

**GROUP
LONG-TERM DISABILITY
BENEFITS**

Creighton University

**All eligible employees of Creighton University
Graduate Medical Education Group**

Revised January 1, 2004

HOW TO OBTAIN PLAN BENEFITS

To obtain benefits see the Payment of Claims provision.

Forward your completed claim form to:

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

CLAIM ASSISTANCE

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

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

When contacting the Company please have your policy number available. Your policy number is GMTD-20W8.

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appear in the following order.

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CERTIFICATE OF INSURANCE

MUTUAL OF OMAHA INSURANCE COMPANY

Home Office: Mutual of Omaha Plaza
Omaha, Nebraska 68175

Mutual of Omaha Insurance Company certifies that Group Policy No(s). GMTD-20W8 (policy) has been issued to Creighton University (Policyholder).

Insurance is provided for certain employees as described in the policy.

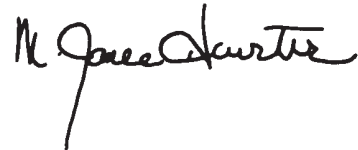
The benefits described in this Certificate are subject to the terms and conditions of the policy. Benefits are effective only if you are eligible for the insurance, become insured and remain insured as described in this Certificate.

This Certificate replaces any previous Certificate issued under the Policy.

MUTUAL OF OMAHA INSURANCE COMPANY



Chairman and CEO



Secretary

DEFINITIONS

When used in the policy or your Certificate-Booklet:

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

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

Sickness means a disease, disorder or condition, including pregnancy, which requires treatment by a physician.

Injury means bodily injury resulting directly from an accident and independently of all other causes.

Disability and disabled means that because of injury or sickness:

- (a) you cannot perform each of the material duties of your regular occupation; and
- (b) after benefits have been paid for 36 months, you cannot perform each of the material duties of any gainful occupation for which you are reasonably fitted by training, education or experience.

Disability and disabled, for pilots, means that because of injury or sickness you cannot perform each of the material duties of any gainful occupation for which you are reasonably fitted by training, education or experience. The loss of a pilot's license for any reason does not, in itself, constitute disability.

Partial disability and partially disabled means that because of injury or sickness you, while unable to perform all of the material duties of your regular occupation on a full-time basis, are:

- (a) performing at least one of the material duties of your regular occupation or another occupation on a part-time or full-time basis; and
- (b) not currently earning more per month than your pre-disability earnings due to that same injury or sickness.

Physician means any of the following licensed practitioners:

- (a) a doctor of medicine (MD), osteopathy (DO), surgical chiropody, podiatry, or chiropractic;
- (b) a licensed clinical psychologist; or
- (c) where group insurance law requires, any other licensed practitioners who are acting within the scope of that license.

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

Hospital means any of the following facilities which are licensed by the proper authority in the area in which they are located:

- (a) A place which is licensed as a general hospital by the proper authority of the area in which it is located;
- (b) A place which:
 - (1) is operated for the care and treatment of resident inpatients;
 - (2) has a registered graduate nurse (RN) always on duty;
 - (3) has a laboratory and X-ray facility; and

- (4) has a place where major surgical operations are performed; or
- (c) A facility which is accredited by the Joint Commission on the Accreditation of Healthcare Facilities, American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities if the function of such facility is primarily of a rehabilitative nature, provided such rehabilitation is specifically for treatment of a physical disability. Such facility need not have major surgical facilities.

When treatment is needed for a mental disease or disorder, **hospital** can also mean a place which meets these requirements:

- (a) Has rooms for resident inpatients;
- (b) Is equipped to treat mental diseases or disorders;
- (c) Has a resident psychiatrist on duty or on call at all times;
- (d) As a regular practice, charges the patient for the expense of confinement; and
- (e) Is licensed by the proper authority of the area in which it is located.

A hospital does not include a hospital or institution or part of a hospital or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged.

Elimination period means a period of consecutive days of disability for which no benefit is payable. The Elimination Period begins on the first day of disability.

Gross monthly benefit means your benefit amount before any reduction for other income benefits and earnings.

Mental and Nervous Disorders/Alcohol and Drug Abuse means any condition or disease, regardless of its cause, listed in the most recent edition of the **International Classification of Diseases** as a Mental Disorder. Not included in this definition are conditions or diseases specifically excluded from coverage.

The policy may include special benefits for any one or more of the conditions included in this definition. If it does, only those special benefits relating to those conditions are available for that condition.

Recurrent disability means a disability which is related to or due to the same cause(s) of a prior disability for which you received a monthly benefit.

Retirement benefit, when used with the term retirement plan, means money which:

- (a) is payable under a retirement plan either in a lump sum or in the form of periodic payments;
- (b) does not represent contributions made by you; and
- (c) is payable upon:
 - (1) early or normal retirement; or
 - (2) disability if the payment does reduce the amount of money which would have been paid at the normal retirement age under the plan if the disability had not occurred.

Note: payments which represent contributions made by you are deemed to be received over your expected remaining life regardless of when such payments are actually received.

Retirement plan means a plan which provides your retirement benefits and which is not funded wholly by your contributions. The term shall not include a profit-sharing plan, a thrift plan, an individual

retirement account (IRA), a tax sheltered annuity (TSA), a stock ownership plan, or a non-qualified plan of deferred compensation.

Employer's Retirement Plan is deemed to include any retirement plan:

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

Rider means a provision added to the policy or your certificate to expand or limit benefits or coverage.

EMPLOYEE ELIGIBILITY PROVISIONS

Eligible Employees

You are eligible on the day you begin active employment with the Policyholder provided you are an:

- (a) intern;
- (b) resident; or
- (c) fellow physician.

You are eligible as long as:

- (a) you are a regular full-time employee of the Policyholder; and
- (b) you are and continue to be actively employed.

Eligible employees shall not include seasonal or temporary employees.

Active Employment and Actively Employed means working 40 hours or more a week at your:

- (a) regular job; and
- (b) customary place of employment or other location to which you must travel to perform your regular job.

When Your Insurance Begins

You will become insured on the day you become eligible, provided you are actively at work on that day. If you are not actively at work, your insurance will begin on the day you return to active work.

Exceptions

1. If your insurance begins on the day:
 - (a) you are on a regular paid day of vacation; or
 - (b) such day is a regular nonworking day;you will still be considered actively at work if you were available for work on the last preceding regular workday.
2. If you do not report to work on the day your insurance is to begin, you will be considered actively at work if you are available for work on that day.
3. If your customary place of employment is at your home, you will be considered actively at work if you are not confined on that day (as described in the Confinement Rule below).

Confinement Rule

If you are:

- (a) hospital confined;
- (b) confined in any institution/facility other than a hospital due to an injury or sickness; or
- (c) confined at home and under the supervision of a physician;

insurance will begin on the day after such confinement ends.

If you are an active employee and you are not:

- (a) confined; and
- (b) available for work because of injury or sickness;

insurance will begin on the day you return to active work.

Amount of Coverage

The amount of coverage for your classification is shown in the Schedule.

Changes in Your Classification or in the Amount of Your Coverage

Any changes in your classification or coverage will take effect on the day of the change, provided you are actively at work on that day. If you are not actively at work, the following conditions will apply.

1. If the change involves an increase in coverage, the change will not take effect until the day you return full-time to your regular job.
2. If the change involves a decrease in coverage, the change will take effect on the day of the change.

In no event will any change take effect during a period of disability.

When Your Insurance Ends

Your insurance will end at midnight on the earliest of:

- (a) the day the policy ends;
- (b) the day any premium for your insurance is due and unpaid;
- (c) the day before you enter the Armed Forces on active duty (except for temporary active duty of two weeks or less); or
- (d) the day you are no longer eligible under the policy.

If you are eligible because of your employment, you will no longer be eligible when:

- (a) you resign or are retired;
- (b) you go on leave of absence or on strike;
- (c) you are dismissed, suspended, laid off, locked out or are not working because of a work stoppage;

- (d) you are no longer in an eligible class;
- (e) you do not satisfy:
 - (1) the requirements for hours worked; or
 - (2) any other eligibility conditions in the policy.

Continuation of Insurance During Disability

If you become disabled, your insurance will continue without payment of premium for as long as you are entitled to receive Monthly Benefits, provided the premium is paid during the elimination period.

FAMILY AND MEDICAL LEAVE as Federally Mandated

Family and Medical Leave

If you become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA) (including any amendments to such Act) your insurance coverage may be continued on the same basis as if you were an actively-at-work employee for up to 12 weeks during the 12 month period, as defined by your employer, for any of the following reasons:

- (a) to care for your child after the birth or placement of a child with you for adoption or foster care; so long as such leave is completed within 12 months after the birth or placement of the child;
- (b) to care for your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition; or
- (c) for your own serious health condition.

In the event you or your spouse are both insured as employees of the Policyholder, the continued coverage under (a) may not exceed a combined total of 12 weeks. In addition, if the leave is taken to care for a parent with a serious health condition, the continued coverage may not exceed a combined total of 12 weeks.

Conditions:

- (a) If, on the day your insurance is to begin, you are already on an FMLA leave of absence you will be considered actively at work. Insurance for you and any eligible dependents (if applicable) will begin in accordance with the terms of the policy. However, if your leave of absence is due to a serious health condition, benefits for that condition will not be payable to the extent benefits are payable under any prior group plan.
- (b) You are eligible to continue coverage under FMLA if:
 - (1) you have worked for your employer for at least one year;
 - (2) you have worked at least 1,250 hours over the previous 12 months;
 - (3) your employer employs at least 50 employees within 75 miles from your worksite; and
 - (4) you continue to pay any required premium for yourself and any eligible dependents (if applicable) in a manner determined by your employer.
- (c) In the event you choose not to pay any required premium during your leave, your insurance coverage will not be continued during the leave. You will be able to reinstate your coverage on the day you return to work, subject to any changes that may have occurred in the policy during the time you were not insured. You and any insured dependents (if applicable) will not be subject to any evidence of good health requirement provided under the policy. Any partially-satisfied waiting periods, including any limitations for a preexisting condition, which are interrupted during the period of time premium was not paid will continue to be applied once coverage is reinstated.
- (d) You and your dependents (if applicable) are subject to all conditions and limitations of the policy during your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.

- (e) If requested by us, you or your employer must submit proof acceptable to us that your leave is in accordance with FMLA.
- (f) This FMLA continuation is concurrent with any other continuation option except for COBRA, if applicable.
- (g) FMLA continuation ends on the earliest of:
 - (1) the day you return to work;
 - (2) the day you notify your employer that you are not returning to work;
 - (3) the day your coverage would otherwise end under the policy; or
 - (4) the day coverage has been continued for 12 weeks.

Definitions

Prior group plan means the group plan providing similar benefits (whether insured or self-insured plans provided by the Policyholder) in effect immediately prior to the effective date of this policy.

Serious Health Condition is defined as stated in the FMLA.

Important Notice:

Contact your employer for additional information regarding FMLA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS as Federally Mandated

Definitions

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such ACT and any interpretive regulations or rulings).

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Uniformed services means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

Reemployment (following service in the uniformed services)

Following your discharge from such service, you may be eligible to apply for reemployment with your former employer in accord with USERRA.

Benefits

Your employer's leave of absence policy will determine your right to participate in any group insurance, such as Life, Accidental Death and Dismemberment, Weekly Disability, and Long Term Disability.

After reemployment, credit will be given, if applicable, for the period of such service, if required to determine your benefit amounts, eligibility, or costs.

Important Notice

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by your employer or former employer, will apply.

THE DEFINITIONS, GENERAL EXCLUSIONS, LIMITATIONS AND RIDERS ARE VERY IMPORTANT PARTS OF YOUR POLICY. PLEASE READ THOSE PAGES CAREFULLY.

SCHEDULE

The amount of insurance for you will be in accord with your classification in this Schedule.

Classification

All eligible employees of Creighton University Graduate Medical Education Group

For You LONG-TERM DISABILITY BENEFITS

Elimination Period

The elimination period is 30 days. Days of disability or partial disability may be used to satisfy the elimination period.

For accumulating the elimination period, the following will apply.

1. The disability will be treated as continuous if disability stops during the elimination period for a total number of accumulated days which is not more than three days.
2. Days that you are not disabled will not count toward the elimination period.

Monthly Benefit

Your monthly benefit is the lesser of:

- (a) 66 2/3% of your basic monthly earnings, less other income benefits; or
- (b) \$2,500.

Your monthly benefit will never be less than \$100 or 10% of the gross monthly benefit, whichever is greater.

However, if you are partially disabled and earning more than 20%, but less than 80%, of your pre-disability earnings in effect immediately prior to your disability in your regular occupation or another occupation, the benefit will be reduced by 50% of your monthly earnings received while you are disabled.

During the first 12 months of disability benefits, the offset for partial disability earnings is not applied to earnings from your regular occupation or another occupation, unless the monthly benefit plus earnings exceeds your pre-disability earnings.

Pre-disability Earnings means your basic monthly earnings in effect just prior to the date of your disability.

Basic Monthly Earnings means your basic monthly salary or rate of pay, as verified by the Policyholders' pay records and by premiums we have received. Basic monthly earnings do not include overtime, commissions, bonuses or other additional salary or pay.

Other Income Benefits

Your monthly benefit will be reduced by the following.

1. The amount for which you are eligible under:
 - (a) a workers' or workmen's compensation law;
 - (b) an occupational disease law; or
 - (c) any other act or law of like intent.
2. The amount of disability income benefits for which you are eligible under any compulsory benefit act or law, not including any automobile No Fault policy.
3. The amount of any disability income benefits for which you are eligible under:
 - (a) any other group insurance plan; or
 - (b) any governmental retirement system as a result of your job with your current employer.
4. The amount of benefits you receive under your employer's retirement plan for any disability benefits and/or retirement benefits. Until the normal retirement age set forth in the employer's retirement plan is attained (or, if later, age 62), the monthly benefit will be reduced by the amount of any retirement benefits that are voluntarily elected to be received.
5. The amount of disability or retirement benefits under the United States Social Security Act or any similar plan or act, as follows for:
 - (a) disability benefits for which you are eligible;
 - (b) retirement benefits you receive; or
 - (c) the following benefits which apply to your spouse, child or children:
 - (1) disability benefits for which they are eligible because of your disability.
 - (2) retirement benefits they receive because of your receipt of the retirement benefits.

These other income benefits, except retirement benefits, must be payable as a result of the same disability for which we pay a benefit.

Law, Plan or Act means the initial enactment and all amendments.

Item 5.(b) and 5.(c)(2) will not apply to disabilities which begin after age 70, if you are already receiving Social Security retirement benefits while continuing to work beyond age 70.

Benefits under items 5.(a) and 5.(c)(1) above will be estimated if such benefits:

- (a) have not been awarded and have not been denied; or
- (b) have been denied and the denial is being appealed.

The monthly benefit will be reduced by the estimated amount. But these benefits will not be estimated provided that you:

- (a) apply for benefits under item 5.(a) and 5.(c)(1); and
- (b) request and sign our Indemnity Agreement.

This agreement states that you promise to repay us an overpayment caused by an award received under item 5.(a) or 5.(c)(1).

If benefits have been estimated, the monthly benefit will be adjusted when we receive proof:

- (a) of the amount awarded; or
- (b) that benefits have been denied.

In the case of (b) above, a lump sum refund of the estimated amounts will be made.

After the first deduction for each of the other income benefits, we will not further reduce your monthly benefit due to any cost of living increases payable under these other income benefits.

Other income benefits which are paid in a lump sum will be prorated on a monthly basis over the time period for which the sum is given. If no time period is stated, the sum will be prorated on a monthly basis over the benefit period as determined by the maximum benefit period shown in this Schedule.

Maximum Benefit Period

If you are disabled because of an injury or sickness, except for disabilities due to a mental or nervous disorder, we will pay in accord with the following:

Age at Disability	Maximum Benefit Period
59 or less	to age 65, but not less than 60 months
60.....	60 months
61.....	48 months
62.....	42 months
63.....	36 months
64.....	30 months
65.....	24 months
66.....	21 months
67.....	18 months
68.....	15 months
69 or over	12 months

Mental and Nervous Disorder Limitation

If you are disabled because of a mental or nervous disorder, we will pay in accord with the following.

Benefits for disability due to a mental or nervous disorder will not exceed 24 months, unless you meet one of the following situations.

1. You are confined in a hospital or institution at the end of the 24-month period. The monthly benefit will be paid during the confinement.

If you are still disabled when you are discharged, the monthly benefit will be paid for a recovery period of up to 90 more days.

If you become reconfined during the recovery period for at least 14 days in a row, benefits will be paid for the confinement and another recovery period up to 90 more days.

2. You continue to be disabled and become confined:

(a) after the 24-month period; and

(b) for at least 14 consecutive days.

The monthly benefit will be payable during the confinement.

In no event will the monthly benefit be payable beyond the Maximum Benefit Period.

LONG-TERM DISABILITY BENEFITS

For You

Benefits

If, while insured under this provision, you become disabled due to injury or sickness, we will pay the Monthly Benefit shown in the Schedule. Benefits will begin after the end of the Elimination Period shown in the Schedule. Benefits will be paid for a period of disability until the earliest of:

- (a) the day you are no longer disabled;
- (b) the day you die;
- (c) the end of the maximum benefit period shown in the schedule; or
- (d) the day your current earnings exceed 80% of your pre-disability earnings.

New Period of Total Disability

Your Long-term Disability Benefits shown in the Schedule will be restored each new period of total disability. The Waiting Period shown in the Schedule will also be applied each new period of total disability.

A new period of total disability begins:

- (a) when you become totally disabled after you have been back to work full time for at least 90 consecutive days since your previous disability; or
- (b) when you become totally disabled due to a cause not related to any cause of the previous disability and the new disability begins after you have been back to work full time for at least one day.

Pre-Existing Conditions

We will not cover any disability:

- (a) caused by, contributed to by or resulting from a pre-existing condition; and
- (b) which begins in the first 12 months after you become insured under the policy.

A **pre-existing condition** means any injury or sickness for which you received medical treatment, consultation, care or services including diagnostic measures, or had taken prescribed drugs or medicines in the three months prior to the day you become insured under the policy.

Three Month Survivor Benefit

We will pay a benefit to your eligible survivor when we receive proof that you died:

- (a) after disability had continued for 180 or more consecutive days; and
- (b) while receiving a monthly benefit.

The benefit will be an amount equal to three times your gross monthly benefit.

Eligible Survivor means your spouse, if living, otherwise your natural and/or adopted children under age 25. Benefits will be paid equally among your eligible children. If there are no eligible survivors, benefits will be paid to your estate.

General Exclusions

We will not pay for any disability:

- (a) during which you are not under the regular care and attendance of a physician;
- (b) which results from your service in the Armed Forces, National Guard or Reserves of any state or country;
- (c) which results from an act of declared or undeclared war or armed aggression;
- (d) which results from your participation in a riot or in the commission of a crime;
- (e) which results, whether you are sane or insane, from:
 - (1) an intentionally self-inflicted injury or sickness; or
 - (2) attempted suicide.

LONG-TERM DISABILITY CONVERSION

Definition

Conversion Coverage means long-term disability insurance, then available, issued without evidence of good health.

NOTE: Conversion coverage does not provide the same insurance benefits you had while insured under the policy. Consequently, coverage under the policy may not be covered by the conversion coverage or may be covered at a different level. You may contact the Plan Administrator or us at any time for a description of the conversion benefits then available. Conversion benefits are subject to change.

Available To You

Conversion coverage is available to you if your long-term disability insurance ends because your eligibility ends; except conversion coverage is not available when:

- (a) the policy ends;
- (b) you have similar individual or group coverage; or
- (c) you have been insured under the policy (including any similar group coverage the policy replaces) less than 12 months immediately before your long-term disability insurance ends;
- (d) you retire from employment with your employer;
- (e) you are disabled; or
- (f) you are age 70 or older.

Option To Obtain Conversion Coverage

If a completed application and the first premium payment is sent to us within 31 days from when long-term disability insurance ends, conversion coverage will be issued in accord with:

- (a) our rules; and
- (b) the conversion law in effect when application is made.

Conditions

Conversion coverage begins immediately after insurance under the policy ends. Coverage for conditions which are excluded under the policy may be excluded under the conversion coverage.

PAYMENT OF CLAIMS

How To File Claims

Before benefits are paid, we must be given a written proof of loss, as described below. In the event of your death or incapacity, your beneficiary or someone else may give us the proof.

Proof of Loss Requirements

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

This request should be made:

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

When we receive the request, we will send a claim form for filing proof of loss. If we do not send it within 15 days, you can meet the proof of loss requirement by giving us a written statement of what happened. We must receive a written statement within the time shown in 3 below.

2. Next, complete and sign the claim form. Have the physician complete and sign his or her part.
3. Finally, return the claim form to the Plan Administrator or to us. The claim form is due within 90 days after the end of the period for which we are liable, and thereafter at least once each 90 days as long as you are disabled. If you do not send us the claim form when due, we will still honor your claim if you send us the claim form as soon as reasonably possible. However, unless you are legally incapable, the claim form must be sent to us not later than one year after it is otherwise required.

How Claims are Paid

Benefits will be paid monthly after we receive acceptable proof of loss.

Benefits will be paid to you, except benefits due but unpaid at your death may be paid, at our option, to:

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

This provision does not apply to any survivor benefits payable under the policy.

Examination

We sometimes require that a claimant be examined by a physician of our choice. We will pay for these examinations. We will not require more than a reasonable number of examinations.

DISABILITY CLAIM REVIEW PROCEDURES

(As Federally Mandated)

Definitions

Capitalized terms have the same meaning as shown in the Policy.

For the purposes of this provision the following term has the following meaning:

Adverse Benefit Determination means a denial, reduction or termination of, or a failure to provide or to make payment (in whole or in part) for a benefit, including any such denial, reduction, termination of, or failure to provide or make payment (in whole or in part) that is based upon the Insured Person's ineligibility for insurance under the Policy.

For the purposes of these Claim Review Procedures, the terms **You, Your, Yours** shall include Your authorized representative.

Disability Claim Review Procedures

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. Please refer to the Payment of Claims provision of the Policy.

In the event an extension is necessary due to matters beyond Our control, We will notify You of the extension and the circumstances requiring the extension. Extensions are limited as set forth below.

If an extension is necessary due to Your failure to submit complete information, We will notify You of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for Us to continue processing Your claim, the missing information must be provided to Us within the time periods set forth below.

You may contact Us at any time for additional details about the processing of the claim.

Disability Claim Review Decisions

- (a) Initial review: We will notify You of Our claim decision within 45 days after Our receipt of Your claim, unless additional information is requested as set forth below;
- (b) Extension period: 30 days; and
- (c) Maximum number of extensions: two.

If additional information is needed, We will notify You within 30 days of Our receipt of the claim. Once You receive Our request for additional information, You will have 45 days to submit the additional information to Us. We will have a total of 105 days (which includes an additional 30-day extension, if necessary, due to circumstances beyond Our control) to process the claim. If We do not receive the additional information within the specified time period, We will make Our determination based on the available information.

Disability Claim Denials

If a claim is denied or partially denied, You will receive a written or electronic notice of the denial which will include:

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

Additionally, if We used an internal rule, guideline, protocol or other similar criterion in making an Adverse Benefit Determination, You will receive a statement of Your right to receive, upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion.

Furthermore, if We make an Adverse Benefit Determination based upon a medical necessity or experimental treatment or a similar exclusion or limitation, We will include a statement that an explanation of the scientific or clinical judgment for such determination will be provided to You upon request and free of charge.

Appeals

If a claim is denied or partially denied, You shall have a reasonable opportunity for an appeal and a right to a full and fair review. Please refer to the Appeal Rights provision.

APPEAL RIGHTS
(Disability)
(As Federally Mandated)

Capitalized terms have the same meaning as shown in the Policy.

Opportunity To Request An Appeal

You may appeal Our claim review decision in accordance with this Appeal Rights provision. As part of the appeal, We will perform a full and fair review of the claim review decision.

The request for an appeal can be written, electronically or orally submitted to Us and should include any additional information You believe may have been omitted from Our review or that should be considered by Us.

We will establish and maintain procedures for hearing, researching, recording and resolving any appeal. The notification You receive regarding Our claim review decision will include instructions on how and where to submit an appeal.

You will have 180 days from Your receipt of notification of Our claim review decision to submit a request for an appeal.

The request for an appeal should include:

- (a) the name of the employee;
- (b) the name of the person filing the appeal if different from the employee;
- (c) the policy number; and
- (d) the nature of the appeal.

By requesting an appeal, You have authorized Us, or anyone designated by Us, to review Your records.

For the purposes of this Appeal Rights provision, the terms **You, Your, Yours** shall include Your authorized representative.

Our Response To An Appeal

Once We receive Your request for an appeal, We will respond no later than 45 days, unless additional information is requested. If additional information is requested, the following extensions apply:

- (a) extension period: 45 days;
- (b) maximum number of extensions: one.

We will have a total of 90 days to process the appeal.

When We make Our determination You will be provided with:

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

STANDARD PROVISIONS

Insurance Contract

The insurance contract consists of:

- (a) the policy;
- (b) the Policyholder's application attached to the policy; and
- (c) your application, if required.

Changes in the Insurance Contract

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

- (a) does not require your or your beneficiary's consent; and
- (b) must be:
 - (1) in writing;
 - (2) made a part of the policy; and
 - (3) signed by one of our officers.

A change may affect any class of insured persons.

Applications

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

Statements in an application are treated as representations, not as warranties.

Legal Actions

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

SUMMARY PLAN DESCRIPTION

for Creighton University

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to eligible participants in an employee benefits plan. The employee benefits plan maintained by the Policyholder shall be referred to herein as the "Plan."

This Certificate is Your ERISA Summary Plan Description for the insurance benefits described herein.

Contributions are made by Your employer and by participants. Contributions are based on the amount of insurance premiums necessary to provide Plan coverage.

The Plan provides coverage for more than one class of employees.

EMPLOYER IDENTIFICATION NUMBER/PLAN NUMBER

E.I.N. 47-0376583	P.N. 501
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PLAN ADMINISTRATOR

The Plan is provided through and administered by:

Creighton University
2500 California Plaza
Omaha, NE 68178
Phone: (402) 255-5767

The benefits under the Plan(s) are fully insured by the insurance company shown on Your Certificate of Insurance under a group insurance policy issued by such Company (the "Policy"). Benefits under the Policy are guaranteed to the extent all Policy provisions are met and subject to all terms and conditions of the Policy (including, but not limited to, all exclusions, limitations and exceptions in the Policy). The insurance company's home office is located at Mutual of Omaha Plaza, Omaha, NE 68175.

AGENT FOR SERVICE OF LEGAL PROCESS

Creighton University
2500 California Plaza
Omaha, NE 68178
Phone: (402) 255-5767

Service of legal process may be served upon the Plan Administrator.

PLAN YEAR

Each 12-month period beginning on January 1 is a Plan Year for the purposes of accounting and all reports to the United States Department of Labor and other regulatory bodies.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

(a) Receive Information About Your Plan and Benefits

- (1) Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) **filed** by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- (2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- (3) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

(b) Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a benefit or exercising Your rights under ERISA.

(c) Enforce Your Rights

If Your claim for a benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to \$110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

(d) Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

PLAN DISCLOSURES

You are entitled to request from the Plan Administrator, without charge, information applicable to the Plan's benefits and procedures. In addition, Your Certificate includes, as applicable, a description of:

- (a) employee eligibility requirements;
- (b) when insurance ends;
- (c) state or federal continuation rights; and
- (d) claims procedures; additional details shall be furnished upon request.

AUTHORITY TO INTERPRET POLICY

By purchasing the Policy, the Policyholder grants Us the discretion and the final authority to construe and interpret the Policy. This means that We have the authority to decide all questions of eligibility and all questions regarding the amount and payment of any Policy benefits within the terms of the Policy as interpreted by Us. Benefits under the Policy will be paid only if We decide, in Our discretion, that a person is entitled to them. In making any decision, We may rely on the accuracy and completeness of any information furnished by the Policyholder or an Insured Person. Our interpretation of the Policy as to the amount of benefits and eligibility shall be binding and conclusive on all persons.

The Policyholder, as Plan sponsor, agrees that the Policyholder retains full responsibility for the legal and tax status of its benefits program and releases Us from all responsibility for the reporting and the employment-based design of the program and from all other responsibilities not accepted in writing by an officer of Ours.

PLAN CHANGES

The persons with authority to change, including the authority to terminate, the Plan or the Policy on behalf of the Policyholder are the Policyholder's Board of Directors or other governing body, or any person or persons authorized by resolution of the Board or other governing body to take such action. Please refer to the provision in Your Certificate entitled "Changes in the Insurance Contract" for additional information about how the Policy can be changed. The Policyholder is authorized to apply for and accept the Policy and any changes to the Policy on behalf of the Policyholder.

FORMS DOCUMENT

The provisions of this Certificate-Booklet are comprised of the forms indicated below which have been filed with the Nebraska Insurance Department.

FORM NAME	FORM NO(S)
CERTIFICATE OF INSURANCE	7000CI-M-EZ No. 6
DEFINITIONS.....	7101GD-RX-EZ 89
EMPLOYEE ELIGIBILITY PROVISIONS	7017GP-EZ 7-86
RIDER FAMILY AND MEDICAL LEAVE as Federally Mandated	2024GR-EZ 94 FMLA-B
RIDER UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS as Federally Mandated.....	2024GR-EZ USERRA No. 1
SCHEDULE	7000GS-RX-EZ
LONG-TERM DISABILITY BENEFITS	7103GI-RX-EZ 89 Rev.
LONG-TERM DISABILITY CONVERSION	7486GI-RX-EZ LTD Rev.
PAYMENT OF CLAIMS	7023PC-EZ No. 4 RX
DISABILITY CLAIM REVIEW PROCEDURES.....	SPD Claims Disab
APPEAL RIGHTS	12279GN-EZ FED Disab
STANDARD PROVISIONS	7024SP-EZ 12-84 EO/LTD

Group Policy Number GMTD-20W8

