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## CERTIFICATE OF INSURANCE VOLUNTARY SHORT TERM DISABILITY INSURANCE

**Policyholder:** SEIU Local 503, Oregon Public Employees Union  
**Policy Number:** 50059083  
**Effective Date:** January 1, 2026  
**Class:** All Eligible Members of the Policyholder  
**State of Issue:** Oregon

This Certificate is a part of the Policy and replaces any other that We may have issued to the Policyholder. You are insured for the benefits described in this Certificate, subject to the provisions of this Certificate. **Pre-existing condition limitations or exclusions and other limitations or exclusions may apply. Please read Your policy carefully.** The maximum benefit duration schedules may limit or reduce benefits or cost of living adjustments may be made based on the attainment of certain ages. You may inspect a copy of the Certificate upon request to the Policyholder.

### READ THE CERTIFICATE CAREFULLY

If the terms and provisions of the Certificate differ from the Policy, the Policy will govern. Your coverage may be canceled or changed in whole or in part under the terms and provisions of the Policy but shall not be less than those stated in this Certificate. You may inspect a copy of the Certificate upon request to Your Participating Employer or Policyholder.

The Policy is delivered in and is governed by the laws of the Issue State and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Any provision of this Certificate that, on or after the Effective Date, conflicts with the applicable law, will be amended as of the effective date of such law or the date of this Certificate (whichever is later), to comply with the minimum requirements of such statute.

For purposes of Effective Dates and ending dates under the Policy, all days begin at 12:00 A.M. and end at 12:00 A.M., local time, at Your Participating Employer's place of business.

Secretary

President

NON-PARTICIPATING, RENEWABLE

## **INSURANCE DEPARTMENT CONTACT INFORMATION**

**Oregon Division of Financial Regulation**

**350 Winter St. NE**

**Fourth floor**

**Salem, OR 97301**

## TABLE OF CONTENTS

Your Certificate is divided into the following sections:

SCHEDULE OF INSURANCE.....	4
DEFINITIONS.....	6
ELIGIBILITY .....	14
ENROLLMENT FOR COVERAGE .....	15
EVIDENCE OF INSURABILITY (EOI) .....	16
EFFECTIVE DATE .....	17
CONTINUITY OF COVERAGE – TAKEOVER PROVISION .....	18
CONTINUITY OF COVERAGE – PRE-EXISTING CONDITION .....	19
CHANGES IN COVERAGE.....	20
TERMINATION OF INSURANCE .....	21
WAIVER OF PREMIUM .....	22
CONTINUATION OF COVERAGE.....	23
REINSTATEMENT .....	25
SHORT TERM DISABILITY PROVISIONS .....	26
TERMINATION OF BENEFITS .....	32
EXCLUSIONS AND LIMITATIONS .....	33
PRE-EXISTING CONDITIONS .....	34
GENERAL INFORMATION .....	40

## SCHEDULE OF INSURANCE

This Schedule of Insurance ("SCHEDULE") is a brief overview of Your benefits if You become Disabled. These benefits are described further in the Certificate, along with other important information about Your coverage.

Defined terms are capitalized and can be located in the Definitions section of the Certificate.

**Policyholder:** SEIU Local 503, Oregon Public Employees Union  
**Policyholder Address:** 1730 Commercial St. SE Salem, OR 97302  
**Policyholder Telephone Number:** 503-540-8404  
**Policy Number:** 50059083  
**Policy Effective Date:** January 1, 2026  
**Certificate Effective Date:** January 1, 2026  
**Annual Enrollment Date:** January 1 of Each Year  
  
**Eligible Class:** Class 1: All Eligible Members of the Policyholder

**Full-Time Employment Requirements:**

**Contributory Benefits:** 40 hours monthly

\* **Weekly Benefit:** The Weekly Benefit is the amount You selected (in \$200 increments)

*\*A Member of the Policyholder can only elect 1 option and can only change options at the Annual Enrollment Period.*

**Payment Frequency:** Weekly

\***Maximum Weekly Benefit:** \$600

**Minimum Weekly Benefit:** \$200

\*We will reduce the amount We pay You by Other Income Amounts, as explained under OTHER INCOME AMOUNTS in the section, SHORT TERM DISABILITY BENEFITS.

**Maximum Benefit Period:** 104 weeks

**Employee Waiting Period:** the Waiting Period is determined by the Policyholder

**Elimination Period:**

If Disability is due to an Accident or Injury, Your Elimination Period is 30 day(s).

If Disability is due to a Sickness, Your Elimination Period is 30 day(s).

The Elimination Period begins on the first day of Your Disability.

**Interruption Period:** If You return to work during the Elimination period for up to 3 day(s), You will not have to fulfill a new Elimination Period.

**Cost of Coverage:** You pay the cost of Your coverage.

## DEFINITIONS

When used in this Certificate, capitalized terms have the following meanings:

**Accident** is an unforeseen occurrence which results in an Accidental Bodily Injury and occurs while this Certificate is in force and is not excluded in the Certificate.

**Accidental Bodily Injury** means an Injury or Injuries for which Treatment is received. The Injury or Injuries must be sustained by a Covered Person and must be the direct cause of the loss, independent of disease or bodily infirmity. All such Injuries, with any complications and any recurrences of complications arising from any one Accident, will be deemed to be a single Injury. Such Injury or Injuries must occur while the Certificate is in force.

**Actively at Work or Active Work** means You are performing all of the usual and customary duties of Your Job on a Full-Time basis for earnings. This may be done at the Participating Employer's place of business, an alternate place approved by the Policyholder a place to which the Participating Employer's business requires You to travel. Commissioners, Directors, Elected Officials, Appointed Officials and other individuals designated by the Participating Employer of the organization are not considered Eligible Person's Actively at Work.

If You are not working on a day Your coverage would otherwise take effect, You will be considered to be at Active Work on that day if:

1. when that work day begins, it would be reasonable to expect that You would be physically and mentally able to complete a week of work in Your Occupation; and
2. You are not Disabled; and
3. Your contract of employment, if applicable, remains active; and
4. You are not on an unapproved, administrative or disciplinary leave.

You will be considered Actively at Work on weekends or during a Participating Employer approved vacations, school breaks, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

**Annual Enrollment** means the event where You may enroll in voluntary coverage if You have completed the waiting period, the policy changed to include Your class, or You became a member of an Eligible Class for coverage.

Any amounts exceeding the in force Guaranteed Issue amount will be subject to satisfactory Evidence of Insurability.

**Annual Enrollment Period** means the 30 days prior to Your Annual Enrollment date shown in the SCHEDULE.

**Application** means the document pertaining to the plan of insurance applied for by the Policyholder. This document is attached to the Policy.

**Appropriate Treatment and Care** means that You:

1. visit a Physician as frequently as medically required according to standard medical practice to effectively treat and manage Your Disabling condition(s); and
2. receive care or treatment appropriate for the Disabling condition(s), conforming with standard medical practice, by a Physician whose specialty or experience is appropriate for the Disabling condition(s) according to standard medical practice.

**Bonus** means supplemental compensation calculated as a monthly average paid to You by Your Participating Employer over the past 52 weeks or over the number of calendar weeks of employment if less than this period.

**Certificate** means this document prepared by Us which describes Your benefits and rights under the Policy, and includes any riders, endorsements, amendments, applications, notices or other attachments to the Certificate.

**Child or Children** means Your biological/natural child ,legally adopted child, child placed for adoption, stepchild, foster child, child to which You are a party in a suit to seek adoption and any other child required to be covered under the civil union, domestic partnership, marriage or other family or domestic relations laws of the state where the Policy is delivered or issued for delivery or are the legal guardian of or other Children in whose lives the Employee or the Employee's Spouse has an insurable interest who is under the age of 26.

**Civil Union Partner** means a person who has entered into a legal Civil Union Partnership with You as recognized by Your state government.

**Civil Union Partnership** means a legal relationship between two people — either of the same or different sex — providing all of the legal obligations, responsibilities, protections and benefits that the law of Your state grants to married couples.

**Commission** means incentive based compensation for services rendered or products or services sold calculated as a weekly average paid to You by Your Participating Employer over the past 52 weeks or over the number of calendar weeks of employment if less than this period.

**Complications of Pregnancy** means:

1. any of the following conditions whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as: acute nephritis, pyelitis of pregnancy, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning Sickness and similar conditions associated with the management of a difficult pregnancy not constituting a condition which is medically classified as a distinct complication of pregnancy;
2. an extra-uterine pregnancy;
3. a complication that requires intra-abdominal surgery after termination of pregnancy;
4. a miscarriage;
5. a non-elective caesarean section;
6. an ectopic pregnancy that is terminated;
7. a spontaneous termination of pregnancy that occurs when a viable birth is not possible;
8. placenta previa, placenta abruptio or premature rupture of membranes;
9. pernicious vomiting of pregnancy (hyperemesis gravidarum); and/or
10. toxemia (eclampsia OR preeclampsia).

**Contributory** means You pay part or all of the cost for Your coverage.

**Covered Person** means an eligible Employee as defined by the Policyholder whose insurance coverage has become and remains effective under all the conditions and provisions of the Policy.

**Disability or Disabled** means a Sickness or Injury that:

1. Prevents You from performing all of the Material and Substantial Duties of Your Regular Occupation or a Reasonable Employment Option offered to You by Your Participating Employer.

**Effective Date** means the date the Policy provides coverage for members of an Eligible Class.

**Eligible Class** means the group(s) of Employees who have met the criteria selected by the Policyholder for eligibility for coverage under the Policy.

**Eligible Person** means a person who:

1. is a citizen of the United States or Canada who either:
  - a. resides in the United States or Canada; or
  - b. resides outside the U.S. or Canada for a period of less than 6 months per year; and
  - c. works for a United States company at a job site in the United States; and
  - d. is not in active, Military Service; or
2. is a foreign national residing in the U.S. who:
  - a. is legally permitted to work in the U.S.

**Eligibility Date** means the date or dates an Employee in an Eligible Class becomes eligible for insurance under this Policy. Classes eligible for insurance are shown in the SCHEDULE OF INSURANCE.

**Elimination Period** means a period of continuous days of Disability before benefits are payable. The Elimination Period begins on the first day of Your Disability and is shown in the SCHEDULE.

**Employee** means an Employee of the union who was covered by a Collective Bargaining Agreement or like agreements for which contributions were been made by a Participating Employer to the SEIU Local 503, Oregon Public Employees Union.

Directors, officers, consultants, elected officials, appointed officials, proprietors, owners, partners, commissioners, or other persons not Actively at Work on behalf of the Participating Employer will not be considered an Employee.

**Enrollment Form** means the paper, electronic or telephonic media used to enroll Your benefits under this Policy, and which is consistent with applicable law and has been approved by Us.

**Evidence of Insurability (EOI)** means a statement of Your health and medical history, which will be used to determine if You will be approved for coverage or an increase in coverage.

**Family and Medical Leave of Absence** means a Leave of Absence for:

1. The birth, adoption or foster care of a Child;
2. The care of Your Child, Spouse or parent who has a serious health condition; or
3. Your own serious health condition;

as those terms are defined by the Family and Medical Leave Act of 1993, as amended, or by applicable state law.

**Full-Time** means Actively at Work for Your Participating Employer as indicated in the SCHEDULE for Full-Time employment.

**Guaranteed Issue** means the maximum amount of insurance available under this Policy without Evidence of Insurability.

**Gross Weekly Benefit** means Your benefit amount before We subtract Other Income Amounts, subject to Maximum Weekly Benefit under this Policy.

**Home Office** means the principal office of USABLE Life in Little Rock, Arkansas or authorized agencies.

**Hospital** means a facility supervised by one or more licensed Physicians which is licensed, accredited and operated under state and local laws. It must have 24-hour nursing service by registered graduate nurses. It may specialize in treating alcoholism, drug addiction, chemical dependency, or mental disease, but it cannot be a rest home, convalescent home, or a home for the aged.

**Immediate Family** means any of the following:

1. Your Spouse;
2. Your natural or adopted child, stepchild, or grandchild;
3. The spouse of Your child, stepchild, or grandchild;
4. Your parent, stepparent, parent-in-law, or grandparent; or
5. Your sibling.

**Injury** means a bodily Injury that requires You to be under the regular care of a Physician and is the direct result of an Accident and not related to any other cause. An Injury that occurs 12 months before You are covered under the Policy will be treated as a Sickness.

**Inpatient** means a person confined in a Hospital, for whom at least one day's room and board charge is made by the Hospital as a result of an Injury or Sickness.

**Intoxicated** means Your normal capacity to act or reason is inhibited by alcohol or any drug, sedative, hallucinogen, controlled substance or narcotic, unless administered by a Physician and taken according to the Physician's instructions and as determined by the laws of the jurisdiction in which the incident occurred. Conviction is not necessary for a determination of being Intoxicated.

**Job** means the position, role, or job that a Covered Person was performing for compensation on the day prior to the Covered Person's loss.

**Leave of Absence** means a temporary absence from Active Work that has been agreed to and approved by the Policyholder for a specified period of time. Normal vacation time or any period of Disability is not considered a Leave of Absence.

**Material and Substantial Duty or Material and Substantial Duties** mean the sets of tasks or skills generally required by Participating Employers from those engaged in an occupation. We will consider one material and substantial duty of Your occupation to be the ability to work for the Participating Employer on a basis as defined in the Policy.

**Maximum Benefit Period** means the longest period of time for which benefits are payable for any one continuous Disability, whether from one or more causes. No benefits are payable after the Maximum Benefit Period, even if You are still Disabled.

**Maximum Capacity** means, based on the limiting factors of Your Sickness or Injury, the greatest extent of work You are able to do in an occupation from which You must be considered Disabled in order to receive benefits under the Policy.

**Military Leave** means a leave of absence that:

1. is subject to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), and any amendments to it; and
2. is taken in accord with the Policyholder's leave Policy and the federal USERRA law; and
3. does not exceed the period required by that law.

**Military Service** means performance of duty on a voluntary or involuntary basis in a Uniformed Service including:

1. Active duty;
2. Active duty for training;
3. Initial active duty for training;
4. Inactive duty training;
5. Full-time National Guard duty;
6. Absence from work for an examination to determine a person's fitness for any of the above types of duty;
7. Funeral honors duty performed by National Guard or reserve members; and
8. Duty performed by intermittent employees of the National Disaster Medical System (NDMS), which is part of the Department of Homeland Security – Emergency Preparedness and Response Directorate (FEMA), when activated for a public health emergency, and approved training to prepare for such service.

**Minimum Weekly Benefit** means the minimum dollar amount of benefits We will pay. We will pay this amount, even if the reduction(s) in Your Weekly Benefit due to Other Income Benefits would reduce Your Weekly Benefit below that dollar amount.

**Motor Vehicle** means a vehicle (such as a car, truck, or motorcycle) that is powered by an engine.

**Net Weekly Benefit** means the amount of benefit payable under the Policy and is Your Gross Weekly Benefit reduced by Other Income Amounts and subject to the Maximum and Minimum Weekly Benefit.

**Non-participating** means that We do not allocate surplus to the policy.

**Occupation** means a group of Jobs or related Jobs:

1. in which a common set of tasks is performed; or
2. which are related in terms of similar objectives and methodologies, and which may be related in terms of materials, products, worker actions, or worker characteristics.

**Participation** with respect to **Riot** or **Act of Terrorism** means promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in such actions. It does not include actions taken in defense of public or private property, or actions taken in defense of the person of the Covered Person, if such actions of defense are not taken against persons seeking to maintain or restore law and order, including but not limited to police officers and firemen.

**Participating Employer** means any contributing Participating Employer or Employee who meets the requirements to participate in the SEIU Local 503, Oregon Public Employees Union.

The Policyholder will maintain a list of Employees and the effective dates of coverage for each. The Policyholder may, by written request, add to or delete from the list of Employees at any time.

**Physician** means a person acting within the scope of his or her license to practice medicine, prescribe drugs or perform surgery. This includes a person whom We are required to recognize as a Physician by the laws or regulations of the governing jurisdiction. However, neither You nor an Immediate Family

Member will be considered a Physician.

**Plan** means the insurance provided for Covered Persons as outlined in the Policy and Certificates of Insurance.

**Plan Year** means January 1st to December 31st.

**Policy** means the instrument by which the benefits under the Plan are approved and issued to the Policyholder, including riders, endorsements or amendments, notices or other attachments.

**Policy Anniversary** means the specified period of time (such as one year) following the Effective Date of the Policy, and each subsequent period.

**Policy Month** means the month in which coverage became effective. The first Policy Month begins on the Effective Date of the Policy. Subsequent Policy Months will begin on the same day of each following calendar month.

**Policy Year** means January 1st to December 31st.

**Policyholder** means the entity to which the Policy is issued.

**Pre-Disability Earnings** means Your gross weekly rate of earnings from the Participating Employer just prior to the date Disability begins. It includes earnings from shift differential, overtime pay and other extra compensation.

It does not include earnings from bonuses, renewal commissions, or commissions.

It includes Your pre-tax contributions to a deferred compensation plan which is defined by a documented, pre-determined formula.

**Pre-Existing Condition** means any condition for which You have done any of the following during the 3 month(s) just prior to Your effective date of coverage:

1. received medical treatment or consultation;
2. taken or were prescribed drugs or medicine; or
3. received care or services, including diagnostic measures;

whether or not that condition is diagnosed at all or is misdiagnosed during that period of time.

**Pregnancy** means childbirth and **Complications of Pregnancy**.

**Premium** means the amount charged for insurance provided under the Policy.

**Prior Plan** means the Policyholder's insurance plan under which a Covered Person may have been insured on the day before the Effective Date of the Policy.

**Proof of Loss** means written evidence satisfactory to Us that a Covered Person has satisfied the conditions and requirements for any benefit described in the Certificate. The Proof of Loss shall establish:

1. The nature and extent of the loss or condition;
2. Our obligation to pay the claim; and
3. The claimant's right to receive payment.

**Reasonable Employment Option** means an employment position with Your Participating Employer for which You are able to perform the Material and Substantial Duties given Your education, training and experience. If You have been working in a Reasonable Employment Option for 12 months or more, the Reasonable Employment Option will then be considered Your Regular Occupation.

**Reciprocal Beneficiary** means one of two persons who have taken the steps required to create a valid Reciprocal Beneficiary relationship formed by consenting adults who are legally prohibited from marrying one another and who are not presently married or in another Reciprocal Beneficiary relationship. In order to enter into a valid Reciprocal Beneficiary relationship:

1. Each of the parties must be at least eighteen years old.
2. Neither of the parties may be married.
3. Neither of the parties may be a party to another Reciprocal Beneficiary relationship.
4. Neither of the parties may be a partner in a civil union.
5. The parties must be legally prohibited from marrying one another.
6. Consent of either party to the Reciprocal Beneficiary relationship may not be obtained by force, duress, or fraud.

**Regular Care** means:

1. You personally visit a Physician as often as is medically required to effectively manage and treat Your condition(s), according to generally accepted medical standards; and
2. You are receiving Appropriate Treatment and Care, according to generally accepted medical standards.

**Regular Occupation** means the occupation You are routinely performing when Your Disability begins, as it is performed locally. Regular Occupation does not mean the Job You are performing for a specific Participating Employer or at a specific location.

**Retirement Plan** means a defined contribution plan or defined benefit plan, as defined in Section 401 of the Internal Revenue Code of 1986, as amended.

**Riot** means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, acting with common intent to damage persons or property or unlawfully acting with the intent or the consequence of such disorder.

**Salary Continuation or Accumulated Sick Leave** means continued payments to You by Your Participating Employer of all or part of Your monthly earnings, after You become Disabled as defined above. This continued payment must be part of an established plan maintained by Your Participating Employer, and includes salary continuation, accumulated sick leave or any similar Participating Employer sponsored paid time off plan. Sick leave does not include PTO, vacation pay, holiday pay, or severance pay.

**Sickness** means a disease or illness, or physical condition (including pregnancy or complications of pregnancy) that requires You to be under the Regular Care of a Physician. It also includes an Injury which occurs 12month(s) before You are insured.

**Signed or Signature** means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

**Spouse** means the sole person who is Your partner through lawful marriage, civil union, registered domestic partnership, unregistered domestic partner (established by a declaration acceptable to us), or Your legally separated Spouse. Your Spouse may not be insured as both a Spouse and an Employee.

**Temporary Recovery** means a period of time after Your initial date of Disability during which We do not consider You to be Disabled, and immediately after which You become Disabled again due to the same Sickness or Injury. Days during any period of Temporary Recovery do not count toward the Elimination Period.

**Terrorism** means any act of violence that is dangerous to human life or potentially destructive of critical infrastructure or key resources committed by a group or individual, with or without foreign direction or inspiration, with the intent to intimidate or coerce a civilian population; or to influence the policy or to affect the conduct of a government by intimidation, coercion, violence, mass destruction, assassination, or kidnapping.

**Treatment** means:

1. Consulting with a Physician;
2. Receiving care or services from a Physician or from another medical professional a Physician recommends;
3. Taking prescribed medicines as prescribed; and
4. Receiving diagnostic measures.

**Uniformed Services** means the active and reserved Armed Forces, the Army National Guard and the Air National Guard, the Commissioned Corps of the Public Health Service, and any other category of persons designated by the President in time of War or national emergency.

**United States of America** means the fifty (50) states of the United States and the District of Columbia. It does not include territories of the United States.

**Waiting Period** is the period of time You must be Actively at Work in an Eligible Class before You are eligible for coverage.

**War** means declared or undeclared War or conflict involving the Uniformed Service of any country, group of countries, governments, or international organization.

**We, Us, and Our** mean USAble Life

**Work Earnings** means income You earn or receive while Disabled. If Your Work Earnings fluctuate, We may average Your Work Earnings over the lesser of the number of weeks You work while Disabled or 52 consecutive weeks.

**Written or Writing** means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

**You and Your** means a member of the Policyholder who has met all the eligibility requirements for coverage, and is:

1. directly employed in the normal business of the Participating Employer; and
2. paid for services by the Participating Employer;
3. and Actively at Work for the Participating Employer.

## **ELIGIBILITY**

### **EMPLOYEE ELIGIBILITY DATE**

If You are in an Eligible Class on the Effective Date of this Certificate, You are eligible for coverage under this Certificate on the later of:

1. The Policy Effective Date; or
2. The date determined from the eligibility requirements for insurance stated in the Agreement between the Employee, Participating Employer, and the Policyholder; or
3. The date You complete the Waiting Period following the Policy Effective Date.

If You are not in an Eligible Class on the Effective Date of this Certificate, You are eligible for coverage under this Certificate on the later of:

1. The date the policy is changed to include Your class;
2. The date You become a member of an Eligible Class for coverage as shown in the SCHEDULE;  
or
3. The date You satisfy the waiting period.

## **ENROLLMENT FOR COVERAGE**

### **ACTIVE WORK REQUIREMENT**

You must be Actively at Work to be eligible for coverage.

If You are not Actively at Work on the date Your coverage or any increase in coverage would otherwise be effective, Your coverage or increase in coverage will be effective on the date You return to Active Work.

If Your coverage is scheduled to take effect on a non-working day, Your Active Work status will be based on the last working day before the scheduled Effective Date.

### **INITIAL COVERAGE ENROLLMENT**

You must apply for coverage. To apply for Contributory coverage, You must:

1. Complete and sign an Enrollment Form; and
2. Return it to Your Participating Employer.

### **INITIAL COVERAGE EFFECTIVE DATE**

Your coverage will be effective on the 1<sup>st</sup> day of the month following the date You have satisfied the Waiting Period.

If Your coverage is subject to EOI requirements, Your coverage will be effective on the 1<sup>st</sup> day of the month following the date Your application is approved.

### **LATE ENTRANT COVERAGE ENROLLMENT**

If You were eligible for coverage under this Plan but did not enroll for coverage during Your initial Open Enrollment for this Plan, You will not be eligible to enroll in coverage until:

1. Your next Annual Enrollment Period; or
2. The date agreed upon by the Policyholder and Us.

Your enrollment for coverage may be subject to EOI requirements.

### **LATE ENTRANT COVERAGE EFFECTIVE DATE**

If Your coverage is subject to EOI requirements, Your coverage will be effective on the 1st- day of the month following the date Your application is approved.

## EVIDENCE OF INSURABILITY (EOI)

Evidence of Insurability (“EOI”) is a process where You provide Us with Your proof of good health and medical information. We use this information to determine if You are eligible for coverage or an increase in coverage under the Policy. This may include, but is not limited to:

1. a completed and signed Statement of Insurability form; and
2. any additional information We may require to complete the underwriting process.

The cost of providing such evidence shall be borne by Us.

We may require You to provide Us with EOI if You:

1. Apply for coverage more than 90 days after the date You are first eligible to apply during Your initial Open Enrollment Period; or
2. Apply for coverage if You previously declined coverage during Your initial Open Enrollment Period; or
3. Voluntarily terminated Your insurance or Your insurance ended for failure to pay premium when due, and You want to reapply for coverage; or
4. Apply for an amount of coverage for which We require EOI.

You and the Policyholder will be notified in Writing of EOI decisions.

If Your EOI is not satisfactory, or If You do not submit EOI, the amount of additional coverage or coverage increase requested will not become effective. The coverage in effect on the date immediately prior to the date of Your request will not change.

## EFFECTIVE DATE

### **Contributory Coverage when Evidence of Insurability (EOI) is not Required:**

You are required to contribute towards the cost of Your coverage. Your coverage will become effective on the 1<sup>st</sup> day of the Policy Month following the date You enroll if You do so by the 10<sup>th</sup> of the month from the date You become eligible for coverage. If after the 10<sup>th</sup> Your coverage will become effective on the 1<sup>st</sup> of the following month.

### **Contributory Coverage when Evidence of Insurability (EOI) is Required:**

You are required to contribute towards the cost of Your coverage. Your coverage will become effective the 1<sup>st</sup> day of the Policy Month following the date You become eligible for coverage, and We approve Your EOI.

## **CONTINUITY OF COVERAGE – TAKEOVER PROVISION**

### **EMPLOYEE CONTINUITY OF COVERAGE**

Except as set forth below, if You are absent from work due to an Injury or Sickness on the date Your coverage under this Policy would otherwise become effective, Your coverage will be effective on the date Your return to Active Work.

If You were insured under the prior carrier's plan on the day before the Effective Date, You will be eligible for coverage under the Policy, even if You are not Actively at Work on the Effective Date, if You meet the following conditions:

1. You are absent from work due to an Injury or Sickness on the date Your coverage under this Policy would otherwise become effective; and
2. You are not eligible to receive benefits under the Prior Plan.

In this situation, We will pay Your benefit as if the Prior Plan were still in effect, and Your benefit will be reduced by any benefits paid or payable by the Prior Plan.

### **CONTINUITY OF COVERAGE TERMINATION**

You will remain insured under this provision until the earliest of:

1. The date You return to Active Work;
2. The date Your coverage terminates for a reason stated in the TERMINATION OF INSURANCE section; or
3. The last day for which You would have been eligible to receive benefits under the Prior Plan, had the Prior Plan not terminated.

## **CONTINUITY OF COVERAGE – PRE-EXISTING CONDITION**

We will consider the total amount of time You were continuously insured under both the prior Policy and this Policy to determine if You satisfy the Pre-Existing Condition exclusion. If You cannot satisfy the Pre-Existing Condition exclusion of either plan, We will not pay a benefit.

If You satisfy the Pre-Existing Condition provision of this Policy, We will use this Policy's provisions to determine Our payments to You. If You do not satisfy the Pre-Existing Condition provision of this Policy, but You do satisfy the prior Policy's Pre-Existing Condition provision:

1. Your weekly payment will be the lesser of:
  - a. The weekly payment that would have been payable under the prior Policy if it had remained in force; or
  - b. The weekly payment under this Policy; and
2. Your benefits will end on the earlier of:
  - a. The date benefits end under this Policy; or
  - b. The date benefits would have ended under the prior Policy had it remained in force.

## **CHANGES IN COVERAGE**

### **POLICYHOLDER POLICY CHANGES**

Following Your initial Enrollment period, the Policyholder may request changes to Your Plan Benefits or benefit amount anytime during the Plan Year.

### **CHANGES IN COVERAGE YOU ELECT**

Following Your initial Enrollment period, You may make changes to Your coverage election during Your Annual Enrollment Period.

If You enrolled for coverage during Your initial Enrollment period and do not change or terminate coverage during Your next Annual Enrollment Period, You will continue to be insured for the same coverage and amounts You elected initially.

### **CHANGES IN FLAT COVERAGE**

Benefit increases requested outside Your Annual Enrollment Period, or over the Guaranteed Issue Amount shown on the SCHEDULE will be subject to EOI approval.

### **CHANGES IN PERCENT OF SALARY COVERAGE**

We will require EOI if, as a result of Your salary increase, the amount of Your benefit exceeds the Policy's Guaranteed Issue amount. The Policyholder must provide Your current earnings.

### **CHANGE IN COVERAGE EFFECTIVE DATE**

#### **Policy Changes**

Changes in coverage due to Policy changes made by the Policyholder will be effective at 12:00 A.M. on the Policy Anniversary date.

#### **Salary and Elected Changes**

Changes in coverage due to a salary change and changes You have elected will become effective at 12:00 A.M. on the later of the:

1. Policy Anniversary date;
2. 1<sup>st</sup> day of the Policy Month following the date of the change;
3. 1<sup>st</sup> day of the Policy Month following the date We approve Your EOI for any amount of insurance that is subject to EOI;
4. 1<sup>st</sup> day of the Policy Month following the date You return to Active Work following Leave of Absence, Sickness, or Injury.

Changes in coverage will not affect a payable claim that occurs prior to the date of the coverage change. Changes in coverage are subject to the Active Work provisions.

## TERMINATION OF INSURANCE

Your coverage under this Policy will end at 12:00 a.m. on the earliest of the following:

1. The date the Policy terminates;
2. The date You are no longer in an Eligible Class;
3. The date You are no longer a member of the SEIU Local 503, Oregon Public Employees Union;  
or
4. The date Your class is no longer eligible for coverage;
5. The date following the last day for which premium for Your coverage is required but has not been paid;
6. The date You cease to be Actively at Work, unless You are Disabled or on a Leave of Absence as defined in the Continuation of Coverage section; or
7. The date You retire.

If You are receiving benefits and the Policy terminates, We will continue to pay any benefit due to You.

## **WAIVER OF PREMIUM**

We will not require premium payments for Your coverage while You remain Disabled and are receiving benefits under the Policy.

Your coverage amount will not increase while Your premiums are being waived. Premiums waived under this provision will not be deducted from any benefits paid under the Policy.

If You want coverage to remain in effect, premiums for coverage must be paid once You return to Active Work with the Participating Employer.

### **WAIVER OF PREMIUM REQUIREMENTS**

You must be Disabled through Your Elimination Period. Your Elimination Period is shown in the SCHEDULE and is the period of continuous Disability You must satisfy.

Premium payments must continue until We notify the Policyholder of the date Your premium waiver begins. For insurance to continue under the Policy, full premium is due when required.

Your premium will be waived once You have completed the elimination period, if:

1. You remain Disabled during the Elimination Period;
2. You meet the notice and proof of claim requirements for Disability, as described in the CLAIM INFORMATION section, while coverage is in effect;
3. Your claim is approved by Us; and
4. all required premiums have been paid.

### **WHEN WAIVER OF PREMIUM ENDS**

Your Waiver of Premium will end on the earliest of the following:

1. the date You are no longer Disabled;
2. the date You fail to submit proof of continuing Disability;
3. the end of the Maximum Benefit Period;
4. the date premium has been waived for 12 months and You reside outside the United States or Canada. You will be considered to reside outside the United States or Canada when You have been outside the United States or Canada for a total period of 6 months or more during any 6 consecutive months in which premium has been waived; or
5. the date You die.

There is no limit to the number of times You are eligible for Waiver of Premium.

## **CONTINUATION OF COVERAGE**

### **CONTINUATION OF COVERAGE GENERAL PROVISIONS**

Any Leave of Absence, leave, Layoff, Labor Dispute, Military Leave, or Family or Medical Leave from Active Work must be approved in advance and in writing by Your Participating Employer.

### **CONTINUATION DURING LABOR DISPUTE**

Your coverage may be continued by the Participating Employer through the end of the 3rd month following the month in which Your labor dispute, including any strike, work slowdown, or lockout begins.

Your premium will be suspended from the first day of the month following the date of Your labor dispute, including any strike, work slowdown, or lockout.

All other terms and conditions of the Policy will apply.

### **CONTINUATION DURING LAYOFF**

Your coverage may be continued by the Participating Employer through the end of the 3rd month following the month in which Your Layoff begins.

Your coverage may be continued by the Participating Employer in accordance with the Policyholder's layoff provisions.

The premium for Your coverage must be paid during Your Layoff.

All other terms and conditions of the Policy will apply.

### **CONTINUATION DURING LEAVE OF ABSENCE**

Your coverage may be continued by the Participating Employer through the end of the 12th month following the month in which Your Leave of Absence begins.

Your coverage may be continued by the Participating Employer in accordance with the Policyholder's leave of absence provisions.

The premium for Your coverage must be paid during Your Leave of Absence.

All other terms and conditions of the Policy will apply.

## **CONTINUATION OF COVERAGE**

### **CONTINUATION DURING FAMILY OR MEDICAL LEAVE**

If You are on a leave mandated by the Family and Medical Leave Act (“FMLA”) or applicable state law, Your coverage will be governed by the Policyholder’s policy regarding Family and Medical Leaves of Absence.

Your coverage will terminate the earlier of the date the Policy terminates, the end of the Continuation period, or the last day for which any required premium has not been paid.

We will continue Your coverage if the following conditions are met:

1. Premiums for the cost of Your continued coverage are paid by You or the Participating Employer; and
2. Your leave is approved in writing by the Participating Employer.

Your coverage will continue for up to the greater of:

1. The leave period required by the federal Family and Medical Leave Act of 1993, as amended; or
2. The leave period required by applicable state law.

We will use Your Pre-Disability Earnings on the day immediately prior to Your Leave of Absence to determine the amount of Your benefit payments.

All other terms and conditions of the Policy will apply.

### **CONTINUATION DURING MILITARY LEAVE**

If You are on a leave of absence for active Military Service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) or applicable state law, Your coverage may be continued for the longer of:

1. The length of time the coverage may be continued under applicable federal or state law; or
2. The length of time the coverage may be continued under the Policy for a leave of absence.

Your continued coverage will terminate on:

1. The date on which the Policy terminates;
2. The end of the Continuation period; or
3. The last day for which any required premium has been paid.

The premium for Your coverage must be paid during the Military Leave.

The Policy does not cover any loss which occurs while on active duty in the Military Service if such loss is caused by or arises out of such Military Service, including but not limited to War or act of war (whether declared or undeclared). Benefits are also subject to any other Exclusions and Limitations under the Policy.

All other terms and conditions of the Policy will apply.

## **REINSTATEMENT**

### **REINSTATEMENT FOLLOWING LOSS OF ELIGIBILITY**

If Your coverage ends because You are no longer eligible for coverage and You again become eligible or return to an eligible class, Your coverage may be reinstated if reinstatement is requested within 90day(s) from the date You again become eligible for coverage or returned to an eligible class.

You will be required to submit EOI and fulfill the eligibility requirements of the Policy again before Your coverage will be reinstated.

Your coverage will be effective on the first day of the month following the date We approve Your EOI.

Reinstatement will be subject to payment of applicable premiums.

All other terms and conditions of the Policy will apply.

## **SHORT TERM DISABILITY PROVISIONS**

### **DETERMINING DISABILITY**

Your Disability must begin while You are covered under the Policy. Your Disability must continue through the Elimination Period shown on the SCHEDULE before benefits become payable. Your loss of earnings must be as a result of, or due to, the same Sickness or Injury for which You are Disabled.

We will not consider You Disabled because of a reduction in Your earnings resulting from any factors not directly related to Your Sickness or Injury. Examples include, but are not limited to, recession, job obsolescence, job restructuring or elimination, pay cuts, job sharing or changes in assigned location or hours.

We will not consider You Disabled because of the loss, suspension, restriction, surrender, or failure to maintain a required state or federal license to engage in Your Regular Occupation.

### **REGULAR CARE OF A PHYSICIAN**

You must be under the Regular Care of a Physician for the Sickness or Injury causing Your Disability in order to be eligible for payments from Us. No benefits are payable for any period in which You are not under the Regular Care of a Physician.

### **INDEPENDENT MEDICAL EXAMINATION**

We may require You to be examined by Physician(s), other medical practitioner(s) or vocational expert(s) of Our choice, at Our expense. Such examinations may include vocational or any other type of testing and evaluations We deem necessary to administer the Policy. We may require an examination as often as is reasonable. We may require You to meet with one of Our authorized representatives for an interview.

### **RETURNING TO WORK DURING THE ELIMINATION PERIOD**

We will consider Your Disability continuous if You have one or more periods of Temporary Recovery during the Elimination Period. If You return to work during Your Elimination Period for a period up to 3 Days of the Elimination Period and become Disabled again due to the same Sickness or Injury, We will treat Your Disability as continuing through the period You returned to work.

## **SHORT TERM DISABILITY BENEFITS**

### **CALCULATING YOUR BENEFIT**

Your Benefit will be determined as follows:

#### **For Flat Benefits:**

- Step 1: Identify the Weekly Benefit Amount in the SCHEDULE.
- Step 2: Compare the result in Step 1 to the Maximum Weekly Benefit in the SCHEDULE. The lesser amount is Your Gross Weekly Benefit.
- Step 3: Subtract Your Other Income Amounts from Your Gross Weekly Benefit. This is Your Net Weekly Benefit.

If Your Net Weekly Benefit Amount is less than the Minimum Weekly Benefit Amount in the SCHEDULE, We will pay the Minimum Weekly Benefit.

### **MINIMUM WEEKLY BENEFIT**

We will pay You a Minimum Weekly Benefit as shown in the SCHEDULE, subject to any overpayments.

### **IF YOU ARE DISABLED FOR ONLY PART OF A WEEK**

Your weekly benefit from Us is pro-rated. This means that if You are Disabled for only part of a week, You will receive a payment equal to 1/7th of Your full weekly benefit for each work day of the week You are Disabled.

### **TEMPORARY RECOVERY**

If You return to work and are no longer Disabled, and the same Sickness or Injury causes Your Disability to occur again within 14 days, We will resume Our payments to You if You were continuously insured under this Policy. You will not need to complete a new Elimination Period for this Disability. Your benefits will continue to be subject to the terms of the Policy in effect prior to Your Temporary Recovery.

If You return to work and become eligible for coverage under any other group short term disability plan, You will not be eligible for payments under this Policy.

We will treat a Disability due to other causes as a new Disability, subject to the terms and provisions of the Policy.

## **SHORT TERM DISABILITY BENEFITS**

### **WORK INCENTIVE BENEFIT:**

If You are working while Disabled and earning less than 20% of Your Pre-Disability Earnings, We will not reduce Your benefit by the amount of Your Work Earnings, or by any weekly income You could have earned from working to Your Maximum Capacity.

If the combined total of Your Gross Weekly Benefit, Work Earnings, and Other Income Amounts exceeds 100% of Your Pre-Disability Earnings, Your Gross Weekly Benefit will be reduced until the sum of Your Gross Weekly Benefit, Work Earnings and Other Income Amounts no longer exceed 100% of Your Pre-Disability Earnings.

## SHORT TERM DISABILITY BENEFITS

### OTHER INCOME AMOUNTS

These amounts, other than payments You are receiving from Us, include:

1. Any disability income benefits You receive or are eligible to receive under:
  - a. Any compulsory benefit act or law;
  - b. Any other group insurance plan with Your Participating Employer, Policyholder, or with an association;
2. Any benefits and awards You receive or are eligible to receive under:
  - a. Workers' Compensation law;
  - b. Occupational disease law; or
  - c. Any other similar act or law.
3. Any benefits under the United States Social Security Act, The Canada Pension Plan, The Quebec Pension Plan and includes any similar plan or act. Benefits include:
  - a. Disability benefits You, Your Spouse, or Your Children receive or are eligible to receive as a result of Your Disability; or
  - b. Retirement benefits You receive.
  - c. If Your Disability begins after Your 65<sup>th</sup> birthday, and You were receiving Social Security retirement benefits before Your Disability began, then We will not reduce Our payments to You by these retirement benefits.
4. Any benefits from Your Participating Employer's or Policyholders Retirement Plan You:
  - a. Receive as disability benefits which do not reduce Your retirement benefit; or
  - b. Receive as retirement benefits from Your Participating Employer's or Policyholders defined benefit plan.
5. Any benefits for loss of time or lost wages You receive from the mandatory portion of a no-fault Motor Vehicle insurance plan or automobile liability insurance policy that relate to Your disability.
6. Any amounts You receive under any unemployment compensation law.
7. Any amounts You receive from a third party (after subtracting attorney's fees) by judgment, settlement or otherwise relating to Your Disability (unless We elect to pursue Our rights through subrogation).

If Other Income Amounts are not paid on a weekly basis (for example, monthly or in a lump sum payment), Your Weekly Benefit will be offset by Our pro-rating of the Other Income Amount over the time period for which the Other Income Amount was paid. If no time period is specified, the sum will be pro-rated based on the number of weeks to the end of Your Maximum Benefit Period.

Other Income Amounts must be payable as a result of the same period of Disability as the one for which You are receiving a payment from Us, except for retirement benefits and Work Earnings.

### ESTIMATES OF OTHER INCOME AMOUNTS

We will offset Your Weekly Benefit based on an estimate of Other Income Amounts You may be eligible to receive. We can reduce Your benefit payments by this estimated amount if:

1. You have not been awarded such benefits but have not been denied such benefits; or

2. You have been denied such benefits and the denial is being appealed; or
3. You are reapplying for such benefits.

We will not reduce Our payments to You by these estimated amounts if:

1. You apply (or reapply) for benefits and appeal Your denial through all of the administrative levels We believe are necessary; and
2. You sign Our payment option form stating You will reimburse Us any overpayment of benefits caused by an award.

If We reduce Our payments to You by an estimated amount:

1. Then We will adjust Our payments to You when You give Us proof of the amount awarded; or
2. We will give You a lump sum refund of the estimated amount if You were denied benefits and have completed all appeals (or reapplications) We believe are necessary.

#### **PAID LEAVE OREGON (PLO) BENEFITS**

You may be eligible for family or medical leave benefits under the Paid Leave Oregon (PLO) program. We will reduce the amount We pay You under this Certificate by any amounts You receive or are estimated to receive from the PLO program. As a condition of receiving benefits from Us, You are required to apply for all PLO benefits for which You may be eligible with respect to Your Disability. We may also require You to appeal any denial of Your claim for PLO benefits through all administrative levels.

#### **APPLYING FOR OTHER INCOME AMOUNTS**

As a condition of receiving benefits from Us, You are required to apply for all Other Income Amounts for which You may be eligible with respect to Your Disability. We may also require that You appeal any denial of Your claim for Other Income Amounts.

#### **PAYMENTS THAT ARE NOT OTHER INCOME AMOUNTS**

We will not subtract from Our payments to You any amounts You receive from the following:

1. 401(k), 457 or 403(b) plans;
2. Profit sharing plans;
3. Thrift plans;
4. Tax sheltered annuities;
5. Stock ownership plans;
6. Credit disability insurance;
7. Non-qualified deferred compensation plans;
8. Pension plans for partners;
9. Military pension and military disability income plans;
10. A Retirement Plan from another employer;
11. Individual retirement accounts (IRA);
12. Disability benefits from the Veteran's Administration;
13. Benefits from individual disability plans not sponsored by Your Participating Employer or Policyholder;
14. Salary Continuation or Accumulated Sick Leave plans.

If Salary Continuation or Accumulated Sick Leave plan payments plus the gross weekly payment and disability earnings exceed 100% of Your weekly earnings, We will subtract the amount in excess of 100%

from Your weekly payment.

**COST OF LIVING INCREASES FOR OTHER INCOME AMOUNTS**

Except for Work Earning increases, once We have subtracted an Other Income Amount from Your Gross Short Term Disability Benefit, We will not reduce Our payments due to a cost of living increase.

**BANKRUPTCY – OREGON REVISED STATUTES §742.031**

Bankruptcy or insolvency of the Covered Person shall not relieve Us of any of Our obligations hereunder. If any person or legal representative of the person shall obtain final judgment against the Covered Person because of any such injuries, and execution thereon is returned unsatisfied by reason of bankruptcy, insolvency or any other cause, or if such judgment is not satisfied within 30 days after it is rendered, then such person or legal representatives of the person may proceed against Us to recover the amount of such judgment, either at law or in equity, but not exceeding the limit of this policy applicable thereto.

## TERMINATION OF BENEFITS

Benefit payments will stop on the earliest of the following dates:

1. The date You are no longer Disabled.
2. The end of Your Maximum Benefit Period.
3. The date Your Work Earnings exceed 80% of Your Pre-Disability Earnings.
4. The date You die.
5. The date You fail to provide proof of continuing Disability.
6. The date You cease to be under the Regular Care of a Physician, or refuse to undergo, at Our expense, an examination or testing by a Physician or vocational, rehabilitation, or health assessment testing when We require such examination or testing.
7. The date You refuse to receive medical treatment (including taking prescribed medicines) that Your Physician has recommended and that is generally acknowledged by Physicians to cure or improve the Sickness or Injury for which You are claiming benefits.
8. The date You reside outside the United States or Canada for a total of 6 months or more during any 6 consecutive months of benefits payments.

## EXCLUSIONS AND LIMITATIONS

### EXCLUSIONS

We will not pay benefits for a Disability if it is due to:

1. War, declared or undeclared, or any act of war except during a period of extended coverage under the terms of the Continuation During Military Leave provision;
2. Intentionally self-inflicted injuries or Sickness, while sane or insane;
3. Your active Participation in a Riot or an act of Terrorism;
4. Your attempt to commit or Your commission of a felony under federal or state law, Your being engaged in an illegal occupation or activity, or commission of a crime for which You have been convicted;
5. An Injury arising out of, or in the course of, any work for wage or profit;
6. Your attempted suicide, regardless of Your mental capacity;
7. A Sickness or Injury for which You are entitled to benefits under any Workers' Compensation law, occupational disease law, compulsory benefit act or law or similar law, unless You are a partner or sole proprietor not covered by any of these acts or laws;
8. Active Military Service of any country, group of countries, governments or international authority;
9. A Pre-Existing Condition, except as described in the provision PRE-EXISTING CONDITIONS.

No benefits are payable for any period during which You are incarcerated in a penal or correctional facility for a period of 30 or more consecutive days.

## **PRE-EXISTING CONDITIONS**

### **PRE-EXISTING CONDITION EXCLUSION**

We will not pay benefits if Your Disability begins in the first 12 month(s) following the effective date of Your coverage or an increase in coverage and Your Disability is caused by, contributed to by, or the result of a Pre-Existing Condition.

## **SURVIVOR BENEFIT**

We will pay a one-time lump sum benefit to Your Eligible Survivor upon receipt of proof of Your death if You die after You have been Disabled for at least 5 consecutive weeks and You were receiving Short Term Disability benefits.

This benefit will be equal to 3 times Your last Gross Weekly Benefit. We will first apply this benefit to any overpayment which may exist on Your claim.

## **ELIGIBLE SURVIVORS**

Your eligible survivor is Your Spouse if living. Otherwise, it will be Your surviving Children under age 26.

Payments due to Your adult Children will be made directly to them in equal shares. Payments to minor Children will be paid to the person who has custody of the minor Children, or to a trust for the benefit of the minor Children.

Payment will be made to Your estate if You do not have any eligible survivors. No payment will be made if there is no estate.

## **CLAIM INFORMATION**

### **NOTIFYING US OF A CLAIM**

You or Your authorized representative should send notification of Your claim to Our Home Office or to Our authorized agent, within 90 days after Your Disability begins. If You are not able to notify Us within this time, You should notify Us as soon as reasonably possible.

### **FILING A CLAIM**

The claim form is available from the Policyholder, Participating Employer, or You can request a claim form from Us.

Within 15 days after We receive Your notice of a claim, We will send claim forms. The claim form is also available from the Policyholder or the Participating Employer. The claim form must be completed and sent to Us at Our home office or to one of Our regional group claims offices. If We do not send You the claim forms within 15 days after receiving notice of Your claim, You shall be deemed to have complied with the requirements of Proof of Claim when You submit Written proof that covers the occurrence, character and extent of the loss for which a claim is made.

### **PROOF OF CLAIM**

You must send written proof of claim to Our Home Office. Telephonic or electronic proof of Your claim may also be submitted if We have agreed to accept such proof. We must receive Your proof of claim no later than 90 days after Your Elimination Period ends. Failure to provide required proof within this time frame will not invalidate or reduce any payable claim if it was not reasonably possible to provide the required proof.

If You are unable to give Us proof of Your claim within this time frame, then You must give Us proof of Your claim within the next 12 months. If You do not have the legal capacity to make responsible decisions concerning Yourself, then You may give Us proof of Your claim after this period.

### **INFORMATION TO INCLUDE IN YOUR PROOF OF CLAIM**

Your proof of claim must include:

1. The date Your Disability began;
2. Proof that You are under the Regular Care of a Physician;
3. The cause of Your Disability as determined by objective medical tests and examinations acceptable to the medical community;
4. The extent of Your Disability, including restrictions and limitations;
5. The name and address of all pharmacies, Hospital(s) or institution(s) where You received Treatment, including all Physicians who prescribed medications or provided Regular Care;
6. Documentation (including tax returns, including all associated schedules and worksheets, and accountant's statements) of Your Pre-Disability Earnings as well as earnings, income or benefits of any kind that You may be receiving while also receiving Short Term Disability benefits under the Policy;
7. Documentation that You have applied for all Other Income Amounts that You may be eligible for as a result of the same Disability for which You are claiming benefits under the Policy; and
8. Documentation of prior disability coverage if applicable.
9. Authorization to obtain additional medical and non-medical information as part of Your claim. We must receive this authorization within 45 days of the date We ask for it.

## **OTHER INFORMATION WE REQUIRE**

You must provide Us with continuing Proof of Loss (such as proof of continuing Disability and that You are under the Regular Care of a Physician) as often as We may reasonably require. You must provide Us with continuing Proof of Loss no more than 60 days from the date of Our request. We may temporarily suspend benefit payments until We have received continuing Proof of Loss. If You do not provide continuing Proof of Loss within the 60-day period, We may deny further benefits and close Your claim.

You, Your Participating Employer or the Policyholder must notify Us immediately when You return to work in any capacity.

## **CLAIM DECISION**

We will provide written notice of our claim decision.

If the claim is denied in whole or in part, the written notice will include:

1. The specific reason(s) for denial of the claim;
2. A specific reference to the provision(s) of the Policy that is the basis for the denial;
3. A description of any additional material or information needed to reverse the denial, or in the case of an incomplete claim, to complete the claim, and an explanation of why it is needed;
4. An explanation of the claim appeal procedures and applicable time limits;
5. If We used or relied on an internal rule, guideline, protocol or other information, the notice will specify the information. If the claimant requests, We will provide free of charge a copy of such rule, guideline, protocol or other data, as well as reasonable access to documents, records and other information relevant to the claim; and, if applicable,
6. A statement regarding the claimant's right to bring a civil action under Section 502(a) of ERISA following a denial of all required appeals.

## **PAYMENT OF YOUR CLAIM**

Once Your claim and Proof of Loss has been approved, We will pay the claim subject to the terms and provisions of this Certificate and the Policy, but not more than 30 days after such proof of claim is received. Claim payments will be paid at the end of each week You qualify for benefits. Any balance remaining unpaid upon the termination of the period of liability will be paid as soon as We receive satisfactory Proof of Loss.

If Your claim is paid more than 30 days after We receive the required Proof of Loss, the delayed payment will be subject to simple interest at the rate of 10% per year beginning with the 31st day after We receive satisfactory Proof of Loss, and ending on the day the claim is paid.

If the claim is denied in whole or in part, We will send You a written notice that includes:

1. The specific reason(s) for denial of the claim;
2. A reference to the specific Policy or Certificate provision(s) that are the basis for the denial;
3. A description of any additional information needed to reverse the denial, or in the case of an incomplete claim, to complete the claim, and an explanation of why it is needed;
4. An explanation of the claim appeal procedures and applicable time limits;
5. If We used or relied on an internal rule, guideline, protocol or other information, the notice will specify the information that was relied upon; and
6. If applicable, a statement regarding Your right to bring a civil action under Section 502(a) of ERISA following a denial on appeal.

On request, We will provide You, free of charge, with reasonable access to documents, records and other information relevant to the claim.

## **APPEAL PROCEDURE**

If Your claim has been denied in whole or in part, You may request a review of the decision. You must file a Written request for appeal within 180 days from the date of the notice of denial of Your claim. The right to appeal the denial may be forfeited if this deadline is not met.

Along with a Written request for a review, You should submit any additional information You believe should be considered during the review.

Upon request, We will provide You with copies of documents, records and other information relevant to Your claim, free of charge.

We will review the claim and respond with a final determination within 45 days. If We need additional time to decide the appeal, We may extend the review by 45 days. If We need such an extension, We will inform You in Writing: (1) that We need an extension, (2) why We need the extension, (3) what additional information We may need to complete the review, and (4) when You can expect a decision. We will notify You of the extension before the expiration of the initial 45-day period.

If We require an extension on the time to decide the appeal due to Your failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until You provide the information or otherwise respond.

## **NOTIFICATION OF APPEAL DECISION**

We will notify You in Writing, of Our final decision. If the claim is denied on appeal, the notice will include the following:

1. The specific reasons for the appeal decision;
2. A reference to the specific provision(s) within the Policy or Certificate on which the decision was based;
3. A statement regarding Your right, upon request and without charge, to a copy of documents, records and other information relevant to the claim; and, if applicable,
4. A statement regarding Your right to bring a civil action under Section 502(a) of ERISA following a denial of all required appeals.

## **CLAIMS SUBJECT TO ERISA (EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974)**

If Your claim is subject to ERISA, You must exhaust available administrative remedies under this Policy. Under this Policy, the plan participant or beneficiary must complete the Appeal Procedure discussed above to seek review of an adverse claim decision. A plan participant or beneficiary may only bring legal action concerning an adverse claim decision after exhaustion of the required appeal process.

## **AUTHORITY**

The Policyholder has delegated to the insurance company or its designee and understands that the insurance company or its designee reserve the right to make determinations regarding the eligibility for participation or benefits and to interpret the terms of the Policy and Certificate for the purpose of administering the terms of the Policy and Certificate.

## **BENEFIT PAYMENTS**

We will make all benefit payments to You if living. Benefit payments that become due after Your death will be made to Your estate.

## **UNPAID PREMIUM**

Upon the payment of a claim under this Certificate, any premium then due from You and unpaid may be deducted from the Your claim payment.

## **CLAIM OVERPAYMENTS**

We have the right to recover any overpayments that We make to You and You must repay any overpaid amount. We will determine the method by which You will repay Us. We may offset Our future payments to You by the amount of any overpayments. We have the right to recover overpayments from Your estate.

## **TIME LIMITS ON LEGAL ACTIONS**

You can start legal action regarding Your claim 60 days after the date You sent Us proof of claim. You have up to three years after the date You sent Us proof of claim to start legal action, unless otherwise provided by law.

## **SUBROGATION AND RIGHT OF REIMBURSEMENT**

If We make any benefit payments to You in connection with a Disability caused in whole or in part by an act or omission of a third party, We reserve any and all rights of recovery available to Us under applicable law in the state where the policy is delivered or issued for delivery that You have against the third party to the extent necessary to protect Our interests. We have the right to bring legal action against the third party on Your behalf to recover payments made by Us. You must agree to furnish all information and documents that are necessary to secure those rights to Us. We will pay for any expenses connected with Our pursuit of subrogation or recovery. Subject to limitations under applicable law in the state where the policy is delivered or issued for delivery, if You make any recovery of amounts from the third party, the amount of Your recovery which is subject to Our subrogation interest must be paid to Us.

With regard to any specific claim, if We elect subrogation, We will not reduce Your benefit payments by any amount We receive from any third party for that same claim.

## **GENERAL INFORMATION**

### **CERTIFICATE OF COVERAGE**

This Certificate is a written document prepared by Us and may include attachments, addendums or amendments. It tells You:

1. The coverage for which You may be eligible;
2. To whom We make payments; and
3. The limitations, exclusions, and requirements applying to the Policy.

It is the responsibility of the Policyholder to distribute the appropriate Certificate and any updates or other notices from Us to You.

### **ENTIRE CONTRACT**

The entire contract consists of:

1. The Policy, any amendments and addenda;
2. The Application of the Policyholder, a copy of which is attached to and made a part of the Policy when issued, or as amended during the term of this Policy;
3. The Certificates and the endorsements or riders which are attached to and made a part of the Policy when issued or as may be amended during the term of this Policy; and
4. For contributory coverage, the signed Enrollment Forms, or any electronic enrollment information in a form deemed acceptable by Us and provided by Your Participating Employer or Policyholder to Us.

Any statement made by the Policyholder, Participating Employer or You will be deemed a representation and not a warranty or guarantee.

### **INFORMATION DISCLOSURE**

The Policyholder must provide Us with information, when and in the manner, We ask, to administer the insurance provided by the Policy. The Policyholder's and Participating Employers records that relate to Your coverage under this Policy are open for Our inspection at any reasonable time. The Policyholder and Participating Employer will give Us information about You including:

1. Information necessary to determine eligibility for coverage;
2. Changes in coverage amounts;
3. Changes in Your Earnings;
4. Termination of coverage; and
5. Any other information We may reasonably require.

Clerical error or omission by the Policyholder, Participating Employer, You, or Us will not:

1. Terminate coverage which should otherwise be in effect;
2. Continue coverage which should otherwise terminate;
3. Create coverage which should not be in effect; or
4. Change the amount of coverage that should otherwise be in effect.

## **INCONTESTABILITY**

We can take legal or other action using statements made in signed applications for coverage only when a Disability occurs during the first two years after a Covered Person's Effective Date. However, in the event of Fraud, We can take Legal Action at any time as permitted by applicable law.

We have the right at any time to assert as a defense to a claim that You were not eligible to become covered because You did not meet certain eligibility requirements in this Certificate. These include, but are not limited to, the requirements that You:

1. be in an Eligible Class;
2. submit and have approved Evidence of Insurability, if required; and
3. meet the Actively at Work requirement.

## **MISSTATEMENT OF AGE**

If Your age is misstated, We have the right to make an equitable adjustment in the premium and/or coverage due for You. We will change the payable benefit to that which would have been purchased at the insured's actual age.

## **AGENCY**

For all purposes of the Policy, the Policyholder acts on their own behalf or as Your agent. Neither the Participating Employer nor the Policyholder is Our agent.

## **WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE**

This Policy does not replace or affect requirements for coverage by Workers' Compensation insurance or state disability insurance.

## **FRAUD**

It is unlawful to knowingly provide false, incomplete or misleading facts or information with the intent of defrauding us. A written application for insurance or statement of claim containing any materially false or misleading information that We relied upon may lead to reduction, denial or termination of benefits or coverage under the policy and recovery of any amounts We have paid. No such information will be used to deny a claim unless fraudulent or material to the risk accepted by us.