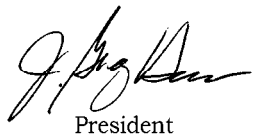
Attachment #6

GROUP INSURANCE CERTIFICATE
AND
SUMMARY PLAN DESCRIPTION

STANDARD INSURANCE COMPANY certifies that you will be insured under the Group Policy described below during the time, in the manner, and for the amounts provided in the Group Policy. Possession of this Certificate does not necessarily mean you are insured.



President

Revised 02/06/2015

GROUP POLICY NUMBER	309780-B
NAME OF POLICYHOLDER	Western States Health & Welfare Trust Fund of the OPEIU
TYPE OF COVERAGE	SHORT TERM DISABILITY INSURANCE
GROUP POLICY EFFECTIVE DATE	July 1, 1989
GROUP POLICY DELIVERED IN	Oregon and governed by the laws of that state.

IMPORTANT: PLEASE READ THIS

You are insured only if you meet the requirements in Part 2. BECOMING INSURED. You will remain insured only until your insurance ends, as explained in Part 3. WHEN INSURANCE ENDS.

A Group Policy has been issued to the Policyholder. Your coverage under that Group Policy is shown in this Certificate. If your coverage is changed by an amendment to the Group Policy, Standard will provide the Policyholder with a notice for you.

PLEASE READ THIS CERTIFICATE CAREFULLY. This Certificate has a Table of Contents to help you find specific provisions. **Defined terms are printed in all capital letters.**

ERISA REQUIREMENTS: ERISA means the Employee Retirement Income Security Act of 1974. Under ERISA, the Plan Administrator gives you this Summary Plan Description of the employee benefits insured under the group policy. General plan information and a statement of your rights as a plan participant are found at the end of this document.

GC181-WI

Table of Contents

Index of Defined Terms

OUTLINE OF YOUR SHORT TERM DISABILITY INSURANCE

THIS OUTLINE IS INTENDED FOR USE WITH THIS CERTIFICATE AND CANNOT BE USED SEPARATELY AS A DESCRIPTION OF YOUR COVERAGE. OTHER PROVISIONS ARE FOUND IN THIS CERTIFICATE. PLEASE READ THIS CERTIFICATE CAREFULLY.

TYPE OF INSURANCE - SHORT TERM DISABILITY INSURANCE provides you with income protection if you become TOTALLY DISABLED from a covered nonoccupational SICKNESS, nonoccupational ACCIDENTAL BODILY INJURY, or PREGNANCY.

SHORT TERM DISABILITY INSURANCE (STD) BENEFITS - The amount of your STD BENEFIT is shown in Part 8.A.

Your ELIMINATION PERIOD for each period of TOTAL DISABILITY is shown in Part 8.B.

Your MAXIMUM BENEFIT PERIOD is shown in Part 8.C.

TOTAL DISABILITY - You are considered TOTALLY DISABLED for purposes of SHORT TERM DISABILITY INSURANCE if you are unable to perform with reasonable continuity the material duties of your own occupation. See Part 5.

EXCLUSIONS AND LIMITATIONS - This INSURANCE does not cover any disability from the following: (1) Work Related; (2) War; and (3) Intentionally Self-Inflicted Injury. This INSURANCE is also subject to limitations described under the following headings: (1) Elimination Period; (2) Maximum Benefit Period; (3) Occupational Benefits; (4) Regular Care of a Physician; and (5) Working. A detailed explanation of these exclusions and limitations is found in Part 7.

BECOMING INSURED - Parts 2 and 3 explain when you become insured and when INSURANCE ends. The EMPLOYER pays the entire cost of your INSURANCE.

Part 1. GENERAL DEFINITIONS

STANDARD means Standard Insurance Company, Portland, Oregon.

EMPLOYER means any employer which a) is making contributions on behalf of its employees to the POLICYHOLDER, and b) has elected to provide INSURANCE under the GROUP POLICY.

GROUP POLICY means STANDARD'S group policy number 309780-B issued to the POLICYHOLDER.

SHORT TERM DISABILITY INSURANCE means your disability insurance coverage provided by the GROUP POLICY.

INSURANCE means your SHORT TERM DISABILITY INSURANCE under the GROUP POLICY.

STD BENEFIT means the SHORT TERM DISABILITY INSURANCE benefit payable to you weekly according to the terms of the GROUP POLICY.

SICKNESS means your sickness, illness, or disease.

PREGNANCY means your pregnancy, childbirth, or related medical conditions.

ACCIDENTAL BODILY INJURY means an injury to your body caused by an accident.

CREDIT MONTH means a calendar month in which a MEMBER works the number of hours specified in the Labor Agreement between the MEMBER'S EMPLOYER and the Local Union.

Providing EVIDENCE OF INSURABILITY, if required, means you must:

1. Complete and sign a health and medical history form provided by STANDARD;
2. Sign STANDARD'S form authorizing STANDARD to obtain information about your health; and
3. Provide any additional information about your insurability reasonably required by STANDARD.

All required information must be provided to STANDARD at your expense.

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Part 2. BECOMING INSURED

To become insured you must meet both of the following requirements plus the ACTIVE WORK requirement:

1. You must be a MEMBER.
2. You must be eligible for INSURANCE.

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A. DEFINITION OF MEMBER

You must be a MEMBER. You are a MEMBER if you are both of the following:

1. An active employee of one or more EMPLOYERS; and
2. An employee for whom contributions for insurance are being made to and accepted by the POLICYHOLDER.

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B. ELIGIBILITY FOR INSURANCE

You must be eligible for INSURANCE. You are eligible for INSURANCE on the later of (A) the effective date of the GROUP POLICY, and (B) the first day of the second calendar month following the completion of one full CREDIT MONTH.

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C. EFFECTIVE DATE OF INSURANCE

Your INSURANCE will become effective on the date you become eligible if you meet the ACTIVE WORK requirement on that date.

D. ACTIVE WORK REQUIREMENT

If you were DISABLED on the day before the scheduled effective date of your INSURANCE, then the effective date of your INSURANCE will be delayed until the first day after you complete one full day of ACTIVE WORK.

For purposes of this ACTIVE WORK requirement, you are DISABLED if you are unable, as a result of SICKNESS, ACCIDENTAL BODILY INJURY, or PREGNANCY, to perform the material duties of your own occupation.

ACTIVE WORK and ACTIVELY AT WORK mean performing the usual duties of your job at your EMPLOYER'S usual place of business.

This ACTIVE WORK requirement also applies to any increase in your INSURANCE.

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Part 3. WHEN INSURANCE ENDS

Your INSURANCE will end automatically on the earliest of the following dates:

a. The date you cease to be a MEMBER as defined in Part 2.A.

b. The date your EMPLOYER ceases to provide INSURANCE under the GROUP POLICY.

c. The date you become a full time member of the armed forces of any country.

d. The date the GROUP POLICY terminates.

e. The last day of the calendar month following a month which is not a CREDIT MONTH. However, your INSURANCE may be continued (unless it ends under items a. through d. above) during the following periods while you are absent from ACTIVE WORK:

(1) During the first six months during which you are unable to be ACTIVELY AT WORK as a result of SICKNESS or ACCIDENTAL BODILY INJURY, and (a) you are receiving time loss or workers' compensation benefits, or (b) your inability to work is the result of a motor vehicle accident. Coverage may be continued during this period, subject to the PREMIUM PAYMENT PROVISION below.

(2) During the ELIMINATION PERIOD and while STD BENEFITS are payable;

(3) During an approved leave of absence under the federal or state-mandated family or medical leave act or law, subject to the PREMIUM PAYMENT PROVISION below.

PREMIUM PAYMENT PROVISION:

If you wish to continue your INSURANCE in accordance with items e. (1) and (3) above, you must pay the entire premium for your INSURANCE to your EMPLOYER on or before each premium due date. Otherwise, INSURANCE will end.

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Part 4. BECOMING INSURED AGAIN AFTER INSURANCE ENDS

You may become insured again under the GROUP POLICY after your INSURANCE ends. The general rule is that you may become insured again on the same basis as a new MEMBER, as provided in Part 2. BECOMING INSURED. However, for the purposes of becoming insured again, the requirements of Part 2 will be modified in specific situations as follows:

1. If your INSURANCE ends because you cease to be a MEMBER, you will be immediately eligible for INSURANCE if you become a MEMBER again within 90 days after your INSURANCE ends.

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.

Your INSURANCE will become effective again on the date determined from Part 2, and will not be retroactive to the date your INSURANCE ended.

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Part 5. DEFINITION OF TOTAL DISABILITY

You are TOTALLY DISABLED if you are unable, as a result of SICKNESS, ACCIDENTAL BODILY INJURY or PREGNANCY, to perform with reasonable continuity the material duties of your own occupation.

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Part 6. SHORT TERM DISABILITY INSURING CLAUSE

Subject to all the terms of the GROUP POLICY, STANDARD will pay the STD BENEFIT described in Part 8 upon receipt of satisfactory written proof that you have become TOTALLY DISABLED while insured under the GROUP POLICY.

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Part 7. EXCLUSIONS AND LIMITATIONS

A. RISKS NOT COVERED

1. WORK RELATED: You are not covered for a disability arising out of or in the course of any employment for wage or profit.
2. WAR: You are not covered for a disability caused or contributed to by war or any 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.
3. INTENTIONALLY SELF-INFLICTED INJURY: You are not covered for a disability caused or contributed to by an intentionally self-inflicted injury.

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B. LIMITATIONS

1. ELIMINATION PERIOD: No STD BENEFITS are payable for the ELIMINATION PERIOD.
2. MAXIMUM BENEFIT PERIOD: No STD BENEFITS are payable after the end of the MAXIMUM BENEFIT PERIOD.
3. OCCUPATIONAL BENEFITS: No STD BENEFITS will be paid for any period when you are eligible to receive benefits under any worker's compensation or occupational disease law. If your claim for those benefits is accepted, compromised or settled, you must reimburse STANDARD for the full amount of the STD BENEFITS paid.
4. REGULAR CARE OF A PHYSICIAN: No STD BENEFITS will be paid for any period of TOTAL DISABILITY when you are not under the regular care of a PHYSICIAN.

   PHYSICIAN means a licensed medical professional, other than yourself, diagnosing and treating you within the scope of the license.
5. WORKING: No STD BENEFITS will be paid for any period when you are working for wage or profit.
6. MOTOR VEHICLE INSURANCE BENEFITS: No STD BENEFITS will be paid for any period when you are eligible to receive Personal Injury Protection loss of time benefits under a Motor Vehicle Insurance policy.

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Part 8. SCHEDULE OF SHORT TERM DISABILITY INSURANCE

A. AMOUNT OF STD BENEFIT

The amount of STD BENEFIT for your Plan is shown below.

Plan C

Week 1 through 13	$100
Week 14 through 26	110

Plan J

Week 1 through 13	$ 90
Week 14 through 26	100

Plan M

Grade I	$248
Grade II	278
Grade III	313
Grade IV	352
Grade V	438
Grade VI	472
Grade VII	518
Grade VIII	540
Terminal Employees	$300

Plan 589-G

Week 1 through 13	$225
Week 14 through 26	$300

Plan 540-N (ATPA)

Week 1 through 13	$150
Week 14 through 26	$170

Plan 539-M

For MEMBERS with:	The STD BENEFIT is:
Less than 3 years of service	50% of your WEEKLY EARNINGS, subject to a maximum STD BENEFIT of $1,000.
3 but less than 5 years of service	60% of your WEEKLY EARNINGS, subject to a maximum STD BENEFIT of $1,000.
5 or more years of service	65% of your WEEKLY EARNINGS, subject to a maximum STD BENEFIT of $1,000.

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B. ELIMINATION PERIOD

ELIMINATION PERIOD means the length of time you must be continuously TOTALLY DISABLED before STD BENEFITS become payable.

If you are insured under Plan 589-G or Plan 540-N (ATPA), your ELIMINATION PERIOD for each period of TOTAL DISABILITY is shown below:

	ELIMINATION PERIOD for ACCIDENTAL BODILY INJURY	ELIMINATION PERIOD for SICKNESS or PREGNANCY
Plan 589-G	None	None
Plan 540-N (ATPA)	None	3 days

If you are insured under Plan 539-M, your ELIMINATION PERIOD for each period of TOTAL DISABILITY is shown below:

	ELIMINATION PERIOD for ACCIDENTAL BODILY INURY	ELIMINATION PERIOD for SICKNESS or PREGNANCY
Plan 539-M	None	3 days

If you are insured under any other Plan, your ELIMINATION PERIOD for each period of TOTAL DISABILITY is shown below:

	ELIMINATION PERIOD for ACCIDENTAL BODILY INJURY	ELIMINATION PERIOD for SICKNESS or PREGNANCY
Plan C or M	None	2 days
Plan J	12 days	12 days

Your ELIMINATION PERIOD begins on the date you become TOTALLY DISABLED. If you are confined as an inpatient in a legally constituted and operated hospital during your ELIMINATION PERIOD, the remainder of your ELIMINATION PERIOD will be waived and STD BENEFITS will be payable beginning on the first day of your HOSPITAL confinement.

No STD BENEFITS are ever payable for the ELIMINATION PERIOD.

You must be seen regularly and treated by a PHYSICIAN during the ELIMINATION PERIOD.

HOSPITAL means a legally operated hospital providing full time medical care and treatment under the direction of a full time staff of licensed physicians (M.D. or D.O.). Rest homes, nursing homes, convalescent homes, homes for the aged, and facilities primarily affording custodial, educational, or rehabilitative care are not HOSPITALS.

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C. MAXIMUM BENEFIT PERIOD

MAXIMUM BENEFIT PERIOD means the longest period of time for which STD BENEFITS are payable for any one period of continuous TOTAL DISABILITY, whether from one or more causes.

Your MAXIMUM BENEFIT PERIOD is 26 weeks.

Your MAXIMUM BENEFIT PERIOD begins at the end of the ELIMINATION PERIOD. STD BENEFITS will stop at your death or at any time during the MAXIMUM BENEFIT PERIOD when you no longer qualify for STD BENEFITS. STD BENEFITS will stop at the end of the MAXIMUM BENEFIT PERIOD even if you are still TOTALLY DISABLED.

TEMPORARY RECOVERY DURING THE MAXIMUM BENEFIT PERIOD:

After STD BENEFITS become payable, a period of temporary recovery from your TOTAL DISABILITY will have the following effect: For purposes of continuing STD BENEFITS during the MAXIMUM BENEFIT PERIOD, any two periods of TOTAL DISABILITY from the same cause or causes will be added together and treated as one period of continuous TOTAL DISABILITY if they are separated by a period of recovery of less than 14 days. Thus, a new ELIMINATION PERIOD will not be required, the amount of your STD BENEFIT will not change, and the MAXIMUM BENEFIT PERIOD will be the balance of the MAXIMUM BENEFIT PERIOD remaining unused before the period of recovery. No STD BENEFITS will be payable under this provision after benefits become payable to you under any other group disability insurance policy. This rule prevents double coverage if you become insured under another policy while you are working during a period of temporary recovery.

D. THIRD PARTY LIABILITY PROVISION

If a MEMBER becomes totally disabled due to injury or sickness as a result of a wrongful act of commission or omission by a third party, the MEMBER will be required to exercise all legal rights to recover from the third party if it is reasonable to exercise such rights. If the MEMBER fails to exercise such rights after a written request by STANDARD, STANDARD will have the right to exercise the MEMBER'S legal rights, and the MEMBER hereby assigns to STANDARD the legal rights against the third party. If STANDARD exercises the legal rights, STANDARD will return to the MEMBER all funds collected from the third party in excess of benefits paid under the group policy for the injury or sickness.

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Part 9. BENEFITS AFTER INSURANCE ENDS OR IS CHANGED

Your right to receive STD BENEFITS for a period of continuous TOTAL DISABILITY which begins while you are insured under the GROUP POLICY will not be affected by:

(a) The termination of the GROUP POLICY after the date you become TOTALLY DISABLED;

(b) The termination of your INSURANCE while the GROUP POLICY remains in force; or

(c) Any amendment to the GROUP POLICY approved after the date you become TOTALLY DISABLED.

If a period of continuous TOTAL DISABILITY is extended by a new cause while STD BENEFITS are payable, STD BENEFITS will continue while you remain TOTALLY DISABLED, subject to the terms of the GROUP POLICY and the following rules:

(a) STD BENEFITS will not be continued beyond the end of the original MAXIMUM BENEFIT PERIOD.

(b) No STD BENEFITS will be paid for any extension of a period of continuous TOTAL DISABILITY which is caused or contributed to by a risk excluded under Part 7.

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Part 10. CLAIMS PROVISIONS AND PROCEDURES FOR STD BENEFITS

A. PAYMENT OF BENEFITS

All STD BENEFITS will be paid to you. Any STD BENEFITS remaining unpaid to you at the time of your death will be paid to your estate.

B. TIME LIMITS FOR FILING A CLAIM

You must claim STD BENEFITS within 120 days after the end of the ELIMINATION PERIOD or as soon thereafter as reasonably possible and, in any case, within one year after the end of that 120-day period. Claims not filed within these time limits will be denied and no STD BENEFIT

will be paid. These time limits will not apply during any period when you lacked the legal capacity to file a claim.

C. FILING A CLAIM

All claims for STD BENEFITS should be submitted on STANDARD'S forms. You should obtain claim forms from the POLICYHOLDER or the Plan Administrator.

You may also request claim forms from STANDARD. If STANDARD fails to provide you with claim forms within 15 days of your request, you may submit your claim in a letter stating the occurrence, character, and extent of the event for which the claim is made.

D. PROOF OF LOSS

Proof of each of the following elements of proof of loss must be provided to STANDARD at your expense. No STD BENEFITS will be paid until STANDARD receives satisfactory written proof:

1. That you became TOTALLY DISABLED while insured under the GROUP POLICY.
2. That you were TOTALLY DISABLED throughout the ELIMINATION PERIOD and the period for which STD BENEFITS are claimed.
3. That your TOTAL DISABILITY results from a cause not excluded in Part 7.
4. That you are being seen regularly and treated by a PHYSICIAN.
5. Of such additional information as STANDARD may reasonably require in connection with your claim for STD BENEFITS.

If your claim is approved, no STD BENEFITS will be continued beyond the end of the period for which you have provided STANDARD with satisfactory written proof of loss.

E. DOCUMENTATION

Completed claims statements, a signed authorization for us to obtain information, and any other items we may reasonably require in support of a claim must be submitted at your expense. If the required documentation is not provided within 45 days after we mail our request, your claim may be denied.

F. INVESTIGATION OF YOUR CLAIM

STANDARD has the right at any time to conduct an investigation of your claim. No STD BENEFITS will be paid until STANDARD has had a reasonable time to conduct an investigation.

G. INDEPENDENT EXAMINATION

STANDARD has the right to have you examined at STANDARD'S expense at reasonable intervals while you are claiming STD BENEFITS. Any such examination will be conducted by one or more PHYSICIANS or vocational specialists of STANDARD'S choice.

STANDARD has the right to defer or suspend payment of STD BENEFITS if you fail to attend an examination or fail to cooperate with the person conducting the examination. In such a case STD BENEFITS may be resumed, provided that the required examination occurs within a reasonable time and STD BENEFITS are otherwise payable.

H. NOTICE OF DECISION ON CLAIM

We will evaluate your claim promptly after you file it. Within 45 days after we receive your claim we will send you: (a) a written decision on your claim; or (b) a notice that we are extending the period to decide your claim for 30 days. Before the end of this extension period we will send you: (a) a written decision on your claim; or (b) a notice that we are extending the period to decide your claim for an additional 30 days. If an extension is due to your failure to

provide information necessary to decide the claim, the extended time period for deciding your claim will not begin until you provide the information or otherwise respond.

If we extend the period to decide your claim, we will notify you of the following: (a) the reasons for the extension; (b) when we expect to decide your 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, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.

b. Reference to the parts of the Group Policy on which our decision is based.

c. Reference to any internal rule or guideline relied upon in making our decision.

d. A description of any additional information needed to support your claim.

e. Information concerning your right to a review of our decision.

I. REVIEW PROCEDURE

If all or part of a claim is denied, you may request a review. You must request a review in writing within 180 days after receiving notice of the denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your request for review. There will be no charge for such copies. You may request the names of medical or vocational experts who provided advice to us about your claim.

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. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request. Within 45 days after we receive your request for review we will send you: (a) a written decision on review; or (b) a notice that we are extending the review period for 45 days. If the extension is due to your failure to provide information necessary to decide the claim on review, the extended time period for review of your claim will not begin until you provide the information or otherwise respond.

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

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

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

a. The reasons for our decision.

b. Reference to the parts of the Group Policy on which our decision is based.

c. Reference to any internal rule or guideline relied upon in making our decision.

d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.

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Part 11. TIME LIMITS ON LEGAL ACTIONS AND CERTAIN DEFENSES

No action at law or in equity may be brought to recover under the GROUP POLICY until 60 days after written proof of loss has been provided to STANDARD.

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

(a) Your INSURANCE would not have been approved except for your misrepresentation;

(b) Your misrepresentation is contained in a written instrument signed by you; and

(c) You have been given a copy of the written instrument containing your misrepresentation.

After your INSURANCE has been in effect for two years, no misrepresentation by you, except a fraudulent misrepresentation made with actual intent to deceive, will be used to reduce or deny your claim or to deny the validity of your INSURANCE.

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Part 12. ASSIGNMENT NOT PERMITTED

Your Certificate is not assignable. The INSURANCE provided and benefits payable are not assignable.

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