UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL *of* OMAHA COMPANY

YOUR GROUP VISION PPO BENEFITS

FOR EMPLOYEES OF:

JDC Management, Humanities Foundation & Quantum Builders

CLASS(ES):

All Eligible Employees

EFFECTIVE DATE:

December 1, 2020

PUBLICATION DATE:

December 16, 2020

NOTICE(S)

THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU. PLEASE READ YOUR CERTIFICATE CAREFULLY. THE POLICY IS ISSUED IN THE STATE OF SOUTH CAROLINA AND PROVIDES ALL OF THE BENEFITS REQUIRED BY APPLICABLE SOUTH CAROLINA LAW.

THIS CERTIFICATE INCLUDES A PPO IN-NETWORK PROVIDER OPTION. YOUR OUT-OF-POCKET EXPENSES MAY BE GREATER WHEN USING AN OUT-OF-NETWORK PROVIDER.

NOTICE

If you have any questions about or concerns with this insurance, please first contact the Policyholder or your benefits administrator. If after doing so you still have a question or concern, you may contact us at:

United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-833-279-4358
www.mutualofomaha.com/vision

When contacting us, please have your Policy number and Member ID available.

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

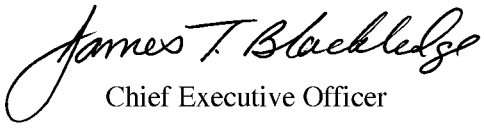
United of Omaha Life Insurance Company certifies that Group Policy Number GUVC-BT79 (the Policy) has been issued to JDC Management, Humanities Foundation & Quantum Builders (the Policyholder).

Insurance is provided for Employees of the Policyholder subject to the terms and conditions of the Policy.

Please read this Certificate carefully. The benefits described in this Certificate are effective only if you and your Dependents, if applicable, are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

If the provisions of this Certificate and those of the Policy do not agree, the provisions of the Policy will apply. The Policy is part of a contract between United of Omaha Life Insurance Company and the Policyholder, and may be amended, changed or terminated without your consent or notice to you.

This Certificate replaces any certificate previously issued under the Policy.



Chief Executive Officer

Corporate Secretary

SCHEDULE

This Schedule describes some of the terms and conditions of the Policy including the benefits, Copayments, allowances, costs, exclusions and limitations. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate.

Benefits under the Policy may vary depending on the services or materials received In-Network or Out-of-Network.

All Providers are independent contractors; they are not our employees or agents. We do not supervise, control or guarantee the outcome or results of any services or materials furnished by any Provider. Your relationship with a Provider is that of provider and patient. The Provider is solely responsible for the services and materials provided to you.

POLICY INFORMATION

Policyholder:	JDC Management, Humanities Foundation & Quantum Builders
Policy Effective Date:	December 1, 2020
Policy Anniversary:	December 1
Policy Number:	GUVC-BT79
Class(es):	All Eligible Employees
Coverage For:	You and your Dependents

GENERAL PROVISIONS

Work in Progress
Benefits will be provided for Vision Materials delivered after the date an Insured Person's insurance ends if such materials are ordered before coverage ended, and the Covered Services are rendered to the Insured Person within 31 days from the date of such order.

BENEFITS

Benefits are payable for each Insured Person under the Policy for Covered Services described in this section, subject to all terms and conditions of the Policy.

In-Network Benefits
Copayments or any cost above the allowance shown for Covered Services described in this section must be paid in full by the Insured Person to the In-Network Provider at the time a Covered Service is provided. We will pay benefits in excess of the Copayment for Covered Services to the In-Network Provider. The In-Network Provider will submit a claim to us on an Insured Person's behalf.

Out-of-Network Benefits
The Insured Person must pay the Out-of-Network Provider the full cost of services and materials at the time a Covered Service is provided. We will reimburse the Insured Person for benefits up to the Out-of-Network maximum dollar amount shown in this section after the Insured Person submits a claim to us.

Out-of-Area
An Insured Person who does not have access to an In-Network Provider within 20 miles of the Insured Person's residence may receive services from an Out-of-Area Provider. The Insured Person must pay the full cost of services and materials at the time a Covered Service is provided and submit a claim to us. Copayments or any cost above the allowance for In-Network benefits shown in this section must be paid in full by the Insured Person.

COVERED SERVICES

SERVICES	In-Network	Out-of-Network
Comprehensive Vision Examination	$10 Copayment	Up to $37
MATERIALS	**In-Network**	**Out-of-Network**
Frames	Up to $130 allowance	Up to $58
Standard Plastic Lenses		
• Single Vision	$25 Copayment	Up to $20
• Bifocal	$25 Copayment	Up to $36
• Trifocal	$25 Copayment	Up to $64
• Lenticular	$25 Copayment	Up to $64
Lens Options		
• Progressive Lenses – Standard (add on to Bifocal)	$65 Copayment	Up to $36
• Progressive Lenses – Premium (add on to Bifocal)	Tier 1: $85 Copayment Tier 2: $95 Copayment Tier 3: $110 Copayment Tier 4: $65 Copayment + 80% of charge, less applicable allowance	Up to $36 Up to $36 Up to $36 Up to $36
Contact Lenses (only one option available per Benefit Frequency)		
• Conventional	Up to $130 allowance	Up to $89
• Disposable	Up to $130 allowance	Up to $104
• Medically Necessary	$0 Copayment	Up to $210
BENEFIT FREQUENCY		
• Examination	Once every 12 months	
• Lenses or Contact Lenses	Once every 12 months	
• Frame	Once every 24 months	

LIMITATIONS

Benefit allowances cannot be carried over and provide no remaining balance for future use within the same Benefit Frequency.

EXCLUSIONS

We will not pay benefits for any services or materials connected with or charges arising from:

a) orthoptic or vision training, subnormal vision aides and any associated supplemental testing;
b) Aniseikonic lenses;
c) medical or surgical treatment of the eye, eyes or supporting structures;
d) any eye or Vision Examination, or any corrective eyewear required by the Policyholder as a condition of employment;
e) safety eyewear;
f) services or materials provided or paid for in whole or in part by a state or federal government or its agencies;
g) services or materials provided or paid for in whole or in part as a result of any workers' compensation or occupational disease law or as required by any federal or state governmental agency or program;
h) Plano (non-prescription) lenses or contact lenses;
i) non-prescription sunglasses;
j) two pair of glasses in lieu of bifocals;
k) services or materials provided or paid for in whole or in part by any other group benefit plan providing vision benefits;
l) certain name brand Vision Materials for which the manufacturer maintains a no-discount practice;
m) services rendered after the date an Insured Person ceases to be covered under the Policy; or
n) lost, stolen, or broken lenses, frames, glasses, or contact lenses until the next Benefit Frequency when Vision Materials would next become available.

ELIGIBILITY

WHEN YOU BECOME ELIGIBLE FOR INSURANCE (ELIGIBILITY WAITING PERIOD)

If you complete the 2 month Eligibility Waiting Period on or before the Policy Effective Date, you become eligible for insurance on the Policy Effective Date.

If you are not eligible for insurance on the Policy Effective Date, or if you are hired after the Policy Effective Date, you become eligible for insurance the day after you complete the 2 month Eligibility Waiting Period.

The day you become eligible for insurance may not be the same as the day your insurance begins. The WHEN YOUR INSURANCE BEGINS provision describes the day your insurance begins.

WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE

Provided you elect insurance for you, your Dependents become eligible for insurance on the later of:

a) the day you become eligible for insurance; or
b) the day you acquire the Dependent.

If both you and your Spouse are eligible for and elect insurance as Employees:

a) neither you nor your Spouse may elect insurance as a Dependent of the other person; and
b) either you or your Spouse, but not both, may elect insurance for your Dependent children.

The day a Dependent becomes eligible for insurance may not be the same as the day insurance begins. The WHEN YOUR DEPENDENT'S INSURANCE BEGINS provision describes the day when insurance begins.

WHEN YOUR INSURANCE BEGINS

You must enroll for any insurance requiring an election by submitting a Written Request for insurance. The Written Request must be submitted to the Policyholder no later than 31 days after the day you become eligible. If the Written Request for insurance is not submitted within the required timeframe, you may not enroll until a Subsequent Enrollment Period is offered.

You become insured on the first day of the month that follows the latest of the day:

a) you become eligible and are Actively Working; or
b) your Written Request is properly completed and signed, if required.

If you are not Actively Working when insurance would otherwise begin, insurance will not take effect until the day after you have completed one full day of Active Work.

WHEN YOUR DEPENDENT'S INSURANCE BEGINS

You must enroll your Dependents for any insurance requiring an election by submitting a Written Request for insurance. The Written Request must be submitted to the Policyholder no later than 31 days after the day your Dependent becomes eligible. If the Written Request for insurance is not submitted within the required timeframe, you may not enroll your eligible Dependents until a Subsequent Enrollment Period is offered.

An eligible Dependent will become insured on the latest of the day:

a) you become insured, unless otherwise agreed to by our authorized representative in our home office;
b) you acquire the eligible Dependent; or
c) your Written Request to enroll the Dependent for insurance is properly completed and signed, if required.

Insurance for a Dependent child who became Incapacitated prior to reaching the age of 26 begins in accordance with the above terms, provided the child otherwise meets the definition of Dependent.

Insurance for a newborn Dependent child begins at the moment of live birth, provided the child otherwise meets the definition of Dependent. Insurance for a newly adopted Dependent child begins with the date of placement into your custody,

or at the moment of live birth if a written agreement to adopt the child was previously entered into by you, provided the child otherwise meets the definition of Dependent. If Dependent child insurance requires an election and Dependent child insurance for any other child is not already in effect, a Written Request for insurance for any newborn or newly adopted Dependent child must be submitted to the Policyholder within 31 days after the day the Dependent child becomes eligible in order to continue insurance beyond the 31-day period.

CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER

If there is a conflict between this provision and any other provision of the Policy, this provision controls.

If the Policy replaces a Prior Plan, the Policy will provide insurance for you and any eligible Dependents if you:

a) were insured under the Prior Plan on the day before the Policy Effective Date;
b) are otherwise eligible, but not Actively Working on the Policy Effective Date due to:
    1. injury or sickness; or
    2. leave of absence protected under:
        a. the federal Family and Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto; or
        b. any other applicable federal or state law that allows for continuation of insurance in certain instances;
c) are not insured under any provision of the Prior Plan;
d) are not a retired Employee; and
e) are approved by our authorized representative in our home office for insurance under this provision.

Insurance under this provision is subject to the following conditions:

a) insurance is subject to uninterrupted payment of premium to us when due; and
b) insurance is subject to all other terms and conditions of the Policy.

We reserve the right to request any information we need from the Policyholder to determine whether the conditions necessary to be eligible for insurance under this provision have been satisfied.

Insurance under this provision will end on the earliest of:

a) the day you return to Active Work for the Policyholder or begin employment with any other employer;
b) the last day you would have been insured under the Prior Plan, if the Prior Plan had not ended or terminated;
c) the day your insurance ends for any reason shown in the WHEN INSURANCE ENDS provision;
d) the last day of the twelfth month following the Policy Effective Date; or
e) the last day of the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation.

If you are eligible for insurance under this provision, you will not be eligible for insurance under any continuation provision in this Certificate.

FIRST ENROLLMENT PERIOD

You may elect insurance for you and any Dependents during the First Enrollment Period.

If you do not elect insurance during your or any Dependent's First Enrollment Period, future elections may only be made in accordance with the SUBSEQUENT ENROLLMENT PERIOD provision, or as otherwise provided under the WHEN ELECTION CHANGES ARE PERMITTED provision.

SUBSEQUENT ENROLLMENT PERIOD

You may elect, drop, or change insurance for you and any Dependents during a Subsequent Enrollment Period.

WHEN ELECTION CHANGES ARE PERMITTED

Life Events
Within 31 days after the date of a Life Event, you may submit a Written Request to change insurance. If the Written Request is submitted more than 31 days after the date of a Life Event, you may not elect or change insurance until a Subsequent Enrollment Period is offered.

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended in accordance with this provision. For any insurance requiring an election, you must submit a Written Request to reinstate insurance within 31 days of your return to Active Work. If the Written Request is submitted more than 31 days after the date you return to Active Work, you may not re-enroll for insurance until a Subsequent Enrollment Period is offered. If insurance is reinstated for you, insurance may also be reinstated for any eligible Dependents.

Reinstated insurance will take effect on the first day of the month that follows the date of the Written Request. If you are not Actively Working on the day the reinstated insurance would otherwise take effect, insurance will become effective on the day after you return to Active Work.

Non-Payment of Premium or Voluntary Termination of Insurance
If insurance ends because you do not pay premium or you voluntarily terminate insurance, you may not re-enroll for insurance until a Subsequent Enrollment Period is offered.

Involuntary Reduction in Hours
If insurance ends because you are no longer Actively Working due to an involuntary reduction of hours worked, insurance may be reinstated without satisfying another Eligibility Waiting Period if you return to Active Work and there was no break in employment with the Policyholder after the date insurance ended.

Rehired Employee Due to Layoff or Termination
If insurance ends because you are no longer Actively Working due to layoff or termination of employment with the Policyholder, insurance may be reinstated without satisfying another Eligibility Waiting Period if you are rehired and return to Active Work within 90 days from the date insurance ended.

Rehired Employee Due to Leave of Absence
If insurance ends because you are no longer Actively Working due to an approved leave of absence, insurance may be reinstated within 90 days from the date insurance ended without satisfying another Eligibility Waiting Period upon return to Active Work. If insurance ends because you are no longer Actively Working due to military leave, insurance may be reinstated upon return to Active Work within 31 days of your discharge from active duty without satisfying another Eligibility Waiting Period.

WHEN INSURANCE ENDS

Insurance ends:

a) for all Insured Persons, the last day of the month in which you are no longer Actively Working;
b) the last day of the month in which a Dependent is no longer eligible for insurance under the Policy;
c) the last day of the calendar year in which your eligible Dependent child reaches the age of 26;
d) the last day of the month in which an Insured Person begins active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 31 days or less), unless otherwise allowed in the Policy;
e) the day the Policy terminates; or
f) in accordance with the GRACE PERIOD provision.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for you and/or your Dependents would otherwise end, you and/or your Dependents may be able to continue insurance under one of the following provisions:

a) CONTINUATION OF INSURANCE FOR LAYOFF OR LEAVE

b) COBRA CONTINUATION

CONTINUATION OF INSURANCE FOR LAYOFF OR LEAVE

If there is a conflict between this provision and any other provision of the Policy, this provision controls.

You may be able to continue insurance for you and your Dependents from the day you cease to be Actively Working in the event of:

a) a temporary involuntary layoff; or
b) a leave of absence approved by the Policyholder due to:
    1. an injury or sickness; or
    2. any personal reason.

In addition, the federal Family Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain instances. Contact the Policyholder for additional information regarding any other continuation options that may be available.

Any insurance continued under this provision is subject to the following conditions:

a) insurance may not be continued beyond the earliest of:
    1. the end of the month for your temporary involuntary layoff;
    2. the end of the month for your leave of absence due to any personal reason; or
    3. the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation;
b) the amount of insurance for any Insured Person may not be increased while insurance is continued under this provision;
c) we receive verification of the approved layoff or leave from the Policyholder upon request; and
d) we continue to receive premium payment when due.

Insurance under this provision ends on the last day of the month which coincides with or follows the earliest of the day:

a) the time period in a) in the preceding paragraph has been satisfied;
b) your temporary involuntary layoff becomes permanent;
c) you return to Active Work;
d) you begin full-time employment with an employer other than the Policyholder; or
e) the Policy terminates.

Insurance under this provision also ends in accordance with the GRACE PERIOD provision.

See the OPTIONS FOR PAYMENT OF PREMIUM FOR APPROVED CONTINUATION OF INSURANCE provision in the Premium Payments section of this Certificate for premium payment options.

COBRA CONTINUATION

The COBRA CONTINUATION provision applies only if the Policyholder employed 20 or more employees on at least 50 percent of its business days during the preceding calendar year.

For You and Your Dependents

You and/or any insured Dependent who is a Qualified Beneficiary may elect to continue insurance under the Policy for as long as 18 months from the day your coverage ends because of these qualifying events:

a) your employment terminates (other than due to gross misconduct); or
b) you no longer satisfy the requirements for hours worked.

If an Insured Person is determined, in accordance with Title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continued coverage, the reference to 18 months in the preceding sentence is deemed a reference to 29 months. Notice of such determination must be given to the Plan Administrator before the first 18 months of continued coverage ends and within 60 days of the date of the determination. Refer to the Payment of Premium section below.

During the period you continue coverage:

a) any new eligible Dependents you acquire may be added in accordance with the WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE provision; and
b) any eligible Dependents you declined to insure before your continued insurance under the Policy began may be added during any open enrollment period provided by the Policy provided any additional premium is paid. However, such Dependents, other than a Qualified Beneficiary, who are added after the qualifying event will not be entitled to continue coverage as Qualified Beneficiaries after an event occurs as shown in the For Your Dependents Only section below.

For Your Dependents Only

Your insured Spouse who is a Qualified Beneficiary and/or each of your insured Dependent children who is a Qualified Beneficiary may elect to continue insurance under the Policy for as long as 36 months from the day coverage ends because of these qualifying events:

a) you die;
b) you become entitled to Medicare benefits;
c) you and your Spouse are legally separated;
d) your marriage is ended by divorce; or
e) a child is no longer an eligible Dependent.

If your Dependent is already continuing coverage under the *For You and Your Dependents* section above when an event shown in the *For Your Dependents Only* section occurs, that second event will not entitle your Dependent to continue coverage beyond 36 months under the *For You and Your Dependents* and *For Your Dependents Only* sections combined.

If your Dependent becomes entitled to continue insurance under both the *For You and Your Dependents* and *For Your Dependents Only* sections on the same day, the periods of continued coverage will run concurrently and will not exceed 36 months.

Notice Requirements

Your employer is required by law to notify the Plan Administrator within 30 days after your termination of employment, reduction in hours, death or entitlement to Medicare. You must notify the Plan Administrator within 60 days after the day you are legally separated or divorced, or your child ceases to be an eligible Dependent.

If an Insured Person is determined, in accordance with Title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continued coverage, that person must:

a) notify the Plan Administrator within 60 days of the date of the determination and before the first 18 months of continued coverage ends; and
b) notify the Plan Administrator within 30 days of the date of any final determination that he or she is no longer disabled. Then, continued coverage ends the first day of the month that begins more than 30 days after the date of such final determination.

Within 14 days after receiving notice of a qualifying event, the Plan Administrator will send you or your Dependent written notice of the continuation right. The Plan Administrator must receive your or your Dependent's written request to continue insurance under the Policy within 60 days after the day:

a) insurance ends; or
b) the Insured Person is sent notice of the continuation right; whichever is later.

Payment of Premium

To continue coverage, you or your Dependent must pay the required premium, including any retroactive premium. The initial premium must be paid to the Plan Administrator within 45 days after the day continued coverage is elected. The Plan Administrator will inform you or your Dependent of procedures to pay subsequent monthly premiums.

End of Continuation

An Insured Person's continued insurance will end at midnight on the earliest of:

a) the day your employer ceases to provide any group vision plan to any employee;
b) the day premium is due and unpaid;
c) the day the Insured Person is covered under any other group vision plan as an employee or otherwise; however, this does not apply when the Insured Person is covered under a similar group plan which contains any preexisting condition limitations which apply to that person. Then, he or she may continue coverage under the Policy until the earlier of:
    1. the day the preexisting conditions limitation under the new group plan no longer applies; or
    2. the day continued coverage would otherwise end;

d) 18 months (or 29 months or 36 months as provided above) from the day your coverage ends under the Policy;
e) the day an Insured Person again becomes covered under the Policy;
f) the day an Insured Person is entitled to benefits under Medicare;
g) the day the Policy terminates.

Other Continuation Provisions

In the event insurance is continued under any other continuation provisions of the Policy, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which premium is paid in whole or in part by your employer, then the premium you are required to pay may increase for the remainder of the 18-month, 29-month, or 36-month period provided above.

PREMIUM PAYMENTS

PAYMENT OF PREMIUM THROUGH PAYROLL DEDUCTION

You are responsible for the payment of your share of the premium for insurance under the Policy. The premium owed by you equals the total of your share of the premium for all Insured Persons.

Premium is automatically deducted from your pay by the Policyholder, then remitted to us, as authorized by you during the enrollment process. Please contact the Policyholder for information regarding your deductions.

Payment of premium does not guarantee eligibility for coverage.

OPTIONS FOR PAYMENT OF PREMIUM FOR APPROVED CONTINUATION OF INSURANCE

When insurance is continued, we must receive premium payment when due for insurance to remain effective. Premium payment may be made in the following ways:

a) the Policyholder may pay the premium; or
b) you may pay premium to the Policyholder who will then submit premium to us.

Contact the Policyholder to determine which option is available to you.

Payment of premium does not guarantee eligibility for coverage.

GRACE PERIOD

There is a grace period of 31 days for payment of premiums. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 31-day period that follows. We will consider premium to be paid on the date we receive it.

Insurance will stay in force during the grace period as long as premium is paid before the end of the grace period. If we receive written notice requesting cancellation of insurance on a current or future date, the grace period will not apply. Coverage will end on the cancellation date specified in such notice, as long as the full premium has been paid up to that date.

If premium is not paid by the end of the grace period, insurance will end the day after the last day of the grace period.

PREMIUM AND PREMIUM CHANGES

The premium for insurance under the Policy is a monthly rate that applies to you and your Dependents.

If you request a change in the amount of insurance for any Insured Person, the Policyholder will provide you with notice of your new premium amount upon request if you are responsible for the payment of premiums for insurance.

If there is a change in the amount of the premium for insurance for any Insured Person in accordance with the terms of the Policy, or a change in the amount of insurance for any Insured Person as the result of a request of the Policyholder, the Policyholder will provide you with notice of the change at least 15 days prior to the date of the change if you are responsible for the payment of premium for insurance.

Premium amounts will change if premium rates under the Policy change.

CLAIMS PROVISIONS

CLAIM FORMS

Before benefits can be considered, we must be given written notice of claim. A claim form can be requested from your Provider, from us or obtained on our website. A request for a claim form should be made within 20 days after a Covered Service occurs or as soon as reasonably possible. If we do not provide a claim form within 15 days of the request, written proof of claim may by submitted that includes the nature, date, cause and extent of the Covered Services for which the claim is made.

You do not need to submit a claim form to us if services are received In-Network. If services are received Out-of-Network, you must submit a claim form to us.

PROOF OF CLAIM

Written proof must be given to us within 90 days from the date of service. If it is not reasonably possible to give us proof within the required time, we will not deny a claim filed for this reason if the proof is supplied as soon as reasonably possible, unless you are legally incapable.

We may require supporting information which may include, but is not limited to, clinical records, charts, x-rays, and other diagnostic aids.

INDEPENDENT EXAMINATION

We may require an Insured Person to be examined by a Provider as we direct to assist in determining whether benefits are payable. You may not impose any conditions on an examination such as pre-approval of the examiner, attendance of a third party or audio/video recording of the examination.

We will pay for these examinations; however, you may be responsible for fees associated with failure to notify the examination office of your appointment cancellation within the required amount of time specified by the examiner. We may recover this fee by reducing benefits that are payable. We will not require more than a reasonable number of such examinations.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form to:
First American Administrators, Inc.
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
First American Administrators, Inc.
P.O. Box 8504
Mason, OH 45040
Call Toll-Free: 1-833-279-4358

PAYMENT OF CLAIMS

Benefits will be paid immediately after we receive acceptable written notice of claim and any other required supporting information, but not later than 60 days after receipt of such notice or supporting information.

Benefits will be paid to the Provider if services are received In-Network. If services are received Out-of-Network, benefits will be paid to you, unless you or your Dependent have assigned benefits to the Provider.

Benefits unpaid at your death will be paid to:

a) any relative who is entitled to the benefits; or
b) your estate.

With each claim payment, we will provide you an explanation of benefits that includes the name of the Provider, services submitted, amount charged, dates of service and a reasonable explanation of the computation of benefits.

CLAIM REVIEW AND APPEAL PROCESS

Claim Review

We will notify the Claimant in writing of our decision to either approve or deny a claim within 30 days of the date it is received by us. If we deny a claim in whole or in part, we will explain the reasons for our denial in our notice. If the Claimant disagrees with the reasons given, the Claimant, or authorized representative of such person, may ask that we reconsider the claim through the appeal process.

Appeal Process

To appeal a denied claim, the Claimant must notify us and ask that we reconsider our original benefit decision within 180 days after receiving notice of our denial. The Claimant's appeal request must be submitted to us in writing and should state the reasons why the Claimant believes the claim denial was incorrect. Any additional information, documents or other materials that might allow us to change our original decision should also be included. Appeal requests must be sent to us at our address shown in the CLAIM ASSISTANCE provision.

The request for an appeal should include:

a) the Policyholder's name and the Policy number;
b) the patient's name and date of birth;
c) the date of service to be reviewed;
d) the Employee name, Member ID, and mailing address;
e) the name and address of the treating Provider; and
f) the reason for the appeal.

By requesting an appeal, you have authorized us, or anyone designated by us, to review any and all records (including medical/vision records) which may be relevant to your appeal.

We will notify the Claimant in writing of our final claim decision within 30 days after receiving the appeal request. If we need more time due to circumstances beyond our control, we will inform the Claimant of our need for an extension prior to the end of this time frame.

Notice

If the administration of the Policy is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the Claimant may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of a claim or to ask questions about the Claimant's rights under ERISA.

REFUND TO US

If it is found that we paid more benefits than we should have paid under the Policy, we will have the right to a refund from you or the recipient of benefits.

We also have a right to a refund for any payments due to:

a) fraud or misrepresentation;
b) any error we make in processing a claim;
c) you or your agent's failure to provide complete information; or
d) an Insured Person not being eligible for coverage.

You or the recipient of benefits must reimburse us in full. We will determine the method the repayment is to be made, including without limitation, reducing or withholding any benefits payable under this or any other group insurance policy issued by us. We will credit any such payments to the refund until the refund is fully recovered.

If it is found that we paid less benefit than we should have paid under the Policy, we will make additional payments, as necessary.

AUTHORITY TO INTERPRET POLICY

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

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, an Insured Person or any other third party. Our interpretation of the Policy as to the amount of benefits and eligibility will be binding and conclusive on all persons.

The Policyholder further grants us the authority to delegate to third parties, our affiliates and any third party administrator with whom we have contracted to provide claims administration and other administrative services, the discretionary authority granted in the Policy. The Policyholder expressly grants such third party the full discretionary authority granted to us under this Policy.

The Insured Person or beneficiary has the right to request a review of our decision. If, after exercising the Policy's review procedures, the Insured Person or beneficiary's claim for benefits is denied or ignored, in whole or in part, the Insured Person or beneficiary may file suit and a court will review the Insured Person or beneficiary's eligibility or entitlement to benefits under the Policy.

STANDARD PROVISIONS

INSURANCE CONTRACT

The insurance contract consists of:

a) the Policy (which includes this Certificate); and
b) the Policyholder's signed application attached to the Policy.

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 the consent of any Insured Person or beneficiary; and
b) must be:
    1. in writing;
    2. made a part of the Policy; and
    3. signed by one of our home office executive officers.

A change may affect any class of Insured Persons included in the Policy.

DELEGATION

We may delegate some of our obligations and responsibilities under the Policy, such as claims administration, network management and other administrative services, to a third party designated by us.

INCONTESTABILITY

We will not contest this Policy after it has been in force for two years during an Insured Person's lifetime, except for nonpayment of premium.

Statements in an application are considered representations and not warranties. We will not use any statements in an Insured Person's application to deny a claim or to contest the validity of this insurance unless we provide you, your beneficiary or legal representative with a copy of that application.

LEGAL ACTIONS

No legal action can be brought until at least 60 days after we have been given written notice of claim. No legal action can be brought more than six years after the date written notice of claim is required, unless otherwise required by state law in your state of residence.

CONFORMITY WITH STATE AND FEDERAL LAW

Any provision of the Policy which, on its effective date, is in conflict with the law of the federal government or the state in which an Insured Person resides on such date is hereby amended to conform to the minimum requirements of such law.

DEFINITIONS

The defined terms used in this Certificate and Policy are shown in this section. With the exception of *our, we, us, you, your* and *yourself*, we have capitalized these terms wherever they appear to make them easier for you to find.

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

Actively Working, *Active Work* means you are:

a) performing the normal duties of your job for the Policyholder on a regular and continuous basis 36 or more hours each week; and
b) receiving compensation from the Policyholder for work performed for the Policyholder.

You will be considered to be actively working on any day that is a regular paid holiday or day of vacation, or regular or scheduled non-working day, provided you were actively working on the last preceding regular work day.

Benefit Frequency means the period of time in which a benefit is payable. The benefit frequency begins on the later of the Insured Person's effective date or last date services were provided to the Insured Person. Each new benefit frequency begins at the expiration of the previous benefit frequency.

Certificate means this document that describes the benefits, terms, conditions, exclusions and limitations of the insurance provided under the Policy.

Claimant means the person who submits a claim for benefits for any Insured Person, including the authorized representative of such person.

Copayment means the designated amount, if any, shown in the Schedule each Insured Person must pay to a Provider before benefits are payable for a covered Vision Examination or Vision Materials each Benefit Frequency.

Covered Service means a vision examination or materials that are:

a) described in the Schedule as a covered examination or materials for which benefits are payable;
b) performed by a Provider; and
c) assigned a procedure code which is generally accepted by the vision insurance industry.

Dependent means a citizen, permanent resident or lawful resident of the United States who is:

a) your Spouse;
b) your natural born, legally adopted or foster child;
c) your stepchild (or child of your domestic partner, civil union partner or equivalent);
d) a child that you or your Spouse are required to provide insurance for under the terms of a decree, judgment or order issued by a court of competent jurisdiction;
e) any other child who lives with you in a regular parent/child relationship and who qualifies as your dependent as defined in the United States Internal Revenue Code; or
f) an Incapacitated person for whom you have been appointed legal guardian and who qualifies as your dependent as defined in the United States Internal Revenue Code.

A dependent does not include:

a) anyone insured as an Employee;
b) anyone who is a member of the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary duty of 31 days or less);
c) your divorced, legally separated, or former Spouse;
d) a child who has reached the age of 26, unless the child is Incapacitated;
e) your child if the child has been legally adopted by another person; or
f) a child placed in your home by a social service agency which retains control over the child.

Eligibility Waiting Period means a continuous period of Active Work that you must satisfy before becoming eligible for insurance as described in the WHEN YOU BECOME ELIGIBLE FOR INSURANCE (ELIGIBILITY WAITING PERIOD) provision.

Employee means a person who is:

a) a citizen or permanent resident of the United States; or
b) lawfully and legally able to work in the United States pursuant to applicable federal and state laws; and
c) receiving compensation from the Policyholder for work performed for the Policyholder at:
    1. the Policyholder's usual place of business;
    2. an alternative work site at the direction of the Policyholder; or
    3. a location to which the employee must travel to perform the job.

An employee does not include a person:
a) who resides outside the United States for a period in excess of 12 consecutive months unless written approval has been received from our authorized representative in our home office;
b) working for the Policyholder on a seasonal or temporary basis; or
c) performing services for the Policyholder as an independent contractor, including persons for whom income is reported on a 1099 form or subject to the terms of a leasing agreement between the Policyholder and a leasing organization.

First Enrollment Period means the 31-day period following the day you or your Dependent becomes eligible for insurance under the Policy or any Prior Plan.

Incapacitated means a Dependent that is continuously incapable of self-sustaining employment by reason of intellectual disability, developmental disability, mental illness, or physical disability.

In-Network means any benefit, service, or material furnished by a Provider who has agreed to accept a specific amount as payment in full for Covered Services through participation in the PPO.

Insured Person means you and/or your Dependent who is insured under the Policy.

Life Event means:
a) a change in your legal marital status (or domestic partnership, civil union partnership or equivalent);
b) a change in the number of your Dependents; or
c) a significant cost or coverage change under any employer or group sponsored vision plan under which you or your Dependents are covered.

Medically Necessary means contact lenses are necessary:
a) due to Keratoconus where vision is not correctable to 20/30 in either or both eyes using standard spectacle lenses, or the Provider attests to the specified level of visual improvement;
b) due to High Ametropia exceeding -10D or +10D in spherical equivalent in either eye;
c) due to Anisometropia of 3D in spherical equivalent or more; or
d) when vision can be corrected by two lines of improvement on the visual acuity chart when compared to a best corrected standard spectacle.

Our, We, Us means United of Omaha Life Insurance Company.

Out-of-Network means any benefit, service or material furnished by a Provider who does not participate in the PPO and has not agreed to accept a negotiated amount as payment in full for Covered Services.

Out-of-Area Provider means an Out-of-Network Provider that is utilized by an Insured Person when there is no In-Network Provider within 20 miles of the Insured's residence.

Plan Administrator means the person or entity designated as the plan administrator for the Policyholder's group vision insurance plan.

Policy means the group policy issued to the Policyholder by us, including this Certificate.

Policyholder means JDC Management, Humanities Foundation & Quantum Builders.

Policy Anniversary means December 1 of each Policy Year.

Policy Effective Date means December 1, 2020.

Policy Year means the period of January 1 through December 31.

Prior Plan means any similar insurance policy:

a) replaced by insurance under part or all of the Policy; and
b) in effect and maintained or sponsored by the Policyholder on the day before the Policy Effective Date.

Preferred Provider Agreement means an agreement between the PPO and Provider that contains the rates and reimbursement methods for Covered Services provided by such Provider.

Preferred Provider Organization ("PPO") means a network of Providers and retail chain stores that has signed a Preferred Provider Agreement.

Provider means a licensed physician or optometrist who is operating within the scope of his or her license or a dispensing optician.

Qualified Beneficiary means any individual who, on the day before the qualifying event, is an Insured Person under the Policy. Qualified Beneficiary also includes a child who is born or is placed for adoption with you during the period of continued coverage.

Spouse means the person to whom you are legally married. Spouse also includes your domestic partner, civil union partner, reciprocal beneficiary, or equivalent, as recognized and allowed by law in your jurisdiction of residence.

Subsequent Enrollment Period means any period designated for enrollment by the Policyholder and agreed to in writing by our authorized representative in our home office.

Vision Examination means any eye or visual examination covered under the Policy and shown in the Schedule.

Vision Materials means lenses, frames and contact lenses as shown in the Schedule.

Written Request means a request that is signed, dated and submitted to the Policyholder or us. The request must be on a form we supply or be in a form and content acceptable to us.

You, Your means the Employee who may be eligible or insured under the Policy.

Group Vision Benefits

JDC Management, Humanities Foundation & Quantum Builders

Group Number: G000BT79

United of Omaha Life Insurance Company

Home Office:
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175