



> Voluntary Critical Illness Insurance



An unexpected critical illness can have a lasting impact on you and your family – physically, emotionally and financially.

As an active employee of East Central College, you can give your family the extra security they need to lessen the financial impact of a serious illness by purchasing Critical Illness insurance through United of Omaha Life Insurance Company.

A critical illness insurance policy provides a lump-sum cash benefit upon diagnosis of a critical illness like a heart attack, stroke or cancer. The benefit can be used to pay out-of-pocket expenses or to supplement your daily cost of living.

How much insurance is enough?

Even if you have the best health insurance plan, it will not cover 100 percent of medical expenses. You also need to consider other expenses associated with the recovery process – time off work, travel to treatment centers, home modifications – that may quickly deplete your savings.

Coverage guidelines and benefits are outlined in the chart below.



ELIGIBILITY - ALL ELIGIBLE EMPLOYEES

Eligibility Requirement	You must be actively working a minimum of 19 hours per week to be eligible for coverage.	
Dependent Eligibility Requirement	To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.	
Premium Payment	The premiums for this insurance are paid in full by you. Child insurance is automatic. A separate premium is not required.	
BENEFIT CATEGORY¹	CONDITION	% OF CI PRINCIPAL SUM
Heart/Circulatory	Heart Attack, Heart Transplant, Stroke	100%
	Heart Valve Surgery, Coronary Artery Bypass, Aortic Surgery	25%

Organ	Major Organ Transplant/Placement on UNOS List, End-Stage Renal Failure	100%	
	Acute Respiratory Distress Syndrome (ARDS)	25%	
Childhood/Developmental *benefits only available to children	Cerebral Palsy, Structural Congenital Defects, Genetic Disorders, Congenital Metabolic Disorders, Type 1 Diabetes	100%	
Cancer	Cancer (Invasive)	100%	
	Bone Marrow Transplant	50%	
	Carcinoma in Situ, Benign Brain Tumor	25%	
COVERAGE GUIDELINES²			
	MINIMUM	MAXIMUM	GUARANTEE ISSUE³
For You Elect in \$10,000 increments	\$10,000	\$10,000	\$10,000
Spouse Elect in \$10,000 increments	\$10,000	100% of employee's CI Principal Sum, up to \$10,000	\$10,000
Child(ren) *benefit for each child	25% of employee's CI Principal Sum, up to \$3,000		\$3,000
ADDITIONAL BENEFITS			
Policy Benefit Maximum	The maximum payout amount is 300% of the CI Principal Sum amount for each insured person. If the policy benefit maximum is reached for an insured person, the coverage will terminate. Dependents will remain insured if you continue to satisfy the eligibility requirements of the policy.		
Health Screening Benefit	Pays a flat, annual benefit of \$50 for a health screening test.		
Additional Occurrence Benefit	Once benefits have been paid for a Critical Illness, no additional benefits are payable for that same Critical Illness for each insured person. Benefits are still payable for any other Critical Illness in the same benefit category, for each insured person.		
Portability	When insurance ends, you have the right to continue group Critical Illness insurance for yourself and your dependents.		
CONDITIONS & LIMITATIONS			
Age Reductions	When you turn age 70, the original amount of insurance will reduce to 50% for both you and your spouse.		
Benefit Waiting Period	There is no benefit waiting period.		
SERVICES			
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.		
Advocacy	Advocacy services give an employee who has been diagnosed with a medical condition access to skilled clinicians and nurses for personalized, problem-solving assistance in a one-on-one setting. Call 1-866-372-5577 Monday – Friday 7 A.M. to 7 P.M. CST or email careadvocates@gilsbar.com for assistance.		

¹Payment of a partial benefit reduces the remaining amount payable in a category.

²The amount of insurance for your spouse and child(ren) will be rounded to the next higher multiple of \$1,000, if not already an even multiple of \$1,000.

³Subject to any reductions, Guarantee Issue is available to new hires. Amounts over the Guarantee Issue will require a health application/evidence of insurability. For late entrants, all amounts will require a health application/evidence of insurability. Amounts over the Guarantee Issue and/or not meeting minimum participation levels will require a health application/evidence of insurability.

Voluntary Critical Illness Coverage Selection and Premium Calculation

Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding.

To select your benefit amount and calculate your premium, do the following:

- 1) Locate the benefit amount you want from the top row of the employee premium table. Your benefit amount must be in an increment of \$10,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.
- 2) Find your age bracket in the far left column.

- 3) Your premium amount is found in the box where the row (your age) and the column (benefit amount) intersect.
- 4) Enter the benefit and premium amounts into their respective areas in the Voluntary Critical Illness section of your enrollment form.

If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want to select. For example, if you want \$20,000 in coverage, you obtain your premium amount by multiplying the rate for \$10,000 times 2.

VOLUNTARY CRITICAL ILLNESS EMPLOYEE PREMIUM RATES (24 PAYROLL DEDUCTIONS PER YEAR)	
Age	\$10,000
0 - 29	\$2.05
30 - 39	\$3.50
40 - 49	\$7.20
50 - 59	\$13.95
60 - 69	\$28.05
70 - 79	\$51.25
80+	\$70.10

> Frequently Asked Questions

Who is eligible for this insurance?

- You must be actively working (performing all normal duties of your job) at least 19 hours per week and be under age 80
- Your dependent(s) must be performing normal activities and not be confined (at home or in a hospital / care facility) and any child(ren) must be under age 26

What is the additional occurrence benefit?

Once benefits have been paid for a Critical Illness, no additional benefits are payable for that same Critical Illness for each insured person. Benefits are still payable for any other Critical Illness in the same benefit category, for each insured person.

Can I take this insurance with me if I change jobs / am no longer a member of this group?

In the event this insurance ends due to a change in your employment / membership status with the group, or for certain other reasons, you or your insured spouse have the right to continue this insurance under the Portability provision, subject to certain conditions.

Are there any limitations or exclusions?

The benefits payable are subject to the following:

- Your plan is subject to a pre-existing condition limitation. A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to your effective date of coverage. The pre-existing condition under this plan is 12/12 which means any condition that you receive medical attention for in the 12 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered.
- Benefits are not payable for any Critical Illness that:
 - Is diagnosed prior to the effective date of insurance under the Policy for the Insured Person
 - Results, whether the insured person is sane or insane, from an intentionally self-inflicted injury or illness, suicide, or attempted suicide
 - Results from an act of declared or undeclared war or armed aggression
 - Is incurred while the insured person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable
 - Results from illegal activities, including participation in an illegal occupation
 - Is the result of the voluntary use of illegal drugs by an insured person; the intentional misuse of over the counter medication or prescription drugs by an insured person that is not in accordance with recommended dosage and/or warning instruction(s); or the excessive or harmful use of alcohol and/or alcoholic drinks by an insured person
 - Is diagnosed outside of the United States

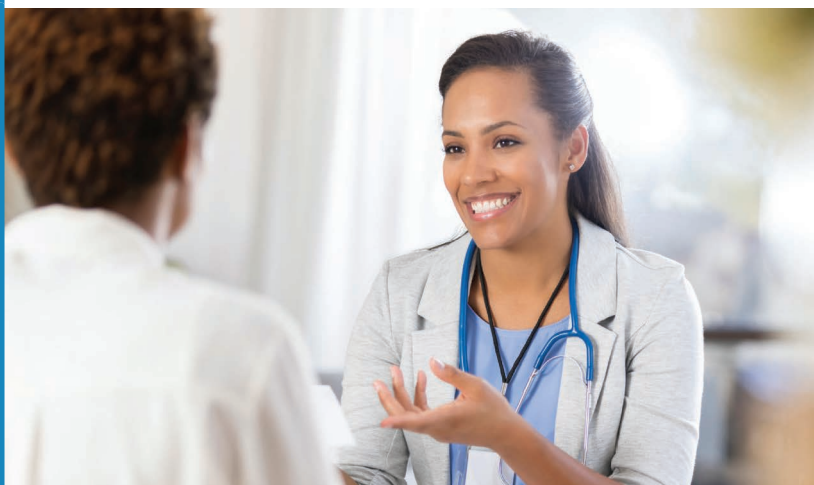
All exclusions may not be applicable, or may be adjusted, as required by state regulations.

This information describes some of the features of the benefits plan. Benefits may not be available in all states. Please refer to the certificate booklet for a full explanation of the plan's benefits, exclusions, limitations and reductions. Should there be any discrepancy between the certificate booklet and this outline, the certificate booklet will prevail. Availability of benefits is subject to final acceptance and approval of the group application by the underwriting company. Critical Illness insurance and accidental death & dismemberment insurance are underwritten by United of Omaha Life Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175, 1-800-769-7159. United of Omaha Life Insurance Company is licensed nationwide, except in New York. Policy form number 7000GM-U-EZ 2010.



Health Screening Benefit

Critical Illness and
Accident Insurance Policy



You've already made the wise decision to purchase a Critical Illness **or** Accident insurance policy. But did you know this coverage also includes a health screening benefit? Your Critical Illness and Accident* policy pays a specified lump sum for certain preventative health screenings to help keep you in good health.

Advantages of Health Screenings

- Find diseases and conditions at an early stage to prevent a critical illness
- Improve outcomes, such as faster treatment, longer life and less suffering
- Determine and influence risk factors

Available Health Screenings Include

- Abdominal aortic aneurysm ultrasound
- Blood test for triglycerides
- Bone marrow testing
- Bone density screening
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- Carotid ultrasound
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy
- CT angiography (detects plaque buildup in heart vessels)
- EKG
- Double contrast barium enema (X-ray of the large intestines, colon and rectum)
- Fasting blood glucose test

- Flexible sigmoidoscopy (examines the rectum and the lower (sigmoid) colon)
- Hemoccult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test (for HDL and LDL levels)
- SPEP (blood test for myeloma and MS)
- Stress test (on a bicycle or treadmill)
- Thermography (study of heat distribution, for example in detecting tumors)

Benefits are paid once per calendar year per insured person for one of the listed screenings. A complete list of the benefit amount payable can be found in the contract.

Here's How to Submit a Claim

1. Complete one of the 24 health screening tests listed
2. Obtain a copy of the test result or provider invoice
3. Submit claim form and test result or provider invoice to submitgpacc@mutualofomaha.com or fax to (402) 977-1898

*With a critical illness insurance policy, the health screening benefit is not approved in CT and the District of Columbia (D.C.). With an accident insurance policy, the health screening benefit is not approved in CO, CT, MT, ND, NH, NY and TX.



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United of Omaha Life Insurance Company
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 Fax (402) 997-1898
 Email submitgrpacc@mutualofomaha.com

Group Critical Illness/Accident Health Screening Benefit Claim Form

Section 1 - Policyholder/Employer Information

Employer Name	Group Number
	G000 ____ _
Employer Address	Employer Phone Number

Section 2 - Claimant Statement (completed by employee/member)

Claimant/Patient Name: First/Last			
Claimant/Patient Date of Birth: Mo./Day/Yr.	Sex: M/F		
Relationship to Employee: Self/Dependent/Spouse/Domestic Partners			
Employee Name: First/Last	Social Security Number		
Employee Date of Birth: Mo./Day/Yr.	Sex: M/F		
Address	City	State	ZIP Code
Phone	Email		

Section 3 - Claimant Information

WHICH POLICY IS THIS BENEFIT BEING REQUESTED FOR? CHECK ALL THAT APPLY: Accident Critical Illness Both Unsure

Section 4 - Health Screening Test/Procedure Information

PLEASE CHECK THE HEALTH SCREENING TEST/PROCEDURE FOR WHICH THIS CLAIM IS BEING FILED:
****Please note this benefit is payable once per calendar year for each Insured Person****

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Abdominal aortic aneurysm ultrasound | <input type="checkbox"/> CA 125 (blood test for ovarian cancer) | <input type="checkbox"/> EKG (electrocardiogram) | <input type="checkbox"/> Pap smear |
| <input type="checkbox"/> Blood test for triglycerides | <input type="checkbox"/> Carotid ultrasound | <input type="checkbox"/> Double contrast barium enema | <input type="checkbox"/> PSA (blood test for prostate cancer) |
| <input type="checkbox"/> Bone marrow testing | <input type="checkbox"/> CEA (blood test for colon cancer) | <input type="checkbox"/> Fasting blood glucose test | <input type="checkbox"/> Serum cholesterol test (HDL & LDL) |
| <input type="checkbox"/> Bone density screening | <input type="checkbox"/> Chest X-ray | <input type="checkbox"/> Flexible sigmoidoscopy | <input type="checkbox"/> SPEP (blood test for myeloma) |
| <input type="checkbox"/> Breast ultrasound | <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Hemoccult stool analysis | <input type="checkbox"/> Stress test (on a bicycle or treadmill) |
| <input type="checkbox"/> CA 15-3 (blood test for breast cancer) | <input type="checkbox"/> CT angiography | <input type="checkbox"/> Mammography | <input type="checkbox"/> Thermography |

DATE THE TEST/PROCEDURE WAS PERFORMED (MM/DD/YYYY)	PHYSICIAN NAME	PHYSICIAN PHONE NUMBER
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Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (Note: This fraud warning does not apply to residents of AL, AR, CA, CO, DC, FL, KS, KY, LA, MA, MD, ME, NJ, NM, NY, OH, OR, PR, RI, TN, VA, VT and WA. Please read the specific fraud warning for your state of residence included with this form or available online at www.mutualofomaha.com.)

By signing below, I certify that I have read and understand the fraud warning that applies to my state of residence, and that all information provided on this form is true and complete to the best of my knowledge and belief.

Section 5 - Acknowledgement & Signature

SIGNATURE OF CLAIMANT	DATE
SIGNATURE OF PATIENT, IF AGE 18 OR OLDER (AND NOT THE CLAIMANT)	DATE
<input type="checkbox"/> Check if Patient is deceased or incapable of signing	