GROUP SHORT TERM DISABILITY INSURANCE POLICY

POLICYHOLDER: PACIFIC UNIVERSITY

POLICY NUMBER: OR 099991

POLICY EFFECTIVE DATE: APRIL 1, 2015

POLICY ANNIVERSARY: APRIL 1, 2016 AND EACH SUCCEEDING APRIL 1

GOVERNING JURISDICTION: OREGON

LIFEMAP ASSURANCE COMPANY agrees to pay the benefits provided by this Policy in accordance with its provisions.

This Policy is issued in consideration of the Application of the Policyholder, a copy of which is attached, and of payment of premiums as provided herein. The coverage offered under the policy is conditionally renewable according to the terms and provisions of the Certificate of Coverage.

Pre-existing limitations or exclusions and other limitations or exclusions may apply. Please read your policy carefully.

This Policy is governed by the laws of the State where it is delivered. This Policy, on its effective date, is amended to comply with the statutes of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. The entire Policy consists of:

1. all Policy provisions and any amendments and/or attachments issued;
2. the Certificate of Coverage; and
3. the Policyholder’s signed application.

All terms of insurance under this Policy begin and end at 12:01 a.m. Standard time in the place where the Policy is delivered.

READ THIS POLICY CAREFULLY: It is a legal contract between the Policyholder and LifeMap Assurance Company.

Signed for LifeMap Assurance Company at its Home Office in Portland, Oregon on the Policy effective date.

Chairman

President

Non-Participating - This Policy Does Not Pay Dividends
POLICY TABLE OF CONTENTS

APPLICATION............................................................................................................ Attached

GENERAL POLICY PROVISIONS................................................................................ PAGE

A. Incorporation Provision...................................................................................... P-3
B. Minimum Enrollment Requirements................................................................. P-3
C. Payment of Premiums ....................................................................................... P-3
D. Changing the Premiums .................................................................................... P-4
E. When This Policy Renews .................................................................................. P-4
F. When This Policy Terminates ............................................................................ P-4
G. Policyholder’s Reports - Records ..................................................................... P-4
H. Incontestability ................................................................................................... P-5

CERTIFICATE OF COVERAGE .................................................................................. C-1
Group Insurance Employer Application
(10 or More Employees)

Applicant Information (Please complete using dark ink)

<table>
<thead>
<tr>
<th>Legal Name of Policyholder</th>
<th>Requested Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pacific University</td>
<td>04/01/2015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td>2043 College Way</td>
<td>Forest Grove</td>
<td>OR</td>
<td>97113</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years In Business</th>
<th>Nature of Business</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>College Education</td>
<td></td>
<td>503-352-2882</td>
</tr>
</tbody>
</table>

Check one: □ C Corporation □ LLC □ LLP □ Subchapter S Corp. □ Partnership
□ Sole Proprietorship □ Government Entity □ Other

Application is being made for the following coverage(s):

<table>
<thead>
<tr>
<th>Basic</th>
<th>Voluntary</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ Short Term Disability</td>
<td>☑ Vol Short Term Disability</td>
</tr>
<tr>
<td>☑ Long Term Disability</td>
<td>☑ Vol Long Term Disability</td>
</tr>
<tr>
<td>☑ Vision</td>
<td>☑ Vol AD&amp;D</td>
</tr>
<tr>
<td>☑ Dental</td>
<td>☑ Vol Critical Illness</td>
</tr>
<tr>
<td></td>
<td>☑ Vol Dependent Life</td>
</tr>
<tr>
<td></td>
<td>☑ Vol Accident Only</td>
</tr>
</tbody>
</table>

Rates: Below are initial rates for groups of 10 or more employees.

Short Term Disability Rate of $0.214/ $10 of Covered Benefit  STD Rate Guaranteed Until 04/01/2016

Rates for voluntary coverage, if elected, are shown in the Benefit Proposal.
The Plan Benefits Will be Those Shown in the Benefit Proposal

Agreement

The Applicant hereby applies for the group insurance coverage(s) shown on page one. The information in this Application is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group insurance. Any statement by the Applicant to obtain coverage for any Policy issued will be a representation and not a warranty. Omission or misstatement of known information on this Application could affect the validity of any insurance issued and cause the denial of an otherwise valid claim. The Applicant understands that the requested group insurance will (a) be issued only if the requested insurance is acceptable to LifeMap Assurance Company (the Company) and is legally permissible; (b) be issued under a group Policy or Policies in the language customarily used by the Company; (c) be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable); (d) be subject to all exclusions and limitations of the Policy; and (e) take effect on the date determined by the Company.

The Applicant understands that no insurance producer has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which an Employee is required to submit satisfactory Evidence of Insurability will be determined in accordance with the Policy's terms, and will be subject to the Active at Work requirement. The Applicant agrees not to (a) collect or pay premiums (other than the Binder Premium) for such insurance, before receiving the Company's notice of approval; or (b) distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

Premium rate quotes were based on data submitted to the Company. Final premium rates will be determined by the actual composition of the group. The Application and the payment of premium constitutes the consideration for any Policy issued. After receipt of the Policy, payment of premium is deemed acceptance of the Policy's terms. This Application shall be attached to any Policy issued.

Disclosure

If you have an insurance producer, they may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from LifeMap Assurance Company. Incentives may be based on any of several factors including the size of group business, the products you buy, your insurance producer's volume of business with LifeMap Assurance Company and the other services your insurance producer provides to you. These incentives may have an indirect impact on your rates. For more information, please contact your insurance producer.

Insurance Fraud Warning

Unless specific state language is provided below, the following general fraud notice applies: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

For residents of Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

I have read and understand this entire Application. The information provided is accurate to the best of my knowledge. I understand that the information on this Application and any other information I provide shall serve as the basis for the insurance to be issued, and that I have a duty to notify the Company of any changes. It is understood and agreed that no insurance shall be effective until approved by the Company at its home office.

Note: The Accidental Death and Dismemberment (AD&D), Critical Illness and Accident Only Insurance Policies provide limited benefits. Review your policy carefully.

<table>
<thead>
<tr>
<th>Name and Title of Authorized Group Executive or Administrator</th>
<th>Initial Payment Amount $ 000 (to be applied to initial premium payment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRACY KING, BENEFITS ADMINISTRATOR</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Group Executive or Administrator</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3/18/2015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Insurance Producer</th>
<th>LifeMap Insurance Producer Appointment Number</th>
<th>Insurance Producer E-Mail Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campbell Gait &amp; Newlands Inc d/b/a US NorthWest</td>
<td>1031 13000</td>
<td><a href="mailto:Ricc.Bocals@usi.biz">Ricc.Bocals@usi.biz</a></td>
</tr>
</tbody>
</table>
GENERAL POLICY PROVISIONS

This section of the Policy explains some of the responsibilities of the Policyholder.

A. INCORPORATION PROVISION

The Certificate of Coverage, and any endorsements or riders enclosed therein, are hereby incorporated in and made a part of this Policy. The terms found in the Certificate of Coverage will control:

1. the benefit plan provisions;
2. eligibility and the Effective Date of coverage;
3. termination of insurance;
4. exclusions; and
5. other general policy provisions pertaining to state insurance law requirements.

B. MINIMUM ENROLLMENT REQUIREMENTS

If the Policyholder pays 100% of the premium for any coverage, then 100% of the eligible employees must be enrolled for that coverage.

If the Employee pays any portion of the premium for any coverage, then at least 75% of the eligible employees must be enrolled for that coverage.

A minimum of two employees must be insured by this Policy.

C. PAYMENT OF PREMIUMS

The premium payable is calculated as of the premium due date by multiplying the Policy's premium rates by:

1. the amount of insurance in force for all employees; or
2. the number of employees insured, if using a composite rate.

Premiums are due monthly.

We allow a grace period of 31 days after the due date for the Policyholder to pay any premium, except for the first. During the grace period, the coverage remains in force. If we do not receive full premium payment within 31 days after the due date, the Policyholder's coverage will terminate on the last day of the grace period. The Policyholder will be charged premium for the grace period.
D. CHANGING THE PREMIUMS

We may change the premium rates after the Policy has been in effect for at least 12 months by giving the Policyholder advance notice at least 30 days prior to the change.

We may change the premium rates or terminate the Policy at any time when:

1. the terms of the coverage change;
2. a division, subsidiary or affiliate is added to the plan of coverage; or
3. enrollment changes by more than 10%;

by giving the Policyholder advance notice at least 30 days prior to the change.

E. WHEN THIS POLICY RENEWS

This Policy may be renewed if the Policyholder and we agree on each Policy anniversary date for another 12 month term as long as premiums are paid in a timely manner.

F. WHEN THIS POLICY TERMINATES

This Policy will terminate:

1. if premiums have not been paid within 31 days after they are due (see Item C. PAYMENT OF PREMIUMS);
2. if the Policyholder, without good and sufficient cause, fails to perform, in good faith, the duties pertaining to this Policy, providing at least 30 days written notice is given; or
3. on the date we or the Policyholder designates, providing at least 30 days written notice is given.

We will honor all valid claims that arise prior to the termination date if the applicable premium is received.

G. POLICYHOLDER'S REPORTS - RECORDS

The Policyholder must, on a timely basis, furnish us with all data that we may require to administer the insurance under this Policy, including:

1. newly eligible employees;
2. changes in insurance amounts; and
3. terminations.

The Policyholder must also keep records of the insured employees and the specifics of their coverage.

At any reasonable time, we may inspect:

1. the Policyholder’s or Employer’s payroll records; and
2. any other records that may affect this insurance.
H. INCONTESTABILITY

Any statement by the Policyholder to obtain coverage under the Policy will be a representation and not a warranty. No misrepresentation will be used to reduce or deny a claim or to deny the validity of coverage unless:

1. coverage would not have been approved except for the misrepresentation;

2. the misrepresentation is contained in the signed Application; and

3. a copy of the Application containing the misrepresentation has been given to the Policyholder.

The validity of the Policy will not be contested after it has been in force for two years, except for nonpayment of premiums.
GROUP SHORT TERM DISABILITY INSURANCE
CERTIFICATE OF COVERAGE

POLICYHOLDER: PACIFIC UNIVERSITY

POLICY NUMBER: OR 099991

EFFECTIVE DATE: APRIL 1, 2015

GOVERNING JURISDICTION: OREGON

This is to certify that LifeMap Assurance Company has issued and delivered the Group Disability Insurance Policy to the Policyholder. The Policy insures the Employees of the Policyholder who are eligible for the insurance, become insured and continue to be insured according to the terms of the Policy. The terms of the Policy that affect your insurance are contained in the following pages. Your coverage may be terminated or modified in whole or in part under the terms and provisions of the Policy.

The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

This Certificate of Coverage describes the benefits that an insured Employee is entitled to receive and becomes a part of the Policy. Pre-existing limitations or exclusions and other limitations or exclusions may apply. PLEASE READ THIS CERTIFICATE CAREFULLY.

This Certificate voids and replaces any prior Certificate issued under the Group Policy Number shown above.

All terms of insurance under the Policy begin and end at 12:01 a.m. Standard time in the place where the Policy is delivered.

The Coverage Outline on Page C-2 will tell you the classes of employees eligible for insurance, when eligibility for insurance begins, if you are required to contribute to the cost of your insurance, and the amounts of insurance provided by the Policy. The Table of Contents on Page C-3 will help you find specific provisions. The Definitions section, beginning on Page C-4 will provide definitions of important terms used in this Certificate.

Signed for LifeMap Assurance Company at its Home Office in Portland, Oregon.

Chairman

President
COVERAGE OUTLINE

ELIGIBLE CLASSES:  Class 01 - All active full-time Employees working a minimum of 1,040 hours per year on a regular basis.

WAITING PERIOD:   For Employees in an eligible class on or before 04/01/15:  Date of Hire*
                   For Employees entering an eligible class after 04/01/15:  Date of Hire*

                   *Eligibility Date is 1st of the month following the Employee's date of hire.

EMPLOYEE CONTRIBUTION:  You are not required to contribute to the cost of your insurance.

BENEFIT SCHEDULE

ELIGIBLE CLASS            EMPLOYEE'S SHORT TERM DISABILITY BENEFITS

Class 01                  Weekly Benefit: 60% of weekly Earnings to a maximum of $1,500 per week. The minimum weekly benefit for a payable claim is $25.

                            Benefit Waiting Period: 29 calendar days for Accidental Bodily Injury
                            29 calendar days for Illness.

                            Maximum Benefit Period: 22 weeks

The following provision applies only if benefits begin on the 15th day of disability or later:
If you return to work for 7 or less days during the Benefit Waiting Period but cannot continue, the waiting period will not restart, but we will count only those days you are disabled to satisfy the waiting period.

STD GUARANTEE ISSUE AMOUNT:  $1,500
# CERTIFICATE OF COVERAGE

## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Page C-4</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page C-8</td>
<td>Eligibility and Effective Dates</td>
</tr>
<tr>
<td></td>
<td>Eligibility</td>
</tr>
<tr>
<td></td>
<td>Effective Date of Insurance</td>
</tr>
<tr>
<td></td>
<td>When We May Require Evidence of Insurability</td>
</tr>
<tr>
<td></td>
<td>Actively At Work Provision</td>
</tr>
<tr>
<td></td>
<td>Continuity of Coverage</td>
</tr>
<tr>
<td></td>
<td>Changes In Insurance</td>
</tr>
<tr>
<td></td>
<td>When Insurance Ends</td>
</tr>
<tr>
<td>Page C-13</td>
<td>Short Term Disability Benefits</td>
</tr>
<tr>
<td></td>
<td>When Benefits Become Payable</td>
</tr>
<tr>
<td></td>
<td>Benefit Amount</td>
</tr>
<tr>
<td></td>
<td>Deductible Sources of Income</td>
</tr>
<tr>
<td></td>
<td>Subsequent Periods of Disability</td>
</tr>
<tr>
<td></td>
<td>Reasonable Accommodation Expense Benefit</td>
</tr>
<tr>
<td></td>
<td>Vocational Rehabilitation Plan Benefit</td>
</tr>
<tr>
<td></td>
<td>Partial Disability Benefits</td>
</tr>
<tr>
<td></td>
<td>When Benefits End</td>
</tr>
<tr>
<td></td>
<td>Three Week Survivor Benefit</td>
</tr>
<tr>
<td></td>
<td>Exclusions</td>
</tr>
<tr>
<td>Page C-18</td>
<td>Claims</td>
</tr>
<tr>
<td></td>
<td>Claim Forms</td>
</tr>
<tr>
<td></td>
<td>Proof of Loss</td>
</tr>
<tr>
<td></td>
<td>Physical Exam</td>
</tr>
<tr>
<td></td>
<td>Incontestability</td>
</tr>
<tr>
<td></td>
<td>Payment of Claims</td>
</tr>
<tr>
<td></td>
<td>Review Procedure</td>
</tr>
<tr>
<td></td>
<td>Overpaid Claims</td>
</tr>
<tr>
<td></td>
<td>Legal Actions</td>
</tr>
<tr>
<td></td>
<td>Insurance Fraud</td>
</tr>
<tr>
<td></td>
<td>Contact Information</td>
</tr>
<tr>
<td>Page C-20</td>
<td>General Provisions</td>
</tr>
<tr>
<td></td>
<td>Misstatement of Age</td>
</tr>
<tr>
<td></td>
<td>Clerical Error or Omission</td>
</tr>
<tr>
<td></td>
<td>Policy Changes</td>
</tr>
<tr>
<td></td>
<td>Agency</td>
</tr>
<tr>
<td></td>
<td>Certificates</td>
</tr>
<tr>
<td></td>
<td>Workers' Compensation</td>
</tr>
</tbody>
</table>
DEFINITIONS

**Accidental Bodily Injury** means immediate physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical which:

1. results directly from an unexpected and unintentional event;
2. is independent of disease, bodily infirmity or any other cause; and
3. is not caused by routine or normal body movements, such as stooping, twisting, bending or chewing.

Any disability which begins more than 180 days after the Accidental Bodily Injury will be considered an Illness for the purpose of determining Short Term Disability Benefits.

**Actively at Work** or **Active Work** means performing the material and substantial duties of your own occupation at the Employer's usual place of business.

**Active Employment** means the Employee is:

1. working for the Employer on a regular and active basis for at least the minimum number of hours stated in the Coverage Outline;
2. receiving regular Earnings from the Employer; and
3. employed:
   a. at the Employer’s usual place of business; or
   b. at a location to which the Employer’s business requires the Employee to travel.

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

**Benefit Waiting Period** means the number of calendar days you must be continuously Totally or Partially Disabled, before STD Benefits become payable. Your Benefit Waiting Period is shown on the Coverage Outline. No STD Benefits are payable during the Benefit Waiting Period. You must be under the care of a Physician during the Benefit Waiting Period.

**Certificate** means a document prepared by us which sets forth:

1. the benefits to which the insured Employee is entitled;
2. the method by which we determine to whom benefits are payable; and
3. the conditions, limitations, exclusions and requirements that apply.

**Confirmation Statement** means a letter that verifies the benefit level you have been approved for and the Effective Date of coverage.

**Contributory Insurance** means you must pay a part or all of the premiums. All such payments must be made directly to the Employer.

**Coverage Outline** means a summary of the eligible classes, Waiting Periods, amounts of insurance, and other relevant information which applies to the coverage provided by the Policy. The Coverage Outline forms Page C-2 of this Certificate.
Earnings means your gross weekly income from your Employer in effect just prior to your date of disability. It includes your total income before taxes, including any shift differential, and any deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It includes income actually received from commissions but does not include renewal commissions, bonuses, overtime pay or any other extra compensation, or income received from sources other than your Employer.

Commissions will be averaged for the lesser of:

1. the 12 full calendar months period of your employment with your Employer just prior to the date your disability begins; or
2. the period of actual employment with your Employer.

Earnings, whether for a full year or partial year, will be converted to a weekly amount for the purpose of calculating the weekly payment.

Effective Date means the date determined by LifeMap Assurance Company on which an Employee becomes insured under this Policy.

Eligible Survivor means your Spouse, if living, otherwise your children under age 26.

Employee means a person who:

1. is in Active Employment with the Employer;
2. is eligible for insurance according to the Coverage Outline;
3. has federal taxes deducted from his or her Earnings and has had FICA deducted, matched and remitted by the Employer;
4. is not a temporary, seasonal or contract Employee; and
5. is a citizen of the United States or legally works in the United States.

Employer means the Policyholder and includes any division, subsidiary or affiliated company named in the Application for the Policy or any Policy amendments.

Evidence of Insurability means a statement or proof of a person's medical history which we will use to determine if the person is approved for insurance. Evidence of Insurability will be at the Employee's expense for late enrollees.

Gross Weekly Benefit means the benefit amount shown in the Coverage Outline.

Guarantee Issue Amount means the amount of insurance coverage an eligible person may receive under the Policy without submitting Evidence of Insurability. This amount is based on the class of insurance for which the person is eligible according to the Coverage Outline.

Hospital means an accredited facility licensed to provide care and treatment for the condition causing your disability.

Illness means sickness, disease, pregnancy, or complications of pregnancy.
**Material Duties** means duties that:

1. are normally required for the performance of your Own Occupation;
2. are job tasks performed in the general labor market and national economy; and
3. cannot be reasonably omitted or modified.

Material Duties are not limited to those specific job tasks as performed for a specific employer or at a specific work site.

**Maximum Benefit Period** means the longest period for which STD benefits are payable for any one period of continuous disability, whether due to one or more causes. It is subject to the conditions of Item D. SUBSEQUENT PERIODS OF DISABILITY. The Maximum Benefit Period begins at the end of the Benefit Waiting Period.

**Noncontributory Insurance** means you are not required to pay any part of the premiums.

**Own Occupation** means your trade, profession or business as it is recognized in the general workplace. Own Occupation does not mean the specific job you are performing for a specific Employer or at a specific location.

**Partial Disability** or **Partially Disabled** means you are working for the Employer or for another employer, but as a result of Illness or Accidental Bodily Injury, you are:

1. able to perform one or more, but not all, of the material duties of your own or any other occupation on a full time or part time basis; or
2. able to perform all of the material and substantial duties of your own or any other occupation on a part time basis; and
3. earning less than 80% of your Predisability Earnings at the time the Partial Disability employment begins.

Loss of a license for any reason does not, in itself, constitute disability. The Employer's approval of a leave of absence under any federal or state Family and Medical Leave Act or law of like intent does not, in itself, constitute disability.

**Physician** means a person who:

1. is licensed to practice medicine and prescribe and administer drugs or perform surgery; or
2. is legally qualified as a medical practitioner providing services within the scope of his license and is required to be recognized under the Policy for insurance purposes according to the insurance statutes/regulations of the governing jurisdiction; and
3. is not the Employee or a relative of the Employee.

**Policy**, when capitalized, means the insurance policy issued and delivered to the Policyholder, including any endorsements, amendments and/or riders.

**Policyholder** means the person, individual firm, trust or other organization named in the Application for the Policy and to whom the Policy has been issued.
**Predisability Earnings** means your rate of Earnings from the Employer in effect immediately prior to the date disability began.

**Proceeds** means the amount of insurance we will pay as a benefit. This amount is based on the class of insurance for which the person is eligible on the last day of Active Work according to the Coverage Outline.

**Proof** or **Proof of Loss** means a properly completed claim form; **plus:**

1. completed statements by the Employee and the Employer;
2. a completed statement by the attending Physician(s), which must describe any restrictions on the Employee’s performance of the duties of his or her regular occupation for STD;
3. proof of any other earnings and/or social security award;
4. a signed authorization for us to obtain more information; and
5. any other items we may reasonably require in support of the claim.

**Regular Care of a Physician** means attended by a Physician whose treatment is:

1. consistent with the diagnosis of the disabling condition;
2. according to guidelines established by medical, research and rehabilitative organizations; and
3. administered as often as needed to achieve the maximum medical improvement.

**Sick Leave or Salary Continuation** means continued payments to you by your employer of all or part of your weekly earnings, after you become disabled as defined by the policy. This continued payment must be part of an established plan maintained by your employer, and includes salary continuation, accumulated sick leave, bereavement, vacation pay or any similar employer sponsored paid time off plan. Sick leave does not include PTO, holiday pay, or severance pay.

**Spouse** means your legal husband, wife or state certified domestic partner as defined by your state of residence.

**Total Disability** or ** Totally Disabled** means that you are unable to perform the Material Duties of your Own Occupation due to an Illness or Accidental Bodily Injury and are under the Regular Care of a Physician. If you become disabled due to organ donation and are unable to perform the Material Duties of your Own Occupation, and are under the Regular Care of a Physician, you will be deemed Totally Disabled under the provisions of this Policy.

Loss of a license for any reason does not, in itself, constitute total disability. The Employer's approval of a leave of absence under any federal or state Family and Medical Leave Act or law of like intent does not, in itself, constitute total disability.

**Waiting Period** means the continuous length of time you must be in Active Employment before becoming eligible for coverage under the Policy. The Waiting Period is shown in the Coverage Outline.

**We, Us and Our** refer to LifeMap Assurance Company.

**You and Your** refer to the insured Employee.
ELIGIBILITY AND EFFECTIVE DATES

This section explains how and when an Employee may enroll under the Policy and when an Employee's insurance will end.

A. ELIGIBILITY

You are eligible for coverage under the Policy if you meet the eligibility requirements stated in the Coverage Outline. Your eligibility date is the later of:

1. the date on which this Policy takes effect; or
2. the date specified in the Coverage Outline which follows your completion of the Waiting Period.

If you are a former employee who is rehired within six months of the date your employment terminated, your previous service in an eligible class will apply toward the waiting period to determine your eligibility date.

B. EFFECTIVE DATE OF INSURANCE

Subject to Item D. ACTIVELY AT WORK PROVISION and any Evidence of Insurability requirements, you will become insured:

1. for Noncontributory Insurance - on your eligibility date;
2. for Contributory Insurance - as follows:
   a. if you enroll for an amount equal to or less than the Guarantee Issue Amount within 31 days after first becoming eligible, coverage will take effect on your eligibility date; or
   b. if you enroll for an amount above the Guarantee Issue Amount within 31 days after first becoming eligible, coverage for the amount above the Guarantee Issue Amount will take effect on the Effective Date assigned by us, as shown on your Confirmation Statement, if your Evidence of Insurability is approved; or
   c. if you enroll for any amount more than 31 days after first becoming eligible, coverage will take effect on the Effective Date assigned by us, as shown on your Confirmation Statement, if your Evidence of Insurability is approved.

C. WHEN WE MAY REQUIRE EVIDENCE OF INSURABILITY

We will require Evidence of Insurability for all persons applying for insurance in any of the following situations:

1. the amount of insurance exceeds the Guarantee Issue Amount shown in the Coverage Outline; or
2. for Contributory Insurance - enrollment is made more than 31 days after you first became eligible.

Approval of coverage is subject to our review of your Evidence of Insurability. If insurance is approved, you will receive a Confirmation Statement verifying the amount and Effective Date of coverage. Coverage will begin on the Effective Date shown on your Confirmation Statement provided you are Actively at Work and performing all the regular duties of your own occupation and the required premium has been paid.
D. ACTIVELY AT WORK PROVISION

Coverage will take effect as scheduled only if you are Actively at Work all day on the last regular working day before the scheduled Effective Date. If you are absent from work due to illness (including pregnancy or complications of pregnancy) or injury; coverage will not become effective until the first day after you complete one full day of Active Work.

However, coverage will take effect on your regular day off, a holiday, or a paid vacation day; if the regularly scheduled Effective Date falls on that date and you were Actively at Work on the last regular working day before that date.

This Actively at Work requirement also applies to any increase in your coverage.

E. CONTINUITY OF COVERAGE

The following provision is included in this Policy to prevent loss of coverage when the Employer changes insurance carriers.

We will cover you, subject to premium payments, if you:

1. were insured with the prior carrier at the time of transfer to this Policy; and

2. you are a member of an eligible class, however are not Actively at Work due to injury or illness.

The benefit payable will be that which would have been paid by the prior carrier had coverage remained in force, less any benefit for which the prior carrier is liable.

G. CHANGES IN INSURANCE

Changes in insurance due to changes in salary, classification and plan design, will become effective on the first day of the month following or coinciding with the date of the change except that:

1. all increases in insurance are subject to Item D. ACTIVELY AT WORK PROVISION; and

2. insurance which exceeds the Guarantee Issue Amount shown in the Coverage Outline will take effect on the Effective Date assigned by us if Evidence of Insurability is approved. In such case, you and the Policyholder will be notified of the Effective Date of the amount of insurance which is over the Guarantee Issue Amount.

An increase in your short term disability coverage may be subject to a pre-existing condition limitation as described in the policy. An increase in coverage will not affect a payable claim that occurs prior to the increase. Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.
H. WHEN INSURANCE ENDS

Your insurance under the Policy will end on the **earliest** of the following dates:

1. the date the Policy terminates;

2. the last day of the period for which you have made any required contribution (Contributory Insurance);

3. the date employment terminates (please note: payment of premium for an employee who no longer meets the eligibility requirement does not continue coverage for such employee);

4. the date you retire;

5. the date you cease to be eligible. However, coverage may be continued during periods in which you are not Actively at Work, but your Employer continues to pay you at least the same Earnings paid to you immediately before you cease to be Actively at Work. If eligible, coverage will be continued until you return to Active Employment with your Employer.

Ceasing to be Actively at Work will be deemed termination of employment except that coverage may be continued with premium payment (unless coverage ends under 1. through 5. above) as follows:

**Disability:**

Coverage may be continued if:

a. you do not meet the definition of Disability in this Policy, but your ability to work is limited due to illness or injury; and

b. your eligibility ends because you are working less than the minimum hours required by the Policy to be a member of an eligible class.

If you meet the requirements of items a. and b. above, coverage will be continued during the period your ability to work is limited, for up to 6 months.

**Temporary Layoff or Labor Dispute:**

Coverage may be continued during a temporary layoff or labor dispute, including any strike, work slowdown, or lockout.

If eligible, coverage will be continued through the end of the month that immediately follows the month in which the temporary layoff or labor dispute begins.

**Military Service Leave of Absence:**

Coverage may be continued during a leave of absence for military service of 30 days or more.

If eligible, coverage will be continued for up to the greater leave period provided under **Leave of Absence** or **Family and Medical Leave of Absence** below.
**Leave of Absence:**

Coverage may be continued during a leave of absence approved in writing in advance by your Employer.

If eligible, coverage will continue through the end of the month that immediately follows the month in which the leave of absence begins.

**Family and Medical Leave of Absence:**

Coverage may be continued during a Family and Medical Leave of Absence as defined by the Federal Family and Medical Leave Act of 1993, and any amendments.

If eligible, coverage will continue up to the greater of the leave period required under the:

i. Federal Family and Medical Leave Act of 1993, and any amendments; or
ii. applicable state law.

If your Employer’s company rules do not provide for continuation of an Employee’s Short Term Disability coverage during a Family and Medical Leave of Absence, your coverage will be reinstated when you return to active employment. We will not:

i. apply a new Waiting Period;
ii. apply a new pre-existing conditions exclusion; or
iii. require Evidence of Insurability.

**Sabbatical Leave of Absence:**

If you are given the opportunity to take a sabbatical leave of absence for research and study, with the required premium payment your coverage will be continued during the sabbatical leave of absence.

To be eligible for a sabbatical leave of absence you must:

a. be in full-time Active Employment with the Employer for at least 6 years;
b. already have been granted tenure or an extended-term appointment at the time of application; and
c. agree to return to Active Employment with the Employer for at least 2 years once the sabbatical leave of absence is completed. Sabbatical leaves of absence are not granted to Employees who contemplate retirement within two years.

Postponement of an authorized sabbatical leave of absence will not invalidate future eligibility. After concluding an initial sabbatical you are eligible to apply again in 6 years. **Exception:** Time spent on sabbatical leaves of absence at an FTE between 0 and 0.49 are not credited to the six-year eligibility period.
You may request a sabbatical leave of absence by making application for the leave to the dean or director by the deadline established by the personnel committee. The personnel committee reviews each proposal and application for the requested sabbatical leave of absence, requesting clarifying material or a revised proposal when necessary. The personnel committee then forwards all relevant materials for the requested sabbatical leave of absence to the Provost, with a recommendation to grant or not to grant the sabbatical leave of absence. Employees potentially affected by your absence must be consulted before making a recommendation to the Provost. Major changes in a sabbatical proposal that may develop during a sabbatical leave of absence must be approved by the personnel committee, dean or director. Awards are announced after acceptance of the application by the Provost and President.

The personnel committee considers the following criteria in making its recommendation for sabbatical leaves of absence:

i. evidence that the sabbatical would lead to accomplishment in one or several areas of scholarship, or development in areas that would enhance your course portfolio;

ii. you have agreed to publish or present results of the sabbatical to peers in your discipline during or upon conclusion of the leave of absence;

iii. the quantity of work proposed for the sabbatical is commensurate with the length of leave requested;

iv. you have demonstrated the ability to bring scholarly projects to successful completion; and

v. results of prior sabbatical leaves of absence.

Consideration is given to the following for a sabbatical leave of absence request:

i. length of time served since the last sabbatical leave of absence;

ii. academic rank; and

iii. the nature of the proposed research project or study plan.

Sabbatical leave shall be compensated as follows:

i. **for 9 and 10 month sabbaticals** - leave is for one-half or one full academic year, as appropriate, with annual Earnings paid as follows:
   1.) full annual Earnings for the half-year sabbatical leave of absence; and
   2.) one-half annual Earnings for the full year sabbatical leave of absence.

ii. **for 11 and 12 month sabbaticals** – leave is for 4, 8 or 12 months as appropriate, with annual Earnings paid as follows:
   1.) full annual Earnings for 4 months;
   2.) two-thirds annual Earnings for 8 months; and
   3.) one-third annual Earnings for 12 months.

Remuneration you receive for research grants, publications, fellowships or employment directly related to your sabbatical leave of absence does not reduce the Earnings paid to you by the Employer. You may not use a sabbatical leave of absence to hold a faculty position at another institution, unless the position is directly connected to your proposed sabbatical research project and does not include earnings for teaching from that institution.

The Employer will continue to contribute to your retirement plan an amount proportional to Earnings paid to you by the Employer during the sabbatical leave of absence. Benefits you normally receive from the Employer will continue while you are on a sabbatical leave of absence.
SHORT TERM DISABILITY BENEFITS

We will pay the Proceeds available under this Short Term Disability Benefits section to you when we receive Proof of your Total or Partial Disability.

A. WHEN BENEFITS BECOME PAYABLE

Benefits will be payable upon completion of the Benefit Waiting Period when we receive Proof that:

1. you became Totally or Partially Disabled:
   a. while insured under the Policy; and
   b. from a cause not excluded under the Policy; and

2. you have been seen and treated by a Physician for the disabling condition; and

3. the Physician has certified the period of disability.

The Benefit Waiting Period is shown in the Coverage Outline.

B. BENEFIT AMOUNT

The weekly benefit for Total Disability is shown in the Coverage Outline. The formula for calculating the weekly benefit for Partial Disability is shown under Item G. PARTIAL DISABILITY BENEFITS. The Maximum Benefit Period for which STD benefits are payable is shown in the Coverage Outline.

If benefits are due for less than a full week of disability, we will divide the weekly benefit by seven days and multiply that amount by the number of days of disability.

C. DEDUCTIBLE SOURCES OF INCOME

The Short Term Disability Proceeds will be reduced by the amount of any benefit for loss of income from the following sources which is provided as a result of the period of disability for which benefits are being claimed under the Policy:

1. any state disability program from which benefits are received or for which you are eligible to receive;

2. any Federal Social Security Benefits you, your spouse, and/or your children receive or are eligible to receive because of your disability or retirement;

3. any Vacation, Sick Leave or Salary Continuation paid by the Employer which, when added to the Short Term Disability Benefit and/or any Partial Disability earnings, exceeds 100% of your Predisability Earnings;

4. any governmental law or program including unemployment;

5. any portion of a settlement or judgment, minus the associated costs of a lawsuit, that represents or compensates for loss of earnings; and

6. any disability income benefits for which the insured is eligible to receive under any other group insurance plan of the employer.
If a lump sum payment is made for any of Items 1. through 6. above, we will pro-rate the lump sum:

1. over the period of time it would have been paid if not paid in a lump sum; or

2. if the period of time cannot be determined, over a period of 60 months.

With the exception of unemployment, we will only subtract deductible sources of income which are payable as a result of the same disability. Deductible sources of income that are paid to you during the Benefit Waiting Period will not affect your weekly disability payment from us.

D. SUBSEQUENT PERIODS OF DISABILITY

Any subsequent disability will be considered a new period of disability when:

1. for the same cause(s) of disability, you return to active full time work with reasonable continuity at your own occupation for a continuous period of 14 or more calendar days; or

2. for different and unrelated causes of disability, you return to active full time work at your own occupation for at least one day.

E. REASONABLE ACCOMMODATION EXPENSE BENEFIT

We may pay a Reasonable Accommodation Expense Benefit to your employer if you return to work in any occupation, excluding self-employment, as a result of a reasonable accommodation your employer has made for you. The benefit will be payable in an amount agreed to by us in writing; not to exceed the actual cost incurred.

F. VOCATIONAL REHABILITATION PLAN BENEFIT

During a period of disability you may be eligible to participate in a vocational rehabilitation plan. We will review your disability claim to determine if you are eligible to participate in these services. If we determine that you are qualified to participate in a rehabilitation plan, we will provide you with a written plan to be agreed upon by you. We may pay for all or some of the expenses incurred as part of the rehabilitation plan.

The Vocational Rehabilitation Plan Benefit may include the following:

1. training and education;

2. coordination with your employer to assist you to return to work;

3. job placement assistance;

4. job related assistance, such as workplace modifications or adaptive equipment; and

5. family care expense assistance.
G. PARTIAL DISABILITY BENEFITS

We will pay a Partial Disability Benefit if we receive Proof that you are Partially Disabled due to Illness or Accidental Bodily Injury; subject to the conditions listed in Item A. WHEN BENEFITS BECOME PAYABLE; except that Total Disability is not required. The Benefit Waiting Period may be met with days of Total Disability, Partial Disability, or both.

The Partial Disability Benefit is calculated as follows:

1. determine the benefit for Total Disability; then

2. subtract 50% of the Partial Disability earnings from the amount in 1. above.

The result is your Partial Disability Benefit; except that your benefit will never be less than the minimum weekly benefit shown in the Coverage Outline.

If you are earning less than 20% of your Predisability Earnings, a Total Disability Benefit will be paid.

Receipt of Partial Disability Benefits will not extend the Maximum Benefit Period shown in the Coverage Outline.
H. WHEN BENEFITS END

Short Term Disability Benefits end on the **earliest** of the following dates:

1. the end of the Maximum Benefit Period;
2. the date the Physician releases you to return to active full time work at your Own Occupation;
3. the date you begin active full time work at an occupation other than your own;
4. the date you refuse to accept a job position with the Employer:
   a. within the same general location;
   b. which takes into account the material and substantial duties which you are able to perform;
   c. which considers your prior education, training or experience; and
   d. with a rate of pay greater than 80% of your Predisability Earnings;
5. the date your Earnings exceed 85% of your Predisability Earnings;
6. the date benefits become payable under the Employer's Group Long Term Disability Plan;
7. the date you die;
8. the date you fail to provide the required Proof of continuing disability;
9. the date you refuse to undergo a medical exam at our request or cooperate with an examiner;
10. the date you become self-employed and are earning at least 60% of your Predisability Earnings;
11. the date you no longer meet the definition of Total or Partial Disability as defined in this policy; or
12. the 45th day after we request additional proof of loss from you, if not provided.

I. THREE WEEK SURVIVOR BENEFIT

We will pay a lump sum benefit to your Eligible Survivor when we receive Proof that you died while receiving a weekly benefit.

The lump sum benefit will be an amount equal to three times your gross weekly benefit and will be paid to your Eligible Survivor. If you do not have an Eligible Survivor, payment will be made to your estate, unless there is none. In this case, no payment will be made.
J. EXCLUSIONS

Benefits are not payable for disability that results from:

1. any injury or illness incurred in the course of any employment for wage or profit;
2. any injury or illness for which you are or were entitled to benefits under any Workers' Compensation or occupational disease law;
3. any suicide attempt or any intentionally self-inflicted injury;
4. committing or attempting to commit an assault or felony;
5. participation in a war, declared or undeclared, or any act of war;
6. elective sterilization, except complications of an elective sterilization;
7. elective cosmetic or plastic surgery unless required due to injury or sickness; except complications of cosmetic or plastic surgery.

In addition, no benefits will be paid for any period of disability:

1. during which you are not under the Regular Care of a Physician;
2. during which you have received 100% of your Predisability Earnings under your Employer’s Sick Leave plan, except that the minimum weekly benefit shown in the coverage outline will be payable;
3. during which you are incarcerated in a corrections facility; or
4. during which you are receiving; or are eligible to receive Workers' Compensation benefits, regardless of the cause of the disability; or for a disability that would be covered by Workers’ Compensation if you had filed a claim.

Note: If we advance weekly benefits to you and your Workers’ Compensation claim is approved, you must refund all monies paid to you by LifeMap Assurance Company.
CLAIMS

This section explains some of the terms and conditions relating to payment of claims.

A. CLAIM FORMS

We will furnish the claim forms for filing Proof of Loss within 15 days after they are requested. If we do not do so, the claimant may comply with the Proof of Loss requirements of the Policy by submitting:

1. written Proof showing the occurrence, nature and extent of the loss for which claim is made;
2. the Proof within the time fixed in Item B. PROOF OF LOSS.

B. PROOF OF LOSS

1. Written Proof of Loss must be furnished to us at our Home Office within 90 days after the date of the loss.
2. Failure to furnish Proof will not invalidate nor reduce any claim if it is not reasonably possible to give Proof within 90 days, provided the Proof is furnished as soon as reasonably possible.
3. In no event, except in the absence of legal capacity of the claimant, may Proof be given later than one year from the time Proof is otherwise required.
4. Proof of continuing disability must be furnished within 90 days of the date such Proof is requested.

C. PHYSICAL EXAM

We have the right and opportunity to have a person whose injury or illness is the basis of a claim examined by a Physician of our choice at our expense. This right may be used as often as reasonably required, while the claim is pending.

D. INCONTESTABILITY

Any statement by you to obtain coverage under the Policy will be a representation and not a warranty. No misrepresentation will be used to reduce or deny a claim or to deny the validity of coverage unless:

1. coverage would not have been approved except for the misrepresentation;
2. the misrepresentation is contained in a written instrument signed by you; and
3. a copy of the written instrument containing the misrepresentation has been given to you.

After coverage has been in effect for two years during the lifetime of the person, no misrepresentation will be used to reduce or deny a claim or to deny the validity of coverage.

The validity of the Policy will not be contested after it has been in force for two years, except for nonpayment of premiums.

E. PAYMENT OF CLAIMS

We will pay the Proceeds for insured losses as soon as we receive satisfactory Proof of Loss. Short Term Disability Benefits 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. Short Term Disability Benefits remaining unpaid at your death will be paid to your estate.
F. REVIEW PROCEDURE

A claimant has the right to a review of any denial by us of all or any part of a claim. To obtain a review for disability insurance claims, a written request for review should be sent to us at our Home Office within 180 days after the claimant receives notice of denial. No special form is required.

The claimant may submit written comments and provide additional documentation in support of the claim, and may review any non-privileged information relating to the request for review.

We will review the claim promptly after receiving the request. For disability insurance claims, we will send the claimant written notice of our decision within 45 days after the request for review is received; or within 90 days if special circumstances require an extension. The notice will include the reasons for the decision and will refer to the specific provisions of the Policy on which the decision is based.

Another person may be authorized to act for the claimant under this review procedure.

G. OVERPAID CLAIMS

We have the right to recover any overpayments due to:

1. fraud;
2. any error made in processing a claim; or
3. deductible sources of income (if any) received by you.

If benefits have been overpaid on any claim, it will be required that reimbursement be made to LifeMap Assurance Company; or we have the right to reduce future benefits until such reimbursement is received. In the event of your death, we also have the right to recover such overpayments from your estate.

H. LEGAL ACTIONS

A claimant or the claimant's authorized representative may not start any legal action:

1. until 60 days after Proof of Loss has been given; or
2. more than three years after the time Proof of Loss is required to be given.

I. INSURANCE FRAUD

Any person who knowingly and with intent to defraud any insurance company; or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be subject to prosecution for insurance fraud.

We may terminate your coverage if you have filed a fraudulent claim or statement with us. We may terminate the group policy if the Policyholder or his administrator has filed or assisted with the filing of a fraudulent claim with us.

J. CONTACT INFORMATION

If you have questions concerning your coverage, you may contact our customer service department at 1 (800) 286-1129 or write to our customer service department at the following address: LifeMap Assurance Company, PO Box 1271, MS E3A, Portland, OR 97207-1271.
GENERAL PROVISIONS

A. MISSTATEMENT OF AGE

If a person's age has been misstated, an equitable adjustment will be made in the premium. If the amount of the benefit is dependent upon the person's age, the benefit amount will be the amount the person would have been entitled to if his or her correct age were known.

NOTE: A refund will not be made for a period more than 12 months before the date we are advised of the error.

B. CLERICAL ERROR OR OMISSION

Clerical error or omission will not:

1. cause an ineligible employee to become insured;
2. invalidate insurance otherwise validly in force; or
3. continue insurance validly terminated.

C. POLICY CHANGES

The Policy may be changed in whole or in part. No change will be valid unless approved by one of our officers. The approval must be in writing and endorsed on or attached to the Policy. No other person, including an insurance producer, may change the Policy or waive any part of it.

D. AGENCY

For all purposes under the Policy the Policyholder acts on its own behalf or as an agent of the Employee. Under no circumstances will the Policyholder be deemed our agent without a written authorization.

E. CERTIFICATES

The Employer is responsible for giving to you a complete copy of the Certificate for your applicable class within 31 days after receipt of the Certificates from us.

F. WORKERS' COMPENSATION

This insurance is not in lieu of Workers' Compensation; it does not affect any requirement for Workers' Compensation coverage.
Pacific University is providing this document to give you an overview of the Plan and to address certain information that may not be addressed in the attached Certificate of Coverage. This Pacific University document, together with the Certificate of Coverage issued by LifeMap Assurance Company, is the Summary Plan Description (SPD) required by the Employee Retirement Income Security Act of 1974 (“ERISA”). This Pacific University document is not intended to give you any substantive rights to benefits that are not already provided by the attached Certificate of Coverage. The following information is furnished by the Plan Administrator and is not a part of the Group Policy or this Certificate of Coverage. LifeMap Assurance Company assumes no responsibility for the accuracy or sufficiency of the information in this section.

GENERAL INFORMATION ABOUT THE PLAN

Plan Name: Short Term Disability Insurance Plan.

Type of Plan: Group Insurance Plan (a type of welfare benefit plan that is subject to the provisions of ERISA).

Plan Year: The Plan year begins April 1 and ends March 31

Plan Number: #501

Effective Date: April 1, 2015

Funding Medium and Type of Plan Administration:
This Plan is fully insured. Benefits are provided under a group insurance contract entered into between Pacific University and LifeMap Assurance Company.

Claims for benefits are sent to the Insurance Company. The Insurance Company, not the Plan Sponsor, is responsible for determining eligibility for and the amount of any benefits payable under the Plan and for providing the claims procedures to be followed and the claims forms to be used by employees pursuant to the Plan. The Insurance Company also has the authority to require employees to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Insurance premiums for employees are paid by the Plan Sponsor.

Plan Sponsor: Pacific University
2043 College Way
Forest Grove, OR 97116
(503) 352-2882

Plan Sponsor’s Employer Identification Number: 93-0386892

Insurance Company: LifeMap Assurance Company
P.O. Box 1271 MS E3A
Portland, Oregon 97207-1271
Tel: (503) 412-7965
Toll-free: (800) 286-1129
Plan Administrator and Pacific University
Named Fiduciary 2043 College Way
Forest Grove, OR  97116
(503) 352-2882
Attention: Human Resources Manager

Agent for Service of President
Legal Process Pacific University
2043 College Way
Forest Grove, OR  97116
(503) 352-2882

Service of legal process may also be made on the Plan Administrator.

Amendment or Termination
The Plan Sponsor has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument signed by the Plan Sponsor President or Human Resources Manager, both of whom are authorized to amend or terminate the Plan and to sign insurance contracts with the Insurance Company or other carriers, including amendments to those contracts. In addition, termination of the group insurance contract entered into between the Plan Sponsor and Insurance Company will constitute termination of the Plan, unless the Plan Sponsor exercises its sole discretion to obtain a substitute contract of insurance.

Important Disclaimer
Benefits hereunder are provided solely pursuant to an insurance contract between the Plan Sponsor and the Insurance Company. If the terms of this summary document conflict with the terms of the insurance contract, the terms of the insurance contract will control, unless superseded by applicable law.
STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 as amended (“ERISA”). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's principal office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
CLAIM REVIEW PROCEDURES

The Insurance Company is responsible for evaluating all benefit claims under the Plan. The Insurance Company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA.

See the attached Certificate of Coverage issued by LifeMap Assurance Company for information about how to file a claim and for details regarding the Insurance Company’s claims procedures.

LIFE INSURANCE

The Plan will make every effort to make a determination on life and accidental death claims within 90 days of receipt of the claim.

If the Plan is not able to make a decision on the claim within 90 days of receipt of the claim for reasons beyond the control of the Plan, the decision may be extended for as many as 90 additional days. If this is the case, written notice will be provided to the claimant prior to the end of the first 90 days that details the specific reason(s) for the delay. The notice will identify the additional information or documents needed to resolve the claim.

The maximum time the Plan will take to make a decision on the claim will be 180 days.

DISABILITY INSURANCE

The Plan will make every effort to make a determination on short term disability, long term disability, and extension of life insurance during total disability (waiver of premium) claims within 45 days of receipt of the claim.

If the Plan is not able to make a decision on the claim within 45 days of receipt of the claim for reasons beyond the control of the Plan, the decision may be extended for as many as 30 additional days. If this is the case, written notice will be provided to the claimant prior to the end of the first 45 days that details the specific reason(s) for the delay. The notice will identify the additional information or documents needed to resolve the claim. The claimant will be allowed at least 45 days to provide any requested information. The time it takes for the claimant to provide this additional information will not count toward the extension period time limit.

A second 30 day extension may occur if the claim still cannot be resolved for reasons beyond the control of the Plan. Again, the claimant will be provided with a written extension notice prior to the end of the first 30 day extension that details the specific reason(s) for the delay. The notice will identify the additional information or documents needed to resolve the claim. The claimant will be allowed at least 45 days to provide any requested information. The time it takes for the claimant to provide this additional information will not count toward the extension period time limit.

The maximum time the Plan will take to make a decision on the claim, not including the time it takes for the claimant to provide any additional information or documents that were requested, will be 105 days.
CLAIM APPEAL PROCEDURES

LIFE INSURANCE

If a life or accidental death claim is denied, the Plan will provide the claimant with a letter stating the specific reason(s) for the adverse determination. The claimant will also be provided with a description of any additional information or material necessary to perfect the claim and an explanation as to why such material is necessary.

The claimant will have 60 days following receipt of an adverse benefit determination to file an appeal. Another person may be authorized to act for the claimant under this appeal procedure.

The appeal will be decided within 60 days after receipt of the appeal. The 60 day time period will start when the appeal is filed without regard to whether all of the information necessary to decide the appeal accompanies the filing.

If, for reasons beyond the control of the Plan, the appeal cannot be decided within 60 days, the appeal decision may be extended for as many as 60 additional days. The maximum time to decide the appeal will be 120 days.

DISABILITY INSURANCE

If a short term disability, long term disability, or extension of life insurance during total disability (waiver of premium) claim is denied, the Plan will provide the claimant with a letter stating the specific reason(s) for the adverse determination. The claimant will also be provided with a description of any additional information or material necessary to perfect the claim and an explanation as to why such material is necessary.

The claimant will have 180 days following receipt of an adverse benefit determination to file an appeal. Another person may be authorized to act for the claimant under this appeal procedure.

The appeal will be decided within 45 days after receipt of the appeal. The 45 day time period will start when the appeal is filed without regard to whether all of the information necessary to decide the appeal accompanies the filing.

If, for reasons beyond the control of the Plan, the appeal cannot be decided within 45 days, the appeal decision may be extended for as many as 45 additional days. The maximum time to decide the appeal will be 90 days.