YOUR GROUP VOLUNTARY HOSPITAL INDEMNITY BENEFITS

FOR EMPLOYEES OF:

Corient Services LLC

CLASS(ES):

All Eligible Employees

EFFECTIVE DATE:

January 1, 2025

PUBLICATION DATE:

December 4, 2024

NOTICE(S)

THE POLICY PROVIDES LIMITED BENEFITS. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. IT DOES NOT FULLY SUPPLEMENT FEDERAL MEDICARE HEALTH INSURANCE. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE *GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE*, AVAILABLE FROM US OR ONLINE AT WWW.MEDICARE.GOV.

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

FRAUD WARNING
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

This insurance pays limited benefits, if you meet the conditions listed in the policy, for treatment and conditions that result from injury or sickness. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company or at *www.medicare.gov*.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

NOTICE(S)

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: 1-800-775-8805
www.mutualofomaha.com

When contacting us, please have your Policy number available.

IF YOU ARE NOT SATISFIED WITH YOUR CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS AFTER YOU RECEIVE IT, UNLESS A CLAIM HAS PREVIOUSLY BEEN RECEIVED BY US UNDER YOUR CERTIFICATE. WE WILL REFUND WITHIN 30 DAYS OF OUR RECEIPT OF THE RETURNED CERTIFICATE ANY PREMIUM THAT HAS BEEN PAID AND THE CERTIFICATE WILL THEN BE CONSIDERED TO HAVE NEVER BEEN ISSUED. YOU SHOULD BE AWARE THAT IF YOU ELECT TO RETURN THE CERTIFICATE FOR A REFUND OF PREMIUMS, LOSSES WHICH OTHERWISE WOULD HAVE BEEN COVERED UNDER YOUR CERTIFICATE WILL NOT BE COVERED.

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

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

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

United of Omaha Life Insurance Company certifies that Group Policy Number GUVH-C29G (the Policy) has been issued to Corient Services LLC (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.

The Policy is nonparticipating, therefore it will pay no dividends.

James T. Blackledge
Chief Executive Officer

Jay A. Vanbeat
Corporate Secretary

SCHEDULE

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, conditions, exclusions and other provisions of the Policy.

CLASSES

All Eligible Employees

HOSPITAL INDEMNITY INSURANCE

You may elect insurance for yourself and your Dependents under this Certificate for one of the following coverage options:

a) yourself only;
b) you and your Spouse;
c) you and your Dependent children; or
d) you, your Spouse and your Dependent children.

Insurance under the Policy is only available if the total number of Employees insured under the Policy attains or remains above 51 Employees or 10% of the eligible Employees, whichever is greater. If the total number falls below the required level, insurance may be reduced, rescinded or terminated.

The benefit amount shown in the Certificate is the same for you and your insured Dependents. If you have questions regarding who is insured for hospital indemnity insurance, you may contact the Policyholder.

Benefits described in this Certificate will only be payable if Treatment for an Injury or Sickness occurs on or after the Insured Person's coverage effective date and while the Policy is in-force. The benefit amounts payable are based on the type and amount of insurance in effect on the date Treatment of an Injury or Sickness occurs, subject to the definitions, limitations, exclusions and other provisions of the Certificate.

BENEFIT OVERVIEW

The benefits payable under this Certificate are as follows:

BENEFIT OVERVIEW

Category	Benefit	Amount
Hospital Admission and Confinement	Hospital Admission	$1,000
	Daily Hospital Confinement	$200
	Intensive Care Unit (ICU) Admission	$2,000
	Daily Intensive Care Unit (ICU) Confinement	$200
Additional Benefits	Health Screening Benefit	$50

EVIDENCE OF INSURABILITY

Evidence of Insurability is not required for any amount of insurance under the Policy, unless otherwise stated in this Certificate.

EXCLUSIONS

Exclusions

We will not pay benefits if the Injury or Sickness:

a) results from elective or cosmetic surgery or procedures, or resulting complications (unless such surgery or procedure is medically necessary for the appropriate diagnosis and treatment of an Insured Person's Injury or Sickness in accordance with generally accepted medical standards);
b) results whether an Insured Person is sane or insane, from:
    1. an intentionally self-inflicted Injury or Sickness; or
    2. attempted suicide;
c) results from an Insured Person's:
    1. voluntary use of illegal drugs;
    2. intentional taking of over the counter medication not in accordance with recommended dosage and warning instruction; or
    3. intentional misuse of prescription drugs;
d) results from an Insured Person being voluntarily Intoxicated;
e) results from an Insured Person's intentional or voluntary use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption, including self-infliction of carbon monoxide poisoning emanating from a motor vehicle;
f) results from an Insured Person's Participation in a Riot, commission of a felony, participation in illegal activities or participation in an illegal occupation;
g) occurs while an Insured Person is incarcerated or imprisoned;
h) results from an act of declared or undeclared war or armed aggression;
i) occurs while an Insured Person is operating, learning to operate, riding as a passenger, boarding, departing or jumping from any aircraft (including those that are not motor driven, such as a hot air balloon), unless riding as a fare-paying passenger in a commercial aircraft on a regularly-scheduled flight or while Traveling on Business of the Policyholder;
j) occurs while an Insured Person is riding in or on any motor vehicle or aircraft engaged in racing, endurance tests, off-road activities (for motor vehicles), acrobatic tricks or stunts (for motor vehicles), or acrobatic or stunt flying (for aircraft);
k) occurs while an Insured Person is practicing for, participating in or officiating any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received by the Insured Person;
l) occurs while an Insured Person is engaged in skydiving, scuba diving, parachuting, hang gliding, bungee jumping, sail gliding, parasailing, parakiting, mountain climbing, base jumping, rock climbing, wingsuit flying, proximity flying, sky surfing, paramotoring, paragliding, jet powered flight, kite surfing, kiteboarding, cave diving, freediving, mountaineering, mountain biking, mountain boarding, ice climbing, missed climbing, abseiling, cliff jumping, rock climbing, free climbing, bouldering, slacklining, ski jumping, speed flying, speed riding, Parkour, Bossaball, Sepak Tekraw, Jai Alai, tricking, freerunning, sandboarding or train surfing; or
m) occurs while an Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable.

In addition, we will not pay benefits for:
a) dental procedures or surgeries;
b) initial confinement of a newborn Dependent child for routine well baby care;
c) elective abortions, or resulting complications;
d) artificial insemination, in vitro fertilization or test tube fertilization; or
e) sterilization, tubal ligation or vasectomy, and reversal of these procedures, unless medically necessary for the appropriate diagnosis and treatment of an Insured Person's Injury or Sickness in accordance with generally accepted medical standards.

BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, conditions, exclusions and other provisions of the Policy.

HOSPITAL ADMISSION AND CONFINEMENT BENEFITS

The Hospital Admission and Confinement benefits payable under this Certificate are as follows:

Hospital Admission and Confinement	Benefit
Hospital Admission	$1,000 per day
Daily Hospital Confinement	$200 per day
Intensive Care Unit (ICU) Admission	$2,000 per day
Daily Intensive Care Unit (ICU) Confinement	$200 per day

Limits

Hospital Admission and ICU Admission benefits under this provision are limited to a combined total of 2 days per Policy Year.

Hospital Confinement and ICU Confinement benefits under this provision are limited to a combined total of 30 days per Policy Year.

We will not pay a Hospital Admission or Confinement benefit or an ICU Admission or Confinement benefit for Treatment in an Emergency Room, Rehabilitation Facility, Skilled Nursing Facility, Hospice Care Facility, Birthing Center, Mental or Nervous Facility or Substance Abuse Facility or for Newborn Nursery Care Confinement, Outpatient Surgery or a stay of less than 18 hours in an Observation Unit or other observation area of a Hospital.

Hospital Admission Benefit

A benefit is payable for Hospital Admission if an Insured Person is admitted to a Hospital for an Injury or Sickness, subject to the following conditions:

a) only one Hospital Admission benefit is payable per period of Hospital Confinement, even if the admission is the result of more than one Injury or Sickness;
b) if a Hospital Admission benefit is payable for a day any other admission benefit is payable under the Policy, only the highest applicable benefit will be payable;
c) if an Insured Person is transferred to an ICU within 72 hours of Hospital Admission, the ICU Admission benefit will be payable instead of a Hospital Admission benefit;
d) if Hospital Admission is due to Treatment of an Injury, the Hospital Admission must begin within 180 days after the Accident;
e) if an Insured Person is admitted to the Hospital and is then transferred to another Hospital, an additional Hospital Admission benefit is not payable; and
f) the date of a subsequent Hospital Admission must be at least 30 days from the date of discharge from the Hospital.

Daily Hospital Confinement Benefit

A benefit is payable for each day of Hospital Confinement if an Insured Person is Hospital Confined for Treatment of an Injury or Sickness, subject to the following conditions:

a) only one Hospital Confinement benefit is payable per day, even if the confinement is the result of more than one Injury or Sickness;
b) a Hospital Confinement benefit is not payable for a day a Hospital Admission benefit is payable;
c) if a Hospital Confinement benefit is payable for a day any other confinement benefit is payable under the Policy, only the highest applicable benefit will be payable; and
d) if Hospital Confinement is due to Treatment of an Injury, the Hospital Confinement must begin within 180 days after the Accident.

Intensive Care Unit (ICU) Admission Benefit

A benefit is payable for ICU Admission if an Insured Person is admitted to an ICU for Treatment of an Injury or Sickness, subject to the following conditions:

a) only one ICU Admission benefit is payable per period of ICU Confinement, even if the admission is the result of more than one Injury or Sickness;

b) if an ICU Admission benefit is payable for a day any other admission benefit is payable under the Policy, only the highest applicable benefit will be payable;
c) if an ICU Admission is due to Treatment of an Injury, the ICU Admission must begin within 180 days after the Accident;
d) if an Insured Person is admitted to the Hospital and is then transferred to another Hospital, an additional ICU Admission benefit is not payable; and
e) the date of a subsequent Hospital Admission or ICU Admission must be at least 30 days from the date of discharge from the Hospital.

Daily Intensive Care Unit (ICU) Confinement Benefit

A benefit is payable for each day of ICU Confinement if an Insured Person is ICU Confined for Treatment of an Injury or Sickness, subject to the following conditions:

a) only one ICU Confinement benefit is payable per day, even if the confinement is the result of more than one Injury or Sickness;
b) an ICU Confinement benefit is not payable for a day an ICU Admission benefit is payable;
c) if an ICU Confinement benefit is payable for a day any other confinement benefit is payable under the Policy, only the highest applicable benefit will be payable.

HEALTH SCREENING BENEFITS

We will pay a health screening benefit of $50 per day for each Insured Person who has a Health Screening Test performed while insured under the Policy. This benefit is payable 1 time per Calendar Year for each Insured Person, for a combined maximum of 6 health screening benefits per Calendar Year for all Insured Persons.

We will not pay a health screening benefit for a screening, procedure or preventative test if benefits are paid or payable under another section of this Certificate.

ELIGIBILITY

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

WHEN YOU BECOME ELIGIBLE FOR INSURANCE

If you are Actively Working on the Policy Effective Date, you become eligible for insurance on the Policy Effective Date.

If you are not Actively Working on the Policy Effective Date or if you are hired after the Policy Effective Date, you become eligible for insurance on the day you begin Active Work.

The day you become eligible for insurance may not be the same as the day insurance begins. The WHEN YOUR INSURANCE BEGINS provision describes the day 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) both you and your Spouse 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 time frame, you may not enroll until a Subsequent Enrollment Period if offered.

You become insured on 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.

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 time frame you may not enroll your eligible Dependents until a Subsequent Enrollment Period if 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. 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 60 days after the day the Dependent child becomes eligible in order to continue insurance beyond the 60-day period.

EXCEPTIONS TO WHEN YOUR INSURANCE BEGINS

This provision does not apply if you are eligible for insurance under the CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER provision.

If you are:

a) not Actively Working due to Injury or Sickness;
b) confined in a Hospital as an inpatient;
c) confined or assigned as a resident inpatient in any institution or facility other than a Hospital; or
d) confined at home and under the care or supervision of a Physician;

on the day insurance would otherwise begin, insurance will not take effect until the day after you are released by your Physician and you return to Active Work.

If you are not Actively Working when insurance would otherwise begin for reasons other than those listed above, insurance will not take effect until the day you return to Active Work.

EXCEPTIONS TO WHEN YOUR DEPENDENT'S INSURANCE BEGINS

This provision does not apply to any Dependent who was eligible and insured under any Prior Plan on the day before the Policy Effective Date.

If your Dependent is:

a) confined in a Hospital as an inpatient;
b) confined or assigned to a bed as a resident inpatient in any institution or facility other than a Hospital; or
c) confined at home and under the care or supervision of a Physician;

on the day insurance is to begin, insurance will not take effect until the day after your Dependent is no longer confined.

In addition, insurance for a Dependent who is unable to perform two or more Activities of Daily Living (ADLs), whether or not confined, will not take effect until the day your Dependent has performed all ADLs for at least 15 consecutive days. This exception does not apply to any Incapacitated Dependent child.

Insurance for a newborn Dependent child, regardless of confinement, will begin in accordance with the WHEN YOUR DEPENDENT'S INSURANCE BEGINS provision.

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. a 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 receiving or eligible to receive benefits under the Prior Plan;
d) are not insured under any provision of the Prior Plan;
e) are not a retired Employee; and
f) 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) the benefit payable will be the amount which would have been paid by the Prior Plan had insurance remained in-force under the Prior Plan, less the amount of any benefit payable under the Prior Plan;
b) insurance is subject to uninterrupted payment of premium to us when due; and
c) 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 your 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 PERIODS provision, or as otherwise provided under the WHEN ELECTION CHANGES ARE PERMITTED provision.

SUBSEQUENT ENROLLMENT PERIODS

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

WHEN ELECTION CHANGES ARE PERMITTED

You may elect, drop, increase, decrease or change insurance as allowed by the Policyholder.

Life Events

Within 31 days after the date of a Life Event, you may submit a Written Request to change insurance.

If you experience a Life Event and you are currently insured, you may change insurance without Evidence of Insurability. If the Written Request is submitted more than 31 days after the date of a Life Event you may not change insurance until a Subsequent Enrollment Period is offered.

If you experience a Life Event and previously declined insurance, you may not enroll until a Subsequent Enrollment Period is offered.

CHANGES TO INSURANCE BENEFITS

Any allowable change in the benefits, class or amount of insurance, whether requested by you or the Policyholder, or as a result of the terms of the Policy, will take effect on the first day of the month that follows the date of the request or the change, unless otherwise stated or allowed in the Policy.

If you are not Actively Working on the day any increase in insurance would otherwise take effect, the increase becomes effective the first day of the month that follows the day you return to Active Work.

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 insurance is reinstated for you, insurance may also be reinstated for any eligible Dependents.

Reinstated insurance will take effect on the date of the Written Request. If you are not Actively Working on the day the reinstated insurance would otherwise take effect, insurance becomes effective on the day 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 if you return to Active Work within 90 days from 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 if you are rehired and return to Active Work within 90 days from the date insurance ended. All other Policy provisions apply.

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 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. All other Policy provisions apply.

Transfer From Portability

If insurance is obtained under the PORTABILITY provision while you are not Actively Working, insurance may be reinstated if you are rehired and return to Active Work. Any insurance provided through the PORTABILITY policy will terminate upon reinstatement of insurance as an Actively Working Employee.

WHEN INSURANCE ENDS

Insurance ends:

a) for all Insured Persons on 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) for all Insured Persons on the last day of the month in which you reach the Attained Age of 80;
e) 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;
f) the day the Policy terminates; or
g) in accordance with the GRACE PERIOD provision.

If insurance under the Policy ends, it will not affect benefits otherwise payable for a claim incurred while an Insured Person was insured under the Policy.

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, LEAVE OR FURLOUGH
b) CONTINUATION OF INSURANCE FOR YOUR DEPENDENTS IN THE EVENT OF YOUR DEATH
c) PORTABILITY
d) FLORIDA SMALL GROUP CONTINUATION OF COVERAGE

CONTINUATION OF INSURANCE FOR LAYOFF, LEAVE OR FURLOUGH

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;
b) a temporary furlough; or
c) a leave of absence approved by the Policyholder due to 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. 12 weeks for your temporary involuntary layoff;
    2. 12 weeks for your temporary furlough;
    3. 12 weeks for your leave of absence due to any personal reason; or
    4. 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, leave or furlough from the Policyholder upon request; and
d) we continue to receive premium payment when due (premiums must be paid by you or on your behalf).

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 or furlough 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.

If continued insurance under this provision ends and you have not returned to Active Work, you and your Dependents may be able to continue or obtain insurance under the PORTABILITY 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.

CONTINUATION OF INSURANCE FOR YOUR DEPENDENTS IN THE EVENT OF YOUR DEATH

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

When insurance under the Policy would otherwise end because of your death, your Dependents may be able to continue insurance under this provision, subject to the following conditions:

a) we receive notification of your death and intent to continue insurance for your Dependents from the Policyholder within 31 days from the date of your death or the date insurance would otherwise end; and
b) we continue to receive premium payment when due (premiums must be paid by your Dependents or on your Dependents behalf).

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.

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

a) that is 3 months from the date of your death; or
b) the Policy terminates.

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

If continued insurance under this provision ends your Dependents may be able to continue or obtain insurance under the PORTABILITY provision.

PORTABILITY

You have the right to continue receiving group hospital indemnity insurance under this provision if you have been insured under the Policy for at least 6 months and are under age 70 when insurance would otherwise end for any of the following reasons:

a) you cease to be Actively Working and are not eligible for insurance under any other continuation provision in this Certificate (if applicable);
b) your employment, membership or association with the Policyholder ends; or
c) the Policy terminates and the Policyholder does not obtain a replacement policy with another insurance carrier within 31 days.

In addition to the above reasons, your Spouse may be able to continue receiving group insurance, including insurance for each Dependent child, under this provision if you have been insured under the Policy for at least 6 months and your Spouse is under age 70 when insurance would otherwise end for any of the following reasons:

a) you enter active duty in the Armed Forces, National Guard or Reserves of any state or country for a period of more than 31 days;
b) divorce or legal separation of you and your Spouse; or
c) your death.

In the event your Spouse continues to receive insurance under this provision, each Dependent child may be insured under you or your Spouse, but not both.

If you are eligible for insurance under this provision and you are not eligible for insurance under any other continuation provision of the Policy (if applicable), you must continue insurance under this provision in order for your Dependents to be eligible.

If you continue to receive group insurance under this provision, you and your Dependents cannot continue insurance under any other continuation provision of the Policy (if applicable).

Notice of the Right to Continue Group Insurance Under this Provision

The portability period is the period of time that is 60 days from the date insurance would otherwise end (Portability Period). When insurance would otherwise end, notice of the right to continue insurance under this provision may be given. If notice is not given at least 15 days after the start of the Portability Period, an extension of the period of time to request continued insurance under this provision will be allowed. Any extension of the Portability Period will expire on the earlier of:

a) 15 days after notice has been received; or
b) 60 days after the end of the Portability Period, even if notice is not received.

How to Continue Group Insurance Under this Provision

You or your Spouse must submit a Written Request for insurance under this provision. The Written Request and the initial premium due must be submitted within the Portability Period.

The Group Hospital Indemnity Insurance Portability Policy

The insurance continued under this provision is available under another group hospital indemnity insurance policy (the "Portability Policy") issued by us, as available at the time insurance under this provision is requested. If you or your Spouse become insured under the Portability Policy, you or your Spouse will receive a certificate of insurance that describes the terms and conditions of insurance under the Portability Policy.

The Portability Policy may not provide all the same benefits or have all the same terms and conditions that are included in the Policy. In addition, the premium rates charged for insurance under the Portability Policy may not be the same as the premium rates charged for insurance under the Policy. The benefits and premium rates of our Portability Policy are described on our portability request form. You may contact the Policyholder or us to obtain our portability request form.

The continued group insurance under the Portability Policy is available as a result of portability rights that arise solely from the Policy, as arranged for you as an employee welfare benefit subject to the Employee Retirement Income Security Act of 1974, as amended.

EXTENSION OF BENEFITS

If an Insured Person is Totally Disabled or Hospital Confined due to Injury or Sickness on the date the Policy terminates, benefits under the Policy will continue to payable until the earliest of:

a) the date the Insured Person is no longer Totally Disabled or Hospital Confined;
b) the date the applicable benefit limit payable has been reached; or
c) 90 days from the date the Policy terminates.

FLORIDA SMALL GROUP CONTINUATION OF COVERAGE

The FLORIDA SMALL GROUP CONTINUATION OF COVERAGE provision applies only if the Policyholder employed fewer than 20 employees 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.

If you are called to active duty in the military reserve or National Guard and your employment terminates, you die, you and your Spouse are legally separated, your marriage is ended by divorce, or a child is no longer an eligible Dependent while you are on active duty, you and/or a Qualified Beneficiary are eligible for a new 18 month continuation period beginning the later of the date your active duty ends or the date of the qualifying event.

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 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 18 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 a Qualified Beneficiary elects to continue insurance under this provision and is called to active duty in the military reserve or National Guard and insurance under this provision is terminated due to the Qualified Beneficiary's eligibility for TRICARE, the Qualified Beneficiary may elect to reinstate insurance under this provision for the remainder of the 18 month continuation period.

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 18 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 18 months.

Notice Requirements

You or your employer must notify the Plan Administrator within 63 days after your termination of employment, reduction in hours, death, entitlement to Medicare, legal separation or divorce, 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 30 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 30 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 hospital indemnity plan to any employee;
b) the day premium is due and unpaid;
c) the day the Insured Person is covered under any other group hospital indemnity 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 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 or 29-month period provided above.

PREMIUM PAYMENTS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

PAYMENT OF PREMIUM THROUGH PAYROLL DEDUCTION

You are responsible for the payment of premium for insurance under the Policy. The premium owed by you equals the total 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, unless otherwise stated or allowed in the Policy. 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 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 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 for each coverage option shown in the Schedule section of this Certificate that applies to you and your Dependents.

If you request a change in your plan type (as shown in the Schedule section of this Certificate) or 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 plan type (as shown in the Schedule section of this Certificate) or 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 45 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

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

CLAIM FORMS

Before benefits are considered, we must be given written proof of claim. A claim form can be requested from the Plan Administrator, from us or obtained on our website. A request for a claim form should be made within 20 days after a loss 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 be submitted that includes the nature, date, cause and extent of the loss for which the claim is made and be considered to have satisfied the proof of loss requirements.

PROOF OF LOSS

Written proof of claim must be given to us within 90 days from the date of loss. If it is not reasonably possible to give us proof within the required time, we will not reduce or deny a claim for this reason if the proof is supplied as soon as reasonably possible.

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

INDEPENDENT EXAMINATION AND AUTOPSY

We may require an Insured Person to be examined by a Physician 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 examinations. Where not prohibited by law or forbidden by your religion, we may also require an autopsy. We will pay for this autopsy.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form to:
United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805

PAYMENT OF CLAIMS

Benefits will be paid immediately after we receive acceptable written proof of claim and any other required supporting information.

Unless you have assigned this insurance, benefits for any Insured Person will be paid to you, except benefits unpaid at your death or payable due to your death will be paid to:

a) your designated beneficiary(ies); if none, then to
b) your surviving Spouse; if none, then to
c) your surviving natural and/or adopted children, in equal shares; if none, then to
d) your surviving parents, in equal shares; if none, then to
e) your estate.

Any benefits paid to a minor may be paid to the legally appointed guardian of the minor. Any benefits paid by us in good faith will discharge our liability to the extent of the benefits payment.

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 45 days of the date a claim 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 60 days after receiving notice of our denial of a claim.

The claimant's appeal request must be submitted to us in writing or electronically and should state the reasons 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 Omaha, Nebraska address shown in the CLAIMS ASSISTANCE provision.

We will notify the claimant in writing of our final claim decision within 60 days after receiving an 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.

BENEFICIARY DESIGNATION

In the event of your death, a beneficiary should be designated. Beneficiary records will be kept by the Policyholder, Plan Administrator or the office where beneficiary records for the Policy are kept. The most current beneficiary designation in effect under a Prior Plan will be accepted as a beneficiary designation under the Policy.

Certain states are community property states. If you live in a community property state and you designate someone other than your Spouse as a beneficiary, state law may require that your Spouse consent to such designation. If you do not obtain your Spouse's consent to the designation, then such designation may not be effective. Community property states as of the Policy Effective Date include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

Your beneficiary may be changed at any time by you or your assignee (if you have assigned this insurance). To make a change, a Written Request should be provided to the Policyholder, Plan Administrator or to the office where beneficiary records for the Policy are kept. When received by the Policyholder, the change will take effect as of the date the Written Request is signed. The change will not apply to any payments or other action taken by us before the Written Request was communicated to us by the Policyholder.

RIGHT OF ASSIGNMENT

The rights provided to you under the Policy for insurance are owned by you, unless you have previously assigned these rights to someone else, or you assign your rights to an assignee. You should consult with a legal counsel prior to making an assignment.

We will recognize an assignee as the owner of the rights assigned only when:

a) the assignment is in writing and acceptable to us; and
b) a signed or certified copy of the assignment has been received and approved by us.

The assignment will not apply to any payments or other action taken by us before the assignment was received and recorded in our home office. We are not responsible for any legal, tax or other implications of any assignment.

FACILITY OF PAYMENT

In the event benefits under the Policy become payable to you or any person who is not legally competent to claim or receive benefits, a minor, or your estate, we may pay an amount of up to $2,000 to any of the following:

a) a person related to you by blood or marriage;
b) a person or entity that has incurred expenses related to your last illness or death;
c) the person who has assumed the care and support of you or any beneficiary; or
d) a personal or legal representative of your estate.

MODE OF PAYMENT

Benefits for each claim will be paid by us in one lump sum, unless otherwise indicated in any benefit provision in this Certificate.

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 to your, your survivors or your estate 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 benefits 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

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

INSURANCE CONTRACT

The insurance contract consists of:

a) the Policy (which includes this Certificate);
b) the Policyholder's signed application attached to the Policy; and
c) any signed application for you or your Dependents (if applicable).

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 our authorized representative in our home office.

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

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 proof of loss. No legal action can be brought more than five years after the date written proof of loss 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* and *your*, 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.

Accident means an external, sudden, unexpected and unintended event resulting in one or more Injuries that occurs while insurance is in effect for an Insured Person. Accident does include bacterial infection that is the natural and foreseeable result of an accidental Injury or accidental food poisoning.

Actively Working, *Active Work* means you are:

a) performing the normal duties of your job for the Policyholder on a regular and continuous basis 30 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.

Activities of Daily Living means the basic activities of daily living consisting of the following self-care tasks:

a) personal hygiene (bathing, grooming, shaving and oral care);
b) dressing and undressing (putting on and taking off all items of clothing and any necessary braces or artificial limbs);
c) eating (the ability to feed one's self);
d) transferring (from bed to chair, and back; from sitting to standing, and back);
e) continence (controlling bladder and bowel function); and
f) toileting (the ability to use a restroom).

Ambulatory Surgery Center means a licensed healthcare facility, outpatient surgery center or same day surgery center providing ambulatory (outpatient) surgical treatment, other than a Hospital, Emergency Room, Urgent Care or Physician's office or clinic.

Attained Age means the age of the Insured Person as of the Policy Anniversary that coincides with or follows the Insured Person's birthday. For example, if an Insured Person's 50th birthday is on April 1, 2024 and the Policy Anniversary is January 1, the Insured Person will reach the attained age of 50 on January 1, 2025.

Birthing Center means an appropriately licensed facility specializing in Treatment of expectant mothers with low-risk pregnancies, labor and childbirth. A birthing center may be a free-standing healthcare facility, separate from a Hospital, or may be a unit within a Hospital if the unit is specifically designated as a birthing center separate and apart from the beds and wards customarily used for patient Hospital Confinement. Treatment is supervised by a Physician or licensed Nurse Midwife, who may also be assisted by a Doula.

Calendar Year means the 12-month period beginning on January 1 of each year and ending on December 31 of the same year.

Cardiac Intensive Care Unit (CICU) means a specifically designated area of a Hospital that provides specialized cardiovascular and coronary Treatment to patients who are critically ill or injured requiring intensive, constant observation and care. Treatment must be provided 24 hours per day, 7 days a week by a Physician or Medical Professional. A CICU must be specifically designated as an CICU and be separate and apart from beds and wards customarily used for Hospital Confinement or ICU Confinement. An CICU does not include private monitored rooms, surgical recovery rooms, an Observation Unit or Step-Down Unit.

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.

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

a) your Spouse;
b) your natural born or legally adopted or foster child;

c) your stepchild (or child of your domestic or 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; or
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.

A dependent does not include:
a) anyone insured under the Policy 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) your Spouse after you reach the Attained Age of 80;
e) a child who has reached the age of 26 unless the child is Incapacitated;
f) an unborn or stillborn child;
g) your child if the child has been legally adopted by another person; or
h) a child placed in your home by a social service agency which retains control over the child.

Doula means a person who is a trained companion employed to provide mental, physical, and emotional guidance and support to an expectant mother during and after childbirth. The doula must be acting within the scope of his/her training. A doula does not include the Insured Person or a member of the Insured Person's Family.

Emergency Room means a specified area within a Hospital or a free-standing emergency facility that is designated for the emergency Treatment of Injury or Sickness. The emergency room or facility must:
a) be staffed and equipped to handle trauma;
b) be under the direct supervision of a Physician;
c) provide Treatment by Physicians or Medical Professionals; and
d) provide Treatment 7 days per week, 24 hours per day.

An Urgent Care Center is not an emergency room.

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.

Evidence of Insurability means proof of good health acceptable to us. This proof may be obtained through questionnaires, physical exams or written documentation, as required by us.

Family means Spouse, former Spouse, children, parents, grandparents, grandchildren, brothers, sisters and the spouses (or domestic partners, civil union partners or equivalent) of such individuals.

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

Health Screening Test includes, but is not limited to, the following health screenings or preventative tests administered by a Physician or Medical Professional to detect diseases or conditions in an Insured Person or to evaluate an Insured Person's overall health:
a) abdominal aortic aneurysm screenings;
b) angiogram/angiography (arteriogram);

c) annual/routine dental, health, hearing, physical, sports physical, vision and/or well women exams;
d) basic and/or comprehensive metabolic screening;
e) body mass index (BMI) assessment and health assessment;
f) bone density screening;
g) cancer preventative care and health screenings such as physical exams and testing, blood chemistry profiles, imaging studies, and/or biopsies;
h) carotid doppler ultrasounds, magnetic resonance angiography and computed tomography;
i) vascular ultrasounds;
j) lower extremity arterial ultrasounds;
k) chest x-ray;
l) child and adolescent age-appropriate history, measurement, sensory screenings, developmental/behavioral screenings, physical exams and procedures, oral health, anticipatory guidance and/or immunizations and vaccinations;
m) diabetes health screenings;
n) domestic violence health screening;
o) echocardiogram (ECHO) and/or electrocardiogram (EKG/ECG/cardiac event/Holter monitoring);
p) exercise, pharmacologic (nuclear) and/or radiological stress test;
q) genetic testing;
r) hepatitis B and C screening;
s) immunizations and vaccinations for adults;
t) lipoprotein profile (HDL, LDL and triglycerides);
u) mental health consultation/evaluation for depression and anxiety;
v) neurological health screening;
w) neurological imaging studies and health screenings (CT, MRI, PET, SPET, EEG, EMG, ENG, myelography, thermography, ultrasounds, spinal/lumbar puncture and X-ray);
x) polysomnogram (PSG);
y) prenatal/perinatal care health screenings, ultrasounds, monitoring, tests and/or vaccines;
z) sexually transmitted diseases or blood borne infection screening; and
aa) substance induced related mental health screening.

Hospice Care means specialized Treatment and emotional support for an Insured Person who is diagnosed with a Terminal Condition, focusing on comfort and quality of life rather than a cure.

Hospice Care Facility means an appropriately licensed facility that provides Hospice Care on an inpatient basis 24 hours per day, 7 days a week by appropriately trained staff who are supervised by a Physician or Medical Professional. A hospice care facility may be a unit within a Hospital if the unit is specifically designated for Hospice Care and is separate and apart from the beds and wards customarily used for patient Hospital Confinement. A hospice care facility does not include:
a) a Rehabilitation Facility;
b) a Skilled Nursing Facility;
c) a Substance Abuse Facility;
d) a Mental and Nervous Facility;
e) a rest home or home for the aged;
f) an assisted living facility;
g) a nursing home; or
h) an extended care facility.

Hospital means a facility that is accredited, approved, certified or licensed as a general hospital by the proper authority of the state in which it is located to provide Treatment for the condition causing confinement. A hospital does not include a facility or institution or part thereof which is licensed or used principally as:
a) a Mental and Nervous Facility;
b) a Substance Abuse Facility;
c) a clinic;
d) a convalescent home;
e) a rest home or home for the aged;
f) a nursing home;
g) a halfway house; or
h) a board and care facility.

Hospital Admission, Admitted means the first day of Hospital Confinement.

Hospital Confined, Confinement means the assignment to a bed as a resident inpatient on the advice of or as prescribed by a Physician with a charge for room and board in a:

a) Hospital;
b) Intensive Care Unit (ICU);
c) Step-Down Unit; or
d) Observation Unit (or other observation area of a Hospital) for a period of at least 18 consecutive hours.

Charge for room and board does not apply to confinement in a Veteran's Administration Hospital or other federal government operated Hospital.

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

Injury, Injuries means bodily harm that:

a) is a direct result of an Accident requiring treatment by a Physician;
b) is independent of bodily infirmity, Sickness or medical or surgical treatment and all other causes; and
c) occurs while insurance is in effect for an Insured Person.

Insured Persons means your and/or your Dependents who are insured under the Policy.

Intensive Care Unit (ICU) means a specifically designated area of a Hospital that provides the highest level of medical Treatment to patients who are critically ill or injured requiring intensive, constant observation and care. Treatment must be provided 24 hours per day, 7 days a week by a Physician or Medical Professional. An ICU must be specifically designated as an ICU and be separate and apart from beds and wards customarily used for Hospital Confinement. An ICU includes, but is not limited to, a Cardiac Intensive Care Unit (CICU), Neonatal Intensive Care Unit (NICU) or Pediatric Intensive Care Unit (PICU). An ICU does not include private monitored rooms, surgical recovery rooms, an Observation Unit or Step-Down Unit.

Intensive Care Unit (ICU) Admission means the first day of ICU Confinement.

Intensive Care Unit (ICU) Confined, Confinement means the assignment to a bed as a resident inpatient on the advice of or as prescribed by a Physician with a charge for room and board in an ICU.

Intoxicated means having a blood alcohol or drug level, at the time of the Accident, which equals or exceeds the legal limit for operating a motor vehicle as defined by the laws of the state where the Accident occurs.

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 hospital indemnity plan or medical plan under which you or your Dependents are covered.

Medical Professional means a person who is duly licensed to provide Treatment, such as a physician's assistant (PA), nurse practitioner (NP/APRN) or registered nurse (RN). The medical professional must be acting within the scope of his/her license. A medical professional does not include the Insured Person the Insured Person's Family Member.

Mental and Nervous Disorder means any condition, disease or disorder, regardless of its cause, listed in the most recent edition of the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental or nervous disorder, where improvement can be reasonably expected with therapy. Not included in this definition are conditions, diseases or disorders related to Substance Abuse.

Mental and Nervous Facility means an appropriately licensed facility that specializes in psychiatric Treatment for Mental and Nervous Disorders on an inpatient basis 24 hours per day, 7 days a week by appropriately trained staff who are supervised by a Physician or Medical Professional. A mental and nervous facility may be a unit within a Hospital if the unit is specifically designated for Mental and Nervous Disorders and is separate and apart from the beds and wards customarily used for patient Hospital Confinement. A mental and nervous facility does not include:

a) a Hospice Care Facility;
b) a Substance Abuse Facility;
c) a Rehabilitation Facility;
d) a Skilled Nursing Facility;

e) a rest home or home for the aged;
f) an assisted living facility;
g) a nursing home; or
h) an extended care facility.

Neonatal Intensive Care Unit (NICU) means a specifically designated area of a Hospital that provides the highest level of Treatment to newborn infants who are premature, critically ill or injured requiring intensive, constant observation and care. Treatment must be provided 24 hours per day, 7 days a week by a Physician or Medical Professional. A NICU must be specifically designated as a NICU and be separate and apart from beds and wards customarily used for Hospital Confinement. An NICU does not include private monitored rooms, surgical recovery rooms, an Observation Unit or Step-Down Unit.

Newborn Nursery Care Confined, Confinement means routine well baby care provided in a Hospital to a newborn Dependent child immediately after the birth of such child.

Nurse Midwife means a person who is trained in both nursing and midwifery and is certified by the American College of Nurse-Midwives (ACNM) to practice midwifery. The nurse midwife must be acting within the scope of his/her license. A nurse midwife does not include the Insured Person or a member of the Insured Person's Family.

Observation Unit means a specified area within a Hospital, apart from an Emergency Room, where a patient can be monitored. This area must:
a) be under the direct supervision of a Physician;
b) provide Treatment by Physicians or Medical Professionals; and
c) provide Treatment 7 days per week, 24 hours per day.

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

Outpatient Surgery means a surgical procedure performed by a Physician in a Hospital or Ambulatory Surgery Center (ASC) for which there is no charge for room/and or board. Outpatient surgery involves an incision of the Insured Person's skin or tissue that, in and of itself, is intended to be curative, palliative or exploratory.

Participation in a Riot means actively participating in a tumultuous disturbance of the peace by three or more persons assembling together of their own authority with intent to mutually assist one another in an illegal or legal act.

Pediatric Intensive Care Unit (PICU) means a specifically designated area of a Hospital that provides the highest level of medical Treatment to children who are critically ill or injured requiring intensive, constant observation and care. Treatment must be provided 24 hours per day, 7 days a week by a Physician or Medical Professional. A PICU must be specifically designated as a PICU and be separate and apart from beds and wards customarily used for Hospital Confinement. An PICU does not include private monitored rooms, surgical recovery rooms, an Observation Unit or Step-Down Unit.

Physician means a legally qualified medical doctor licensed to practice medicine, prescribe drugs, perform surgery, or any other licensed healthcare provider who is deemed to be the same as a legally qualified medical doctor. The physician must be acting within the scope of his/her license. A physician does not include the Insured Person or a member of the Insured Person's Family.

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

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

Policyholder means Corient Services LLC.

Policy Anniversary means January 1 of each Policy Year.

Policy Effective Date means January 1, 2025.

Policy Year means the period commencing on the Policy Effective Date and ending on the next succeeding Policy Anniversary and, thereafter, each 12-month period commencing on the Policy Anniversary.

Pregnancy Complications means any condition, whether or not a pregnancy is terminated, whose diagnosis is distinct from pregnancy but is adversely affected or caused by pregnancy. Pregnancy complications include:

a) acute nephritis;
b) anemia of pregnancy;
c) cardiac decompensation;
d) ectopic pregnancy that is surgically terminated;
e) hyperemesis gravidarum;
f) incompetent cervix;
g) missed abortion;
h) nephrosis;
i) non-elective caesarean section;
j) Physician prescribed rest during pregnancy that requires confinement in a Hospital;
k) placenta previa;
l) pre-eclampsia or eclampsia;
m) pre-term premature rupture of membranes (PPROM);
n) puerperal infection;
o) spontaneous termination of pregnancy that occurs during a period of gestation when a viable birth is not possible; or
p) any other similar conditions of comparable severity.

Pregnancy complications does not include:

a) advanced maternal age;
b) back pain;
c) elective caesarean section unrelated to a diagnosed pregnancy complication;
d) false labor;
e) morning sickness;
f) multiple gestation pregnancy;
g) occasional spotting;
h) Physician prescribed rest during pregnancy that does not require confinement in a Hospital;
i) postpartum depression;
j) pre-term contractions;
k) any similar conditions associated with a difficult pregnancy but not considered a classifiable, distinct pregnancy complication; or
l) any other condition associated with pregnancy but has not been diagnosed by a Physician as a pregnancy complication as defined.

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 or available through the Policyholder on the day before the Policy Effective Date.

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.

Rehabilitation Care Services means coordinated multidisciplinary physical restorative services (the combined use of medical, social, educational and vocational services) to enable Insured Person who is disabled by an Injury or Sickness to achieve the highest possible functional ability. Services are provided by or under the supervision of Physicians or Medical Professionals experienced in rehabilitative medicine.

Rehabilitation Facility means an appropriately licensed facility that provides Rehabilitation Care Services on an inpatient basis. A rehabilitation facility may be a unit within a Hospital if the unit is specifically designated for Rehabilitation Care Services and is separate and apart from the beds and wards customarily used for patient Hospital Confinement. A rehabilitation facility does not include:

a) a Hospice Care Facility;
b) a Substance Abuse Facility;
c) a Mental and Nervous Facility;
d) a Skilled Nursing Facility;
e) a rest home or home for the aged;
f) an assisted living facility;
g) a nursing home; or

h) an extended care facility.

A rehabilitation facility also does not include a nursing home or an extended care facility unless the Insured Person is receiving Rehabilitation Care Services at such home or facility.

Routine Pregnancy and Childbirth means a normal pregnancy without Pregnancy Complications that results in a vaginal or elective Cesarean section delivery of a child or children.

Sickness means a physical or mental disease, illness, infection, disorder or condition that requires treatment by a Physician after the Policy Effective Date and while insurance is in effect for an Insured Person. This definition includes Routine Pregnancy and Childbirth and Pregnancy Complications. Sickness does not include routine newborn nursery care or well-baby care.

Skilled Nursing Facility means an appropriately licensed facility that provides nursing Treatment 24 hours per day, 7 days a week by appropriately trained staff who are supervised by a Physician or Medical Professional. A skilled nursing facility may be a unit within a Hospital if the unit is specifically designated for skilled nursing Treatment and is separate and apart from the beds and wards customarily used for patient Hospital Confinement. A skilled nursing facility does not include:

a) a Hospice Care Facility;
b) a Substance Abuse Facility;
c) a Mental and Nervous Facility;
d) a Rehabilitation Facility;
e) a rest home or home for the aged;
f) an assisted living facility;
g) a nursing home; or
h) an extended care facility.

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

Step-Down Unit means a specifically designated part of a Hospital that provides a level of Treatment below intensive care, but above a regular private or semi-private Hospital room or ward. Treatment must be provided 24 hours per day, 7 days a week by appropriately trained staff supervised by a Physician or Medical Professional. A step-down unit may include a progressive care unit, an intermediate care unit, or a sub-acute intensive care unit within a Hospital if the unit is specifically designated for step-down care and is separate and apart from the beds and wards customarily used for patient Hospital Confinement.

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.

Substance Abuse means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases or Controlled Substances Act as an alcohol or drug related condition or disease.

Substance Abuse Facility means an appropriately licensed facility that specializes in habilitation, rehabilitation, Treatment and related services for Substance Abuse on an inpatient basis 24 hours per day, 7 days a week by appropriately trained staff who are supervised by a Physician or Medical Professional. A substance abuse facility may be a unit within a Hospital if the unit is specifically designated for Substance Abuse and is separate and apart from the beds and wards customarily used for patient Hospital Confinement. A substance abuse facility does not include:

a) a Hospice Care Facility;
b) a Mental and Nervous Facility;
c) a Rehabilitation Facility;
d) a Skilled Nursing Facility;
e) a rest home or home for the aged;
f) an assisted living facility;
g) a nursing home; or
h) an extended care facility.

Total Disability, Totally Disabled means that because of Injury or Sickness you are completely and continuously unable to perform any work or engage in any occupation.

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. If this trip is made on a private aircraft, then the aircraft must:

a) have a current and valid Federal Aviation Administration of the United States (FAA) standard airworthiness certificate; and
b) be operated by a person holding a current and valid FAA pilot's certificate authorizing such person to operate the aircraft.

Treatment means medical advice, consultation, care or services (including diagnostic measures) received by an Insured Person, or the use of drugs or medicines by an Insured Person.

Urgent Care means a licensed, free-standing healthcare walk-in facility providing immediate, short-term medical Treatment without an appointment, other than a Hospital, Emergency Room, Physician's office or clinic. The urgent care facility must be under the direct supervision of a Physician and provide Treatment by Physicians or Medical Professionals.

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.

ADDITIONAL SUMMARY PLAN DESCRIPTION INFORMATION

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

This document, in conjunction with Your Certificate, is Your ERISA Summary Plan Description for the insurance benefits described herein.

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

The benefits under the Plan are fully insured by us under a group insurance policy issued by us. 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). Our home office is located at 3300 Mutual of Omaha Plaza, Omaha, Nebraska 68175.

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

The Employer Identification Number (EIN) is: 87-3513335
The Plan Number is: 501

PLAN ADMINISTRATOR

The Plan is provided through and administered by:

Corient Services LLC
2 S Biscayne Blvd
32 Floor
Miami, FL 33131
Phone: (732) 603-1628

AGENT FOR SERVICE OF LEGAL PROCESS

The agent for service of legal process upon the Plan is:

Corient Services LLC
2 S Biscayne Blvd
32 Floor
Miami, FL 33131
Phone: (732) 603-1628

In addition, service of process may be made upon the Plan Administrator (if different from the Agent for Service of Legal Process).

PLAN YEAR

Each 12-month period beginning on January 1 is a "plan year" for the purposes of accounting and all reports to the U.S. 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 domestic relations order or 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 Plan's benefits and procedures. In addition, your Certificate includes, as applicable, a description of:

a) employee eligibility requirements;
b) when insurance ends;
c) state or federal continuation rights; and
d) claims procedures.

PLAN CHANGES

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

Group Voluntary Hospital Indemnity Benefits

Corient Services LLC

Group Number: G000C29G

United of Omaha Life Insurance Company

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