Multnomah County Oregon

Your Group Short Term Disability Plan

Policy No. 387791.1

Underwritten by Unum Life Insurance Company of America

07-2014

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CERTIFICATE OF COVERAGE

The UNUM Life Insurance Company of America (referred to as "we," "our" and "us") welcomes your employer as a client.

This is your certificate of coverage as long as you are eligible for this insurance, become insured and remain insured. Keep it in a safe place. Check the Description of Eligible Classes to determine those benefits that apply to your employee class.

A few words about this certificate .....

We have written it in plain English. But a few terms and provisions are written as required by insurance law. You will want to read it carefully. If you have any questions about any terms and provisions, please contact the Insurance Administrator at your work location or write to our claims paying office. We will assist you in any way we can to help you understand your benefits.

Also, if the terms of your certificate of coverage and the policy differ, the policy will govern. You may examine the policy at the Insurance Administrator's office. Your coverage may be terminated or modified in whole or in part at any time under the terms and provisions of the policy.

President

PLAN OUTLINE

SCHEDULE

Short Term Disability Benefits For You

- Description of Eligible Classes

Class 1	All non-exempt employees* Earnings $210.40 but less than $249.00 weekly
Class 2	All non-exempt employees* Earnings $240.00 but less than $306.50 weekly
Class 3	All non-exempt employees* Earnings $306.50 but less than $383.00 weekly
Class 4	All non-exempt employees* Earnings $383.00 but less than $446.00 weekly
Class 5	All non-exempt employees * Earnings $446.00 but less than $517.50 weekly
Class 6	All non-exempt employees * Earnings $517.50 but less than $600.50 weekly
Class 7	All non-exempt employees * Earnings $600.50 but less than $697.00 weekly
Class 8	All non-exempt employees * Earnings $697.00 but less than $809.50 weekly
Class 9	All non-exempt employees * Earnings $809.50 but less than $939.50 weekly
Class 10	All non-exempt employees * Earnings $939.50 but less than $1084.50 weekly
Class 11	All non-exempt employees * Earnings $1084.50 or more weekly

* Excluding Local 701 Operating Engineers

- Amounts of Insurance

	Short Term Disability Amount
Class 1	$140 per week less any amounts you receive or are entitled to receive under: 1. the mandatory portion of any "no-fault" motor vehicle plan; and 2. any state compulsory benefit act or law.
Class 2	$180 per week less any amounts you receive or are entitled to receive under: 1. the mandatory portion or any "no-fault" motor vehicle plan; and 2. any state compulsory benefit act or law.
Class 3	$200 per week less any amounts you receive or are entitled to receive under: 1. the mandatory portion of any "no-fault" motor vehicle plan; and 2. any state compulsory benefit act or law.

Class 4	$250 per week less any amounts you receive or are entitled to receive under: 1. the mandatory portion of any "no-fault" motor vehicle plan; and 2. any state compulsory benefit act or law.
Class 5	$290 per week less any amounts you receive or are entitled to receive under: 1. the mandatory portion of any "no-fault" motor vehicle plan; and 2. any state compulsory benefit act or law.
Class 6	$337.50 per week less any amounts you receive or are entitled to receive under: 1. the mandatory portion of any "no-fault" motor vehicle plan; and 2. any state compulsory benefit act or law.
Class 7	$390 per week less any amounts you receive or are entitled to receive under: 1. the mandatory portion of any "no-fault" motor vehicle plan; and 2. any state compulsory benefit act or law.
Class 8	$452.50 per week less any amounts you receive or are entitled to receive under: 1. the mandatory portion of any "no-fault" motor vehicle plan; and 2. any state compulsory benefit act or law.
Class 9	$525 per week less any amounts you receive or are entitled to receive under: 1. the mandatory portion of any "no-fault" motor vehicle plan; and 2. any state compulsory benefit act or law.

Class 10	$607.50 per week less any amounts you receive or are entitled to receive under: 1. the mandatory portion of any "no-fault" motor vehicle plan; and 2. any state compulsory benefit act or law.
Class 11	$700 per week less any amounts you receive or are entitled to receive under: 1. the mandatory portion of any "no-fault" motor vehicle plan; and 2. any state compulsory benefit act or law.

- Day Benefits Begin:
  31st day injury;
  31st day sickness, or to when sick leave is no longer paid.

- Maximum Benefit Period:
  9 weeks injury
  9 weeks sickness

- Pregnancy:
  Covered the same as a sickness.

GENERAL INFORMATION

Minimum Requirement for Active Employment: 32 hours or 3 10-hour shifts per week

Waiting Period:

- If you are in an eligible class on or before the policy effective date: None
- If you enter an eligible class after the policy effective date: None

You must be in continuous active employment in an eligible class during the specified waiting period.

Contributions:

Who pays for the plan?

You pay for the plan.

Definition of Earnings:

- "Weekly Earnings" means your basic gross weekly income from your Employer in effect just prior to your date of disability. It includes your basic income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from pay premiums such as shift differential pay, swing shift pay or bi-lingual pay, commissions, bonuses, overtime pay, any other extra compensation or income received from sources other than your Employer.

Changes Effective:
Subject to the delayed effective dates exceptions, changes in insurance take effect immediately.

Continuation of Your Insurance During Absences:

Type of Absence	Time Limit
Temporary Layoff	Coverage ends at the end of the month after the employee ceases to be actively at work on regular work days.
Paid Leave of Absence	If you are on an approved paid leave of absence, and if premium is paid, coverage will be continued through the end of the month following six months after the leave of absence begins, except for Workers Compensation Supplemental Pay leaves. If the employee returns to active employment within six months after coverage ends, coverage will be reinstated without requiring eveidence of insurability.
Unpaid Leave of Absence	If you are on an approved unpaid leave of absence, and if premium is paid, coverage will be continued through the end of the month following the month in which the approved unpaid leave of absence begins. This Provision also applies to Workers Compensation Supplemental Pay leaves. If the employee returns to active employment within six months after coverage ends, coverage will be reinstated without requiring eveidence of insurability.
Strike or work stoppage	Coverage continues with payment of premiums for the first 90 days of absence.

Discretionary Authority:

In making any benefits determination under the Policy, we shall have the discretionary authority both to determine your eligibility for benefits and to construe the terms of the Policy.

TERMS YOU OUGHT TO KNOW

Many terms used in your certificate of coverage have special meanings. A list of these terms and meanings follows.

- "Active employment" means you must be working:
  1. for your employer on a permanent full-time basis and paid regular earnings;
  2. at least the minimum number of hours shown in the Plan Outline; and either
  3. at your employer's usual place of business; or
  4. at a location to which your employer's business requires you to travel.

- "Complications of pregnancy" means that part of a pregnancy during which abnormal conditions or concurrent disease significantly affect the pregnancy's usual medical management.
  A complication may exist:
  1. during the pregnancy;
  2. during the delivery; or
  3. after the delivery.

  But complications of pregnancy does not include an elective cesarean section.

- "Employee" means a person in active employment with the employer.

- "Employer" means the Policyholder and includes any division, any subsidiary or any affiliated company named in the policy.
- "Evidence of insurability" means a statement or proof of a person's medical history upon which acceptance for insurance will be determined by us.

- "Home office" means the UNUM Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122.

- Male pronoun whenever used includes the female.

- "Occupational" means arising out of, or in the course of, any employment for pay or profit.

- "Physician" means a person who is:
  1. operating within the scope of his license; and either
  2. licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
  3. legally qualified as a medical practitioner and required to be recognized, under the policy for insurance purposes, according to the insurance statutes or the insurance regulations of the governing jurisdiction.

  It does not include a claimant or his spouse, daughter, son, father, mother, sister or brother.

- "Retirement date" means the first of the following to occur:
  1. the effective date of your retirement benefits under:
     a. any plan of a federal, a state, a county, a municipal or an association retirement system for which you are eligible as a result of employment with your employer;
     b. any plan your employer sponsors; or
     c. any plan for which your employer:
        i. makes contributions; or
        ii. has made contributions.
  2. the effective date of your retirement benefits under the United States Social Security Act or any similar plan or act.
     But if you are in active employment and receiving retirement benefits under the United States Social Security Act or any similar plan or act you will not be considered retired.

- "Sickness" means illness or disease. It includes pregnancy unless excluded elsewhere.
- "Total disability" and "totally disabled" mean that, as a result of sickness or injury you are unable to perform each of the material duties of your regular occupation.
- "Waiting period", as described in the Plan Outline, means the continuous length of time immediately before your eligibility date during which you must be in an eligible class.
- "You" means you, the employee.

ENROLLMENT AND THE DATE INSURANCE STARTS

When can you enroll?
You can enroll if you:

1. are in active employment with your employer; and
2. are in an employee class that is eligible for insurance.

What is your date of eligibility?
You will be eligible for insurance on the later of these dates:

1. the policy effective date, if you have completed the waiting period; or
2. the day after you complete the waiting period.

If employment ends or you are no longer eligible and you are rehired or regain eligibility within 12 months, you may be insured on your eligibility date for the coverage you had under the plan when you ended employment or you became ineligible without having to submit evidence of insurability.

If employment ends or you are no longer eligible and you are rehired or regain eligibility within 12 months, after you became ineligible and you had not elected coverage prior to ending employment or you are ineligible, you will be required to submit evidence of insurability for any elected amount.

All other policy provisions will apply.

When does insurance start for you?
Insurance will start at 12:01 a.m. on the day determined as follows, but only if your request for insurance is: (1) made with us through your employer; and (2) on a form satisfactory to us.

If you do contribute toward any cost of any of the coverages for yourself, you will be insured for such contributory coverage on the latest of these dates:

1. your date of eligibility provided you have enrolled on or before that date;
2. your enrollment date provided you have enrolled on or before the 31st day after your date of eligibility; or
3. the date we give our approval, if you:
   a. enrolled more than 31 days after your date of eligibility; or
   b. terminated your insurance while continuing to be eligible.
   In both cases, you must submit an application and evidence of insurability to us for approval. This will be at your expense.

Please note this exception.
The effective date of any initial, increased or additional insurance will be delayed if you are not in active employment because of an injury, a sickness, a temporary layoff or a leave of absence on the date that insurance would otherwise be effective. That insurance for you will start on the date you return to active employment.

SHORT TERM DISABILITY BENEFITS FOR YOU

What is your short term disability benefit?
A short term disability benefit will be paid to you as a result of an injury or a sickness if you:

1. become totally disabled while insured;
2. require the regular care of a physician; and
3. submit proof of your total disability.

Benefits will only be paid for up to the maximum benefit period during any one continuous period of total disability. A new maximum benefit period will start if you become totally disabled due to:

a. the same or a related cause only after you have returned to active employment for two full consecutive weeks; or
b. an unrelated cause only after you have returned to active employment for one full day.

The short term disability amount, the day benefits begin and the maximum benefit period are shown in the Plan Outline. The short term disability amount will be reduced by any of the other disability income benefits shown below. Benefits payable for less than one week will be paid to you at the rate of 1/7th of the short term disability amount for each day of total disability.

Other Disability Income Benefits.

Other disability income benefits means those benefits shown below that are payable for the same disability for which we pay a short term disability benefit.

- Any amount you receive or are entitled to receive under the mandatory portion of any "no-fault" motor vehicle plan.
- The amount you receive or are entitled to receive under any state compulsory benefit act or law.

What are the short term disability benefits exclusions?
No short term disability benefits will be paid for loss resulting from:

1. war, declared or undeclared, or any act of war;
2. active participation in a riot;
3. committing or attempting to commit an assault or a felony; or
4. an occupational injury or sickness.

When do short term disability benefits terminate?
Short term disability benefits will terminate on the earliest of the following dates.

1. The date you are no longer totally disabled.
2. The date you receive retirement benefits under any plan your employer sponsors.
3. The date you return to work in any gainful occupation.
4. The date you die.
5. The end of the maximum benefit period.

How does our right of recovery interest affect your claim?
We have the right to recover any weekly benefits payments for total disability resulting from an injury or a sickness for which a third party is liable, and for which recovery is made from the third party. This right of recovery applies to the full amount recovered, whether by judgement, settlement or otherwise.

The amount recovered is the amount left after deducting any reasonable and necessary expenditures (including attorney fees) incurred in effecting the recovery.

We also have the right to recover any overpayments made because of any error in processing a claim.

SOME GENERAL INFORMATION TO KNOW

When does your insurance terminate?
Your insurance under the policy terminates at the earliest time stated below.

1. The date the policy is terminated.
2. The date you no longer are in a class eligible for insurance.
3. The date your class is no longer covered by the policy.
4. The end of the period for which your last contribution for your insurance has been paid.
5. The date your employment terminates. Your employment will be considered terminated if you cease active employment.

But what happens if you are not in active employment because of an approved absence?

- Injury or sickness, temporary layoff or leave of absence.
  Your insurance may be continued by your employer, subject to premium payment, up to the time limits shown in the Plan Outline.

How can statements made in any application for this insurance be used?
In the absence of fraud, all statements you made when applying for this insurance and providing evidence of insurability are considered representations and not warranties (absolute guarantees). No statements by you will be used to reduce or deny a claim unless a copy of your statements has been given to:

1. you; or
2. your beneficiary, if any.

How do you file claims?
If you have a claim, there are some conditions and time limits which you or a person acting for you and we must meet.
They are:

- Notice of claim.
  Written notice of a claim must be given to us within 30 days after the date of loss on which claim is based. If that is not possible, we must be notified as soon as it is reasonably possible to do so.
- The claim form.
  When we have written notice of claim, we will send our claim forms unless your employer has already provided them. If the claim forms are not received by you within 15 days after that notice is sent, written proof of claim can be sent to us without waiting for the forms.
- Proof of claim.
  1. For short term disability benefits.
     Proof of your claim must be given to us within 90 days after the end of the first weekly period for which we are liable.
     Continuing proof of your total disability and regular attendance of a physician must be given to us within 45 days after the requested date for that proof.
  2. If it is not possible to give proof within this time limit, it must be given as soon as reasonably possible. But proof of claim may not be given later than 1 year after the time proof is otherwise required, except if you are legally unable to notify us.
  3. The proof must cover:
     a. what the loss is;
     b. the date of the loss; and
     c. the cause of the loss.
  4. We may require as part of the proof authorizations to obtain medical and nonmedical information.
- Time of payment of claims.
  Accrued short term disability benefits will be paid each week during any period for which we are liable.

- Payment of claims.
  All benefits are payable to you. Any benefit unpaid at your death will be payable to your estate. If such benefits become payable to your estate, we have the right to pay up to $2,000 to any of your relatives whom we consider entitled to it. Such a payment might also be made if you are a minor or you are not competent. If we pay benefits in good faith to a relative, we will not have to pay such benefits again.

What are our examination rights?
We have the right to require that you be examined at our expense by a physician of our choice. We may do this when and as often as it is reasonably required.

What are the time limits for legal proceedings?
You or an authorized representative cannot start any legal action:

1. until 60 days after proof of claim has been given; nor
2. more than 3 years after the time proof of claim is required.

What happens if facts are misstated?
If relevant facts about you were not accurate:

1. a fair adjustment of premium will be made; and
2. the true facts will decide if and in what amount insurance is valid.

Can the policyholder act as our agent?
For all purposes of the policy, the Policyholder acts on its own behalf or as your agent. Under no circumstances will the Policyholder be deemed our agent.

ADDITIONAL CLAIM AND APPEAL INFORMATION

APPLICABILITY OF ERISA

If this policy provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. Whether a Plan is governed by ERISA is determined by a court, however, your Employer may have information related to ERISA applicability. If ERISA applies, the following items constitute the Plan: the additional information contained in this document, the policy, including your certificate of coverage, and any additional summary plan description information provided by the Plan Administrator. Benefit determinations are controlled exclusively by the policy, your certificate of coverage, and the information in this document.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum Life Insurance Company of America (hereinafter referred to as the "Insurance Company") must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact the Insurance Company directly.

CLAIMS PROCEDURES

The Insurance Company will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if the Insurance Company both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you of the circumstances requiring the extension of time and the date by which the Insurance Company expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, the Insurance Company may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the Plan will:

1. state the specific reason(s) for determination;
2. reference specific Plan provision(s) on which the determination is based;
3. describe additional material or information necessary to complete the claim and why such information is necessary;
4. describe Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from the Insurance Company on appeal; and
5. disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If the Insurance Company determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). The Insurance Company will notify you in writing if an additional 45 day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, the Insurance Company may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U. S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by the Insurance Company and will be made by a person different from the person who made the initial determination and such person will not be the original decisionmaker's subordinate. In the case of a claim denied on the grounds of a medical judgement, the Insurance Company will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, the Insurance Company will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

1. the specific reason(s) for determination;

2. a reference to the specific Plan provision(s) on which the determination is based;

3. a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);

4. a statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision;

5. the statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and

6. the statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency".

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

OTHER RIGHTS

The Insurance Company, for itself and as claims fiduciary for the Plan, is entitled to legal and equitable relief to enforce its right to recover any benefit overpayments caused by your receipt of deductible sources of income from a third party. This right of recovery is enforceable even if the amount you receive from the third party is less than the actual loss suffered by you but will not exceed the benefits paid you under the policy. The Insurance Company and the Plan have an equitable lien over such sources of income until any benefit overpayments have been recovered in full.

DISCRETIONARY ACTS

The Plan, acting through the Plan Administrator, delegates to the Insurance Company and its affiliate Unum Group discretionary authority to make benefit determinations under the Plan. The Insurance Company and Unum Group may act directly or through their employees and agents or further delegate their authority through contracts, letters or other documentation or procedures to other affiliates, persons or entities. Benefit determinations include determining eligibility for benefits and the amount of any benefits, resolving factual disputes, and interpreting and enforcing the provisions of the Plan. All benefit determinations must be reasonable and based on the terms of the Plan and the facts and circumstances of each claim.

Once you are deemed to have exhausted your appeal rights under the Plan, you have the right to seek court review under Section 502(a) of ERISA of any benefit determinations with which you disagree. The court will determine the standard of review it will apply in evaluating those decisions.