United of Omaha Life
Insurance Company
A Mutual of Omaha Company
3300 Mutual of Omaha Plaza | Omaha, NE 68175

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

This Policy is issued to **Aristocrat Technologies, Inc.** (the "Policyholder").

This Policy is a legal contract between the Policyholder and us. It is issued in consideration of payment of premiums and the Policyholder's application. **PLEASE READ THIS POLICY CAREFULLY.**

This Policy will be interpreted under the Employee Retirement Income Security Act of 1974, as amended (ERISA). This Policy is issued in the State of Nevada. To the extent state law is not preempted by ERISA, and only to that extent, this Policy will also be interpreted under the law of the State of Nevada, without giving effect to the principles of conflicts of law of that state or any other state, territory or district. Any part of this Policy which is in conflict with the applicable laws of the State of Nevada is changed to conform to the minimum requirements of that state's laws.

This Policy is effective January 1, 2020 at the Policyholder's main office.

We agree to pay benefits subject to the terms, conditions, and limitations of this Policy.

The Certificate is made a part of this Policy.

GROUP POLICY NO. GVTL-BML6

As Revised: January 1, 2025

Publication Date: October 8, 2024

UNITED OF OMAHA LIFE INSURANCE COMPANY

James T. Blackledge
Chief Executive Officer

Jayd Vankat
Corporate Secretary

GENERAL PROVISIONS

Capitalized terms are defined in the Certificate or other documents made a part of this Policy.

PREMIUM CHANGES

We reserve the right to change premium rates any time after:

a) the most recent premium rate guarantee date described in this Policy;
b) there is an increase or decrease of 10% or more in the Policyholder's Employee population or the number of Employees insured under this Policy*;*
c) our liability or cost of administration is changed due to a change in federal, state, or local law, statute or regulation;
d) this Policy's terms are changed;
e) coverage is reinstated following the Policyholder's failure to pay premium during the grace period;
f) a division, subsidiary, associated company, affiliated company or an eligible class is added to or deleted from this Policy;
g) we decide to non-renew a class of business; or
h) there is a change which materially affects the risk for insurance provided by this Policy.

We must give the Policyholder at least 90 days advance written notice of any premium rate change.

PAYMENT OF PREMIUMS

The premium for this Policy equals the sum of the individual premiums for each Insured Person as described in the Premium Rider. The first premium is due on the effective date of this Policy. Subsequent premiums are due on the first day of each subsequent month or other modal period agreed to in writing by an authorized representative in our home office. Premium payments must be made to our home office or to a location we designate, using a payment method we accept. We will consider premium to be paid on the date we receive it.

GRACE PERIOD

There is a grace period of 45 days for payment of premium. 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 45-day grace period that follows. We 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 on the premium due date.

TERMINATION

Following at least 60 days advance written notice to the Policyholder, we have the right to terminate this Policy if:

a) the number of Employees insured is less than 10 or less than 25% of those eligible for insurance;
b) the Policyholder does not perform one or more of its duties under this Policy;
c) the Policyholder relocates to a state where this Policy is not marketed;
d) our liability or cost of administration is changed due to a change in federal, state, or local law, statute or regulation;
e) there is an increase or decrease of 15% or more in the Policyholder's Employee population or the number of Employees insured under this Policy*;*
f) a division, subsidiary, associated company, affiliated company or an eligible class is added to or deleted from this Policy;
g) we decide to non-renew a class of business; or
h) there is a change which materially affects the risk for insurance provided by this Policy.

The Policyholder has the right to terminate this Policy at any time. The Policyholder must give us reasonable advance written notice before the date this Policy is to terminate, unless the Policyholder gives us written notice that this Policy will terminate during the grace period.

This Policy will automatically terminate on the premium due date if the Policyholder fails to pay its portion of the premium.

If this Policy terminates for any reason:

a) all unpaid premiums up to the date of termination are due, including premiums for the grace period or any part of the grace period; and
b) all unpaid premiums are due no later than the date of termination.

Termination of this Policy will not affect benefits otherwise payable for a claim incurred while this Policy is in force.

REINSTATEMENT AFTER TERMINATION

If this Policy terminates for any reason, the Policyholder may request to reinstate it. We will reinstate only if:

a) an authorized representative in our home office agrees in writing to reinstate this Policy;
b) the Policyholder agrees in writing to accept any written conditions of reinstatement that we impose;
c) all past due premiums are paid, including any premium for the time insurance was in effect during the grace period; and
d) the premium due from the date of reinstatement until the next premium due date is paid.

CERTIFICATES

We will electronically issue the Policyholder a Certificate form for delivery by the Policyholder to each Insured Person. The Certificate describes the benefits, terms, conditions, exclusions and limitations of the insurance provided under this Policy.

ENTIRE CONTRACT AND CHANGES

The entire contract of insurance consists of this Policy, the Certificate, the Policyholder's signed application, any supplemental applications made part of the Certificate, any riders and any endorsements.

This insurance contract may be changed any time we and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. No change in this Policy will be effective until approved by our authorized representative in our home office. Such approval must be in writing and attached to and made a part of this Policy.

MISSTATEMENT OF AGE OR GENDER

If an Insured Person's age or gender is misstated, we may adjust the premium or the benefits payable. An adjustment of the benefits payable will be based on what the premium would have purchased at the correct age or gender.

INCONTESTABILITY

We will not contest this Policy after it has been in force two years, except for nonpayment of premium.

POLICYHOLDER RESPONSIBILITIES

The Policyholder will notify:

a) list billed classes - both the Insured Person and us when the Insured Person's insurance under this Policy ends if the Insured Person ceases to be eligible for insurance under this Policy;
b) each Insured Person and us when insurance under this Policy ends if this Policy is terminated and is not replaced by another policy or plan with no interruption in coverage; and
c) list billed classes - us when the amount of insurance coverage for which an Insured Person is eligible changes.

Notice shall be provided within 31 days from the date insurance ends or, for any list billed classes, the amount of insurance coverage changes for the Insured Person. Notice to the Insured Person shall include information about any options available to continue or obtain insurance.

If we do not receive notice under a) above within this 31 day time period, we may require the Policyholder to reimburse us for the amount of any claims paid on behalf of any ineligible person and/or any dependents of such person during the time the person was ineligible. The Policyholder must reimburse us for claims under this provision within 60 days after receipt of our written request for payment.

The Policyholder is responsible for keeping the following records:

a) persons insured by classification and any persons eligible but not insured;
b) the amount of money the Policyholder contributes toward premiums;
c) beneficiary designation information, if applicable; and
d) any other information which we may reasonably request.

The Policyholder will provide us with copies of these records upon request. These records must be open to us for inspection at any reasonable time.

The Policyholder will provide, as we require, any information on our forms which is needed for insurance administration. The Policyholder is responsible for enrolling eligible persons for coverage under this Policy and performing other administrative duties agreed to by us. The Policyholder will perform its responsibilities in accordance with the terms of this Policy and our policies and procedures. The Policyholder may delegate some of its responsibilities to a third party.

The Policyholder and any third party utilized by the Policyholder to perform such administrative functions, act on behalf of the Policyholder and do not represent us or act on our behalf. The Policyholder and such third party have no authority to alter or expand our liability under this Policy and have no authority to waive, modify or compromise any defense or right we may have under this Policy.

The Policyholder agrees to indemnify and hold us harmless from and against any and all claims, actions, damages, liability and expenses, including, without limitation, reasonable attorneys' fees, arising from or related to the failure of the Policyholder, or a third party to whom the Policyholder has delegated its responsibilities, to perform its responsibilities in accordance with the terms of this Policy or our policies and procedures.

ASSIGNMENT

No assignment of this Policy is binding upon us unless an officer in our home office agrees to it in writing and not until it is recorded with us at our home office.

PREMIUM RIDER

This rider is made a part of Group Policy GVTL-BML6.

This rider is effective January 1, 2025.

CLASS(ES)

All Eligible Employees

LIFE INSURANCE PREMIUMS

Employee or Spouse

The monthly premium for each $1,000 of life insurance for each Employee or Spouse is as follows:

Attained Age of Employee	Monthly Premium
< 25	$0.050
25 - 29	$0.050
30 - 34	$0.076
35 - 39	$0.110
40 - 44	$0.170
45 - 49	$0.287
50 - 54	$0.507
55 - 59	$0.837
60 - 64	$1.386
65 - 69	$2.110
70 - 74	$2.110
75 - 79	$2.111
80 - 84	$2.109
85 - 89	$2.109
90 - 100	$2.109

The premium for Spouse life insurance under the Policy is based on the Employee's Attained Age.

Dependent Child(ren)

The monthly premium for all Dependent children is $0.170 for each $1,000 of life insurance.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE PREMIUMS

The monthly premium for AD&D insurance is as follows:

Employee and Spouse	$0.050 for each $1,000
All Dependent Children	$0.040 for each $1,000

RATE GUARANTEE DATE

January 1, 2027 or any date thereafter agreed to in writing by our authorized representative in our home office.

PREMIUM ALLOCATION

The total amount of premium paid or remitted by the Policyholder for this Policy and any other group insurance policy the Policyholder has with us or any of our affiliates ("Other Policy") will be allocated to this Policy and each Other Policy on a pro-rata basis. This means that if the Policyholder does not pay or remit the full premium that is due for this Policy or any Other Policy by the due date, the full amount of premium for this Policy and each Other Policy will be past due, resulting in termination of this Policy and each Other Policy in accordance with the applicable grace period for this Policy and each Other Policy.

PUBLICATION DATE

October 8, 2024

UNITED OF OMAHA LIFE INSURANCE COMPANY

Corporate Secretary

GENERAL INFORMATION REGARDING THE NEVADA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

NEVADA GUARANTY ASSOCIATION SUMMARY DOCUMENT (2020)

Residents of Nevada who purchase life insurance, annuities, health insurance, or Health Maintenance Organization (HMO) should know that the insurance companies licensed in this state to write these types of insurance are members of the Nevada Life and Health Insurance Guaranty Association (Association). The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

THE NEVADA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION MAY NOT PROVIDE COVERAGE FOR THIS POLICY. IF COVERAGE IS PROVIDED, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS, AND REQUIRE CONTINUED RESIDENCY IN NEVADA. YOU SHOULD NOT RELY ON COVERAGE BY THE NEVADA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION IN SELECTING AN INSURANCE COMPANY OR IN SELECTING AN INSURANCE POLICY.

COVERAGE IS **NOT** PROVIDED FOR YOUR POLICY OR ANY PORTION OF IT THAT IS NOT GUARANTEED BY THE INSURER OR FOR WHICH YOU HAVE ASSUMED THE RISK, SUCH AS A VARIABLE CONTRACT SOLD BY PROSPECTUS.

Insurance companies are required by law to deliver this notice to you. **However, insurance companies and their agents are prohibited by law from using the existence of the Association for sales, solicitation or to induce the purchase of any kind of insurance policy.**

The state law that provides for this safety-net coverage is called the Nevada Life and Health Insurance Guaranty Association. Below is a brief summary of this law's coverages, exclusions and limits. The summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act, or the rights or obligations of the Association. **Anyone may obtain additional information from the Association or file a complaint with the Commissioner of Insurance to allege a violation of any provision of the Nevada Life and Health Insurance Guaranty Association Act, at the applicable address listed below:**

The Nevada Life and Health Insurance Guaranty Association
4600 Kietzke Lane, Suite O-269
Reno, Nevada 89502

Commissioner of Insurance, State of Nevada
Department of Business and Industry, Division of Insurance
1818 E. College Parkway,
Suite 103
Carson City, Nevada 89706

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and **hold a life, health, an annuity, or HMO insurance contract or if they are insured under a group insurance contract, issued by a member insurer.** The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

MAXIMUM BENEFIT LIMITS

(For any one policyholder per company no matter how many policies you have)

a) Life Insurance
   1. $300,000
   2. $100,000 for cash surrenders
b) Annuities
   1. $250,000 in present value of annuity benefits
   2. $250,000 in cash surrenders including structured settlement annuities

c) Disability Income Insurance
    1. $300,000
d) Long Term Care
    1. $300,000

Basic Hospital, Medical and Surgical Insurance or Major Medical Insurance and HMO's (Known as Health Benefit Plans as defined in NRS 687B.470): For any one person: $100,000, excluding benefits for basic hospital, medical and surgical insurance or major medical insurance; or an aggregate of $500,000 in benefits, including benefit for basic hospital, medical or surgical insurance or major medical insurance.

With respect to one owner of several non-group policies of life insurance, whether the owner is a natural person or an organization and whether the persons insured are officers, managers, employees or other persons, the Association will not pay more than $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner.

With respect to each participant in a governmental retirement plan covered by an unallocated annuity contract as described in NRS 686C, the maximum allowed is an aggregate of $250,000 regardless of the number of contracts issued by any one member company.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are [not] protected by this Association if:

a) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
b) the insurer was not authorized to do business in this state; or
c) their policy was issued by a nonprofit hospital or medical service organization (the “Blues”), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

a) Any policy or portion of a policy which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
b) Where interest rate yields exceed an average rate;
c) Credits given in connection with the administration of a policy by a group contract holder;
d) Any dividends;
e) Employers' plans to the extent they are self-funded (not insured by an insurance company or administered by an insurance company);
f) Unallocated annuity contracts (which gives rights to group contract holders and not to individuals) other than annuity owned by a governmental retirement plan established under section 401, 403(b) or 457 of the Internal Revenue Code and the Nevada Revised Statute 686C.130; or
g) Medicare or Medicare Advantage contracts.

FOR MORE INFORMATION AND ANSWERS TO THE MOST FREQUENTLY ASKED QUESTIONS, PLEASE VISIT THE ASSOCIATION’S WEB SITE:
www.nvlifega.org

ADDITIONAL SERVICES DISCLOSURE

From time to time, We or our affiliates may offer, provide, or arrange through a third party to provide certain services to Policyholders and/or their Employees. Some services may be provided at a reduced cost.

The additional services may include one or more of the following:

- employee assistance program
- travel assistance
- identity theft
- Family and Medical Leave Act administration
- benefit administration
- care advocacy
- healthcare financial management
- medical cost and quality comparisons
- medical second opinion
- surgery benefit management
- pharmaceutical cost comparisons
- audit services
- payroll services

We are not responsible for the provision of services by our affiliates or third parties. We are also not liable to Policyholders or their Employees for the failure to provide or the negligent provision of such services by our affiliates or third parties.