YOUR GROUP
TERM LIFE BENEFITS

FOR RETIREES OF:

Douglas County School District 0001

CLASS(ES):

All Eligible Retired Classified Employees Who Are Less Than Age 65

REVISION EFFECTIVE DATE:

September 1, 2016

PUBLICATION DATE:

August 14, 2017

NOTICE(S)

THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU. PLEASE READ YOUR CERTIFICATE CAREFULLY. BENEFITS ARE PROVIDED THROUGH A GROUP POLICY ISSUED IN THE STATE OF NEBRASKA.

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
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  
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:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy Number GLUG-DT60 (the Policy) has been issued to Douglas County School District 0001 (the Policyholder).

Insurance is provided for Retirees 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 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.

[Signatures]

Chief Executive Officer

Corporate Secretary
SCHEDULE

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

CLASS(ES)

All Eligible Retired Classified Employees Who Are Less Than Age 65

LIFE INSURANCE FOR YOU (THE RETIREE)

Your amount of life insurance is $25,000.

If You have questions regarding the amount of Your life insurance, You may contact the Policyholder.

EVIDENCE OF INSURABILITY

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

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

DEFINITIONS

_Actively Eligible, Active Eligibility_ means a Retiree is eligible for insurance under the Policy in accordance with the terms and conditions of this Eligibility section.

If the Policyholder’s rules of eligibility for insurance conflict with any of the terms and conditions of this Eligibility section, the terms and conditions of this Eligibility section shall control. Any changes to the Policyholder’s rules of eligibility after the Policy Effective Date will not be effective for purposes of becoming or remaining eligible for insurance under the Policy unless such changes have been approved by Our authorized representative in Our home office.

WHEN A RETIREE BECOMES ELIGIBLE FOR INSURANCE

A Retiree who was covered under a Prior Plan on the day before the Policy Effective Date will be eligible for insurance under the Policy on the Policy Effective Date.

A Retiree who was covered under a Prior Plan immediately prior to retirement and retires on or after the Policy Effective Date becomes eligible for insurance under the Policy on the day of retirement.

The day on which a Retiree becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

WHEN INSURANCE BEGINS

An eligible Retiree will become insured on the first day of the month that coincides with or follows the latest of the day:

a) the Retiree begins Active Eligibility; or
b) the Retiree submits a Written Request to enroll for insurance, if applicable.

WHEN INSURANCE ENDS

Insurance will end on the earliest of the day:

a) an Insured Person is no longer eligible for insurance under the Policy;
b) You reach the age of 65;
c) an Insured Person begins active duty in the Armed Forces, National Guard or Reserves of any state or county (except for temporary active duty of 31 days or less); or
d) You return to employment with the Policyholder.

Insurance will also end:

a) on the day the Policy terminates; or
b) in accordance with the Grace Period provision.

NOTICE TO YOU WHEN INSURANCE ENDS

The Policyholder is required to notify You when insurance under the Policy ends if:

a) You cease to be eligible for insurance under the Policy; or
b) the Policy is discontinued and is not replaced by another policy or plan with no interruption in coverage.

Notice shall be provided within 15 days from the date insurance ends for You, and shall include information about any options available to continue or obtain insurance.
EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for You would otherwise end, You may be able to obtain insurance under one of the following provisions:
   a) Portability
   b) Conversion

PORTABILITY

You have the right to continue receiving group life insurance under this provision if You are under age 70 when insurance would otherwise end for any of the following reasons:
   a) You cease to be Actively Eligible and are not eligible for insurance under any other continuation provision in this Certificate (if applicable);
   b) Your employment with the Policyholder ends;
   c) You retire; or
   d) the Policy terminates and the Policyholder does not obtain group life coverage within 31 days.

If an Insured Person requests to continue to receive group insurance under this provision, the amount of insurance shall not exceed the lesser of:
   a) the amount in effect under the Policy on the day insurance ended; or
   b) $500,000.

The amount of insurance may not be increased after insurance continues under this provision.

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

The Group Term Life Insurance Portability Policy
Group insurance continued under this provision is available under another group term life insurance policy (the “Portability Policy”) issued by Us, as available at the time insurance under this provision is requested. If You become insured under the Portability Policy, You will receive a certificate of insurance that describes the terms and conditions of coverage 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.

Notice of the Right to Continue Group Insurance Under this Provision
The portability period is the period of time that is 31 days from the date insurance under the Policy ends (“Portability Period”). When insurance under the Policy ends, notice of the right to continue receiving 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 in which to apply for a Portability Policy 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 must submit a Written Request for insurance under the Portability Policy. The Written Request and the initial premium due must be submitted within the Portability Period.

CONVERSION

This provision allows for conversion of life insurance.

When Membership Ends or the Amount of Insurance Reduces
If group life insurance ends because Your membership in a class (as shown under Class(es) on the Schedule) ends or Your benefit amount reduces, You may apply for an individual policy of life insurance other than term insurance (“Conversion Policy”).
The Conversion Policy issued under this provision will be:
   a) any type of individual policy of life insurance then customarily issued by Us for purposes of conversion, except term insurance; and
   b) issued without any supplemental benefits.

Premium shall be based on the standard premium rate for the Conversion Policy according to the amount of insurance, class of risk, gender and age of the applicant on the date the Conversion Policy takes effect.

The Conversion Policy will become effective on the later of the date of issue or 31 days after the date insurance under the Policy ended or was reduced.

When the Policy or a Class Terminates
You may apply for a Conversion Policy if insurance under the Policy ends due to termination of the Policy or termination of Your class (as shown under Class(es) on the Schedule), provided You have been insured under the Policy or any Prior Plan for at least 5 consecutive years.

The Conversion Policy issued under this provision will be:
   a) any type of individual policy of life insurance then customarily issued by Us for purposes of conversion, except term insurance;
   b) issued without any supplemental benefits;
   c) for an amount of life insurance that does not exceed the lesser of:
      1. $10,000; or
      2. the amount of insurance that ended under the Policy less the amount of any other group life insurance for which the applicant becomes eligible within 31 days after insurance under the Policy ended.

Premium shall be based on the standard premium rate for the Conversion Policy according to the amount of insurance, class of risk, gender and age of the applicant on the date the Conversion Policy takes effect.

The Conversion Policy will become effective on the later of the date of issue or 31 days after the date insurance under the Policy ended or was reduced.

Notice of the Right to Obtain Insurance Under this Provision
The conversion period is the period of time that is 31 days from the date insurance under the Policy ends or reduces (“Conversion Period”). When insurance ends under the Policy, notice of the right to convert may be given. If notice is not given at least 15 days after the start of the Conversion Period, an extension of the period of time in which to apply for a Conversion Policy will be allowed. Any extension will expire on the earlier of:
   a) 15 days after notice has been received; or
   b) 60 days after the end of the Conversion Period, even if notice is not received.

If You are entitled to obtain a Conversion Policy and die within 31 days after insurance under the Policy ends or reduces, We will pay the amount of life insurance which could have been converted, even if You did not apply for a Conversion Policy.

How to Request Insurance Under this Provision
Insurance is available without providing Evidence of Insurability. You must submit a Written Request for a Conversion Policy. The Written Request and the initial premium due must be submitted to Us within the Conversion Period.

Conversion Insurance and Your Return to Active Eligibility
If You are issued a Conversion Policy and again become eligible for insurance under the Policy, insurance under the Policy will become effective (subject to all eligibility requirements) only if any Conversion Policy(ies) is/are surrendered to Us.
PREMIUM PAYMENTS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

GRACE PERIOD

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

Insurance will stay in force during the grace period, unless You or the Policyholder provides Us with written notice that insurance will terminate during the grace period. If We receive such notice, insurance will terminate on the date requested.

If any premium due is not paid during the grace period, insurance will end on the last day of the grace period. If insurance ends, it may be reinstated as described in the Reinstatement of Insurance provision.

PREMIUM CHANGES

If You request a change in the amount of insurance, 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 in accordance with the terms of the Policy, or a change in the amount of insurance as the result of a request of the Policyholder, the Policyholder will provide You with notice of the change at least 15 days prior to the date of the change if You are responsible for the payment of premiums for insurance.

Premium amounts will change if premium rates under the Policy are changed.
LIFE INSURANCE BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

BENEFITS

In the event of death while insured under the Policy, We will pay the amount of life insurance in effect at the time of death for You. Benefits payable by reason of Your death will be paid to Your beneficiary.

BENEFICIARY DESIGNATION

At the time You elect(ed) insurance under the Policy or any Prior Plan, 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.

If You have not designated a beneficiary, or no beneficiary survives You, in the event of Your death, benefits will be paid to:
   a) Your surviving Spouse; if none, then to
   b) Your surviving natural and/or adopted child(ren), in equal shares; if none, then to
   c) Your surviving parent(s), in equal shares; if none, then to
   d) Your estate.

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.

BENEFICIARY CHANGE

Your beneficiary may be changed, subject to any restrictions or limitations in the Policy. 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. If You do not know where the records are kept, then You may send the Written Request to Us. 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 received.

FACILITY OF PAYMENT

We may pay an amount of up to $2,000 to any person or entity that has incurred expenses related to Your death and subsequent burial. An amount, if paid, will be deducted from the amount of life insurance benefits payable.
PAYMENT OF CLAIMS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

CLAIM FORMS

Before benefits are paid, We must be given written proof of loss as described in this section.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form to:
Compensation & Benefits Division
Douglas County School District 0001
3215 Cuming St
Omaha, Nebraska 68131

CLAIM ASSISTANCE

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

Within 15 days of receiving notification of a claim, We will provide the necessary claim forms, instructions and assistance to the Insured Person or the beneficiary.

PROOF OF LOSS

The Insured Person or the beneficiary has 90 days from the date of loss to furnish Us with a completed claim form and other information needed to prove loss. Failure to furnish such proof within this time period shall not invalidate nor reduce any claim if:

   a) it was not reasonably possible to give proof within that 90-day period; and
   b) proof is furnished as soon as reasonably possible, but not later than one year after the date of loss, unless the Insured Person or the beneficiary is not legally capable.

We may occasionally require an Insured Person to be examined by a Physician of Our choice to assist in determining whether benefits are payable. We will pay for these examinations. We will not require more than a reasonable number of examinations. Where not prohibited by law, We may also require an autopsy. We will pay for this autopsy.

PAYMENT OF CLAIMS

Benefits will be paid after We receive acceptable written proof of loss. Benefits will be paid only if We determine that the claimant is entitled to benefits under the terms of the Policy. We may require supporting information which may include, but which is not limited to, the following:

   a) clinical records;
   b) charts;
   c) x-rays; and
   d) other diagnostic aids.

Benefits will be paid to the Insured Person or the beneficiary in accord with the Life Insurance Benefits section.
MODE OF PAYMENT

Life insurance benefits will be available in one lump sum.

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 recover any payments due to:
   a)   fraud or misrepresentation; or
   b)   any error We make in processing a claim.

You or the recipient of benefits must reimburse Us in full. We will determine the method by which the repayment is to be made.

AUTHORITY TO INTERPRET POLICY

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

The Policyholder further grants Us the authority to delegate to third parties, including, without limitation, United of Omaha Life Insurance Company 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.

The Policyholder, as Plan sponsor, agrees that the Policyholder retains full responsibility for the legal and tax status of its benefits program and releases Us from all responsibility for the reporting and the employment-based design of the program and from all other responsibilities not accepted in writing by Our authorized representative in Our home office.
CLAIM REVIEW AND APPEAL PROCEDURES FOR LIFE BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

IMPORTANT NOTICE: In addition to the requirements described in this document, applicable state laws may contain requirements for claims review and appeal procedures. To the extent that any requirement in this document is inconsistent with any state law requirement, the requirement that is most favorable to the person insured under the Policy shall prevail. If you have any questions, please contact Us.

DEFINITIONS

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

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, any such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

Claimant means the person who submits a claim for benefits under the Policy, including the authorized representative of such person.

CLAIM REVIEW PROCEDURES

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except where the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant’s failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

INITIAL CLAIM DECISION

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

a) Initial claim decision period: 90 days
b) Extension period: 90 days

If additional information is needed, We will notify the Claimant within 15 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 30 days to submit the additional information to Us. We will make Our determination within 60 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

CLAIM DENIALS

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

a) the specific reason(s) for the denial;
b) reference to the specific Policy provisions on which the denial is based;
c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 60 days and the right to bring a civil action following the appeal process; and
d) any other information which may be required under state or federal laws and regulations.
Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

**OPPORTUNITY TO REQUEST AN APPEAL**

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 60 days from the Claimant’s receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

- a) the Insured Person’s name;
- b) the name of the person filing the appeal if different from the Claimant;
- c) the Policy number; and
- d) the nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

**RESPONSE TO APPEALS**

We will respond no later than 60 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 60 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

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

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant’s failure to submit information necessary to decide a claim, the period for making the appeal decision shall be “tolled” or suspended from the date on which the extension notice is sent until the earlier of (1) the date on which We receive the response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.
STANDARD PROVISIONS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

INSURANCE CONTRACT

The insurance contract consists of:
   a) the Policy;
   b) the Policyholder’s signed application attached to the Policy; and
   c) any signed application for You.

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 or Your beneficiary with a copy of that application.

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 use any statements in an Insured Person's application to contest the validity of this insurance after it has been in force during the lifetime of the Insured Person for two years.

LEGAL ACTIONS

No legal action can be brought until at least 60 days after We have been given written proof of loss. No legal action can be brought more than three years after the date written proof of loss is required, unless otherwise required by state law in Your state of residence.
GENERAL DEFINITIONS

The following capitalized terms have the meanings assigned in this section. These terms are used throughout the Policy.

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

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.

Hospital means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing confinement. A hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

Injury, Injuries means an accidental bodily injury that requires treatment by a Physician. It must result in loss independently of Sickness and other causes.

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

Physician means any of the following licensed practitioners:
   a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
   b) a licensed doctoral clinical psychologist;
   c) a Master’s level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist;
   d) a licensed physician’s assistant (PA) or nurse practitioner (NP); or
   e) where required by law, any other licensed practitioner of a healing art who is acting within the scope of his/her license.

A physician does not include:
   a) a naturopathic doctor;
   b) an acupuncturist;
   c) a physician in training; or
   d) You, Your Spouse or a child, brother, sister or parent of You or Your Spouse or any person who lives with You.

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

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

Policy Anniversary means September 1 of each Policy Year.

Policy Effective Date means October 19, 1970.

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.

Prior Plan means any policy or plan of benefits:
   a) replaced by insurance under part or all of the Policy; and
   b) in effect and maintained or sponsored by the Policyholder on the day before the Policy Effective Date.

Retiree means a former classified employee of the Policyholder who has retired through the Omaha Public Schools Retirement system and who is a citizen or permanent resident of the United States.

Schedule means the section of the Certificate identified as the “Schedule”.

Sickness means a disease, disorder or condition that requires treatment by a Physician.
Spouse means the person to whom You are legally married, or Your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable federal law, state law, or law of the county, city or local government in Your jurisdiction of residence. A spouse may include Your same sex or opposite sex domestic or civil union partner or equivalent if:
   a) You submit to the Policyholder a written declaration of partnership signed by You and Your partner in a form acceptable to Us; or
   b) You submit evidence acceptable to Us that all applicable requirements of the jurisdiction in which you reside regarding the establishment of a domestic or civil union partnership have been met; or
   c) You and Your partner satisfy the Policyholder’s requirements for such partnerships.

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, Insured Person means the Retiree who is insured under the Policy.
Group Term Life Benefits

Douglas County School District 0001

Group Number: G000DT60

United of Omaha Life Insurance Company

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175