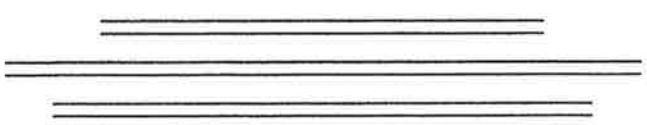
YOUR GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Sacramento Independent Hotel, Restaurant & Tavern Employees Welfare Trust

Effective January 1, 1998



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HOW TO OBTAIN PLAN BENEFITS

To obtain benefits see the Payment of Claims provision.

Forward your completed claim form to:

Sacramento Independent Hotel, Restaurant & Tavern Employees
Welfare Trust
1787 Tribute Rd
Ste. E
Sacramento, CA 95815

CLAIM ASSISTANCE

If you need assistance with filing your claim or an explanation of how your claim was paid, contact the:

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

NOTICE

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

United of Omaha Life Insurance Company
San Francisco Group Office
2400 Camino Ramon, Suite 290
San Ramon, CA 94583
Telephone: 1-510-901-5050

Should you feel you are not being treated fairly, we want you to know you may contact the California Department of Insurance with your complaint.
To contact the Department, write or call:

Consumer Division
Department of Insurance, Los Angeles Office
300 South Spring Street
Los Angeles, CA 90013
Call Toll Free: 1-800-927-4357

When contacting the Company please have your policy number available. Your policy number is GLUG-26M9.

The key sections of the Certificate appear in the following order.

Table of Contents

CERTIFICATE OF INSURANCE

UNITED OF OMAHA
LIFE INSURANCE COMPANY

Home Office: Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy No. GLUG-26M9(policy) has been issued to the Sacramento Independent Hotel, Restaurant & Tavern Employees Welfare Trust (Policyholder).

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

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

UNITED OF OMAHA LIFE INSURANCE COMPANY

Daniel P. Neary

Chairman of the Board and Chief Executive Officer

Corporate Secretary

DEFINITIONS

When used in the policy or your certificate:

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

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

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

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

Physician means any of the following licensed practitioners:

(a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);

(b) a licensed doctoral clinical psychologist;

(c) a 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

(e) where required to cover by law, any other licensed practitioner who is acting within the scope of his/her license.

A physician does not include a person who lives with you or is part of your family (you; your spouse; or a child, brother, sister or parent of you or your spouse).

Total Disability or Totally Disabled means that because of an injury or sickness you are completely and continuously unable to perform any work or engage in any occupation.

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

EMPLOYEE ELIGIBILITY

Eligibility

Eligibility for the current month will be available if the employee worked for the required number of hours two months before the current month, and contributions have been received on time by the Administration Office, based on qualifying periods of employment as listed in "Effective Date" section below.

Eligibility Will Be Determined as Follows:

TRADE EMPLOYEES - (and employees with job classifications covered under the Bargaining Agreement)

Classification of Employees	Number of Hours Per Month
Full Time or Part-Time	60 or more
Banquet Workers (see Banquet Workers" Section)	60 or more

NON-TRADE EMPLOYEES AND/OR EMPLOYERS
(Employees and Employers not covered by the Bargaining Agreement, including Corporate Officers and the Manager/Supervisor who hires, fires and sets schedules).

	Number Hours Per Day	Number Hours Per Month
Full- time Employees (Non Trade) or Corporate Officers		60 or more
Employers (Partners or Sole Proprietor) average 10 hours per week, 40 hours per month)	2	

TRADE EMPLOYEES ELIGIBILITY

(Those employees with job classifications covered under the Bargaining Agreement.)

All employees who are employed by an employer participating in the Sacramento Independent Hotel, Restaurant and Tavern Employees Welfare Trust, including all Employees performing duties or services under the jurisdiction of the Local Union, are eligible and must be covered, if hours qualify, with the contribution paid by the employer beginning with the second calendar month of employment.

Effective Date

If you work at least 60 hours each month for a contributing employer and your contributions are paid by the employer and received by the Administration Office for a period of three months during a four consecutive month period, your will be eligible on the first day of the 2nd month following such three month qualifying period of employment. The first calendar month of employment does not count towards this qualifying period.

Example: If contributions are made for work in January, February and April (no contributions are made for March), you will be eligible for benefits beginning June 1. From then on eligibility will be provided in the second month after the month that the qualifying hours are worked.

December	First month of work-no contributions required under Collective Bargaining Agreement
January	60 or more hours, full contribution
February	60 or more hours, full contribution
March	Less than 60 hours, no contribution
April	60 or more hours, full contribution
May	Skip month
June	Eligible for benefits because of April contributions for 60 or more hours

To Maintain Coverage

In order to remain eligible after becoming initially qualified, you must work the minimum required number of hours per month for an employer in each calendar month thereafter, and have your contributions paid by the employer and received by the Administration Office.

If you do not work the minimum required number of hours during any month, you shall be ineligible for benefits during the 2nd month following the month in which less than 60 hours were worked. In such event, you shall again be eligible for benefits on the first day of the 2nd month following the month during which you work the minimum required number of hours, except that if you have a lapse of coverage for three consecutive months, you will be treated as a new employee and must re-establish your eligibility in accordance with the Effective Date provisions above.

Eligibility for the current month is based on hours worked 2 months before the current month.

Special Contribution Provisions

Employers have agreed to make contributions for employees in the following instances. Eligibility for coverage will be recognized as if active work were performed.

1. Medical Leave: An Employer may make contributions for any qualified employee who has not worked because of medical reasons if stated in the Collective Bargaining Agreement. A qualified employee shall be an employee who has been working sufficient hours for a single employer to have contributions made in his/her behalf to this plan for at least twelve consecutive months. Some contracts require only one month of contributions, some require no contributions during disability, some require different qualifying periods, and some provide this payment only for certain types of disabilities. You may review your collective bargaining agreement for the rule that applies to you.

2. **Vacation:** The Employer will pay contributions for periods of vacation which are paid in accordance with the Collective Bargaining Agreement. For the purpose of determining minimum hours, paid vacation hours will be counted as if the employee has actually worked.

BANQUET WORKERS

Payment Provisions for Bargaining Unit Employees

In establishing original eligibility and maintaining continuing eligibility, a banquet worker who works at least 16 hours for one or more employers participating in the Sacramento Independent Hotel, Restaurant & Tavern Employees Welfare Trust, but fewer than 60 hours during a calendar month, may elect to make self-payment. In order to be eligible for benefits, such self payment must:

1. Be received by the Administration Office no later than the 15th of the month following the month in which fewer than 60 hours were worked.

2. Eligibility must be continuous. If no self-payment or Employer contribution is made for any calendar month the employee must requalify as a new employee.

3. All other eligibility requirements apply.

NON-TRADE ELIGIBILITY

Non-trade employees or owners (with job classifications not covered under the Bargaining Agreement) who meet the minimum hours per month while working for a contributing employer, and contributing employers working the minimum average hours per day may also be covered under the plan subject to the following conditions.

The employer agrees to offer the same level of coverage or combination of coverages to all non-trade employees or contributing employers working the required monthly hours.

Non-Trade Enrollment

1. When your date of employment is prior to or coincident with the effective date of participation for the participating employer, you must enroll within 30 days of the employee's effective date. Coverage shall become effective for you and on the effective date specified below.

2. When your date of employment is after the effective date of participation for the employer, you must enroll in the plan with a 30-day period. Coverage shall become effective for you on the effective date specified below.

3. If you do not enroll as required under 1. or 2. above, or you wish to re-enroll after coverage has been terminated although you remain eligible, you must furnish, at your own expense, evidence of good health satisfactory to the plan. Coverage shall not effective until the Board of Trustees approves the application, and the eligibility and effective date requirements stated below are met.

4. Proprietors, signatory to the Bargaining Agreement and actively participating in the operation of business at least an average of 2 hours daily, for an average of 10 hours per week or 40 hours per month, may enroll in the Plan provided they apply within 30 days of signing the Bargaining Agreement. No proprietor can participate in the Plan unless there are qualified employees who could also participate in the Plan. Proprietors once enrolled who fail to pay their contribution for 60 days will be terminated. If a proprietor does not enroll within 30 days, or was terminated from coverage due to delinquent contributions or voluntarily terminated coverage for any other reason, he or she must furnish for him or herself, at his or her own expense, evidence of good health satisfactory to the plan. Coverage shall not be effective until the Board of Trustees approves the application, and the eligibility and effective date requirements are met.

Eligibility Period and Effective Date for Non-Trade Employees

If you work the required hours and are shown on the employer's report on a full-time basis for three months during a four-month period you will become eligible for benefits on the first day of the 2nd month following such three month period of employment if contributions are paid by the employer and received by the Administration Office. The first calendar month of employment does not count towards this qualifying period.

To Maintain Coverage

In order to remain covered after becoming initially eligible, you must work the minimum required number of hours for an employer in each calendar month thereafter, and have your contributions paid by the employer and received by the Administration Office. If you do not work the minimum required number of hours during any month, you shall be ineligible for benefits during the 2nd month following the month in which less than the minimum hours were worked. In such event, you shall again be eligible for benefits on the first day of the 2nd month following the month during which you work the minimum required number of hours, and contributions are made on your behalf. If you have a lapse of coverage for three consecutive months or more, you will be treated as a new

employee and must re-establish your eligibility in accordance with 1. and 2. above.

When Your Insurance Begins

You will become insured on the day you become eligible, provided you are actively at work on that day. If you are not actively at work on that day, your insurance will begin on the day you return to active work.

Exceptions

1. If, on the day your insurance is to begin:

   (a) you are on a regular paid day of vacation; or

   (b) such day is a regular non-working day;

   you will still be considered actively at work if you were available for work on the last preceding regular work day.

2. If, on the day your insurance is to begin you do not report to work, you will be considered actively at work if you are available for work on that day.

3. If your customary place of employment is at your home, you will be considered actively at work if you are not confined on that day (as described in the Confinement Rule below).

Confinement Rule

If you are:

(a) hospital confined;

(b) confined in any institution/facility other than a hospital due to an injury or sickness; or

(c) confined at home and under the supervision of a physician;

insurance will begin on the first day of the policy month which coincides with or follows the day after such confinement ends.

If you are not:

(a) confined; and

(b) available for work because of injury or sickness; insurance will begin on the first day of the policy month which coincides with or follows the day you return to active work.

Amount of Coverage

The amount of coverage for your classification is shown in the Schedule.

Changes in Your Classification or in the Amount of Your Coverage

Any changes in your classification or coverage will take effect on the first day of the policy month which coincides with or follows the day of the change provided you are actively at work on that day. If you are not actively at work, the following conditions will apply:

(a) If the change involves an increase in coverage, the change will not take effect until the first day of the policy month which coincides with or follows the day you return full-time to your regular job.

(b) If the change involves a decrease in coverage, the change will take effect on the day of the change.

When Your Insurance Ends

Your insurance will end at midnight on the earliest of:

(a) the day the policy ends;

(b) the day any premium for your insurance is due and unpaid;

(c) the day before you enter the Armed Forces on active duty (except for temporary active duty of two weeks or less);

(d) the day you are no longer eligible under the policy; or

(e) the day your employer ceases to be a Signatory Employer.

You will no longer be eligible when:

(a) you are no longer in an eligible class; or

(b) you do not satisfy:
  (1) the requirements for hours worked; or
  (2) any other eligibility condition in the policy.

However, upon uninterrupted payment of premium to us, you may be eligible to continue your coverage in accord with the following continuation provisions. You should contact the Policyholder to determine the amount of contribution, if any, you are required to make in order to continue your insurance.

Continuation of Life Insurance and Accidental Death and Dismemberment Benefits
Due to Total Disability

Your Life Insurance coverage will continue during the disability Elimination Period as long as you remain totally disabled. The Disability Elimination Period is the 12 consecutive months of total disability beginning on the date you first become totally disabled. After completing the Disability Elimination Period you may be eligible to continue your Life Insurance in accord with the Continuation of Life Insurance Due to Total Disability provision shown below.

If you are eligible for Continuation of Life Insurance during the Disability Elimination Period, Accidental Death and Dismemberment coverage will be continued under the same conditions as the Life benefit, however Accidental Death and Dismemberment coverage automatically terminates on the earlier of:

(a) the completion of the Disability Elimination Period; or

(b) the date you are no longer totally disabled.

This policy does not allow continuation of coverage as provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Continuation of Life Insurance Due to Total Disability

If you are totally disabled, your life insurance will not end in accord with the When Your Insurance Ends provision, but will be continued without payment of premium provided:

(a) the disability began while you were insured under this policy;

(b) the disability began before you reached age 60;

(c) you have completed your Disability Elimination Period; and

(d) proof of the disability is given to us as described in the following paragraph.

You must notify us of your total disability during the Disability Elimination Period. After receiving your notification, we will send you an Initial Proof of Total Disability Form for you and your physician to complete. You must return this form within 90 days after receipt. Upon acceptance of your initial proof and completion of the Disability Elimination Period, your Life Insurance will continue without premium for at least one year.

Thereafter, we will periodically send you a Subsequent Proof of Disability Form for you and your physician to complete. If proof is acceptable, your Life Insurance will be continued for at least one year.

In order to confirm that you are totally disabled, we have the right to have you examined by a physician of our choice. We will pay for these examinations, we may have you examined any time during the first two years of disability and once a year from then on.

Your continued life insurance is the amount in force on the day insurance would have otherwise ended. Life Insurance provided under the Continuation of Life Insurance due to Total Disability provision is subject to the reductions and terminations shown in the Schedule.

When Continuation of Life Insurance due to Total Disability Ends:

Your insurance will end at midnight on the earliest of:

(a) the day you are no longer totally disabled;

(b) the day your Disability Elimination Period ends without providing Initial Proof of Total Disability;

(c) 90 days after a Subsequent Proof of Total Disability Form is sent, but not returned;

(d) the day you fail to attend an examination or cooperate with an examiner; or

(e) the day you reach age 70.

When your total disability ends, you have 31 days to convert your coverage to an individual policy of life insurance; but you may not convert if you again become insured under the policy. Conversion may be made only in accord with the Life Insurance Conversion Privilege provision.

CONTINUATION OF LIFE AND HEALTH INSURANCE

DURING LABOR DISPUTE RIDER

This rider is made a part of Group Policy GLUG-26M9.

This rider is effective the later of January 1, 1998, or the day you become insured under the policy..

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

Definition

Health Insurance (as used in this rider) means any hospital, surgical, medical, dental, prescription drug or vision care insurance provided under the policy.

Continuation Privilege

When insurance is provided in accord with a collective bargaining agreement, you may continue life insurance and health insurance for as long as six months during a work stoppage due to a labor dispute if:

(a) you make timely payment of the required premium to the Policyholder (including the part usually paid by your employer);

(b) the Policyholder makes timely payment of the premium to us; and

(c) the insurance is continued by at least 75% of the employees who are not eligible due to a labor dispute.

Conditions

1. We may increase the premium rate(s):

   (a) during a work stoppage by up to 20% (or any higher percent approved by the Commissioner) to cover:
   (1) increased administrative costs; and
   (2) increased mortality and morbidity; and

   (b) on any date before, during or after a work stoppage in accord with the terms of the policy.

2. Nothing in this rider permits any coverage(s) to be continued:

   (a) beyond the time insurance is continued by fewer than 75% of the employees who are not eligible due to a labor dispute;

   (b) beyond the time you are employed full time with another employer; or

   (c) more than six months after work stops.

For further information on your premium rate, the premium due date and where to submit your premium, consult your Plan Administrator.

RIDER
FAMILY AND MEDICAL LEAVE

as Federally Mandated

This rider is made a part of Group Policy GLUG-26M9.

This rider is effective on the later of: (a) the effective date of the policy; or (b) the date required by Federal law.

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

Family and Medical Leave

If you become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA) (including any amendments to such Act) your insurance coverage may be continued on the same basis as if you were an actively-at-work employee for up to 12 weeks during the 12 month period, as defined by your employer, for any of the following reasons:

(a) to care for your child after the birth or placement of a child with you for adoption or foster care; so long as such leave is completed within 12 months after the birth or placement of the child;

(b) to care for your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition; or

(c) for your own serious health condition.

In the event you or your spouse are both insured as employees of the Policyholder, the continued coverage under (a) may not exceed a combined total of 12 weeks. In addition, if the leave is taken to care for a parent with a serious health condition, the continued coverage may not exceed a combined total of 12 weeks.

Conditions:

(a) If, on the day your insurance is to begin, you are already on an FMLA leave of absence you will be considered actively at work. Insurance for you and any eligible dependents (if applicable) will begin in accordance with the terms of the policy. However, if your leave of absence is due to a serious health condition, benefits for that condition will not be payable to the extent benefits are payable under any prior group plan.

(b) You are eligible to continue coverage under FMLA if:
   (1) you have worked for your employer for at least one year;
   (2) you have worked at least 1,250 hours over the previous 12 months;
   (3) your employer employs at least 50 employees within 75 miles from your worksite; and
   (4) you continue to pay any required premium for yourself and any eligible dependents (if applicable) in a manner determined by your employer.

(c) In the event you choose not to pay any required premium during your leave, your insurance coverage will not be continued during the leave. You will be able to reinstate your coverage on the day you return to work, subject to any changes that may have occurred in the policy during the time you were not insured. You and any insured dependents (if applicable) will not be subject to any evidence of good health requirement provided under the policy. Any partially-satisfied waiting periods, including any limitations for a preexisting condition, which are interrupted during the period of time premium was not paid will continue to be applied once coverage is reinstated.

(d) You and your dependents (if applicable) are subject to all conditions and limitations of the policy during your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.

(e) If requested by us, you or your employer must submit proof acceptable to us that your leave is in accordance with FMLA.

(f) This FMLA continuation is concurrent with any other continuation option except for COBRA, if applicable.

(g) FMLA continuation ends on the earliest of:
   (1) the day you return to work;
   (2) the day you notify your employer that you are not returning to work;
   (3) the day your coverage would otherwise end under the policy; or
   (4) the day coverage has been continued for 12 weeks.

Definitions

Prior group plan means the group plan providing similar benefits (whether insured or self-insured plans provided by the Policyholder) in effect immediately prior to the effective date of this policy.

Serious Health Condition is defined as stated in the FMLA.

Important Notice:

Contact your employer for additional information regarding FMLA.

RIDER
UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS

as Federally Mandated

This rider is made a part of Group Policy No. GLUG-26M9.

This rider is effective on the later of: (a) the effective date of the policy; or (b) the date required by Federal Law.

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

Definitions

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such ACT and any interpretive regulations or rulings).

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Uniformed services means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

Reemployment (following service in the uniformed services)

Following your discharge from such service, you may be eligible to apply for reemployment with your former employer in accord with USERRA.

Benefits

Your employer's leave of absence policy will determine your right to participate in any group insurance, such as Life, Accidental Death and Dismemberment, Weekly Disability, and Long Term Disability.

After reemployment, credit will be given, if applicable, for the period of such service, if required to determine your benefit amounts, eligibility, or costs.

Important Notice

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by your employer or former employer, will apply.

THE DEFINITIONS, GENERAL EXCLUSIONS AND LIMITATIONS AND RIDERS ARE VERY IMPORTANT PARTS OF YOUR POLICY. PLEASE READ THOSE PAGES CAREFULLY.

SCHEDULE

The amount of insurance for you will be in accord with your classification in this Schedule.

Classification

Class 1 - All eligible employees

For You
(Class 1)
LIFE INSURANCE

Life Insurance Benefits

Amount of Life Insurance.....$2,000

Facility of Payment Amount.....*$500

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

Life Insurance Benefits end on the date of your retirement.

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

Life Insurance Benefits
Living Benefits Option

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

HEALTH INSURANCE
(For You)

Accidental Death and Dismemberment Benefits

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

LIFE INSURANCE BENEFITS

For You

Benefits

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

(a) to your surviving spouse; if none, then

(b) to your surviving natural and/or adopted children; if none, then

(c) to your surviving parent(s); if none, then

(d) to your estate.

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

Mode of Payment

We will pay benefits:

(a) in a lump sum; or

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

Beneficiary or Mode of Payment Change

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

Facility of Payment

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

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

(a) the beneficiary is a minor or, in our opinion, does not have the legal capacity to sign a receipt for payment; and

(b) there is no court-appointed guardian or conservator.

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

Conversion Privilege

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

(a) You may apply for any of our individual life insurance policies except term insurance. You may not apply for any supplemental coverage.

(b) You may apply for an amount which is not more than the amount of your terminated group life insurance.

(c) The premium for your conversion policy will be at our standard rate for that type of policy according to:
   (1) your class of risk; and
   (2) your age on the date the policy takes effect.

(d) You must submit your written application and your first conversion premium to us within 31 days after your group life insurance ends or reduces.

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

(a) $3,000.00; or

(b) the amount of your terminated group life insurance less the amount of any other group life insurance for which you become eligible within 31 days.

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

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

(a) you terminate the conversion policy; or

(b) you submit, at your own expense, evidence of good health acceptable to us.

LIFE INSURANCE BENEFITS

For You LIVING BENEFITS OPTION (ACCELERATED BENEFITS)

Benefits

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

Conditions

(a) To be insured for Living Benefits, you must be insured for Life Insurance Benefits.

(b) We may require your beneficiary's, and in community property states, your spouse's written consent before Living Benefits are paid.

(c) Your Life Insurance Benefits and the amount you may convert in accordance with the life Conversion Privilege will be reduced by the Living Benefit amount paid under this provision.

(d) An insured person may receive Living Benefits only once.

Definition

Terminal Condition means an injury or sickness:

(a) expected to result in your death within 12 months; and

(b) from which there is no reasonable prospect of recovery;

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

Exceptions

This Living Benefits provision will not apply:

(a) when you have irrevocably assigned your Life Insurance Benefits;

(b) when all or a portion of your Life Insurance Benefits are to be paid to your former spouse as part of a divorce agreement;

(c) to any intentionally self-inflicted injury or suicide attempt;

(d) if your Life Insurance ends;

(e) if the required premium is due and unpaid;

(f) to any supplemental life insurance benefits to which you may be entitled; or

(g) if the Master Policy ends.

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

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

For You

Benefits

If, while insured under this provision, you are accidentally injured, and that injury is independent of sickness and all other causes, we will pay the **Benefit** shown in the **Table** below for any of the following losses:

TABLE

Loss	**Benefit**
Life	Principal Sum
Both hands, both feet or both eyes	Principal Sum
One hand and one foot, one hand and one eye or one foot and one eye	Principal Sum
One hand, one foot or one eye	One-half Principal Sum
Thumb and index finger of same hand	One-fourth Principal Sum

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

Loss of a hand means the severance at or above the wrist joint.

Loss of a foot means the severance at or above the ankle joint.

Loss of thumb and index finger means the severance of two or more phalanges of both the thumb and the index finger.

Loss of an eye means the total loss of sight in that eye.

If the injury causes more than one loss, we will pay only the **largest** Benefit.

Payment for Loss of Life
Beneficiary

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

(a) to your surviving spouse; if none, then

(b) to your surviving natural and/or adopted children; if none, then

(c) to your surviving parent(s); if none, then

(d) to your estate.

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

Mode of Payment

We will pay death benefits:

(a) in a lump sum; or

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

Beneficiary or Mode of Payment Change

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

Payment for Other Than Loss of Life

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

Definition

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

Exceptions

We will not pay for any loss which:

(a) is not permanent;

(b) occurs more than 90 days after the injury;

(c) is caused by carbon monoxide poisoning;

(d) is caused by allergic reactions;

(e) results from injuries you receive in any aircraft other than while riding as a passenger in a commercial aircraft on a regularly scheduled flight; or while:
   (1) operating;
   (2) riding as a passenger in; or
   (3) boarding or leaving;

   any aircraft while you are traveling on business of the Policyholder, provided the aircraft:

   (4) has a current and valid FAA (Federal Aviation Administration of the United States) standard air worthiness certificate; and
   (5) is operated by a person holding a current and valid FAA pilot's certificate of rating authorizing him or her to operate the aircraft;

(f) results from injuries you receive while riding in any aircraft engaged in:
   (1) racing;
   (2) endurance tests; or
   (3) acrobatic or stunt flying; or

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

GENERAL EXCLUSIONS AND LIMITATIONS

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

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

(a) any loss which results, whether the insured person is sane or insane, from:
  (1) an intentionally self-inflicted injury or sickness; or
  (2) suicide or attempted suicide;

(b) any loss resulting from the insured person's participation in a riot or in the commission of a felony;

(c) any loss which results from an act of declared or undeclared war or armed aggression; or

(d) any loss:
  (1) which is incurred while the insured person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country; and
  (2) for which any governmental body or its agencies are liable.

PAYMENT OF CLAIMS

How to File Claims

Before benefits are paid, we must be given a written proof of loss, as described below. In the event of your death or incapacity, your beneficiary or someone else may give us the proof.

Proof of Loss Requirements

1. First, request a claim form from the Plan Administrator or from us.

   This request should be made:

   (a) within 20 days after a loss occurs; or

   (b) as soon as reasonably possible.

   When we receive the request, we will send a claim form for filing proof of loss. If we do not send it within 15 days, you can meet the proof of loss requirement by giving us a written statement of what happened. We must receive a written statement within the time shown in 3 below.

2. Next, complete and sign the claim form. If a physician must complete part of the claim form, have the physician complete and sign that part.

3. Finally, return the claim form to the Plan Administrator or to us. The claim form is due:

   (a) within 90 days after the loss occurs; or

   (b) as soon as reasonably possible, but not later than one year after (a) above, unless the claimant is not legally capable.

When Claims are Paid

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

Direct Payments

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

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

(a) your beneficiary; or

(b) your estate.

If your beneficiary is unable to give a valid release or if benefits unpaid at your death are not more than $1,000, we may pay up to $1,000 to any relative of yours who we find is entitled to the benefit.

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

Examination and Autopsy

We sometimes require that a claimant be examined by a physician of our choice. We will pay for these examinations. We will not require more than a reasonable number of examinations. Where not prohibited by law, we may also require an autopsy. We will pay for this autopsy.

STANDARD PROVISIONS

Insurance Contract

The insurance contract consists of:

(a) the policy;

(b) the Policyholder's application attached to the policy; and

(c) your application, if required.

Changes in the Insurance Contract

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time we and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

(a) does not require your or your beneficiary's consent; and

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

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

Applications

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

Statements in an application are treated as representations, not as warranties.

Legal Actions

No legal action can be brought until at least 60 days after we have been given written proof of loss. No legal action can be brought more than two years after the date written proof of loss is required.

SUMMARY PLAN DESCRIPTION

for
Sacramento Independent Hotel, Restaurant & Tavern Employees Welfare Trust

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to eligible participants in an Employee Benefits Plan.

This certificate is your ERISA Summary Plan Description. Contributions are made solely by your employer. Contributions are based on the amount of insurance premiums necessary to provide Plan coverage.

PLAN IDENTIFICATION NUMBER

E.I.N.	P.N.
501	94-6277871

PLAN ADMINISTRATION

This Plan is provided through and administered by:
Sacramento Independent Hotel, Restaurant & Tavern Employees
Welfare Trust
1779 Tribute Rd.
Ste. L
Sacramento, CA 95815
Phone (916) 921-3388

AGENT FOR SERVICE OF LEGAL PROCESS

Sacramento Independent Hotel, Restaurant & Tavern Employees Welfare Trust

1779 Tribute Rd.
Ste. L
Sacramento, CA 95815
Phone (916) 921-3388

***or any of the Trustees shown below.**

TRUSTEES

Employer Trustees	Union Trustees
Dennis Hammond(Chairman) Vagabond Cocktail Lounge 1415 Fulton Avenue Sacramento, CA 95825-3605 (916)484-9666	Ted Hansen (Secretary) Local 49 1824 Tribute Road, Suite D Sacramento, CA 95815 (916)564-4949
Sandra Parker Ponderosa Inss 1100 H Street Sacramento, CA 95814 (916)441-1314	Joseph McLaughlin Local 49 1824 Tribute Road, Suite D Sacramento, CA 95815 (916)564-4949
John Newman Clarion Hotel 700 16th Street Sacramento, CA 95815 (916)444-8000	Rebecca Garcia Local 49 1824 Tribute Road, Suite D Sacramento, CA 95815 (916)564-4949
	Karl Neubuerger Local 49 1824 Tribute Road, Suite D Sacramento, CA 95815 (916)564-4949

PLAN YEAR

Each 12-month period beginning on July 1 is a Plan Year for the purposes of accounting and all reports to the United States Department of Labor and other regulatory bodies.

STATEMENT OF ERISA RIGHTS

As a participant in this Group Insurance Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants shall be entitled to:

(a) examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts and collective bargaining agreements, a list of participating employers and employee organizations sponsoring the Plan and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions. Upon written request you may receive information as to whether a particular employer or employee organization is a sponsor of the Plan and, if so, the sponsor's address.

(b) obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

(c) if there are 100 or more participants in this Plan, all Plan participants shall be entitled to 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.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefits 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, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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. 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 the 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 or fees; for example, if it finds your claim is frivolous.

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, you should contact the nearest area office of the U.S. Labor-Management Services Administration, Department of Labor.

CLAIM REVIEW PROCEDURES

If your claim is denied or partly denied, you will receive written notice of the denial, together with the specific reason for the denial, directly from us. You may appeal any denial directly to us within 60 days after receiving the denial notice. We will inform you within 60 days after we receive your written appeal, unless an unusual circumstance requires an extension of time to investigate or consider your appeal. If this occurs, we will inform you or the reason and the additional time needed, not to exceed an additional 60 days.

We will make a claim decision within 90 days following our receipt of your written claim for benefits, unless an unusual circumstance requires an extension of time to investigate or consider your claim. If this occurs, we will inform you of the reason and the additional time needed, not to exceed an additional 90 days.

AUTHORITY TO INTERPRET POLICY

By purchasing this 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. In making any decision, we may rely on the accuracy and completeness of any information furnished by the Policyholder or an insured person. Our interpretation of the Policy as to the amount of benefits and eligibility shall be binding and conclusive on all persons.

The Policyholder, as plan sponsor, agrees that the Policyholder retains full responsibility for the legal and tax status of its benefits program and releases us from all responsibility for the reporting and the employment-based design of the program and from all other responsibilities not accepted in writing by an officer of ours.

PLAN CHANGES

The persons with authority to change, including the authority to terminate the Plan or the Insurance Contract on behalf of the Policyholder is 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 additional information about how the Insurance Contract 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.

RIDER

This rider is made a part of Group Policy GLUG-26M9.

This rider is effective the later of January 1, 1998, or the day you become insured under the policy.

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

1. The following provision are deleted from the policy:

   LIFE INSURANCE BENEFITS - 1008GI-B-EZ No. 2

   ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS - 306GI-C-EZ

2. The following provisions are added to the policy:

   LIFE INSURANCE BENEFITS - 1008GI-B-EZ No. 2 W/O Parents

   ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS - 306GI-C-EZ W/O Parents

UNITED OF OMAHA LIFE INSURANCE COMPANY

Daniel P. Neary

Chairman of the Board and Chief Executive Officer

LIFE INSURANCE BENEFITS

For You

Benefits

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

(a) to your surviving spouse; if none, then

(b) to your surviving natural and/or adopted children; if none, then

(c) to your estate.

Benefits will be paid equally among surviving children.

Mode of Payment

We will pay benefits:

(a) in a lump sum; or

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

Beneficiary or Mode of Payment Change

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

Facility of Payment

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

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

(a) the beneficiary is a minor or, in our opinion, does not have the legal capacity to sign a receipt for payment; and

(b) there is no court-appointed guardian or conservator.

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

Conversion Privilege

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

(a) You may apply for any of our individual life insurance policies except term insurance. You may not apply for any supplemental coverage.

(b) You may apply for an amount which is not more than the amount of your terminated group life insurance.

(c) The premium for your conversion policy will be at our standard rate for that type of policy according to:
   (1) your class of risk; and
   (2) your age on the date the policy takes effect.

(d) You must submit your written application and your first conversion premium to us within 31 days after your group life insurance ends or reduces.

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

(a) $3,000.00; or

(b) the amount of your terminated group life insurance less the amount of any other group life insurance for which you become eligible within 31 days.

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

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

(a) you terminate the conversion policy; or

(b) you submit, at your own expense, evidence of good health acceptable to us.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

For You

Benefits

If, while insured under this provision, you are accidentally injured, and that injury is independent of sickness and all other causes, we will pay the **Benefit** shown in the **Table** below for any of the following losses:

TABLE

Loss	**Benefit**
Life	Principal Sum
Both hands, both feet or both eyes	Principal Sum
One hand and one foot, one hand and one eye or one foot and one eye	Principal Sum
One hand, one foot or one eye	One-half Principal Sum
Thumb and index finger of same hand	One-fourth Principal Sum

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

Loss of a hand means the severance at or above the wrist joint.

Loss of a foot means the severance at or above the ankle joint.

Loss of thumb and index finger means the severance of two or more phalanges of both the thumb and the index finger.

Loss of an eye means the total loss of sight in that eye.

If the injury causes more than one loss, we will pay only the **largest** Benefit.

Payment for Loss of Life
Beneficiary

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

(a) to your surviving spouse; if none, then

(b) to your surviving natural and/or adopted children; if none, then

(c) to your estate.

Benefits will be paid equally among surviving children.

Mode of Payment

We will pay death benefits:

(a) in a lump sum; or

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

Beneficiary or Mode of Payment Change

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

Payment for Other Than Loss of Life

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

Definition

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

Exceptions

We will not pay for any loss which:

(a) is not permanent;

(b) occurs more than 90 days after the injury;

(c) is caused by carbon monoxide poisoning;

(d) is caused by allergic reactions;

(e) results from injuries you receive in any aircraft other than while riding as a passenger in a commercial aircraft on a regularly scheduled flight; or while:
   (1) operating;
   (2) riding as a passenger in; or
   (3) boarding or leaving;

   any aircraft while you are traveling on business of the Policyholder, provided the aircraft:

   (1) has a current and valid FAA (Federal Aviation Administration of the United States) standard air worthiness certificate; and
   (2) is operated by a person holding a current and valid FAA pilot's certificate of rating authorizing him or her to operate the aircraft;

(f) results from injuries you receive while riding in any aircraft engaged in:
   (1) racing;
   (2) endurance tests; or
   (3) acrobatic or stunt flying; or

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

This certificate or verification of insurance is not an insurance policy and does not amend, extend or alter the coverage afforded by the policies listed herein. Not withstanding any requirement, term or condition of any contract or other document with respect to which this certificate or verification of insurance may be issued or may pertain, the insurance afforded by the policies described herein is subject to all the terms, exclusions and conditions of such policies.