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

YOUR GROUP SHORT-TERM DISABILITY BENEFITS

FOR EMPLOYEES OF:

Hellebusch Tool & Die, Inc.

4 Southlink Drive
Washington, MO 63090
(636) 239-7543

CLASS(ES):

All Eligible Employees

EFFECTIVE DATE:

October 1, 2025

PUBLICATION DATE:

September 25, 2025

NOTICE(S)

THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU. PLEASE READ YOUR CERTIFICATE CAREFULLY. THE POLICY IS ISSUED IN THE STATE OF MISSOURI. THE MISSOURI DIVISION OF INSURANCE MAY BE REACHED AT 1-573-751-3365.

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.

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: 1-800-877-5176
www.mutualofomaha.com

When contacting us, please have your Policy number available.

FOR RESIDENTS OF FLORIDA

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.

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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 GUG-CSL3 (the Policy) has been issued to Hellebusch Tool & Die, Inc. (the Policyholder).

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

PLEASE READ THIS CERTIFICATE CAREFULLY. **Benefits may be subject to certain requirements, reductions, limitations and exclusions**. We certify that the benefits described in this Certificate are effective 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, but in no event will your benefits and rights under the Policy be less than those stated in the Certificate. 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. You may inspect a copy of the Policy at the Policyholder's home office.

This Certificate replaces any certificate previously issued under the Policy.

The Policy may include access to certain third party goods and services selected by the Policyholder that are related to the benefits provided to Employees under this Policy and are made available to the Employee and to his or her dependents.

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

UNITED OF OMAHA LIFE INSURANCE COMPANY

James T. Blackledge
Chief Executive Officer

Terrance S. ReWald
Corporate Secretary

SCHEDULE

This Schedule describes some of the terms and conditions of the Policy including, but not limited to, the maximum amounts of benefits payable under the Policy, exclusions, and limitations. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of this Certificate.

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

POLICY INFORMATION

Minimum Work Hours Required:	30 hours per week
Eligibility Present Waiting Period:	30 day
Eligibility Future Waiting Period:	30 day
When Insurance Begins:	The first day of the month that follows the day the Employee becomes eligible. Additional eligibility conditions apply as described in the Certificate.
Premium Contribution:	Non-contributory
Elimination Period:	
Injury:	0 calendar days
Sickness:	7 calendar days

BENEFITS

Weekly Benefit Percentage:	60%
Maximum Weekly Benefit:	$700
Maximum Benefit Period:	26 weeks
Reasonable Accommodation Benefit:	The lesser of 100% for covered services expenses, $1,000 or an amount equal to the total Gross Weekly Benefit.
Vocational Rehabilitation Benefit:	Voluntary 10%

SHORT-TERM DISABILITY BENEFITS

If you become Disabled due to an Injury or Sickness, while insured under the Policy, we will pay the Weekly Benefit. Benefits begin after you satisfy the Elimination Period.

ELIMINATION PERIOD

You must satisfy the Elimination Period with consecutive days of Disability to receive benefits. The Elimination Period begins on the first day of Disability.

If your Disability is a result of an Injury, there is no Elimination Period. Benefits begin immediately. If your Disability begins more than 7 calendar days after your Injury date, the Elimination Period for Sickness applies.

If your Disability is a result of a Sickness, the Elimination Period is 7 calendar days.

WEEKLY BENEFIT CALCULATION

When less than a full week of Disability benefits is due, a pro rata benefit will be paid for each day of Disability. This pro rata benefit is equal to 1/7th of your Weekly Benefit.

Weekly Benefit for Total Disability

If you are Disabled and earning less than 20% of your Basic Weekly Earnings, the Weekly Benefit while Disabled is the lesser of:

a) 60% of your Basic Weekly Earnings, less Other Income Sources; or
b) the Maximum Weekly Benefit, less Other Income Sources.

Weekly Benefit for Partial Disability

If you are Disabled and you are able to generate Current Earnings of at least 20% and not more than 99% of your Basic Weekly Earnings, the Weekly Benefit payable is the Weekly Benefit for Total Disability, unless the sum of:

a) the Gross Weekly Benefit while you are Disabled; plus
b) Other Income Sources you receive or are eligible to receive; plus
c) Current Earnings while you are Disabled

exceeds 100% of your Basic Weekly Earnings. If this sum exceeds 100% of your Basic Weekly Earnings, the Weekly Benefit will be reduced by the amount in excess of 100% of your Basic Weekly Earnings.

OTHER INCOME SOURCES

We take into account the total of all your income from other sources of income in determining the amount of your Weekly Benefit. Your Other Income Sources include any amounts you receive or are eligible to receive as a result of your Disability or the Sickness and/or Injury that caused, in whole or in part, your Disability. Other Income Sources also include retirement payments and family leave benefits received for any reason.

Other Income Sources include:

a) payments under:
    1. a workers' compensation law;
    2. an occupational disease law;
    3. the Jones Act, (Title 46 United States Code Section 688); or
    4. any other act or law of similar intent;
b) any amount under another group short-term or long-term disability insurance policy or plan for which the Policyholder has paid any part of the cost to the extent that such policy or plan covers the same Basic Weekly Earnings, except any group short-term or long-term disability insurance policy or plan underwritten by United of Omaha Life Insurance Company;
c) any amount under another individual short-term or long-term disability insurance policy or plan for which the Policyholder has paid any part of the cost, which exceed 100% of your Basic Weekly Earnings when combined with the Gross Weekly Benefit;

d) disability income payments under any:
    1. state compulsory benefit act or law;
    2. government retirement system as a result of your job with the Policyholder; or
    3. work loss provision in a no-fault motor vehicle insurance plan, as allowed by state law;
e) any amount you receive as a result of any city, state or federal or Policyholder-sponsored family leave benefit or any other law, rule or regulation providing a family leave benefit, unless prohibited by applicable law;
f) the amount you:
    1. receive as retirement payments when you reach the normal retirement age defined under the Policyholder's Retirement Plan;
    2. voluntarily elect to receive as retirement payments prior to reaching the normal retirement age defined under the Policyholder's Retirement Plan; or
    3. receive or are eligible to receive as a disability benefit under the Policyholder's Retirement Plan prior to reaching the normal retirement age;
g) any amount payable as:
    1. salary continuance, except paid time off (PTO) that is not specified as sick leave, vacation and any earned time off program; but including maternity;
    2. sick leave; or
    3. severance allowance;
h) any amount from a third party (after subtracting attorneys' fees) by judgment, settlement or otherwise because of an act of omission by the third party. If the amount received does not specify the lost income amount, we will estimate the amount using a percentage of the settlement amount based on your Basic Weekly Earnings, prorated to cover the period for which the judgment, settlement or otherwise was made;
i) any amount from any unemployment insurance law or program; and
j) any benefits you or your Spouse or Dependent Child receive or are eligible to receive as a result of your disability or retirement payments under:
    1. the U.S. Social Security Act;
    2. the Canada Pension Plan;
    3. the Quebec Pension Plan;
    4. the Railroad Retirement Act;
    5. any public employee retirement plan;
    6. any teachers employment retirement plan; or
    7. any similar plan or act.

We will not reduce your Weekly Benefit by your Social Security retirement income if your Disability begins after your Social Security Normal Retirement Age and you were already receiving Social Security retirement benefits.

Any income benefits your Spouse or Dependent Child receives or is eligible to receive as a result of his or her own disability under the U.S. Social Security Act are not included in Other Income Sources.

EXPLANATION OF OTHER INCOME SOURCES

You must apply for and pursue Other Income Sources for which you are or may become eligible, including but not limited to Social Security disability and/or dependent benefits, and do what is needed to obtain them. If your application or claim for Other Income Sources is denied, we may require that you appeal the decision to a level that is satisfactory to us and provide written proof of all levels of appeal.

As part of your proof of Disability, we require that you furnish evidence to us that you have applied for and pursued Other Income Sources for which you are or may become eligible.

After the initial reduction for each type of Other Income Sources, we will not further reduce your Weekly Benefit due to any cost of living increases payable under such type of Other Income Sources.

Other Income Sources that are paid in a lump sum will be prorated on a weekly basis over a period for which the sum is given. If no time period is stated, the sum will be prorated on a weekly basis over the lesser of the following:
a) the Policy's Maximum Benefit Period; or
b) 12 equal payments.

If Other Income Sources are paid on a retroactive basis, we may reduce or suspend the Weekly Benefit to recover any overpayment.

Regardless of how funds from a Retirement Plan are distributed, we will consider your contributions and the Policyholder's contributions to be distributed simultaneously during your lifetime.

We will pay the full amount of the Weekly Benefit if you:
a) apply for Other Income Sources; and
b) sign our Reimbursement Agreement.

Until you have signed our Reimbursement Agreement and have given written proof to us that application has been made or all available appeals have been exhausted for Other Income Sources, we may:
a) estimate your Other Income Sources; and
b) reduce your Weekly Benefit by that amount.

If we reduce your benefit on this basis, and if all of your appeals are denied, we will restore your Weekly Benefit amount and refund any underpayment to you in a lump sum.

MAXIMUM BENEFIT PERIOD

The maximum number of weeks that benefits are payable for a continuous period of Disability is 26 weeks.

WHEN DISABILITY BENEFITS END

Benefits will be paid during a period of Disability until the earliest of the day:
a) you are no longer Disabled;
b) you die;
c) the Maximum Benefit Period ends;
d) you fail to provide us satisfactory proof of continuous Disability;
e) you fail to provide us satisfactory Proof of Earnings;
f) you have been incarcerated or imprisoned in a correctional facility for 31 days or longer;
g) you fail to comply with our request for a medical examination as explained in the INDEPENDENT EXAMINATION provision of the Claims Provisions;
h) you are able to pursue any health exam required to obtain your professional license, occupational license, or certification and do not do so;
i) you are not under Regular Medical Care for the Injury or Sickness that caused the Disability; or
j) you are able to return to work with the Policyholder on a part-time or Full-Time basis and do not do so.

If you are eligible to receive Disability payments on the day the Policy ends, benefits will continue subject to all other Policy provisions.

RECURRENT DISABILITY

A Recurrent Disability will be treated as part of your prior claim and you will not be required to satisfy a new Elimination Period if:
a) you were continuously insured under the Policy from the date benefits ended for your prior claim to the date your Recurrent Disability begins; and
b) your Recurrent Disability occurs within 180 days after the date benefits ended for your prior claim.

In order to prevent over insurance because of duplication of benefits, benefits payable under this Recurrent Disability provision will cease if benefits are payable to you under any other Policyholder-sponsored group long-term disability income policy or plan.

EXCLUSIONS

We will not pay benefits for any Disability or loss which:
a) results from an act of declared or undeclared war;
b) results from your Participation in a Riot or your commission of or attempt to commit a felony;

c) 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 your Injury or Sickness in accordance with generally accepted medical standards, including reconstructive surgery to repair a functional defect because of a congenital disease or anomaly);
d) arises out of or in the course of employment with the Policyholder for which you:
    1. receive or are eligible to receive benefits under any workers' compensation, occupational disease or similar law; or
    2. receive any settlement from the workers' compensation carrier;
e) results, whether you are sane or insane, from:
    1. an intentionally self-inflicted Injury; or
    2. attempted suicide;
f) occurs while you are incarcerated or imprisoned in a penal or correctional facility for any period exceeding 31 days.

ADDITIONAL BENEFITS

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

REASONABLE ACCOMMODATION BENEFIT

While you are receiving Disability benefits from us, we may pay a Reasonable Accommodation Benefit to the Policyholder if it will enable you to return to work. The purpose of this benefit is to cover costs incurred by the Policyholder to make workplace modifications to assist you. Covered services include:

a) tools, special seating, equipment and/or furniture;
b) accessible parking space;
c) labor costs for installation; and
d) other services reasonably necessary to help you return to work.

If we determine benefits are payable, we will pay the Policyholder the lesser of:

a) 100% of the expense incurred for covered services;
b) $1,000; or
c) an amount equal to the total Gross Weekly Benefit that would be payable for the Maximum Benefit Period, less any benefits already paid.

Any proposed modification is subject to approval by you, the Policyholder and us. We will provide a written modification plan to you and the Policyholder which includes the purpose of the proposed modification, the costs associated with the modification and completion timeline.

We will pay the benefit once we determine:

a) you have the physical and mental capability to perform your Regular Job or another job for the Policyholder based on your education, training and experience;
b) there is reasonable prospect the workplace modification will help you return to Active Work based on input from you, your Physician and the Policyholder;
c) the reasonable accommodation is complete; and
d) the Policyholder has incurred expenses for the services.

The total amount of the Reasonable Accommodation Benefit is payable once per Disability.

VOLUNTARY VOCATIONAL REHABILITATION BENEFIT

While you are receiving Disability benefits from us, we may pay for a vocational rehabilitation program if it will help you return to some type of work.

Rehabilitation is voluntary. The rehabilitation program may start at your or your Physician's request, or we may suggest it. Any rehabilitation program must be mutually agreed upon between you and us. The program must be approved in writing by us before it begins. Covered services may include, but are not limited to:

a) worksite modification and/or special equipment;
b) job placement assistance, including resume preparation;
c) retraining for a new occupation;
d) educational expenses;
e) other services reasonably necessary to help you return to work.

Eligibility for vocational rehabilitation assistance is based on your education, training, experience and physical/mental capabilities. To qualify for covered services:

a) your Disability must prevent you from performing some or all of the Material Duties of your Regular Job;
b) you must have the physical and mental capability to complete a rehabilitation program; and
c) there must be reasonable expectation that rehabilitation services will help you return to Active Work.

We will make the final determination of any vocational rehabilitation services provided, eligibility for participation and any continued benefit payments. If you choose to not participate in the vocational rehabilitation program, it will not affect our determination of whether you are Disabled under the Policy. If you fail to participate without Good Cause once we have started to pay vocational rehabilitation benefits, it may result in reduction or termination of Disability benefits. Reduction of

benefits will be based on your income potential if you were employed after a vocational rehabilitation program. We will consider the opinion of your Physician in determining Good Cause, however we reserve the right to make a final determination based on the medical opinions of a Physician or qualified rehabilitation specialist approved by us. In the case of conflicting opinions, you have the right to appeal the determination as described in the CLAIM REVIEW AND APPEALS PROCESS provision.

We will not duplicate benefits under this provision that are payable under the Reasonable Accommodation Benefit section.

Additional Benefit for IWRP

A more comprehensive type of vocational rehabilitation program involves the development of an Individual Written Rehabilitation Plan (IWRP). If you participate in an IWRP, we will increase the Weekly Benefit by 10% and continue to pay Disability benefits. Eligibility for further payment of the Weekly Benefit will be assessed at the completion of the IWRP.

We will develop the IWRP, which may include input from you, your Physician and the Policyholder. The IWRP will describe:

a) the vocational rehabilitation goals and services;
b) our duties, your duties and those of any third parties associated with the IWRP;
c) the times and dates of the vocational rehabilitation services;
d) the expected duration of the IWRP; and
e) all costs associated with the services.

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 (ELIGIBILITY WAITING PERIOD)

If you complete the 30 day Eligibility Waiting Period on or before the Policy Effective Date, you become eligible for insurance on the Policy Effective Date.

If you are not eligible for insurance on the Policy Effective Date, or if you are hired after the Policy Effective Date, you become eligible for insurance the day after you complete the 30 day Eligibility Waiting Period.

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

WHEN INSURANCE BEGINS

You become insured on the first day of the month that follows the day you become eligible and are Actively Working.

EVIDENCE OF INSURABILITY

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

EXCEPTIONS TO WHEN 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 not Actively Working due to:

a) Injury or Sickness;
b) confinement in a Hospital as an inpatient;
c) confinement or assignment to a bed as a resident inpatient in any institution or facility other than a Hospital; or
d) being housebound and under the care or supervision of a Physician;

on the day insurance would otherwise begin, insurance will not take effect until the day 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.

WAIVER OF COVERAGE

You may waive coverage:

a) for religious or faith-based reasons;
b) to avoid possible federal and/or state income tax liability; or
c) for any other reason approved by us.

You must submit a Written Request to waive coverage. The request must be signed by you, and in community property states, your Spouse, if applicable. The waiver is effective the date we receive and record the Written Request.

The waiver is irrevocable for one year from the date we record it. After one year, you may elect coverage by providing Evidence of Insurability at your own expense. You are eligible for insurance if we approve Evidence of Insurability.

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 you are not Actively Working on the Policy Effective Date due to an Injury or Sickness, but were covered under a Prior Plan on the day before the Policy Effective Date, you will be insured under the Policy on the earliest of:

a) the day your return to Active Work; or
b) the day any period for continuation of coverage under the Prior Plan ends.

If you are not Actively Working on the Policy Effective Date for reasons other than due to an Injury or Sickness, but were covered under a Prior Plan on the day before the Policy Effective Date, you will be insured under the Policy for the benefits provided under the Prior Plan until the earliest of:

a) the day your return to Active Work; or
b) the day any period for continuation of coverage under the Prior Plan ends.

Insurance under this provision is subject to the following conditions:

a) insurance may not exceed your amount of insurance under the Prior Plan on the day before the Policy Effective Date;
b) 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;
c) the Policyholder must notify us in writing prior to the Policy Effective Date of the amount of your insurance under the Prior Plan on the day before the Policy Effective Date;
d) insurance is subject to uninterrupted payment of premium to us when due; and
e) 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; or
c) the day your insurance ends for any reason shown in the WHEN INSURANCE ENDS provision

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

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.

For any increase in insurance, we will use the Policyholder's records and/or the premium we receive to verify that the amount of insurance requested is the appropriate insurance amount you are eligible for under the terms of the Policy.

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

In no event will any change take effect during a period of Disability.

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended in accordance with this provision.

Reinstated insurance will take effect on the first day of the month that follows the date you become eligible for insurance. 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.

Involuntary Reduction in Hours

If insurance ends because you are no longer Actively Working due to an involuntary reduction of hours worked, insurance may be reinstated without satisfying another Eligibility Waiting Period if you return to Active Work 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 without satisfying another Eligibility Waiting Period if you are rehired and return to Active Work within 90 days from the date insurance ended. All other Policy provisions, except the PRE-EXISTING CONDITION LIMITATION provision, apply. Credit will be given towards satisfaction of the PRE-EXISTING CONDITION LIMITATION provision previously served under the Policy.

Rehired Employee Due to Leave of Absence

If insurance ends because you are no longer Actively Working due to an approved leave of absence, insurance may be reinstated within 90 days from the date insurance ended without satisfying another Eligibility Waiting Period upon return to Active Work. If insurance ends because you are no longer Actively Working due to military leave, insurance may be reinstated upon return to Active Work within 31 days of discharge from active duty without satisfying another Eligibility Waiting Period. All other Policy provisions, except the PRE-EXISTING CONDITION LIMITATION provision, apply. Credit will be given towards satisfaction of the PRE-EXISTING CONDITION LIMITATION provision previously served under the Policy.

WHEN INSURANCE ENDS

Insurance ends:

a) the day you are no longer eligible for insurance under the Policy;
b) the day you begin 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 stated or allowed in the Policy;
c) the day the Policy terminates; or
d) in accordance with the GRACE PERIOD provision.

If you are Disabled on the day the Policy terminates, benefits will continue subject to the WHEN DISABILITY BENEFITS END provision in the Schedule.

EXCEPTIONS TO WHEN INSURANCE ENDS

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

a) CONTINUATION OF INSURANCE DURING DISABILITY
b) CONTINUATION OF INSURANCE FOR FEDERAL AND STATE LAWS

CONTINUATION OF INSURANCE DURING DISABILITY

If you become Disabled, your insurance will continue with payment of premium for as long as you are entitled to receive Weekly Benefits.

CONTINUATION OF INSURANCE FOR FEDERAL AND STATE LAWS

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

The federal Family and 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. You may be able to continue insurance from the day you cease to be Actively Working due to one of these laws.

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

a) insurance may not be continued beyond the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation;
b) the amount of insurance may not be increased while insurance is continued under this provision; and
c) 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 day the earliest of the day:

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

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

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

PREMIUM PAYMENTS

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

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 grace period that follows. We consider premium to be paid on the date we receive it.

Insurance will stay in force during the grace period. 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 and any unpaid premiums for the grace period or any part of the grace period will be due.

PREMIUM AND PREMIUM CHANGES

The premium for insurance under the Policy is a monthly rate.

The premium for insurance under the Policy is paid (in full) by the Policyholder. Contact the Policyholder for additional information on the current premium for the Policy.

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, the Policyholder will provide you with notice of the change at least 15 days prior to the date of the change if you are responsible for the payment of premium for insurance.

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

CLAIMS PROVISIONS

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 Disability. 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 30 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.

PROOF OF DISABILITY

Written proof of Disability must be given to us within 90 days after the end of the Elimination Period. 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 proof is supplied as soon as reasonably possible. In any case, proof must be given no more than 12 months from the time specified, unless you were legally incapacitated.

You must provide us with written authorization that allows us to validate Proof of Earnings, proof of continued Disability, Regular Medical Care and any Other Income Sources. This proof must be given to us upon request and must be received within 60 days of our request. If it is not, benefits may be denied or suspended until acceptable proof is received.

INDEPENDENT EXAMINATION

We may require you to be examined by a Physician or vocational rehabilitation expert 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.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form for proof of Disability to:
Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-877-5176

You will be responsible for any fees charged by your Physician for completing a claim form.

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-877-5176

PAYMENT OF CLAIMS

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

If we do not pay a benefit within 30 days after receipt of acceptable proof of Disability, we will pay interest from the 31st day after our receipt of acceptable proof of Disability to the date of payment at the interest rate of 10% per year.

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

a) your Eligible Survivor; or
b) your estate.

CLAIM REVIEW AND APPEAL PROCESS

Claim Review

We will notify you in writing of our decision to either approve or deny a claim within 15 days of the date it is received by us. If we deny your claim in whole or in part, we will explain the reasons for our denial in our notice. If you disagree with the reasons given, you or your authorized representative may ask that we reconsider your claim through the appeal process.

Appeal Process

To appeal a denied claim, you or your authorized representative must notify us within 180 days after receiving notice of our denial and ask that we reconsider our original benefit decision. Your appeal request must be submitted to us in writing or electronically and should state the reasons you believe the claim denial was incorrect. You should also include any additional information, documents or other materials that might allow us to change our original decision. Send your appeal request to us at our Omaha, Nebraska address shown in the CLAIMS ASSISTANCE provision.

Within 60 days after receiving your appeal request, we will notify you or your authorized representative in writing of our final claim decision. If we need more time due to circumstances beyond our control, we will inform you of our need for an extension prior to the end of this time frame.

You have the right to review copies of all documents, records and other information used to decision your claim, free of charge.

Notice

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

MODE OF PAYMENT

Benefits will be paid weekly by us.

REFUND TO US

If it is found that we paid more benefits than we should have paid under the Policy, we 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;
d) your not being eligible for coverage; or
e) your receipt of or right to payment from Other Income Sources.

You or the recipient of benefits must reimburse us in full. We will determine the repayment method, including without limitation, reducing or withholding your Weekly Benefit or any benefits payable to you 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 payment(s), 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 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 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, you or any other third party.

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 authority granted in the Policy. The Policyholder expressly grants such third party the full authority granted to us under this Policy.

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

CLAIM REVIEW AND APPEAL PROCESS AMENDMENT RIDER

This rider is made a part of Group Policy GUG-CSL3.

This rider is effective October 1, 2025.

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

The definition of "Adverse Benefit Determination" is made part of the DEFINITIONS section in the Certificate.

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.

The CLAIM REVIEW AND APPEAL PROCESS within the CLAIMS PROVISIONS section in the Certificate is changed to read as follows:

Claim Review Procedures

Once we receive information necessary to evaluate the claim, we will make a decision within the time periods stated 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 when the Claimant voluntarily agrees to provide us with additional time, extensions are limited as stated 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 within the time periods stated below.

In order for us to continue processing the claim, the missing information must be provided to us within the time periods stated 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, regardless to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are:

a) initial claim decision period: 45 days unless additional information is requested.
b) extension period: 30 days; and
c) maximum number of extensions: two.

If additional information is needed, we will notify the Claimant within 10 days of our receipt of the claim and the Claimant will be given no less than 45 days to submit the additional information to us. If we do not receive the additional information within the specified time period, we will make our determination based upon the available information.

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 claim decision will 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 stated by us in the notice of extension for providing the requested information.

Claim Denials

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

a) the specific reasons 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 180 days and the right to bring a civil action following the appeal process; and
d) any other information that may be required under state or federal laws and regulations.

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.

The Claimant has the right to review copies of all documents, records and other information used to decide the claim, 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 180 days from when the Claimant receives of notification of our claim review decision to submit a request for an appeal. The request should include:

a) the Claimant'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 must be submitted to us in writing or electronically stating the reasons the Claimant believes the claim denial was incorrect. The Claimant should also include any additional information, documents or other materials that might allow us to change our original decision. Requests for an appeal may be submitted to us at our Omaha, Nebraska address shown in the CLAIM ASSISTANCE provision.

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) that we may determine to be relevant to the appeal.

A document, record, or other information will be considered relevant to a claim if it:

a) was relied upon in making the claim decision;
b) was submitted, considered, or generated in the course of making the claim decision, regardless to whether it was relied upon in making the claim decision; or
c) demonstrates compliance with administrative processes and safeguards designed to ensure and verify that claim decisions are made in accordance with the Policy and that, where appropriate, Policy provisions have been applied consistently with respect to similarly situated claimants.

We will respond no later than 45 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 45 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date we expect to make the appeal decision.

If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide an appeal, the period for making the appeal decision will 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 stated by us in the notice of extension for providing the requested information.

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 the claim or to ask questions about rights under ERISA.

UNITED OF OMAHA LIFE INSURANCE COMPANY

Terrance S. ReWald
Corporate Secretary

STANDARD PROVISIONS

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

INSURANCE CONTRACT

Insurance is provided under a contract of group insurance with the Policyholder. The insurance contract consists of:

a) the Policy (which includes this Certificate);
b) the Policyholder's signed application attached to the Policy;
c) any signed application for you (if applicable); and
d) any riders, amendments or endorsements to the Policy.

CHANGES IN THE INSURANCE CONTRACT

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time we and the Policyholder both agree to a change. Any riders, amendments or endorsements to the Policy is subject to approval by IIPRC. Any changes will be consistent with IIPRC standards. No one else has the authority to change the insurance contract. A change in the insurance contract:

a) does not require your consent; and
b) must be:
    1. in writing;
    2. made a part of the Policy or Certificate (if applicable); and
    3. signed by an officer in our home office.

A change may affect any class of Insured Persons included in the Policy and will become effective on the date of change, or the retroactive date of change if required by IIPRC.

INCONTESTABILITY

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

Statements in an application are considered representations and not warranties. We will not use any statements in your application that are material to the risk we have accepted 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 disability. No legal action can be brought more than three years after the date written proof of disability is required, unless otherwise required by state law in your state of residence.

MISSTATEMENT OF AGE

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

CONFORMITY WITH IIPRC STANDARDS

The Certificate and Policy is approved by the IIPRC and issued under the IIPRC standards. Any provision of the Certificate or Policy which, on its effective date, is in conflict with the IIPRC standards on such date is hereby amended to conform to the minimum requirements of such standards in effect as of the Certificate and Policy approval effective date.

DEFINITIONS

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

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

Actively Working, *Active Work* means you are:

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

Basic Weekly Earnings for salaried Employees means your gross annual salary from the Policyholder in effect on the day immediately prior to the date on which your Disability began, divided by 52.

Basic weekly earnings for hourly Employees means your hourly rate of pay from the Policyholder in effect on the day immediately prior to your Disability multiplied by the average number of hours you worked per week, not including overtime, during the 6 month period immediately prior to the date on which your Disability began. If you were employed with the Policyholder for a period of less than 6 months, basic weekly earnings means your hourly rate of pay multiplied by the average number of hours you worked per week during that period, not including overtime.

Basic weekly earnings is verified by premium we have received.

Basic weekly earnings includes Employee contributions to Deferred Compensation plans received from the Policyholder.

Basic weekly earnings does not include commissions, bonuses, overtime pay, Policyholder contributions to Deferred Compensation plans, Differentials, and other extra compensation received from the Policyholder.

We require Proof of Earnings.

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, including the authorized representative of such person.

Current Earnings means any actual pre-tax weekly income you receive while you are working and eligible to receive a Weekly Benefit, or the pre-tax earnings you could receive if you were working at your Maximum Capacity. If your current earnings fluctuate, we may average your current earnings over the most recent three-month period and continue your claim provided the average does not exceed the percentage of Basic Weekly Earnings allowed by the Policy. A Weekly Benefit is not payable for any week during which your current earnings exceed that percentage.

Deferred Compensation means a plan or arrangement under the following Internal Revenue Code (IRC) sections or any other plan or arrangement defined as deferred compensation under the IRC:

a) 401(k);
b) 403(b);
c) 408(k);
d) 409A; or
e) 457.

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

a) your natural born, legally adopted or foster child;
b) your child from a civil union, domestic partnership, marriage or other family or domestic relationship where required by law of the state where the Policy is issued;
c) your stepchild or child of your civil union partner or equivalent; or
d) any other child who lives with you in a regular parent/child relationship and who qualifies as your dependent as defined in the U.S. Internal Revenue Code.

A dependent child does not include:

a) your child who is married, in a domestic partnership, in a civil union partnership or equivalent;
b) your child if the child has been legally adopted by another person; or
c) a child placed in your home by a social service agency which retains control over the child.

Differentials mean additional compensation you receive from the Policyholder for time or duties beyond those normally required or to accommodate specific working conditions, including, but not limited to:

a) shift differentials;
b) hazardous duties differentials;
c) pay for longevity;
d) on-call pay;
e) lead nurse differentials;
f) English as a Second Language (ESL) differentials;
g) charge pay;
h) weekend differentials;
i) coaching and other extra-curricular activities compensation; and
j) on-call differentials.

Disability and *Disabled* mean that because of an Injury or Sickness, a significant change in your mental or physical functional capacity has occurred and:

a) during the Elimination Period, you are prevented from performing at least one of the Material Duties of your Regular Job (on a part-time or Full-Time basis); and
b) after the Elimination Period, you are:
    1. prevented from performing at least one of the Material Duties of your Regular Job (on a part-time or Full-Time basis); and
    2. unable to generate Current Earnings which exceed 99% of your Basic Weekly Earnings due to that same Injury or Sickness.

Disability is determined relative to your ability or inability to work. It is not determined by the availability of a suitable position with the Policyholder.

The suspension, surrender, or revocation of a professional license or certificate does not alone constitute Disability.

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

Eligible Survivor means your Spouse, if living; otherwise, it means your Dependent Child under age 26. An eligible survivor must be living at the time of your death.

Elimination Period means the number of consecutive days of Disability which must be satisfied before you are eligible to receive benefits. The elimination period is shown in the Schedule.

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 partner or civil union partner or equivalent) of such individuals.

Full-Time means working the required number of hours to be considered a full-time employee of the Policyholder.

Good Cause means documented physical or mental impairments that:

a) prevent you from being rehabilitated;
b) interfere with a medical program you are currently participating in; or
c) conflict with any other program you are participating in that will enable you to return to active employment.

Gross Weekly Benefit means your Weekly Benefit amount before any reduction for Other Income Sources and Current Earnings.

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 care and 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 clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

Injury 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 after the Policy Effective Date and while you are insured under the Policy.

Insured Person means a person who is insured under the Policy.

Material Duties means the essential tasks, functions, and operations relating to your Regular Job that cannot be reasonably omitted or modified. In no event will we consider working more than the required Full-Time hours per week in itself to be a part of material duties.

Maximum Capacity means, based on your medical restrictions and limitations, the greatest extent of work you are able to do in your Regular Job.

Maximum Weekly Benefit means the maximum dollar amount of disability benefit you may receive per week as shown in the Schedule.

Non-contributory means the Policyholder pays the entire premium cost for insurance.

Other Income Source(s) has the meaning set forth in the OTHER INCOME SOURCES provision of the Schedule.

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

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.

Physician means a legally qualified medical doctor who is licensed to practice medicine, prescribe drugs or 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 you or any Family member.

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

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

Policy Anniversary means October 1 of each Policy Year.

Policy Effective Date means October 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.

Policyholder means Hellebusch Tool & Die, Inc..

Policyholder's Retirement Plan means any Retirement Plan:

a) which is part of any federal, state, county, municipal, or association retirement system; and
b) for which you are eligible as a result of employment with the Policyholder.

Prior Plan means any similar insurance policy:

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

Proof of Earnings means:

a) copies of your U.S. individual income tax returns and business income tax returns, including all forms, schedules and attachments, if applicable;
b) payroll records; and
c) any other records we request.

Recurrent Disability means a Disability which is caused by; attributable to, or resulting from the same Injury or Sickness that caused the prior Disability for which you received a Weekly Benefit under the Policy.

Regular Medical Care means treatment, consultations and diagnostic services that are appropriate and provided, ordered or prescribed by a Physician whose specialty is suitable for treating your Injury or Sickness. Such care must be received in-person at a frequency that is appropriate to effectively manage and treat your Injury or Sickness according to generally accepted medical standards.

Regular Job means the job you are routinely performing when your Disability begins.

Reimbursement Agreement means the written agreement that we provide to you and you agree to repay us any overpayment resulting from your or your Spouse's or Dependent Child's receipt of Other Income Sources.

Retirement Plan means a plan that:

a) provides benefits to you, either in a lump sum or in the form of periodic payments, upon the later of:
    1. early or normal retirement as defined in the plan;
    2. early or normal retirement under the U.S. Social Security Act; or
    3. disability, if the payment does not reduce the amount of money which would have been paid at the normal retirement age under the plan if the disability had not occurred; and
b) is not funded wholly by your contributions.

A retirement plan does not include a profit-sharing plan or a plan such as a 401(k), a thrift plan, an individual retirement account (IRA), a tax sheltered annuity (TSA), a stock ownership plan, a pension plan for partners, a military pension or disability income plan, a retirement plan from another plan sponsor or a Deferred Compensation plan.

Sickness means a physical or mental disease, illness, infection, disorder or condition, including pregnancy, that requires treatment by a Physician. Disability resulting from a sickness must occur while you are insured under the Policy. Sickness includes the donation of an organ in a non-experimental organ transplant procedure.

Social Security Normal Retirement Age (SSNRA) means your normal retirement age under the U. S. Social Security Act.

The Social Security Normal Retirement Age table is available online at www.ssa.gov/oact/progdata/nra/html or any other online website address which replaces this address.

Spouse means the person to whom you are legally married. Spouse also includes your domestic partner, civil union partner or equivalent, as recognized and allowed by marriage or other family or domestic relations law or case law in the state where the Policy is issued.

Weekly Benefit means the amount of disability benefit you may receive per week as described in the Schedule.

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

You, Your, Yourself 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 the Policyholder. 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, NE 68175.

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

The Employer Identification Number (EIN) is: 43-1006595
The Plan Number is: 501

PLAN ADMINISTRATOR

The Plan is provided through and administered by:

Hellebusch Tool & Die, Inc.
4 Southlink Drive
Washington, MO 63090
Phone: (636) 239-7543

AGENT FOR SERVICE OF LEGAL PROCESS

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

Hellebusch Tool & Die, Inc.
4 Southlink Drive
Washington, MO 63090
Phone: (636) 239-7543

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 October 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) 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 Short-Term Disability Benefits

Hellebusch Tool & Die, Inc.

Group Number: G000CSL3

United of Omaha Life Insurance Company

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