
**YOUR GROUP LIFE AND
ACCIDENTAL DEATH AND
DISMEMBERMENT
BENEFITS**

New Prime, Inc., D/B/A Prime, Inc.

All eligible office and shop employees

Effective February 1, 2003

READ YOUR POLICY CAREFULLY CERTAIN WAR, AVIATION RISKS ARE NOT ASSUMED
IN CASE OF ANY FURTHER DOUBT, WRITE YOUR COMPANY FOR FURTHER
EXPLANATION

HOW TO OBTAIN PLAN BENEFITS

To obtain benefits see the Payment of Claims provision.

Forward your completed claim form to:

New Prime, Inc., D/B/A Prime, Inc.
2740 N. Mayfair
Springfield, MO 65803

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
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805

NOTICE

If any questions or problems arise regarding this insurance, you may contact the Company at:

United of Omaha Life Insurance Company
Kansas City Group Office
Southcreek Office Park, Building 12A
7200 W. 132nd Street, Suite 280
Overland Park, KS 66213
Telephone: 1-913-685-0233

When contacting the Company please have your policy number available. Your policy number is GLUG-87F4.

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appear in the following order.

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office: Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy No. GLUG-87F4 (Policy) has been issued to New Prime, Inc., D/B/A Prime, Inc. (Policyholder).

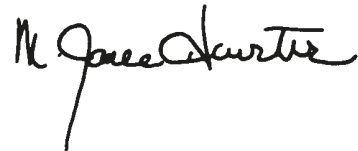
Insurance is provided for certain employees as described in the policy.

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

UNITED OF OMAHA LIFE INSURANCE COMPANY



President



Secretary

DEFINITIONS

When used in the policy or your certificate:

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

You, Your, Insured Person means an employee or member who is insured under the policy.

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

Injury means an accidental bodily injury which requires treatment by a physician. It must result in loss independently of sickness and other causes.

Physician means any of the following licensed practitioners:

- (a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
- (b) a licensed doctoral clinical psychologist;
- (c) a MasterTMlevel counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist;
- (d) a licensed physicianTMassistant (PA); or
- (e) where required to cover by law, any other licensed practitioner who is acting within the scope of his/her 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).

Total Disability or Totally Disabled means that because of an injury or sickness you are completely and continuously unable to perform the material and substantial duties of your regular occupation.

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

EMPLOYEE ELIGIBILITY

Life Insurance

Definitions

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

Active Employment or **Actively Employed** means Actively Working on a regular and consistent basis for the Policyholder 30 or more hours each week.

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

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

An Employee will be considered Actively Working on any day that is:

- (a) a regular paid holiday or day of vacation;
- (b) a regular or scheduled non-working day; or
- (c) a day on which the Employee is on a qualified family or medical leave of absence as defined by the Family and Medical Leave Act of 1993;

provided the Employee was Actively Working on the last preceding regular work day.

If an EmployeeTMs customary place of employment is at home, the Employee will be considered Actively Working if not confined on that day as described in the Confinement Rule.

Confinement Rule

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

- (a) in a hospital as an inpatient;
 - (b) in any institution or facility other than a hospital; or
 - (c) at home and under the supervision of a Physician;
- insurance will begin on the day the Employee returns to Active Work.

2. If an eligible Employee is not:

- (a) confined; and
 - (b) available for work because of an Injury or Sickness;
- insurance will begin on the day the Employee returns to Active Work.

Employee means a person who receives compensation from the Policyholder for work performed for the Policyholder.

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

- (a) subject to the terms of a leasing agreement between the Policyholder and a leasing organization;
- (b) who receives income which is reported by the Policyholder on IRS form 1099;
- (c) on a seasonal basis; or
- (d) on a temporary basis.

Eligible Employees

An Employee who has completed one month of continuous Active Employment on or before February 1, 2003 becomes eligible for insurance under this Policy on February 1, 2003.

An Employee who is not eligible for insurance under this Policy on February 1, 2003 becomes eligible the first Saturday following completion of one month of continuous Active Employment. An Employee who is hired after February 1, 2003 becomes eligible on the first Saturday following completion of one month of continuous Active Employment.

When Insurance Begins

An eligible Employee must request insurance by:

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

If We receive an EmployeeTM properly completed and signed enrollment form on or within 31 days following the day the Employee becomes eligible, the Employee will become insured on the later of:

- (a) the day the Employee becomes eligible; or
- (b) the date the enrollment form is properly completed and signed by the Employee, provided the Employee is Actively Working on that day. If the Employee is not Actively Working on that day, insurance will begin on the day the Employee returns to Active Work.

Evidence of Good Health

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

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

Reinstatement of Insurance

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

- (a) If insurance ended because the eligible Employee voluntarily let insurance lapse, the Employee must provide evidence of good health to Us. If such evidence is acceptable to Us, We will determine the day insurance begins.
- (b) If insurance ends because the Employee is on a family or medical leave of absence allowed by federal or state law, and the Employee becomes eligible again immediately following the maximum leave of absence period allowed by that law, insurance will be reinstated in accordance with that law.

When Your Classification or the Amount of Insurance Changes

Any change in Your classification, coverage or amount of Your insurance as shown in the **Schedule** will take effect on the day of the change, provided You are Actively Working on that day. We will use the Policyholder™ payroll records and premiums We have received to determine the appropriate amount of insurance. If You are not Actively Working on that day, the following conditions will apply:

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

When Your Insurance Ends

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

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

Continuation of Life Insurance and Accidental Death and Dismemberment Benefits

Upon uninterrupted payment of premium to Us, You may continue insurance in accordance with this provision after insurance would otherwise end. You should contact the Policyholder to determine the amount of contribution, if any, You are required to make in order to continue insurance.

Layoff or Leave of Absence

Your insurance will continue until the last day of the month in which You have been laid off or go on a leave of absence approved by the Policyholder.

Disability Elimination Period

Your insurance will continue during the Disability Elimination Period as long as You remain Totally Disabled. The Disability Elimination Period is the nine consecutive months of Total Disability beginning on the date You first become Totally Disabled.

If Your employment or membership in a class ends, or if this Policy or a class terminates during Your Disability Elimination Period, You may apply for an individual life insurance conversion policy according to the terms of the **Conversion Privilege** provision in this Policy. If Your proof of Total Disability is accepted by Us in accordance with the **Continuation of Life Insurance Benefits Due to Total Disability** provision, You may surrender Your conversion policy and premiums paid for such policy will be refunded.

If You die during the Disability Elimination Period, and We determine that You were Totally Disabled on the day before the date of Your death, benefits under this Policy will be paid to Your beneficiary. If a conversion policy has been issued to You, We will pay benefits under the **Continuation of Life Insurance Benefits Due to Total Disability** provision:

- (a) upon Our acceptance of Your proof of Total Disability in accordance with the **Continuation of Life Insurance Benefits Due to Total Disability** provision; and
- (b) upon Your death during the Disability Elimination Period,

only if the conversion policy is surrendered or terminated without claim. We will refund all paid conversion policy premiums if Your conversion policy is surrendered or terminated for this reason.

After completing the Disability Elimination Period, You may continue Your insurance in accordance with the **Continuation of Life Insurance Benefits Due to Total Disability** provision.

If You are eligible for continuation of Life Insurance Benefits during the Disability Elimination Period, Accidental Death and Dismemberment Benefits will be continued under the same conditions as for Life Insurance Benefits; however, Accidental Death and Dismemberment Benefits shall automatically terminate on the earlier of:

- (a) the completion of the Disability Elimination Period; or
- (b) the date You are no longer Totally Disabled.

Continuation of Life Insurance Benefits Due to Total Disability

If You are Totally Disabled, Your Life Insurance Benefits will not end in accordance with the **When Your Insurance Ends** provision, but will be continued without payment of premium provided:

- (a) the Total Disability began while You were insured under this Policy;
- (b) the Total Disability began before You reached age 60;
- (c) You have completed Your Disability Elimination Period; and
- (d) Proof of the Total Disability is given to Us as described in the following paragraphs.

You must notify Us in writing of Your Total Disability during the Disability Application Period. The Disability Application Period is the nine consecutive months of Total Disability beginning on the date You first become Totally Disabled. After receiving Your notification, We will send You an Initial Proof of Total Disability form for You and Your Physician to complete. You must return this form to Us within 90 days after receipt. Upon Our satisfactory acceptance of Your initial proof of Total Disability, Your Life Insurance Benefits will continue without payment of premium for at least one year as long as You continue to be Disabled.

After You have completed Your Disability Elimination Period, We will periodically send You a Subsequent Proof of Disability form for You and Your Physician to complete. If Your Subsequent Proof of Disability is not acceptable to Us, You will be notified in writing, otherwise Your Life Insurance Benefits will be continued without payment of premium for at least one year, as long as You continue to be Disabled.

In order to confirm that You are Totally Disabled, We have the right to have You examined by a Physician of Our choice at Our expense. We may have You examined any time during the first two years of disability and once a year thereafter.

Your continued Life Insurance Benefits is the amount of insurance in force on the day insurance would have otherwise ended. However, continued Life Insurance Benefits provided under this **Continuation of Life Insurance Benefits Due to Total Disability** provision shall be reduced or terminated in accordance with the terms of the **Schedule**.

When Continuation of Life Insurance Ends Total Disability

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

- (a) the day You are no longer Totally Disabled;
- (b) 90 days after an Initial or Subsequent Proof of Total Disability form is sent to You, but not returned to Us;
- (c) the day You fail to attend an examination or cooperate with an examiner in accordance with the **Continuation of Life Insurance Benefits Due to Total Disability** provision; or
- (d) the day You reach age 65.

When Your Total Disability ends, You have 31 days to convert Your insurance to an individual life insurance conversion policy; but Your conversion insurance will end if You again become insured under this Policy. A conversion policy may only be obtained in accordance with the **Conversion Privilege** provision in this Policy.

Layoff or Leave of Absence

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

- (a) the day this Policy ends;
- (b) the day any premium contribution for Your insurance is due and unpaid;
- (c) the day before You enter the Armed Forces on active duty (except for temporary active duty of two weeks or less);
- (d) the day You return to Active Employment or begin employment with an employer other than the Policyholder; or
- (e) on the last day of the month in which You have been laid off or go on a leave of absence approved by the Policyholder.

EXTENDED LIFE INSURANCE RIDER

This Rider is made a part of Group Policy GLUG-87F4.

This Rider is effective the later of February 1, 2003, or the day You become insured under the Policy.

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

Extended Life Insurance

In the event the Policy ends during any Continuance of Life Insurance Benefits Due to Total Disability provision of the Policy, Your group life insurance will not end until the earlier of:

- (a) the date Total Disability ends; or
- (b) the expiration of any period of time shown in such continuance provision, subject to any requirement that You:
 - (1) submit proof of continued disability; and
 - (2) be examined by a Physician of Our choice.

RIDER
FAMILY AND MEDICAL LEAVE

as Federally Mandated

This rider is made a part of Group Policy GLUG-87F4.

This rider is effective on the later of:

- (a) the effective date of the policy; or
- (b) the date required by Federal law.

If the provisions of this rider and those of the policy or Your certificate do not agree, the provisions of this rider will apply.

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

1. 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.

2. You are eligible to continue coverage under FMLA if:
 - (a) You have worked for Your employer for at least one year;
 - (b) You have worked at least 1,250 hours over the previous 12 months;
 - (c) Your employer employs at least 50 employees within 75 miles from Your worksite; and
 - (d) You continue to pay any required premium for yourself and any eligible dependents (if applicable) in a manner determined by Your employer.
3. 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.
4. 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.
5. If requested by Us, You or Your employer must submit proof acceptable to Us that Your leave is in accordance with FMLA.
6. This FMLA continuation is concurrent with any other continuation option except for COBRA, if applicable.
7. FMLA continuation ends on the earliest of:
 - (a) the day You return to work;
 - (b) the day You notify Your employer that You are not returning to work;
 - (c) the day Your coverage would otherwise end under the policy; or
 - (d) 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.

THE DEFINITIONS, GENERAL EXCLUSIONS AND 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(s)

All eligible office and shop employees

**For You
LIFE INSURANCE**

Life Insurance Benefits

Amount of Life Insurance.....\$15,000
 Facility of Payment Amount.....*\$2,000

*This amount, if paid, will be deducted from the Amount of Life Insurance shown above.

Life Insurance Benefits will be reduced as follows:

If you are age:	The Amount of Life Insurance shown above will reduce to:
65	65%
70	45%
75	30%
80	20%
85	15%
90	10%

The reduction will be made on the day you attain the specified age.

If you are age 65 or older on the day you become insured under the policy, the reduction will be made in accord with your attained age.

Life Insurance Benefits end on the date of your retirement.

NOTE: The Amount of Life Insurance outlined above will be reduced by the Amount of Living Benefits paid under the Living Benefits Option. In the event of your death, the life insurance benefit will equal the original Amount of Life Insurance multiplied by the life reduction percentage, reduced by any Living Benefits paid under this policy.

Life Insurance Benefits

Living Benefits Option

Amount of Living Benefits..... 50% of the amount of life insurance in force on your life, but not to exceed \$100,000.

**HEALTH INSURANCE
(For You)**

Accidental Death and Dismemberment Benefits

Principal Sum An amount equal to the Amount of Life Insurance in force on your life; however, if your Life Insurance Benefit has been reduced by the Living Benefits Option, such reduction will not apply to this Accidental Death and Dismemberment Principal Sum.

LIFE INSURANCE BENEFITS

For You

Benefits

If you die while insured under this provision, we will pay the **Amount of Life Insurance** shown in the **Schedule**. Benefits will be paid to the beneficiary you name. If you do not name a beneficiary or if no beneficiary survives you, benefits will be paid:

- (a) to your surviving spouse; if none, then
- (b) to your surviving natural and/or adopted children; if none, then
- (c) to your surviving parent(s); if none, then
- (d) to your estate.

Benefits will be paid equally among surviving children or surviving parents.

Mode of Payment

We will pay benefits:

- (a) in a lump sum; or
- (b) in other than a lump sum if:
 - (1) another mode of payment is requested as described below; and
 - (2) we agree to it in writing.

Beneficiary or Mode of Payment Change

The beneficiary and mode of payment may be changed unless this right has been given up. To make a change, written request should be sent to the office where the beneficiary records are kept. If you do not know where the records are kept, send the request to us. When recorded and acknowledged, the change will take effect as of the date the request is signed. However, the change will not apply to any payments or other action taken by us before the request was acknowledged.

Facility of Payment

We may pay up to the Facility of Payment Amount to any person who has incurred expenses for your fatal illness or burial. The **Facility of Payment Amount** is shown in the **Schedule**.

We may also make monthly payments of not more than \$50.00 to someone other than a beneficiary if:

- (a) the beneficiary is a minor or, in our opinion, does not have the legal capacity to sign a receipt for payment; and
- (b) there is no court-appointed guardian or conservator.

We will make these payments to the person or institution who cares for or supports the beneficiary until claim is made for the remainder of the proceeds by a court-appointed guardian or conservator.

Conversion Privilege

If any of your life insurance ends because your employment or membership in a class ends, you may apply for an individual policy of life insurance (called a conversion policy) without giving information about your health. Issuance of a conversion policy is subject to the following conditions:

- (a) You may apply for any of our individual life insurance policies except term insurance. You may not apply for any supplemental coverage.
- (b) You may apply for an amount which is not more than the amount of your terminated group life insurance.
- (c) The premium for your conversion policy will be at our standard rate for that type of policy according to:
 - (1) your class of risk; and
 - (2) your age on the date the policy takes effect.
- (d) You must submit your written application and your first conversion premium to us within 31 days after your group life insurance ends or reduces.

If your group life insurance ends because of termination of the policy or termination of a class, and you have been insured under the policy at least five years, you may apply within 31 days for a conversion policy. Issuance of the conversion policy is subject to conditions (a), (c) and (d) above. Your converted life insurance may not exceed the lesser of:

- (a) \$10,000.00; or
- (b) the amount of your terminated group life insurance less the amount of any other group life insurance for which you become eligible within 31 days.

If you die within the 31-day period after insurance ends, we will pay the amount of group life insurance you were entitled to convert.

If we issue a conversion policy and you again become eligible for group life insurance under the policy, coverage will become effective only if:

- (a) you terminate the conversion policy; or
- (b) you submit, at your own expense, evidence of good health acceptable to us.

RIDER

This rider is made a part of Group Policy GLUG-87F4.

This rider is effective the later of February 1, 2003, or the day You become insured under the Policy.

If the provisions of this rider and those of the policy or your certificate do not agree, the provisions of this rider will apply.

This provision applies only to the Life Insurance provisions of the policy.

1. The following is made a part of the Life Insurance Benefits provision:

Exception

No benefits are payable for loss incurred while an insured person is in the Armed Forces on active duty.

2. Any provision of the policy which terminates eligibility for life insurance because of entry into the Armed Forces on active duty is deleted.

LIFE INSURANCE BENEFITS

For You

LIVING BENEFITS OPTION

(ACCELERATED BENEFITS)

Benefits

If you incur a Terminal Condition while insured under this provision, you or your legal representative, while you are living, may request Living Benefits. The **Amount of Living Benefits** is shown in the **Schedule**, and will be payable provided you are living at the time payment is made. Benefits will be paid in one lump sum.

Conditions

1. To be insured for Living Benefits, you must be insured for Life Insurance Benefits.
2. We may require your beneficiaryTM and in community property states, your spouseTM written consent before Living Benefits are paid.
3. Your Life Insurance Benefits and the amount you may convert in accordance with the life Conversion Privilege will be reduced by the Living Benefit amount paid under this provision.
4. An insured person may receive Living Benefits only once.

Definition

Terminal Condition means an injury or sickness:

- (a) expected to result in your death within 12 months; and
- (b) from which there is no reasonable prospect of recovery;

as determined by us, our medical staff, or a qualified party selected by us.

Exceptions

This Living Benefits provision will not apply:

- (a) when you have irrevocably assigned your Life Insurance Benefits;
- (b) when all or a portion of your Life Insurance Benefits are to be paid to your former spouse as part of a divorce agreement;
- (c) to any intentionally self-inflicted injury or suicide attempt while sane;
- (d) if your Life Insurance ends;
- (e) if the required premium is due and unpaid;
- (f) to any supplemental life insurance benefits to which you may be entitled; or

(g) if the Master Policy ends.

NOTE: Benefits paid under this provision may be taxable. If so, you or your beneficiary may incur a tax obligation. As with all tax matters, you should consult your personal tax advisor to assess the impact of this benefit.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

For You

Benefits

If, while insured under this provision, You are injured as a result of an Accident, and that Injury is independent of Sickness and all other causes, We will pay the Benefit shown in the Table below for any of the following losses:

TABLE

<u>Loss</u>	<u>Benefit</u>
Loss of Life	Principal Sum
Loss of Both Hands	Principal Sum
Loss of Both Feet	Principal Sum
Loss of Entire Sight of Both Eyes	Principal Sum
Loss of Entire Sight of One Eye	One-half Principal Sum
Loss of One Hand and One Foot	Principal Sum
Loss of One Hand and Entire Sight of One Eye	Principal Sum
Loss of One Foot and Entire Sight of One Eye	Principal Sum
Loss of Thumb and Index Finger of same Hand	One-fourth Principal Sum
Loss of Speech and Hearing (both ears)	Principal Sum
Loss of Speech or Hearing (both ears)	One-half Principal Sum
Loss of One Hand or One Foot	One-half Principal Sum

The **Principal Sum** is shown in the **Schedule**.

If the Injury causes more than one loss, We will pay only the **largest** Benefit.

Definitions

Accident means a sudden, unexpected and unintended event, independent of sickness and all other causes. Accident does not include sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. Accident does include bacterial infections that result from the accidental ingestion of contaminated substances and pyogenic infections that result from an accidental bodily injury.

Loss of a Hand or Foot means complete Severance of at least four whole fingers from one hand or Severance above the ankle joint.

Loss of Sight means the total, permanent Loss of Sight of the eye. The Loss of Sight must be irrecoverable by natural, surgical or artificial means.

Loss of Speech means total, permanent and irrecoverable loss of audible communication.

Loss of Hearing means total and permanent Loss of Hearing in both ears which cannot be corrected by any means.

Loss of a Thumb and Index Finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

Severance means the complete separation and dismemberment of the part from the body.

Traveling on Business of the Policyholder means any trip made by You on assignment by or with authorization of the Policyholder for the purpose of furthering the business of the Policyholder.

Payment For Loss of Life
Beneficiary

Benefits payable under this provision because of Your death, will be paid to the beneficiary You name. If You do not name a beneficiary or if no beneficiary survives You, benefits will be paid:

- (a) to Your surviving spouse; if none, then
- (b) to Your surviving natural and/or adopted children; if none, then
- (c) to Your surviving parent(s); if none, then
- (d) to Your estate.

Benefits will be paid equally among surviving children or surviving parents.

Mode of Payment

We will pay death benefits:

- (a) in a lump sum; or
- (b) in other than a lump sum if:
 - (1) another mode of payment is requested as described below; and
 - (2) We agree to it in writing.

Beneficiary or Mode of Payment Change

The beneficiary and mode of payment may be changed unless this right has been given up. To make a change, written request should be sent to the office where the beneficiary records are kept. If You do not know where the records are kept, send the request to Us. When recorded and acknowledged, the change will take effect as of the date the request is signed. However, the change will not apply to any payments or other action taken by Us before the request was acknowledged.

Payment For Other Than Loss Of Life

Benefits payable under this provision for any loss other than life will be paid to You in a lump sum.

Exposure and Disappearance

You will be presumed to have died, for the purposes of this coverage, if after the forced landing, stranding, sinking or wrecking of a vehicle:

- (a) You disappear;
- (b) Your body is not found; and
- (c) a valid death certificate is issued by a court of appropriate jurisdiction.

This benefit is paid in addition to the Principal Sum.

In no event will this benefit exceed the Maximum Common Carrier Benefit shown in the Schedule.

Exceptions

We will not pay for any loss which:

- (a) is not permanent;
- (b) occurs more than 365 days after the Injury;
Note: This 365 day limit will not apply if You are in a coma or being kept alive by an artificial support system at the end of the 365 days.
- (c) does not result from an Accident;
- (d) is caused by intentional, self-infliction of carbon monoxide poisoning emanating from a motor vehicle;
- (e) results from injuries You receive in any aircraft other than while riding as a passenger in a commercial aircraft on a regularly scheduled flight; or while:
 - (1) operating;
 - (2) riding as a passenger in; or
 - (3) boarding or leaving

any aircraft while You are Traveling on Business of the Policyholder, provided the aircraft:

- (1) has a current and valid FAA (Federal Aviation Administration of the United States) standard air worthiness certificate; and
 - (2) is operated by a person holding a current and valid FAA pilotTM certificate of rating authorizing him or her to operate the aircraft;
- (f) results in injuries You receive while riding in any aircraft engaged in:
 - (1) racing;
 - (2) endurance tests; or
 - (3) acrobatic or stunt flying; or
 - (g) is caused by You, and is a result of injuries You receive, while under the influence of any Controlled Drug, unless administered on the advice of a Physician;

Note: Controlled Drug means any drug having the capacity to affect behavior and regulated by law with regard to possession and use.

(h) is caused by You, and is a result of injuries You receive, while Intoxicated;

Note: Intoxicated means Your blood alcohol level at death or dismemberment equals or exceeds the legal limit for operating a motor vehicle in the jurisdiction in which the loss occurs; or

(i) is excluded under the General Exclusions and Limitations.

GENERAL EXCLUSIONS AND LIMITATIONS

These General Exclusions and Limitations do not apply to any Life Insurance Benefits provisions.

We do not pay under the Accidental Death and Dismemberment Benefits provisions for:

- (a) any loss which results, while the insured person is sane, from:
 - (1) an intentionally self-inflicted injury or sickness; or
 - (2) suicide or attempted suicide;
- (b) any loss resulting from the insured personTM participation in a riot or in the commission of a felony;
- (c) any loss which results from an act of declared or undeclared war or armed aggression; or
- (d) any loss:
 - (1) which is incurred while the insured person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country (upon notice to the Company of entry into such service, the pro rata unearned premiums shall be refunded); and
 - (2) for which any governmental body or its agencies are liable.

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. If a physician must complete part of the claim form, have the physician complete and sign that part.
3. Finally, return the claim form to the Plan Administrator or to us. The claim form is due:
 - (a) within 90 days after the loss occurs; or
 - (b) as soon as reasonably possible, but not later than one year after (a) above, unless the claimant is not legally capable.

When Claims are Paid

Policy benefits will be paid as soon as we receive acceptable proof of loss.

Direct Payments

Any loss of life benefit will be paid in accord with the Life Insurance Benefits and/or Accidental Death and Dismemberment Benefits provision(s).

Any other benefits will be paid to you except that benefits unpaid at your death may be paid, at our option to:

- (a) your beneficiary; or
- (b) your estate.

If your beneficiary is unable to give a valid release or if benefits unpaid at your death are not more than \$2,000, we may pay up to \$2,000 to any relative of yours who we find is entitled to the benefit.

Any payment made in good faith will fully discharge us to the extent of the payment.

Examination and Autopsy

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. Where not prohibited by law, we may also require an autopsy. We will pay for this autopsy.

CLAIM REVIEW AND APPEAL PROCEDURES

(As Federally Mandated)

For Group Policy GLUG-87F4, this provision is effective the later of:

- (a) the effective date of the Policy; or
- (b) the date required by Federal law.

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 the person submitting the claim of the extension and the circumstances requiring the extension. Extensions are limited as set forth below.

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

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

We may contact the person submitting the claim at any time for additional details about the processing of the claim.

Claim Review Decisions

- (a) Initial review: We will notify the person submitting the claim of Our claim decision within 45 days after Our receipt of the 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 the person submitting the claim within 30 days of Our receipt of the claim. Once Our request for additional information is received, the person submitting the claim 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.

Claim Denials

If a claim is denied or partially denied, the person submitting the claim will receive a written or electronic notice of the denial that 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 the right to request an appeal within 180 days and the 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.

Opportunity To Request An Appeal

The person submitting the claim may appeal Our claim review decision in accordance with this Claim Review and Appeal Procedures provision. As part of the appeal, We will perform a full and fair review of the decision.

The request for an appeal can be submitted to Us in writing, electronically, or orally and should include any additional information that the person submitting the claim believes should have been considered by Us.

The request for an appeal should include:

- (a) the name of the person for whom the claim has been submitted;
- (b) the name of the person filing the appeal;
- (c) the policy number; and
- (d) the nature of the appeal.

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

The person submitting the claim will:

- (a) have 180 days from receipt of notification to submit a request for an appeal;
- (b) be provided the opportunity to submit written comments, documents, records and other information relating to the claim; and
- (c) be provided, upon request and free of charge, reasonable access to and copies of documents, records and other information relevant to the claim.

In reviewing the appeal, We will consider all comments, documents, records and other information submitted without regard to whether such information was submitted or considered in the claim decision.

A request for an appeal authorizes Us, or anyone designated by Us, to review records relevant to the claim.

Our Response To An Appeal

Once We receive a request for an appeal, We will respond within 45 days, unless additional information is requested. If additional information is requested, the following extensions apply:

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

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

When We make Our decision, the person submitting the claim will be provided with:

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

STANDARD PROVISIONS

Insurance Contract

The insurance contract consists of:

- (a) the policy;
- (b) the Policyholder™ 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™ consent; and
- (b) must be:
 - (1) in writing;
 - (2) made a part of the policy; and
 - (3) signed by one of our officers.

A change may affect any class of insured persons, including retirees if retiree coverage is included in the policy.

Applications

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

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
New Prime, Inc., D/B/A Prime, Inc.

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 fiPlan.fl

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.	43-1396933	P.N.	501
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PLAN ADMINISTRATOR

The Plan is provided through and administered by:

New Prime, Inc., D/B/A Prime, Inc.
2740 N. Mayfair
Springfield, MO 65803
Phone: (417) 866-0001

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 fiPolicyfl). 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 companyTMhome office is located at Mutual of Omaha Plaza, Omaha, NE 68175.

AGENT FOR SERVICE OF LEGAL PROCESS

New Prime, Inc., D/B/A Prime, Inc.
2740 N. Mayfair
Springfield, MO 65803
Phone: (417) 866-0001

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

PLAN YEAR

Each 12-month period beginning on February 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 Employee Benefits Security 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security 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 Employee Benefits Security Administration.

PLAN DISCLOSURES

You are entitled to request from the Plan Administrator, without charge, information applicable to the PlanTM 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 PolicyholderTM 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^{fl} 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.

Group Policy Number GLUG-87F4



Mutual of Omaha