Services provided during a Phase I, II, III or IV cancer clinical trial, we will pay benefits in the same manner as any other covered service, subject to the following conditions and limitations.

CONDITIONS

A clinical trial must:

- (a) be intended to treat cancer in a patient who has been so diagnosed;
- (b) have been peer-reviewed;
- (c) be approved by one of the following:
 - (1) the United States National Institutes of Health;
 - (2) a Cooperative Group or Center of the National Institutes of Health;
 - (3) a qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;
 - (4) the United States Food and Drug Administration in the form of an investigational new drug exemption;
 - (5) the United States Departments of Defense or Veterans Affairs; or
 - (6) with respect to Phase II, III or IV clinical trials only, a qualified institutional review board;
- (d) have facility and personnel conducting the clinical trial that are capable of doing so by virtue of their experience and training and the volume of patients treated to maintain their expertise;
- (e) with respect to Phase I clinical trials, the facility shall be an academic medical center or an affiliated facility, and the clinicians conducting the trial shall have staff privileges at said academic medical center;
- (f) admit patients which meet the patient selection criteria enunciated in the study protocol for participation in the clinical trial;
- (g) have patients which have provided their informed consent for participation in the clinical trial, in a manner that is consistent with current legal and ethical standards;
- (h) have available clinical or pre-clinical data that provides a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial;
- (i) not unjustifiably duplicate existing studies; and
- (j) have a therapeutic intent and must, to some extent, assess the effect of the intervention on patients.

EXCLUSIONS

We will not pay benefits for:

- (a) an investigational drug or device;
- (b) any drug or device paid for by the manufacturer, distributor or provider of the drugs or devices;
- (c) non-healthcare services that a patient may be required to receive as a result of being enrolled in the clinical trial;
- (d) costs associated with managing the research associated with the clinical trial;
- (e) costs that would not be covered for non-investigational treatments;
- (f) any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the clinical trial;
- (g) the costs of services which are inconsistent with widely accepted and established national or regional standards of care;
- (h) the costs of services which are provided primarily to meet the needs of the trial, including, but not limited to, tests, measurements and other services which are typically covered but which are being provided at a greater frequency, intensity or duration;
- (i) services or costs that are not covered under the policy or certificate; or
- (j) anything excluded under the policy or certificate, except that any such exclusion that conflicts with the above provisions will not apply.

NONDUPLICATION OF BENEFITS

No benefits are payable under this rider for that portion of expense for which benefits are payable under the policy or certificate or another rider attached to it. If benefits are payable under more than one provision, then benefits will be provided only under the provision providing the greater benefit.

MUTUAL OF OMAHA INSURANCE COMPANY



Corporate Secretary



TEMPOROMANDIBULAR JOINT DYSFUNCTION LIMITATION

This rider is made a part of your policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider.

Rider Date (July 1, 1989, or the Policy Date or Certificate Date, whichever is later)

The Exceptions and Limitations provision of your policy or certificate is amended to add the following:

EXCEPTIONS AND LIMITATIONS

Benefits for temporomandibular joint dysfunction are, subject to all policy or certificate provisions, payable, except for: crowns which correct vertical dimension; splints, orthopedic repositioning appliances, biteplates and equilibration treatments (including splint equilibration and adjustments); bite, functional or occlusal registration, with or without splints, and kinesiographic analysis; any orthodontic treatment, including extraction of teeth; study models, except for the complete model made necessary when surgical intervention is completed. Surgical charges for correction of orthognathic conditions are covered. Charges for those services and supplies not covered will not be used toward satisfying the Deductible or Out-of-Pocket Expense Amount or be considered covered expense.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



CANCER CLINICAL TRIAL BENEFITS RIDER

This rider is made a part of your policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider.

Rider Date (March 4, 2002, or the Policy Date or Certificate Date, whichever is later)

If your policy or certificate provides hospital, surgical or medical benefits on an expense incurred basis, then the following applies.

DEFINITIONS

Clinical Trial means a course of treatment provided to a patient for the purpose of prevention of reoccurrence, early detection or treatment of cancer for which no equally or more effective standard cancer treatments exists.

Cooperative Group means a formal network of facilities that collaborate on research projects and have established federal National Institutes of Health-approved peer review program operating within the group.

Federal-Wide Assurance of Protection of Human Subjects means a contract between an institution and the office for Human Research Protection of the federal department of health and human services that defines the relationship of the institution to that department and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects participating in Clinical Trials.

Institutional Review Board means a board, committee or other group that is both:

- (a) formally designated by an institution to approve the initiation of, and to conduct periodic review of, biomedical research involving human subjects and in which the primary purpose of the review is to assure the protection of the rights and welfare of the human subjects and not to review a Clinical Trial for scientific merit; and
- (b) approved by the federal National Institutes of Health for protection of the research risks.

Investigational Drug or Device means a drug or device that has not been approved by the Federal Food and Drug Administration.

Routine Patient Care Cost means:

- (a) a medical service or treatment that would be covered if the insured person were receiving standard cancer treatment; or
- (b) a drug provided during a cancer Clinical Trial if the drug has been approved by the Federal Food and Drug Administration, whether or not that organization has approved the drug for use in treating the Insured Person's particular condition, but only to the extent that the drug is not paid for by the manufacturer, distributor or provider of the drug.

BENEFITS

Benefits will be provided for Routine Patient Care Costs incurred as a result of participation in a Phase II, III or IV cancer Clinical Trial, subject to the following Conditions.

Benefits are subject to any policy or certificate maximums, deductible and coinsurance provisions.

CONDITIONS

1. The Clinical Trial is not designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent.
2. The Clinical Trial is being provided in the state of New Mexico as part of a scientific study of a new therapy or intervention and is for the prevention of reoccurrence, early detection, treatment or palliation of cancer in humans and in which the scientific study includes all of the following:
 - (a) specific goals;
 - (b) a rationale and background for the study;
 - (c) criteria for patient selection;
 - (d) specific direction for administering the therapy or intervention and for monitoring patients;
 - (e) a definition of quantitative measures for determining treatment response;
 - (f) methods for documenting and treating adverse reactions; and
 - (g) a reasonable expectation that the treatment will be at least as efficacious as standard cancer treatment.
3. The Clinical Trial is being conducted with approval by at least one of the following:
 - (a) one of the Federal National Institutes of Health;
 - (b) a Federal National Institutes of Health Cooperative Group or center;
 - (c) the Federal Department of Defense;
 - (d) the Federal Food and Drug Administration in the form of an investigational new drug application;
 - (e) the Federal Department of Veterans Affairs; or
 - (f) a qualified research entity that meets the criteria established by the Federal National Institutes of Health for grant eligibility.
4. The Clinical Trial is being provided as part of a study being conducted in a Phase II, III, or IV cancer Clinical Trial.
5. The proposed Clinical Trial or study has been reviewed and approved by an Institutional Review Board that has an active Federal-Wide Assurance of Protection of Human Subjects.
6. The personnel providing the Clinical Trial or conducting the study:
 - (a) are providing the Clinical Trial or conducting the study within their scope of practice, experience and training and are capable of providing the Clinical Trial because of their experience, training and volume of patients treated to maintain their expertise;
 - (b) agree to accept reimbursement as payment in full from the health care plan at the rates that are established by that plan and are not more than the level of reimbursement applicable to other similar services provided by health care providers within the plan's provider network; and
 - (c) agree to provide written notification to us when a patient enters or leaves a Clinical Trial.
7. There is no non-investigational treatment equivalent to the Clinical Trial.
8. The available clinical or pre-clinical data provide a reasonable expectation that the Clinical Trial will be at least as efficacious as any non-investigational alternative.

APPEAL PROCESS

If you are denied coverage of a cost and contend that the denial is in violation, the patient may appeal the decision to deny coverage to the Superintendent of Insurance. That appeal shall be expedited to ensure resolution of the appeal within no more than thirty days after the date of appeal to the Superintendent of Insurance. Programs pursuant to Title 19 or Title 21 of the federal Social Security Act, which have their respective expedited appeal processes, shall be exempt from this appeal process.

EXCEPTIONS AND LIMITATIONS

Benefits will not be provided for:

- (a) any portion of a cancer Clinical Trial that is customarily paid for by government, biotechnical, pharmaceutical, or medical device industry sources;
- (b) any Investigational Drug or Device or procedure that have not been approved for market for any indication by the U.S. Food and Drug Administration (FDA) or the costs of any drug being studied under an FDA-approved investigational new drug exemption for the purpose of expanding the drug's labeled indications;
- (c) any non-health care services that the insured person is required to receive as a result of participation in the Clinical Trial;
- (d) costs associated with managing the research that is associated with the Clinical Trial;
- (e) costs that would not be covered if non-investigational treatments were provided;
- (f) costs of those extra tests that would not be performed except for participation in the cancer Clinical Trial;
- (g) costs paid or not charged for by the Clinical Trial providers.

NONDUPLICATION OF BENEFITS

No benefits are payable under this rider for that portion of expense for which benefits are payable under the policy or certificate or another rider attached to it. If benefits are payable under more than one provision, then benefits will be provided only under the provision providing the greater benefit.

MUTUAL OF OMAHA INSURANCE COMPANY



Corporate Secretary



CLINICAL TRIAL BENEFITS RIDER

This rider is made a part of the policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider. In the event of a conflict between this rider and any other provision of the policy or certificate, this rider shall control.

Rider Date (December 1, 2001, or the Policy Date or Certificate Date, whichever is later)

If your policy or certificate provides coverage for hospital, surgical or medical benefits on an expense incurred basis, then the following applies.

DEFINITION

Clinical Trials mean Phase II, Phase III and Phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that:

- (a) involve the treatment of life-threatening medical conditions;
- (b) are medically indicated and preferable compared to available non-investigational treatment alternatives; and
- (c) have clinical and pre-clinical data that shows the trial will likely be more effective for that patient than available non-investigational alternatives.

Clinical Trials must:

- (a) involve determinations by a physician, relevant scientific data and opinions of experts in relevant medical specialties;
- (b) be approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration (FDA), the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, the Department of Veterans Affairs or sponsored by other entities; and
- (c) be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience and volume of patients.

BENEFITS

If an insured person incurs expenses associated with Clinical Trials including:

- (a) those related to health care services typically provided absent a Clinical Trial;
- (b) the diagnosis and treatment of complications; and
- (c) medically necessary monitoring;

we will pay benefits in the same manner and subject to the same conditions and limitations as any other covered service.

EXCEPTIONS

We will not pay for:

- (a) Clinical Trials funded by national agencies, commercial manufacturers, distributors or other research sponsors;
- (b) non-FDA approved drugs provided to an insured person during a Clinical Trial, after the Clinical Trial has been discontinued;
- (c) expenses incurred solely to satisfy data collection and analysis;
- (d) investigational drugs and devices;
- (e) expenses not provided for the direct clinical management of the insured person.

NONDUPLICATION OF BENEFITS

No benefits are payable under this rider for that portion of expense for which benefits are payable under the policy or certificate or another rider attached to it. If benefits are payable under more than one provision, then benefits will be provided only under the provision providing the greater benefit.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



ACQUIRED BRAIN INJURY BENEFITS RIDER

This rider is made a part of your policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider. In the event of a conflict between this rider and any other provision of the policy or certificate, this rider shall control.

Rider Date (January 1, 2002 or the Policy Date or Certificate Date, whichever is later)

If your policy or certificate provides hospital, medical and/or surgical benefits on an expense incurred basis, then the following applies.

DEFINITIONS

Acquired Brain Injury means a neurological insult to the brain that is not hereditary, congenital or degenerative. The injury to the brain has occurred after birth, causing a change in neuronal activity which results in an impairment of physical functioning, sensory processing, cognition or psychosocial behavior.

Cognitive Communication Therapy means services designed to address modalities of comprehension and expression, including understanding, reading, writing and verbal expression of information.

Cognitive Rehabilitation Therapy means services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

Community Reintegration Services mean services that facilitate the continuum of care as an affected insured person transitions into the community.

Neurobehavioral Testing means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the insured person, family or others.

Neurobehavioral Treatment means interventions that focus on behavior and the variables that control behavior.

Neurocognitive Rehabilitation means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive Therapy means services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback Therapy means services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

Neurophysiological Testing means an evaluation of the functions of the nervous system.

Neurophysiological Treatment means interventions that focus on the functions of the nervous system.

Neuropsychological Testing means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological Treatment means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Post-Acute Transition Services mean services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Psychophysiological Testing means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological Treatment means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Remediation means the processes of restoring or improving a specific function.

Therapy means the scheduled remedial treatment provided through direct interaction with the insured person to improve a pathological condition resulting from an Acquired Brain Injury.

ACQUIRED BRAIN INJURY BENEFITS

We will pay benefits for the following services in the same manner and subject to the same conditions and limitations as any other covered service when such services are medically necessary as a result of, and related to, an Acquired Brain Injury.

- (a) Cognitive Rehabilitation Therapy;
- (b) Cognitive Communication Therapy;
- (c) Neurocognitive Therapy and Neurocognitive Rehabilitation;
- (d) Neurobehavioral, Neurophysiological, Neuropsychological and Psychophysiological Testing or Treatment;
- (e) Neurofeedback Therapy;
- (f) Remediation; and
- (g) Post-Acute Transition Services or Community Reintegration Services.

EXCLUSIONS

The exclusions, exceptions and limitations shown in the policy or certificate apply to this rider. In applying them, substitute "rider" for "policy" or "certificate".

If your policy or certificate excludes benefits for biofeedback therapy expense, such exclusion will not apply for covered services due to an Acquired Brain Injury.

NONDUPLICATION OF BENEFITS

No benefits are payable under this rider for that portion of expense for which benefits are payable under the policy or certificate or another rider attached to it. If benefits are payable under more than one provision, then benefits will be provided only under the provision providing the greater benefit.

MUTUAL OF OMAHA INSURANCE COMPANY



Corporate Secretary



OFF-LABEL PRESCRIPTION DRUG RIDER

This rider is made a part of your policy or certificate to which it is attached. It is subject to all parts of your policy or certificate not in conflict with this rider.

Rider Date (July 1, 1999, or the Policy or Certificate Date, whichever is later.)

If your policy or certificate provides benefits for prescription drugs, then the following applies.

BENEFITS

If, while insured under this provision, you or your dependent incurs expense for drugs, including their administration, that has not been approved by the Federal Food and Drug Administration (FDA) for the treatment of a specific type of cancer, we will pay the expense incurred on the same basis as any other covered drug, provided the drug is recognized as effective for treatment of such indication in one of the standard reference compendia.

Benefits are subject to any policy or certificate deductible and coinsurance provisions.

DEFINITION

Standard Reference Compendia means:

- (a) The American Hospital Formulary Service-Drug Information;
- (b) The United States Pharmacopoeia-Drug Information; or
- (c) The American Medical Association Drug Evaluations.

EXCEPTIONS

We will not pay for:

- (a) any drug when the FDA has determined its use to be contraindicated;
- (b) experimental drugs not otherwise approved for any indication by the FDA;
- (c) any drug not approved by the FDA; or
- (d) any drug in excess of the recommended dosage, unless prescribed by a physician for a patient with intractable cancer pain.

NONDUPLICATION OF BENEFITS

No benefits are payable under this rider for that portion of expense for which benefits are payable under the policy or certificate or another rider attached to it. If benefits are payable under more than one provision, then benefits will be provided only under the provision providing the greater benefit.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary



Mutual of Omaha

AMENDMENT RIDER

If you need to contact someone about your policy/certificate, you may contact the Company.

Home Office:

Mutual of Omaha
Mutual of Omaha Plaza
Omaha, Ne 68175
Phone 1-800-524-2324

If you have been unable to contact or obtain satisfaction from the Company, you may contact the Virginia Bureau of Insurance.

Virginia Insurance Department:

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Phone 1-800-552-7945 (in-state only)
Phone 1-804-371-9741 (out-of-state)

Written correspondence is preferable so a record of your inquiry is maintained. When contacting the Company or Bureau of Insurance, have your policy/certificate number available.

MUTUAL OF OMAHA INSURANCE COMPANY

Corporate Secretary