

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

People. Not Just Policies.®

CERTIFICATE AND SUMMARY PLAN DESCRIPTION: GROUP LIFE INSURANCE

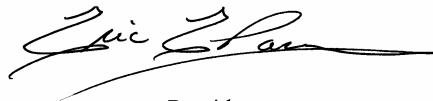
Policyowner:	Pacific Coast Shipyards Metal Trades Trust Fund
Policy Number:	615521-A
Effective Date:	January 1, 1994

A Group Policy has been issued to the Policyowner. We certify that you will be insured as provided by the terms of the Group Policy. If your coverage is changed by an amendment to the Group Policy, we will provide the Policyowner with a revised Certificate or other notice to be given to you.

This policy includes an Accelerated Benefit. Death benefits will be reduced if an Accelerated Benefit is paid. The receipt of this benefit may be taxable and may affect your eligibility for Medicaid or other government benefits or entitlements. However, if you meet the definition of "terminally ill individual" according to the Internal Revenue Code Section 101, your Accelerated Benefit may be non-taxable. You should consult your personal tax and/or legal advisor before you apply for an Accelerated Benefit.

Possession of this Certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate. If the terms of the Certificate differ from the Group Policy, the terms stated in the Group Policy will govern.

"We", "us" and "our" mean Standard Insurance Company. "You" and "your" mean the Member. All other defined terms appear with the initial letter capitalized. Section headings, and references to them, appear in boldface type.



President

CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION ACT
SUMMARY DOCUMENT AND DISCLAIMER

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the California Life and Health Insurance Guarantee Association ("CLHIGA"). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guarantee Association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guarantee Association is not unlimited, however, as noted below, and is not a substitute for consumers' care in selecting insurers.

The California Life and Health Insurance Guarantee Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the guarantee association to induce you to purchase any kind of insurance policy.**

Policyholders with additional questions should first contact their insurer or agent or may then contact:

The California Life and Health Insurance Guarantee Association

PO Box 17319

Beverly Hills CA 90209-3319

OR

Consumer Services Division

California Department of Insurance

300 S Spring St, 14th Fl

Los Angeles CA 90013

The state law that provides for this safety-net coverage is called the California Life and Health Guarantee Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE

Generally, individuals will be protected by the California Life and Health Insurance Guarantee Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guarantee Association if:

Their insurer was not authorized to do business in this state when it issued the policy or contract;

Their policy was issued by a health care service plan (HMO, Blue Cross, Blue Shield), a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;

They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.

The Guarantee Association also does not provide coverage for:

Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contract holders, not individuals;

Employer or association plans, to the extent they are self-funded or uninsured;

Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

Any policy of reinsurance unless an assumption certificate was issued;

Interest rate yields that exceed an average rate;

Any portion of a contract that provides dividends or experience rating credits.

LIMITS ON AMOUNT OF COVERAGE

The Act limits the Association to pay benefits as follows:

LIFE AND ANNUITY BENEFITS

80% of what the insurance company would owe under a policy or contract up to \$100,000 in cash surrender values,

\$100,000 in present value of annuities, or

\$250,000 in life insurance death benefits.

A maximum of \$250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

HEALTH BENEFITS

A maximum of \$200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

PREMIUM SURCHARGE

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.

CALIFORNIA NOTICE OF COMPLAINT PROCEDURE

Should any dispute arise about your premium or about a claim that you have filed, write to the company that issued the group policy. If the problem is not resolved, you may also write to the State of California, Department of Insurance, Consumer Services Division, 300 S. Spring Street, 14th FL, Los Angeles, CA 90013, or call toll-free 1-800-927-HELP (4357). This notice of complaint procedure is for information only and does not become a part or condition of this group policy/certificate.

Table of Contents

COVERAGE FEATURES	1
GENERAL POLICY INFORMATION	1
BECOMING INSURED.....	1
SCHEDULE OF INSURANCE	2
REDUCTIONS IN INSURANCE	2
OTHER PROVISIONS	2
PREMIUM CONTRIBUTIONS.....	2
ERISA SUMMARY PLAN DESCRIPTION INFORMATION.....	3
LIFE INSURANCE.....	4
A. Insuring Clause.....	4
B. Amount Of Life Insurance	4
C. When Life Insurance Becomes Effective.....	4
D. When Life Insurance Ends	4
E. Reinstatement Of Life Insurance	4
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE.....	4
A. Insuring Clause.....	4
B. Definition Of Loss For AD&D Insurance.....	4
C. Amount Payable.....	5
D. Seat Belt Benefit.....	5
E. AD&D Insurance Exclusions	5
F. When AD&D Insurance Becomes Effective	5
G. When AD&D Insurance Ends.....	5
WAIVER OF PREMIUM	6
ACCELERATED BENEFIT.....	7
RIGHT TO CONVERT.....	8
CLAIMS	9
ASSIGNMENT.....	12
BENEFIT PAYMENT AND BENEFICIARY PROVISIONS	12
ALLOCATION OF AUTHORITY	13
TIME LIMITS ON LEGAL ACTIONS	14
INCONTESTABILITY PROVISIONS.....	14
DEFINITIONS.....	15
ERISA INFORMATION AND NOTICE OF RIGHTS.....	15

Index of Defined Terms

The page number shown below is where the term is defined. For terms defined by an entire section, the page number below is the page on which that section begins.

Accelerated Benefit, 7	Pregnancy, 15
Active Work, Actively At Work, 15	Prior Plan, 15
AD&D Insurance, 15	Proof Of Loss, 10
Automobile, 5	Qualifying Event, 8
	Qualifying Period, 2
Beneficiary, 12	Recipient, 13
	Right To Convert, 8
Class Definition, 1	Seat Belt, 5
Contributory, 15	Sickness, 15
Conversion Period, 8	Spouse, 15
Domestic Partner, 15	Totally Disabled, 6, 9
Eligibility Period, 2	Waiting Period (for Waiver of Premium), 6
Eligibility Waiting Period, 15	Waiver Of Premium, 6
Employer(s), 1	War, 5
Evidence Of Insurability, 15	you, your (for Right To Convert), 8
Group Policy, 15	
Group Policy Effective Date, 1	
Group Policy Number, 1	
Injury, 15	
Insurance (for Accelerated Benefit), 8	
Insurance (for Right To Convert), 8	
Insurance (for Waiver of Premium), 6	
Life Insurance, 15	
Loss (for AD&D Insurance), 4	
Maximum Conversion Amount, 2	
Member, 1	
Minimum Time Insured, 2	
Noncontributory, 15	
Physician, 8	
Plan Administrator, 3	
Policyowner, 1	

COVERAGE FEATURES

This section contains many of the features of your group life insurance. Other provisions, including exclusions and limitations, appear in other sections. Please refer to the text of each section for full details. The Table of Contents and the Index of Defined Terms help locate sections and definitions.

GENERAL POLICY INFORMATION

Group Policy Number:	615521-A
Type of Insurance Provided:	
Life Insurance:	Yes
Accidental Death And Dismemberment (AD&D) Insurance:	Yes
Policyowner:	Pacific Coast Shipyards Metal Trades Trust Fund
Employer(s):	Any employer which participates in the Pacific Coast Shipyards Metal Trades Trust and makes contributions pursuant to the trust agreement.
Group Policy Effective Date:	January 1, 1994
State of Issue:	California

BECOMING INSURED

To become insured for Life Insurance you must: (a) Be a Member; (b) Complete your Eligibility Waiting Period; and (c) Meet the requirements in **Life Insurance**. The requirements for becoming insured for coverages other than Life Insurance are set out in the text.

Definition of Member:	You are a Member if contributions on your behalf are made by the Employer to the trust fund for the maintenance of the health and welfare plan, and you are:
	<ol style="list-style-type: none">1. An active employee who meets the eligibility rules established by the Pacific Coast Shipyards Metal Trades Trust Fund; and2. Employed in California, Washington or Oregon.
	You are not a Member if you are a full-time member of the armed forces of any country.
Class Definition:	None
Eligibility Waiting Period:	You are eligible on the first day of the Eligibility Period following a Qualifying Period for which you are credited with at least 400 hours, determined by the minimum hourly contribution required by the Policyowner and the rate at which your Employer contributes.

Once you become eligible, you will remain eligible for the following Eligibility Period, subject to D. When Life Insurance Ends of the **Life Insurance** section.

However, if you have not been insured under the Group Policy during the preceding 12 months, you may become eligible on the first day of the Eligibility Period following two Qualifying Periods for which you are credited with at least 400 hours, determined by the minimum hourly contribution required by the Policyowner and the rate at which your Employer contributes.

Eligibility Period means the period from January 1 through March 31 and each successive three calendar month period thereafter.

Qualifying Period means the period from December 1 through the last day of February and each successive three calendar month period thereafter.

SCHEDULE OF INSURANCE

Life Insurance:	\$10,000
AD&D Insurance:	\$10,000

The amount payable for certain Losses will differ. See **Accidental Death And Dismemberment Insurance.**

REDUCTIONS IN INSURANCE

Your insurance is not subject to reductions due to age.

OTHER PROVISIONS

Waiver Of Premium:	Yes
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Limits on Right To Convert if
Group Policy terminates or is
amended:

Minimum Time Insured:	5 years
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Maximum Conversion Amount:	\$2,000
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PREMIUM CONTRIBUTIONS

Life and AD&D Insurance:	Noncontributory
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ERISA SUMMARY PLAN DESCRIPTION INFORMATION

Name of Plan: Life and AD&D Insurance

Name, Address of Plan Sponsor: Pacific Coast Shipyards Metal Trades Trust Fund
5 Third St Ste 525
San Francisco CA 94103-3206

Plan Sponsor Tax ID Number: 94-1248513

Plan Number: 501

Type of Plan: Group Insurance Plan

Type of Administration: Contract Administration

Name, Address, Phone Number of Plan Administrator: Plan Sponsor

Name, Address of Registered Agent for Service of Legal Process: Plan Administrator

If Legal Process involves Claims
For Benefits Under The Group Policy,
Additional Notification of Legal
Process Must Be Sent To:
Standard Insurance Company
1100 SW 6th Ave
Portland OR 97204-1093

Sources of Contributions: Employer

Funding Medium: Standard Insurance Company - Fully Insured

Plan Fiscal Year End: June 30

LIFE INSURANCE

A. Insuring Clause

If you die while insured for Life Insurance, we will pay benefits according to the terms of the Group Policy after we receive satisfactory Proof Of Loss.

B. Amount Of Life Insurance

See the **Coverage Features** for the amount of your Life Insurance.

C. When Life Insurance Becomes Effective

Your Life Insurance becomes effective on the date you become eligible.

D. When Life Insurance Ends

Life Insurance ends automatically on the earliest of:

1. The last day of an Eligibility Period which begins during a Qualifying Period (a) for which you are not credited with at least 400 hours, and (b) in which you no longer have at least 400 hours in your hour bank.
2. The date the Group Policy terminates;
3. The date you cease to be a Member. However, your Insurance may be continued with payment of premium during a leave of absence if continuation of your insurance under the Group Policy is required by the federal or state mandated family or medical leave act or law.

E. Reinstatement Of Life Insurance

If your Life Insurance ends, you may become insured again as a new Member. However, 1 and 2 below will apply.

1. If you exercised your Right To Convert, you must provide Evidence Of Insurability to become insured again.
2. If your insurance ends because you are on a federal or state mandated family or medical leave of absence, and you become a Member again immediately following the period allowed, your insurance will be reinstated pursuant to the federal or state mandated family or medical leave act or law.

LI.LF.64X

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

A. Insuring Clause

If you have an accident while insured for AD&D Insurance, and the accident results in a Loss, we will pay benefits according to the terms of the Group Policy after we receive satisfactory Proof Of Loss.

B. Definition Of Loss For AD&D Insurance

Loss means loss of life, hand, foot, or sight which:

1. Is caused solely and directly by an accident;
2. Occurs independently of all other causes; and
3. Occurs within 365 days after the accident.

With respect to a hand or foot, Loss means actual and permanent severance from the body at or above the wrist or ankle joint. With respect to sight, Loss means entire and irrecoverable loss of sight.

C. Amount Payable

The amount payable is equal to a percentage of your AD&D Insurance in effect on the date of the accident (See **Coverage Features**). The percentage is shown below.

Loss:	Percentage
Life	100%
One hand, one foot, or sight of one eye	50%
Two or more of the above Losses	100%

No more than 100% of your AD&D Insurance will be paid for all Losses resulting from one accident.

D. Seat Belt Benefit

The amount of the Seat Belt Benefit is the lesser of (1) \$50,000 or (2) the amount of AD&D Insurance payable for Loss of life.

We will pay a Seat Belt Benefit if:

1. You die as a result of an Automobile accident for which an AD&D Insurance benefit is payable; and
2. You were wearing a Seat Belt at the time of the accident, as evidenced by a police accident report.

Seat Belt means a properly installed seat belt, lap and shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration.

Automobile means a motor vehicle licensed for use on public highways.

E. AD&D Insurance Exclusions

No AD&D Insurance benefit is payable if the Loss is caused or contributed to by any of 1 through 7 below.

1. War or act of War. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.
2. Suicide or other intentionally self-inflicted injury, while sane or insane.
3. Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.
4. The voluntary use or consumption of any poison, chemical compound or drug, unless used or consumed according to the directions of a physician.
5. Sickness or Pregnancy existing at the time of the accident.
6. Heart attack or stroke.
7. Medical or surgical treatment for any of the above.

F. When AD&D Insurance Becomes Effective

Your AD&D Insurance becomes effective on the date your Life Insurance becomes effective.

G. When AD&D Insurance Ends

Your AD&D Insurance ends automatically on the earlier of:

1. The date your Life Insurance ends; and
2. The date your Waiver Of Premium begins.

LI.AD.01X

WAIVER OF PREMIUM

A. Waiver Of Premium Benefit

Insurance will be continued without payment of premiums while you are Totally Disabled if:

1. You become Totally Disabled while insured under the Group Policy and under age 60;
2. You complete your Waiting Period; and
3. You give us satisfactory Proof Of Loss.

However, continuation of insurance without payment of premiums is limited to 12 months if you become Totally Disabled on or after age 60.

B. Definitions For Waiver Of Premium

1. Insurance means all your insurance under the Group Policy, except AD&D Insurance.
2. Totally Disabled means that, as a result of Sickness, accidental Injury, or Pregnancy, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience.
3. Waiting Period means the 180 consecutive day period beginning on the date you become Totally Disabled. Waiver Of Premium begins when you complete the Waiting Period.

C. Premium Payment

Premium payment must continue until the later of:

1. The date you complete your Waiting Period; and
2. The date we approve your claim for Waiver Of Premium.

D. Refund Of Premiums

We will refund up to 12 months of the premiums that were paid for Insurance after the date you become Totally Disabled.

E. Amount Of Insurance

The amount of Insurance continued without payment of premium is the amount in effect on the day before you become Totally Disabled, subject to the following:

1. Insurance will be reduced or terminated according to the Group Policy provisions in effect on the day before you become Totally Disabled.
2. If you receive an Accelerated Benefit, Insurance will be reduced according to the **Accelerated Benefit** provision.

F. Effect Of Death During The Waiting Period

If you die during the Waiting Period and are otherwise eligible for Waiver Of Premium, the Waiting Period will be waived.

G. Termination Or Amendment

Insurance will not be affected by termination or amendment of the Group Policy or termination of the Employer's participation under the Group Policy after you become Totally Disabled.

H. When Waiver Of Premium Ends

Waiver of Premium ends on the earliest of:

1. The date you cease to be Totally Disabled;

2. Twelve months after the date you become Totally Disabled, if you become Totally Disabled on or after age 60;
3. 90 days after the date we mail you a request for additional Proof Of Loss, if it is not given;
4. The date you fail to attend an examination or cooperate with the examiner;
5. With respect to the amount of Insurance which an insured has converted, the effective date of the individual life insurance policy issued to the insured; and

LI.WP.30X

ACCELERATED BENEFIT

A. Accelerated Benefit

If you qualify for Waiver Of Premium and give us satisfactory proof of having a Qualifying Medical Condition while you are insured under the Group Policy, you may have the right to receive during your lifetime a portion of your Insurance as an Accelerated Benefit. You must have at least \$10,000 of Insurance in effect to be eligible.

Qualifying Medical Condition means:

1. You are terminally ill, with a life expectancy of less than 12 months; or
2. You are permanently confined to a Nursing Home and have been in residence there for at least 60 days.

We may have you examined at our expense in connection with your claim for an Accelerated Benefit. Any such examination will be conducted by one or more Physicians of our choice.

B. Application For Accelerated Benefit

You must apply for an Accelerated Benefit. To apply you must give us satisfactory Proof Of Loss on our forms. Proof Of Loss must include a statement from a Physician that you have a Qualifying Medical Condition.

C. Amount Of Accelerated Benefit

You may receive an Accelerated Benefit of up to 50% of your Insurance. The maximum Accelerated Benefit is \$250,000. The minimum Accelerated Benefit is \$5,000 or 10% of your Insurance, whichever is greater.

If the amount of your Insurance is scheduled to reduce within 12 months following the date you apply for the Accelerated Benefit, your Accelerated Benefit will be based on the reduced amount.

The Accelerated Benefit will be paid to you once in your lifetime in a lump sum. If you recover from your Qualifying Medical Condition after receiving an Accelerated Benefit, we will not ask you for a refund.

D. Effect On Insurance And Other Benefits

For any purpose other than premium payment, the amount of your Insurance after payment of the Accelerated Benefit will be the greater of the amounts in (1) and (2) below; however, if you assign your rights under the Group Policy, the amount of your Insurance will be the amount in (2) below.

- (1) 10% of the amount of your Insurance as if no Accelerated Benefit had been paid; or
- (2) The amount of your Insurance as if no Accelerated Benefit had been paid; minus

An interest charge calculated as follows:

A times B times C divided by 365 = interest charge.

A = The amount of the Accelerated Benefit.

B = The monthly average of our variable policy loan interest rate.

C = The number of days from payment of the Accelerated Benefit to the earlier of (1) the date you die, and (2) the date you have a Right To Convert.

Your AD&D Insurance, if any, is not affected by payment of the Accelerated Benefit.

E. Exclusions

No Accelerated Benefit will be paid if:

1. All or part of your Insurance must be paid to your Child(ren), or your Spouse or former Spouse as part of a court approved divorce decree, separate maintenance agreement, or property settlement agreement.
2. You are married and live in a community property state unless you give us a signed written consent from your Spouse.
3. You have made an assignment of all or part of your Insurance unless you give us a signed written consent from the assignee.
4. You have filed for bankruptcy, unless you give us written approval from the Bankruptcy Court for payment of the Accelerated Benefit.
5. You are required by a government agency to use the Accelerated Benefit to apply for, receive, or continue a government benefit or entitlement.
6. You have previously received an Accelerated Benefit under the Group Policy.

F. Definitions For Accelerated Benefit

Insurance means your Life Insurance under the Group Policy.

Physician means a licensed M.D. or D.O., acting within the scope of the license. Physician does not include you or your Spouse, or the brother, sister, parent or child of either you or your Spouse.

LI.AB.160X

RIGHT TO CONVERT

A. Right To Convert

You may buy an individual policy of life insurance without Evidence of Insurability if:

1. Your Insurance ends or is reduced due to a Qualifying Event; and
2. You apply in writing and pay us the first premium during the Conversion Period.

Except as limited under C. Limits On Right To Convert, the maximum amount you have a Right To Convert is the amount of your Insurance which ended.

B. Definitions For Right To Convert

1. Conversion Period means the 31-day period after the date of any Qualifying Event.
2. Insurance means all your insurance under the Group Policy, including insurance continued under Waiver Of Premium, but excluding AD&D Insurance.
3. Qualifying Event means termination or reduction of your Insurance for any reason except:
 - a. The Member's failure to make a required premium contribution.
 - b. Payment of an Accelerated Benefit.

4. You and your mean any person insured under the Group Policy.
5. Totally Disabled means that, as a result of Sickness, accidental Injury, or Pregnancy, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience.

C. Limits On Right To Convert

If your Insurance ends or is reduced because of termination or amendment of the Group Policy, 1 and 2 below will apply.

1. You may not convert Insurance which has been in effect for less than the Minimum Time Insured. See **Coverage Features**.
2. The maximum amount you have a Right To Convert is the lesser of:
 - a. The amount of your Insurance which ended, minus any other group life insurance for which you become eligible during the Conversion Period; and
 - b. The Maximum Conversion Amount. See **Coverage Features**.

However, if your Insurance ends or is reduced because of termination or amendment of the Group Policy, the limitations in 1 and 2 above will not apply to you provided that:

1. You are Totally Disabled on the date of such termination or reduction of your Insurance; and
2. You are not covered under a Waiver of Premium Benefit.

D. The Individual Policy

You may select any form of individual life insurance policy we issue to persons of your age, except:

1. A term insurance policy;
2. A universal life policy;
3. A policy with disability, accidental death, or other additional benefits; or
4. A policy in an amount less than the minimum amount we issue for the form of life insurance you select.

The individual policy of life insurance will become effective on the day after the end of the Conversion Period. We will use our published rates for standard risks to determine the premium.

E. Death During The Conversion Period

If you die during the Conversion Period, we will pay a death benefit equal to the maximum amount you had a Right To Convert, whether or not you applied for an individual policy. The benefit will be paid according to the **Benefit Payment And Beneficiary Provisions**.

LI.RC.17

CLAIMS

A. Filing A Claim

Claims should be filed on our forms. If we do not provide our forms within 15 days after they are requested, the claim may be submitted in a letter to us.

B. Time Limits On Filing Proof Of Loss

Proof Of Loss must be provided within 90 days after the date of the loss. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after that 90-day period.

Proof Of Loss for Waiver Of Premium must be provided within 12 months after the end of the Waiting Period. We will require further Proof Of Loss at reasonable intervals, but not more often than once a year after you have been continuously Totally Disabled for two years.

If Proof Of Loss is filed outside these time limits, the claim will be denied. These limits will not apply while the Member or Beneficiary lacks legal capacity.

C. Proof Of Loss

Proof Of Loss means written proof that a loss occurred:

1. For which the Group Policy provides benefits;
2. Which is not subject to any exclusions; and
3. Which meets all other conditions for benefits.

Proof Of Loss includes any other information we may reasonably require in support of a claim. Proof Of Loss must be in writing and must be provided at the expense of the claimant. No benefits will be provided until we receive Proof Of Loss.

D. Investigation Of Claim

We may have you examined at our expense at reasonable intervals. Any such examination will be conducted by specialists of our choice.

We may have an autopsy performed at our expense, except where prohibited by law.

E. Time Of Payment

We will pay benefits within 60 days after Proof Of Loss is satisfied.

F. Notice Of Decision On Claim

We will evaluate a claim for benefits promptly after we receive it. With respect to all claims except Waiver Of Premium claims, within 90 days after we receive the claim we will send the claimant: (a) a written decision on the claim; or (b) a notice that we are extending the period to decide the claim for an additional 90 days.

With respect to Waiver Of Premium claims, within 45 days after we receive the claim we will send the claimant: (a) a written decision on the claim; or (b) a notice that we are extending the period to decide the claim for 30 days. Before the end of this extension period we will send the claimant: (a) a written decision on the Waiver Of Premium claim; or (b) a notice that we are extending the period to decide the claim for an additional 30 days. If an extension is due to the claimant's failure to provide information necessary to decide the Waiver Of Premium claim, the extended time period for deciding the claim will not begin until the claimant provides the information or otherwise responds.

If we extend the period to decide the claim, we will notify the claimant of the following: (a) the reasons for the extension; (b) when we expect to decide the claim; (c) an explanation of the standards on which entitlement to benefits is based; (d) the unresolved issues preventing a decision; and (e) any additional information we need to resolve those issues.

If we request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, we may decide the claim based on the information we have received.

If we deny any part of the claim, we will send the claimant a written notice of denial containing:

1. The reasons for our decision.
2. Reference to the parts of the Group Policy on which our decision is based.
3. Reference to any internal rule or guideline relied upon in deciding a Waiver Of Premium claim.

4. A description of any additional information needed to support the claim.
5. Information concerning the claimant's right to a review of our decision.
6. Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA if the claim is denied on review.

G. Review Procedure

If all or part of a claim is denied, the claimant may request a review. The claimant must request a review in writing:

1. Within 180 days after receiving notice of the denial of a claim for Waiver Of Premium;
2. Within 60 days after receiving notice of the denial of any other claim.

The claimant may send us written comments or other items to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for such copies. Our review will include any written comments or other items the claimant submits to support the claim.

We will review the claim promptly after we receive the request. With respect to all claims except Waiver Of Premium claims, within 60 days after we receive the request for review we will send the claimant: (a) a written decision on review; or (b) a notice that we are extending the review period for 60 days.

With respect to Waiver Of Premium claims, within 45 days after we receive the request for review we will send the claimant: (a) a written decision on review; or (b) a notice that we are extending the review period for 45 days.

If an extension is due to the claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the claimant provides the information or otherwise responds.

If we extend the review period, we will notify the claimant of the following: (a) the reasons for the extension; (b) when we expect to decide the claim on review; and (c) any additional information we need to decide the claim.

If we request additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, we may conclude our review of the claim based on the information we have received.

With respect to Waiver Of Premium claims, the person conducting the review will be someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based on a medical judgement, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original medical judgement and will not be subordinate to that person. The claimant may request the names of medical or vocational experts who provided advice to us about a claim for Waiver Of Premium.

If we deny any part of the claim on review, the claimant will receive a written notice of denial containing:

1. The reasons for our decision.
2. Reference to the parts of the Group Policy on which our decision is based.
3. Reference to any internal rule or guideline relied upon in deciding a Waiver Of Premium claim.
4. Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim.
5. Information concerning the right to bring a civil action for benefits under section 502(a) of ERISA.

The Group Policy does not provide voluntary alternative dispute resolution options. However, you may contact your local U.S. Department of Labor Office and your State insurance regulatory agency for assistance.

LI.CL.29

ASSIGNMENT

The rights and benefits under the Group Policy cannot be assigned.

LI.AS.01

BENEFIT PAYMENT AND BENEFICIARY PROVISIONS

A. Payment Of Benefits

Benefits payable because of your death will be paid to the Beneficiary you name. See B through E of this section.

The benefits below will be paid to you if you are living.

1. AD&D Insurance dismemberment benefits.
2. Accelerated Benefits.

Any AD&D Insurance dismemberment benefits which are unpaid at your death will be paid to the Beneficiary you name to receive Life Insurance benefits.

B. Naming A Beneficiary

Beneficiary means a person you name to receive death benefits.

You may name one or more Beneficiaries. Two or more surviving Beneficiaries will share equally, unless you specify otherwise. You may name or change Beneficiaries at any time without the consent of a Beneficiary.

Your Beneficiary designation must be the same for Life Insurance and AD&D Insurance death benefits.

You must name or change Beneficiaries in writing. Your designation:

1. Must be dated and signed by you;
2. Must be delivered to the Policyowner or Employer during your lifetime;
3. Must relate to the insurance provided under the Group Policy; and
4. Will take effect on the date it is delivered to the Policyowner or Employer.

If we approve it, a written designation signed and dated by you under the Prior Plan will be accepted as your Beneficiary designation under the Group Policy.

C. Simultaneous Death Provision

If a Beneficiary dies on the same day you die, or within 15 days thereafter, benefits will be paid as if that Beneficiary had died before you, unless Proof Of Loss with respect to your death is delivered to us before the date of the Beneficiary's death.

D. No Surviving Beneficiary

If you do not name a Beneficiary, or if you are not survived by one, benefits will be paid in equal shares to the first surviving class of the classes below.

1. Your Spouse.
2. Your children.
3. Your parents.
4. Your brothers and sisters.
5. Your estate.

E. Methods Of Payment

Recipient means a person who is entitled to benefits under this **Benefit Payment and Beneficiary Provisions** section.

1. Lump Sum

If the amount payable to a Recipient is less than \$25,000, we will pay it in a lump sum.

2. Standard Secure Access Checking Account

If the amount payable to a Recipient is \$25,000 or more, we will deposit it into a Standard Secure Access checking account which:

- a. Bears interest;
- b. Is owned by the Recipient;
- c. Is subject to the terms and conditions of a confirmation certificate which will be given to the Recipient; and
- d. Is fully guaranteed by us.

3. Installments

Payment to a Recipient may be made in installments if:

- a. The amount payable is \$25,000 or more;
- b. The Recipient chooses; and
- c. We agree.

To the extent permitted by law, the amount payable to the Recipient will not be subject to any legal process or to the claims of any creditor or creditor's representative.

LI.BB.09X

LOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Policyowner, we have full and exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy.

Our authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;

2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it;
3. The right to determine:
 - a. Eligibility for insurance;
 - b. Entitlement to benefits;
 - c. Amount of benefits payable;
 - d. Sufficiency and the amount of information we may reasonably require to determine a., b., or c., above.

Subject to the review procedures of the Group Policy, any decision we make in the exercise of our authority is conclusive and binding.

LI.AL.01

TIME LIMITS ON LEGAL ACTIONS

No action at law or in equity may be brought until 60 days after we have been given Proof Of Loss. No such action may be brought more than three years after the earlier of:

1. The date we receive Proof Of Loss; and
2. The time within which Proof Of Loss is required to be given.

LI.TL.01

INCONTESTABILITY PROVISIONS

A. Incontestability Of Insurance

Any statement made to obtain insurance is a representation and not a warranty.

No misrepresentation will be used to reduce or deny a claim unless:

1. The insurance would not have been approved if we had known the truth; and
2. We have given you or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

We will not use a misrepresentation to reduce or deny a claim after the insured's insurance has been in effect for two years.

B. Incontestability Of Group Policy

Any statement made by the Policyowner or Employer to obtain the Group Policy is a representation and not a warranty.

No misrepresentation by the Policyowner or Employer will be used to deny a claim or to deny the validity of the Group Policy unless:

1. The Group Policy would not have been issued if we had known the truth; and
2. We have given the Policyowner or Employer a copy of a written instrument signed by the Policyowner or Employer which contains the misrepresentation.

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

LI.IN.01

DEFINITIONS

Active Work and Actively At Work mean performing the material duties of your own occupation at your Employer's usual place of business.

AD&D Insurance means accidental death and dismemberment insurance, if any, under the Group Policy.

Contributory means you pay all or part of the premium for insurance.

Eligibility Waiting Period means the period you must be a Member before you become eligible for insurance. See **Coverage Features**.

Evidence Of Insurability means an applicant must:

1. Complete and sign our medical history statement;
2. Sign our form authorizing us to obtain information about the applicant's health;
3. Undergo a physical examination, if required by us, which may include blood testing; and
4. Provide any additional information about the applicant's insurability that we may reasonably require.

Group Policy means the group life insurance policy issued by us to the Policyowner and identified by the Group Policy Number.

Injury means an injury to your body.

Life Insurance means life insurance under the Group Policy.

Noncontributory means the Policyowner or Employer pays the entire premium for insurance.

Pregnancy means your pregnancy, childbirth, or related medical conditions, including complications of pregnancy.

Prior Plan means your Employer's group life insurance plan in effect on the day before the effective date of your Employer's coverage under the Group Policy and which is replaced by the Group Policy.

Sickness means your sickness, illness, or disease.

Spouse means:

1. A person to whom you are legally married; or
2. Your Domestic Partner. Your Domestic Partner means an individual recognized as such under California state law.

For purposes of insurance under the Group Policy, Spouse does not include a person who is a full-time member of the armed forces of any country or a person from whom you are divorced or legally separated or from whom you have terminated a Domestic Partner relationship.

LI.DF.18

ERISA INFORMATION AND NOTICE OF RIGHTS

The following information and notice of rights and protections is furnished by the Plan Administrator as required by the Employee Retirement Income Security Act of 1974 (ERISA)

A. General Plan Information

The General Plan Information required by ERISA is shown in the **Coverage Features**.

B. Termination Or Amendment Of The Group Policy Or Employer Coverage

The Group Policy which provides benefits for this Plan may be terminated by the Policyowner at any time with prior written notice to Standard Insurance Company.

An Employer may terminate coverage under the Group Policy at any time with prior written notice to Standard Insurance Company. Insurance will terminate automatically for nonpayment of premium.

Standard Insurance Company may terminate the Group Policy or an Employer's coverage under the Group Policy on any Premium Due Date if the number of persons insured is less than the required minimum, or if Standard believes the Policyowner or an Employer has failed to perform its obligations relating to the Group Policy.

The Group Policy may be changed in whole or in part. No change or amendment will be valid unless it is approved in writing by a Standard Insurance Company executive officer. No change in an Employer's coverage under the Group Policy will be valid unless it is approved in writing by a Standard Insurance Company executive officer. No agent has authority to change the Group Policy or an Employer's coverage under the Group Policy, or to waive any of its provisions.

The Group Policy contains the complete termination and amendment provisions.

C. Statement Of Your Rights Under ERISA

1. Right To Examine Plan Documents

You have the right to examine all Plan documents, including any insurance contracts or collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. These documents may be examined free of charge at the Plan Administrator's office.

2. Right To Obtain Copies Of Plan Documents

You have the right to obtain copies of all Plan documents, including any insurance contracts or collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies.

3. Right To Receive A Copy Of Annual Report

The Plan Administrator must give you a copy of the Plan's summary annual financial report, if the Plan was required to file an annual report. There will be no charge for the report.

4. Right To Review Of Denied Claims

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have the right: a) to know why this was done; b) to obtain copies of documents relating to the decision, without charge; and c) to have your claim reviewed and reconsidered, all within certain time schedules.

D. Obligations Of Fiduciaries

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

E. Enforcing ERISA Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay 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.

F. Plan And ERISA Questions

If you have any questions about the 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

ERISA.90.03