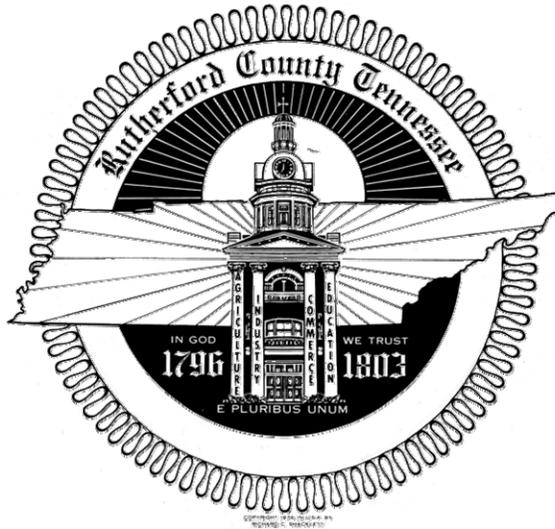


**RUTHERFORD COUNTY**

**LONG TERM DISABILITY**



## Table Of Contents

RUTHERFORD COUNTY .....	1
LONG TERM DISABILITY .....	1
QUESTIONS ABOUT YOUR COVERAGE .....	4
NON TENNESSEE COMPLAINT RESOLUTION CONTACTS .....	5
NON TENNESSEE STATUTORY NOTIFICATIONS .....	6
TEXAS STATUTORY NOTIFICATION .....	9
SCHEDULE OF INSURANCE .....	10
COST OF COVERAGE: .....	10
ELIGIBLE CLASS(ES) FOR COVERAGE: .....	10
ELIGIBILITY WAITING PERIOD FOR COVERAGE: .....	10
ELIMINATION PERIOD: .....	10
MAXIMUM MONTHLY BENEFIT: .....	10
MINIMUM MONTHLY BENEFIT: .....	10
BENEFIT PERCENTAGE: .....	11
MAXIMUM DURATION OF BENEFITS TABLE .....	11
ADDITIONAL BENEFITS: .....	11
ELIGIBILITY AND ENROLLMENT .....	12
ELIGIBLE PERSONS: .....	12
ELIGIBILITY FOR COVERAGE: .....	12
ENROLLMENT: .....	12
PERIOD OF COVERAGE .....	12
EFFECTIVE DATE: .....	12
DEFERRED EFFECTIVE DATE: .....	12
TERMINATION: .....	13
CONTINUATION PROVISIONS: .....	13
COVERAGE WHILE DISABLED: .....	14
WAIVER OF PREMIUM: .....	14
EXTENSION OF BENEFITS FOR TOTAL DISABILITY: .....	14
BENEFITS .....	15
DISABILITY BENEFIT: .....	15
MENTAL ILLNESS AND SUBSTANCE ABUSE BENEFITS: .....	15
RECURRENT DISABILITY: .....	15
PERIOD OF DISABILITY: .....	16
RECOVER OR RECOVERY: .....	16
CALCULATION OF MONTHLY BENEFIT: RETURN TO WORK INCENTIVE: .....	16
CALCULATION OF MONTHLY BENEFIT: .....	17
MINIMUM MONTHLY BENEFIT .....	17
PARTIAL MONTH PAYMENT: .....	17
TERMINATION OF PAYMENT: .....	17
FAMILY CARE CREDIT BENEFIT: .....	18
SURVIVOR INCOME BENEFIT: .....	19
SURVIVING SPOUSE .....	20
SURVIVING CHILDREN .....	20
WORKPLACE MODIFICATION BENEFIT .....	20

WORKPLACE MODIFICATION.....	21
EXCLUSIONS AND LIMITATIONS .....	21
EXCLUSIONS:.....	21
PRE-EXISTING CONDITIONS LIMITATION:.....	21
PRE-EXISTING CONDITION MEANS:.....	22
MEDICAL CARE.....	22
TREATMENT includes, but is not limited to:.....	22
GENERAL PROVISIONS.....	23
NOTICE OF CLAIM: .....	23
CLAIM FORMS:.....	23
PROOF OF LOSS: .....	23
ADDITIONAL PROOF OF LOSS:.....	24
SENDING PROOF OF LOSS: .....	24
CLAIM PAYMENT: .....	24
CLAIMS TO BE PAID: .....	25
CLAIM DENIAL:.....	25
CLAIM APPEAL:.....	25
SOCIAL SECURITY: .....	26
BENEFIT ESTIMATES: .....	26
OVERPAYMENT: .....	27
SUBROGATION: .....	28
Third Party.....	28
LEGAL ACTIONS: .....	28
INSURANCE FRAUD: .....	29
MISSTATEMENTS: .....	29
POLICY INTERPRETATION: .....	29
DEFINITIONS .....	29

## **QUESTIONS ABOUT YOUR COVERAGE**

1. In the event you have questions regarding any aspect of your coverage, you should contact your Employee Benefits Manager or you may write to us at:  
The Hartford  
Group Benefits Division, Customer Service  
P.O. Box 2999  
Hartford, CT 06104-2999
  
2. Or, call us at: 1-800-523-2233  
When calling, please give us the following information:
  - A. The policy number; and
  - B. The name of the policyholder (employer organization), as shown in your Certificate of Insurance.
  
3. Or, you may contact our Sales Office:  
Hartford Life and Accident Insurance Company  
Group Sales Department  
810 Crescent Center Drive  
Suite 120  
Franklin, TN 37067  
TOLL FREE: 866-371-1554  
FAX: 615-778-2545

**NON TENNESSEE COMPLAINT RESOLUTION CONTACTS**

If you have a complaint, and contacts between you and the insurer or an agent or other representative of the insurer have failed to produce a satisfactory solution to the problem, the following states require we provide you with additional contact information:

<b>For Residents of:</b>	<b>Write to:</b>	<b>Telephone:</b>
Arkansas	Arkansas Insurance Department Consumer Services Division 1200 West Third St. Little Rock, AR 72201-1904	1 (800) 852-5494
California	State of California Insurance Dept. Consumer Communications Bureau 300 South Spring St., South Tower Los Angeles, CA 90013	1 (800) 927-HELP
Illinois	Illinois Department of Insurance Consumer Services Station Springfield, Illinois 62767	Consumer Assistance: 1-866-445-5364 Officer of Consumer Health Insurance: 1-877527-9431
Indiana	Public Information/Market Conduct Indiana Department of Insurance 311 W. Washington St. Suite 300 Indianapolis, IN 46204-2787	Consumer Hotline: 1-800-622-4461 In Indianapolis area: 1-317-232-2395
Virginia	Life and Health Division Bureau of Insurance P.O. Box 1157 Richmond, VA 23209	Inside Virginia: 1-804-371-9741 Outside Virginia: 1-800-552-7945
Wisconsin	Office of the Commissioner of Insurance Complaints Department P.O. Box 7873 Madison, WI 53707-7873	Outside Madison: 1-800-236-8517 Inside Madison: 1-608-266-0103 To request complaint form

## NON TENNESSEE STATUTORY NOTIFICATIONS

<b>For Residents of :</b>	<b>Please Note:</b>
Arizona	This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully.
Florida	The benefits of the policy providing you coverage are governed primarily by the law of a state other than Florida
Maryland	The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all the benefits required by Maryland Law.
Montana	The benefits of the policy providing your coverage are governed primarily by the law of a state other than Montana.
Georgia	The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family abuse.
Maine	<p>The benefits under this policy are subject to reduction due to other sources of income.</p> <p>This means that your benefits will be reduced by the amount of any other benefits for loss of time provided to you or for which you are eligible as a result of the same period of disability for which you claim benefits under this policy.</p> <p>Other sources of income are plans or arrangements of coverage that provide disability-related benefits such as Worker's Compensation or other similar governmental programs or laws, or disability-related benefits received from your employer or as the result of your employment, membership or association with any group, union, association or other organization. Other sources of income include disability-related benefits under the United States Social Security Act or an alternate governmental plan, the Railroad Retirement Act, and other similar plans or acts. Other sources of income may also include certain disability-related or retirement benefits that you receive because of your retirement unless you were receiving them prior to becoming disabled.</p> <p>What comprises other sources of income under this policy is determined by the nature of the policyholder. Therefore, we strongly urge you to <b>READ YOUR CERTIFICATE CAREFULLY</b>. A full description of the plans and types of plans considered to be other sources of income under this policy will be found in the definition of "Other Income Benefits" located in the Definitions section of your certificate.</p>

North Carolina

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, FINANCIAL AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP LIFE INSURANCE, GROUP HEALTH OR GROUP HEALTH PLAN PREMIUMS, SHALL:

1. CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP LIFE INSURANCE, GROUP HEALTH INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSON INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT; AND
2. WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

**IMPORTANT TERMINATION INFORMATION**

**YOUR INSURANCE MAY BE CANCELLED BY THE COMPANY. PLEASE READ THE TERMINATION PROVISION IN THIS CERTIFICATE.**

**THIS CERTIFICATE OF INSURANCE PROVIDES COVERAGE UNDER A GROUP MASTER POLICY. THIS CERTIFICATE PROVIDES ALL OF THE BENEFITS MANDATED BY THE NORTH CAROLINA INSURANCE CODE, BUT YOU MAY NOT RECEIVE ALL OF THE PROTECTIONS PROVIDED BY A POLICY ISSUED IN NORTH CAROLINA AND GOVERNED BY ALL OF THE LAWS OF NORTH CAROLINA.**

**PRE-EXISTING LIMITATION  
READ CAREFULLY**

**NO BENEFITS WILL BE PAYABLE UNDER THIS PLAN FOR PRE-EXISTING CONDITIONS WHICH ARE NOT COVERED**

	<p><b>UNDER THE PRIOR PLAN. PLEASE READ THE LIMITATIONS IN THIS CERTIFICATE.</b></p>
--	------------------------------------------------------------------------------------------

**READ YOUR CERTIFICATE CAREFULLY**

**TEXAS STATUTORY NOTIFICATION**

ENGLISH	SPANISH
IMPORTANT NOTICE	AVISO IMPORTANTE
To obtain information or make a complaint:	Para obtener informacion o para someter una queja:
<p>You may call The Hartford's toll-free telephone number for information or to make a complaint at: 1-800-523-2233</p> <p>You may also write to The Hartford at: P.O. Box 2999 Hartford, CT 06104-2999</p> <p>You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at: 1-800-252-3439</p> <p>You may write to the Texas Department of Insurance at: P.O. Box 149104 Austin, TX 78714-9410 Fax# 512-475-1771</p> <p>Web: <a href="http://www.tdi.state.tx.us">http://www.tdi.state.tx.us</a> E-mail: <a href="mailto:ConsumerProtection@tdi.state.tx.us">ConsumerProtection@tdi.state.tx.us</a></p>	<p>Usted puede llamar al numero de telefono gratis de The Hartford para informacion o para someter una queja al: 1-800-523-2233</p> <p>Usted tambien puede escribir a The Hartford: P.O. Box 2999 Hartford, CT 06104-2999</p> <p>Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al: 1-800-252-3439</p> <p>Puede escribir al Departamento de Seguros de Texas: P.O. Box 149104 Austin, TX 78714-9410 Fax# 512-475-1771</p> <p>Web: <a href="http://www.tdi.state.tx.us">http://www.tdi.state.tx.us</a> E-mail: <a href="mailto:consumerProtection@tdi.state.tx.us">consumerProtection@tdi.state.tx.us</a></p>
<p><b>PREMIUM OR CLAIM DISPUTES:</b> Should you have a dispute concerning your premium or about a claim you should contact the agent or The Hartford first. If the dispute is not resolved, you may contact the Texas Department of Insurance.</p>	<p><b>DISPUTAS SOBRE PRIMAS O RECLAMOS:</b> Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o The Hartford primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).</p>
<p><b>THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.</b></p>	

## **SCHEDULE OF INSURANCE**

The Policy of long term Disability insurance provides You with long term income protection if You become Disabled from a covered injury, Sickness or pregnancy.

### **COST OF COVERAGE:**

You do not contribute toward the cost of coverage.

### **ELIGIBLE CLASS(ES) FOR COVERAGE:**

All Full-time Active and All Part-time Active Board of Education, County General and Highway Employees, who are citizens or legal residents of the United States, its territories and protectorates, excluding temporary, leased or seasonal Employees.

1. Class 1: Board of Education, County General and Highway Employees hired prior to January 1, 2009.
2. Class 2: Board of Education, County General and Highway Employees hired on or after January 1, 2009.

Full-time Employment: at least 30 hours weekly

### **ELIGIBILITY WAITING PERIOD FOR COVERAGE:**

None.

### **ELIMINATION PERIOD:**

180 day(s)

### **MAXIMUM MONTHLY BENEFIT:**

\$6,000

### **MINIMUM MONTHLY BENEFIT:**

The greater of:

1. \$100; or
2. 10% of the benefit based on Monthly Income Loss before the deduction of Other Income Benefits.

**BENEFIT PERCENTAGE:**

66 2/3%

**MAXIMUM DURATION OF BENEFITS TABLE**

<b>AGE WHEN DISABLED</b>	<b>BENEFITS PAYABLE</b>
Prior to Age 63	To normal retirement age or 42 months, if greater
Age 63	To normal retirement age or 36 months, if greater.
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months
Normal Retirement Age means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act. It is determined by your date of birth as follows:	
<b>Year of Birth</b>	<b>Normal Retirement Age</b>
1937 or before	65
1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 – 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or after	67

**ADDITIONAL BENEFITS:**

1. Family Care Credit Benefit  
See Benefit
2. Survivor Income Benefit  
See Benefit
3. Workplace Modification Benefit  
See Benefit

## **ELIGIBILITY AND ENROLLMENT**

### **ELIGIBLE PERSONS:**

Who is eligible for coverage?

All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

### **ELIGIBILITY FOR COVERAGE:**

When will I become eligible?

You will become eligible for coverage on the later of:

1. the Policy Effective Date; or
2. the date you complete the Eligibility Waiting Period for Coverage shown in the Schedule of Insurance, if applicable.

### **ENROLLMENT:**

How do I enroll for coverage?

All eligible Active Employees will be enrolled automatically by the Employer.

## **PERIOD OF COVERAGE**

### **EFFECTIVE DATE:**

When does my coverage start?

Your coverage will start on the date you become eligible.

### **DEFERRED EFFECTIVE DATE:**

When will my effective date for coverage or a change in my coverage be deferred?

If you are absent from work due to:

1. accidental bodily injury;
2. sickness;
3. Mental Illness;
4. Substance abuse; or
5. Pregnancy;

On the date your insurance, or increase in coverage, would otherwise have become effective, your insurance, or increase in coverage will not become effective until you are Actively at Work one full day.

### **TERMINATION:**

When will my coverage end?

Your coverage will end on the earliest of the following:

1. the date The Policy terminates;
2. the date The Policy no longer insures Your class;
3. the date the premium payment is due but not paid;
4. the last day of the period for which You make any required premium contribution;
5. the date Your Employer terminates Your employment; or
6. the date You cease to be a Full time Active Employee in an eligible class for any reason;

unless continued in accordance with any of the Continuation Provisions.

### **CONTINUATION PROVISIONS:**

Can my coverage be continued beyond the date it would otherwise terminate?

Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:

1. is subject to any reductions in The Policy;
2. is subject to payment of premium by the Employer; and
3. terminates if:
  - A. The Policy terminates; or
  - B. Coverage for Your class terminates.

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

**Family Medical Leave:** If you are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, your coverage may be continued for up to 12 weeks, or 26 weeks if you qualify for Family Military Leave, or longer if required by other applicable law, following the date your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

**COVERAGE WHILE DISABLED:**

Does my insurance continue while I am Disabled and no longer an Active Employee?

If you are Disabled and you cease to be an Active Employee, your insurance will be continued:

1. during the Elimination Period while you remain Disabled by the same Disability; and
2. after the Elimination Period for as long as you are entitled to benefits under The Policy.

**WAIVER OF PREMIUM:**

Am I required to pay Premiums while I am Disabled?

No premium will be due for you:

1. after the Elimination Period; and
2. for as long as benefits are payable.

**EXTENSION OF BENEFITS FOR TOTAL DISABILITY:**

Do my benefits continue if The Policy terminates?

If you are entitled to benefits while Disabled and The Policy terminates, benefits:

1. will continue as long as you remain Disabled by the same Disability; but
2. will not be provided beyond the date We would have ceased to pay benefits had the insurance remained in force.

Termination of The Policy for any reason will have no effect on Our Liability under this provision.

## **BENEFITS**

### **DISABILITY BENEFIT:**

What are my Disability Benefits under The Policy?

We will pay You a Monthly Benefit if You:

1. become Disabled while insured under The Policy;
2. are Disabled throughout the Elimination Period;
3. remain Disabled beyond the Elimination Period; and
4. submit Proof of Loss to Us.

Benefits accrue as of the first day after the Elimination Period and are paid monthly. However, benefits will not exceed the Maximum Duration of Benefits.

### **MENTAL ILLNESS AND SUBSTANCE ABUSE BENEFITS:**

Are benefits limited for Mental Illness or Substance Abuse?

If You are Disabled because of :

1. Mental Illness that results from any cause;
2. any condition that may result from Mental Illness;
3. alcoholism which is under treatment; or
4. the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance;

then, subject to all other provisions of The Policy, We will limit the Maximum Duration of Benefits.

Benefits will be payable:

1. for as long as you are confined in a hospital or other place licensed to provide medical care for the disabling condition; or
2. if not confined, or after you are discharged and still Disabled, for a total of 24 month(s) for all such disabilities during your lifetime.

### **RECURRENT DISABILITY:**

What happens if I Recover but become Disabled again?

Periods of Recovery during the Elimination Period will not interrupt the Elimination Period, if the number of days You return to work as an Active Employee are less than one-half (1/2) the number of days of Your Elimination Period.

Any day within such period of Recovery, will not count toward the Elimination Period.

After the Elimination Period, if You return to work as an Active Employee and then become Disabled and such Disability is:

1. due to the same cause; or
2. due to a related cause; and
3. within 6 month(s) of the return to work;

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Policy remains in force.

If you return to work as an Active Employee for 6 month(s) or more, any recurrence of a Disability will be treated as a new Disability. The new Disability is subject to a new Elimination Period and a new maximum Duration of Benefits.

### **PERIOD OF DISABILITY:**

Means a continuous length of time during which You are Disabled under The Policy.

### **RECOVER OR RECOVERY:**

Means that You are no longer Disabled and have returned to work with the Employer and premiums are being paid for You.

### **CALCULATION OF MONTHLY BENEFIT: RETURN TO WORK INCENTIVE:**

How are my Disability benefits calculated?

If you remain Disabled after the Elimination Period, but work while You are Disabled, We will determine Your Monthly Benefit for a Period of up to 12 consecutive months as follows:

1. multiply Your Pre-Disability Earnings by the Benefit Percentage;
2. compare the result with the Maximum Benefit; and
3. from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit. Current Monthly Earnings will not be used to reduce Your Monthly Benefit. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds 100% of Your Pre-Disability Earnings, We will reduce Your Monthly Benefit by the amount of excess.

The 12 consecutive month period will start on the last to occur of:

1. the day You first start work; or
2. the end of the Elimination Period.

If You are Disabled and not receiving benefits under the Return to Work Incentive, We will calculate Your Monthly Benefit as follows:

1. multiply Your Monthly Income Loss by the Benefit Percentage;
2. compare the result with the Maximum Benefit; and
3. from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

### **CALCULATION OF MONTHLY BENEFIT:**

What happens if the sum of my Monthly Benefit, Current Monthly Earnings and Other Income Benefits exceeds 100% of my Pre-Disability Earnings?

If the sum of Your Monthly Benefit, Current Monthly Earnings, and Other Income Benefits exceeds 100% of Your Pre-disability Earnings, We will reduce Your Monthly Benefit by the amount of the excess. However, Your Monthly Benefit will not be less than the Minimum Monthly Benefit.

If an overpayment occurs, We may recover all or any portion of the overpayment, in accordance with the Overpayment Recovery provision.

### **MINIMUM MONTHLY BENEFIT**

Is there a Minimum Monthly Benefit?

Your Monthly Benefit will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.

### **PARTIAL MONTH PAYMENT:**

How is the benefit calculated for a period of less than a month?

If a Monthly Benefit is payable for a period of less than a month, we will pay 1/30 of the Monthly Benefit for each day You were Disabled.

### **TERMINATION OF PAYMENT:**

When will my benefit payments end?

Benefit payments will stop on the earliest of:

1. the date You are no longer Disabled;
2. the date You fail to furnish Proof of Loss;

3. the date You are no longer under the Regular Care of a Physician;
4. the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;
5. the date of Your death;
6. the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;
7. the last day benefits are payable according to the Maximum Duration of Benefits Table; or
8. the date Your Current Monthly Earnings exceed:
  - A. 80% OF Your Indexed Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation; or
  - B. The product of Your Indexed Pre-disability Earnings and the Benefit percentage if You are receiving benefits for being Disabled from Any Occupation.
9. the date no further benefits are payable under any provision in The Policy that limits benefit duration;
10. the date You refuse to participate in a Rehabilitation program, or refuse to cooperate with or try:
  - A. modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the essential duties of Your Occupation;
  - B. adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
  - C. modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; or
  - D. adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation;

provided a qualified Physician or other qualified medical professional agrees that such modifications, Rehabilitation program or adaptive equipment accommodate Your medical limitation.

### **FAMILY CARE CREDIT BENEFIT:**

What if I must incur expenses for Family Care Services in order to participate in a Rehabilitation program?

If You are working as part of a program of Rehabilitation, We will, for the purpose of calculating Your benefit, deduct the cost of Family Care from earnings received from work as a part of a program of Rehabilitation, subject to the following limitations:

1. Family Care means the care or supervision of:
  - A. Your children under age 13; or
  - B. A member of Your household who is mentally or physically handicapped and dependent upon You for support and maintenance.
2. the maximum monthly deduction allowed for each qualifying child or family member is:
  - A. \$350 during the first 12 months of rehabilitation; and
  - B. \$175 thereafter;  
But in no event may the deduction exceed the amount of Your monthly earnings;
3. Family Care Credits may not exceed the amount of Your monthly earnings;
4. the deduction will be reduced proportionally for periods of less than a month;
5. the charges for Family Care must be documented by a receipt from the caregiver;
6. the credit will cease on the first to occur of the following:
  - A. You are no longer in a Rehabilitation program; or
  - B. Family Care Credits for 24 months have been deducted during Your Disability; and
7. no Family Care provided by someone Related to the family member receiving the care will be eligible as a deduction under this provision.

Your Current Monthly Earnings after the deduction of Your Family Care Credit will be used to determine Your Monthly Income Loss. In no event will You be eligible to receive a Monthly Benefit under The Policy if Your Current Monthly Earnings before the deduction of the Family Care Credit exceed 80% of Your Indexed Pre-disability Earnings.

### **SURVIVOR INCOME BENEFIT:**

Will my survivors receive a benefit if I die while receiving Disability Benefits?

If You were receiving a Monthly Disability Benefit at the time of Your death, We will pay a Survivor Income Benefit, when We receive proof satisfactory to Us:

1. of Your death; and
2. that the person claiming the benefit is entitled to it.

We must receive the satisfactory proof for Survivor Income Benefits within 1 year of the date of Your death.

The Survivor Income Benefit will only be paid:

1. to Your Surviving Spouse; or
2. if no Surviving Spouse, in equal shares to Your Surviving Children.

If there is no Surviving Spouse or Surviving Children, then no benefit will be paid.

However, We will first apply the Survivor Income Benefit to any overpayment which may exist on Your claim.

The Survivor Income Benefit is calculated as 3 times the lesser of:

1. Your Monthly Income Loss multiplied by the Benefit Percentage in effect on the date of Your death; or
2. The Maximum Monthly Benefit.

**SURVIVING SPOUSE** means Your wife or husband who was not legally separated or divorced from You when You died. "Spouse" will include Your domestic partner, provided You have executed a domestic partner affidavit acceptable to us, establishing that You and Your partner are domestic partners for purposes of The Policy. You will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit.

**SURVIVING CHILDREN** means Your unmarried children, step children, legally adopted children who, on the date You die, are primarily dependent on You for support and maintenance and who are under age 24.

The term Surviving Children will also include any other children related to You by blood or marriage or domestic partnership and who:

1. lived with You in a regular parent-child relationship; and
2. were eligible to be claimed as dependents on Your federal income tax return for the last tax year prior to Your death.

If a minor child is entitled to benefits, We may, at Our option, make benefit payments to the person caring for and supporting the child until a legal guardian is appointed.

### **WORKPLACE MODIFICATION BENEFIT**

Will the Rehabilitation program provide for modifications to my workplace to accommodate my return to work?

We will reimburse Your Employer for the expense of reasonable Workplace Modifications to accommodate Your Disability and enable You to return to work as an Active Employee. You qualify for this benefit if:

1. Your Disability is covered by The Policy;
2. the Employer agrees to make modifications to the workplace in order to reasonably accommodate Your return to work and the performance of the Essential Duties of Your job; and
3. We approve, in writing, any proposed Workplace Modifications.

Benefits paid for such workplace modification shall not exceed the amount equal to the amount of the Maximum Monthly Benefit.

We have the right, at Our expense, to have You examined or evaluated by:

1. a Physician or other health care professional; or
2. a vocational expert or rehabilitation specialist;

of Our choice so that We may evaluate the appropriateness of any proposed modification.

We will reimburse the Employer's costs for approved Workplace Modifications after:

1. the proposed modifications made on Your behalf are complete;
2. We have been provided written proof of the expenses incurred to provide such modification; and
3. You have returned to work as an Active Employee.

**WORKPLACE MODIFICATION** means change in Your work environment, or in the way a job is performed, to allow You to perform, while Disabled, the Essential Duties of Your job. Payment of this benefit will not reduce or deny any benefit You are eligible to receive under the terms of The Policy.

## **EXCLUSIONS AND LIMITATIONS**

### **EXCLUSIONS:**

What Disabilities are not covered?

The Policy does not cover, and We will not pay a benefit for any Disability:

1. unless You are under the Regular Care of a Physician;
2. that is caused or contributed to by war or act of war (declared or not);
3. caused by Your commission of or attempt to commit a felony;
4. caused or contributed to by Your being engaged in an illegal occupation; or
5. caused or contributed to by an intentionally self inflicted injury.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

1. was sponsored by Your Employer; and
2. was terminated before the Effective Date of the Policy;

no benefits will be payable for the Disability under The Policy.

With respect to Class 2 only – Does not apply to Class 1

### **PRE-EXISTING CONDITIONS LIMITATION:**

Are benefits limited for Pre-existing Conditions?

We will not pay any benefit, or any increase in benefits, under The Policy for any Disability that results from, or is caused or contributed to by, a Pre existing Condition, unless, at the time You become Disabled:

1. You have not received Medical Care for the condition for 90 consecutive day(s) while insured under The Policy; or
2. You have been continuously insured under The Policy for 365 consecutive day(s).

**PRE-EXISTING CONDITION MEANS:**

1. any accidental bodily injury, sickness, Mental Illness, pregnancy, or episode of Substance Abuse; or
2. any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, or Substance Abuse;

for which You received Medical Care during the 90 day(s) period that ends the day before:

1. Your effective date of coverage; or
2. the effective date of a Change in Coverage.

Complications of Pregnancy will be a pre-existing condition only if Medical Care is received for such complications during the 12 month period that ends the day before Your effective date of coverage, or the effective date of a change of coverage.

**MEDICAL CARE** is received when a physician or other health care provider:

1. is consulted or gives medical advice; or
2. recommends, prescribes or provides Treatment.

**TREATMENT** includes, but is not limited to:

1. medical examinations, tests, attendance, or observation; and
2. use of drugs, medicines, medical services, supplies or equipment.

## **GENERAL PROVISIONS**

### **NOTICE OF CLAIM:**

When should I notify the Company of a claim?

You must give Us, written notice of a claim within 30 days after Disability or loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible after that. Such notice must include Your name, Your address and the Policy Number.

### **CLAIM FORMS:**

Are special forms required to file a claim?

We will send forms to You to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If We do not send the forms within 15 days, You may submit any other written proof which fully describes the nature and extent of Your claim.

### **PROOF OF LOSS:**

What is Proof of Loss?

Proof of Loss may include but is not limited to the following:

1. documentation of:
  - A. the date Your Disability began;
  - B. the cause of Your Disability;
  - C. the prognosis of Your Disability;
  - D. Your Pre-disability Earnings, Current Monthly Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
  - E. Evidence that You are under the Regular Care of a Physician;
2. any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
3. the names and addresses of all:
  - A. Physicians or other qualified medical professionals You have consulted;
  - B. Hospitals or other medical facilities in which You have been treated; and
  - C. Pharmacies which have filled Your prescriptions within the past three years;
4. Your signed authorization for Us to obtain and release:
  - A. Medical, employment and financial information; and
  - B. Any other information We may reasonably require;
5. Your signed statement identifying all Other Income Benefits; and
6. proof that You and Your dependents have applied for all Other Income Benefits which are available.

You will not be required to claim any retirement benefits which You may only get on a reduced basis. All proof submitted must be satisfactory to Us.

### **ADDITIONAL PROOF OF LOSS:**

What additional proof of loss is the Company entitled to?

To assist Us in determining if You are Disabled, or to determine if You meet any other term or condition of The Policy, We have the right to require You to:

1. meet and interview with our representative; and
2. be examined by a Physician, vocational expert, functional expert, or other medical or vocational professional of Our choice.

Any such interview, meeting or examination will be:

1. at Our expense; and
2. as reasonably required by Us.

Your Additional Proof of Loss must be satisfactory to Us. Unless We determine You have a valid reason for refusal, We may deny, suspend or terminate Your benefits if You refuse to be examined or meet to be interviewed by Our representative.

### **SENDING PROOF OF LOSS:**

When must proof of Loss be given?

Written Proof of Loss must be sent to Us within 90 days after the start of the period for which We are liable for payment. If proof is not given by the time it is due, it will not invalidate nor reduce the claim if:

1. it was not possible to give proof within the required time; and
2. proof is given as soon as possible; but
3. not later than 1 year after it is due, unless You are not legally competent.

We may request Proof of Loss throughout Your Disability. In such cases, We must receive the proof within 30 day(s) of the request.

### **CLAIM PAYMENT:**

When are benefit payments issued?

When We determine that You;

1. are Disabled; and
2. eligible to receive benefits;

We will pay accrued benefits at the end of each month that You are Disabled. We may, at Our option, make an advance benefit payment based on Our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid as soon as Proof of Loss satisfactory to Us is received.

### **CLAIMS TO BE PAID:**

To whom will benefits for my claim be paid?

All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

1. Your estate;
2. a person who is a minor; or
3. a person who is not legally competent;

then We may pay up to \$1,000 to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

### **CLAIM DENIAL:**

What notification will I receive if my claim is denied?

If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

1. give the specific reason(s) for the denial;
2. make specific reference to The Policy provisions on which the denial is based;
3. provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and
4. provide an explanation of the review procedure.

### **CLAIM APPEAL:**

What recourse do I have if my claim is denied?

On any claim, You or Your representative may appeal to Us for a full and fair review. To do so You:

1. must request a review upon written application within:
  - A. 180 days of receipt of claim denial if the claim requires Us to make a determination of disability; or
  - B. 60 days of receipt of claim denial if the claim does not require Us to make a determination of disability; and
2. may request copies of all documents, records, and other information relevant to Your claim; and
3. may submit written comments, documents, records and other information relating to Your claim.

We will respond to You in writing with Our final decision on the claim.

## **SOCIAL SECURITY:**

When must I apply for Social Security Benefits?

You must apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within 45 days from the date of Our request. If the Social Security Administration denies Your eligibility for benefits, You will be required:

1. to follow the process established by the Social Security Administration to reconsider the denial; and
2. if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

## **BENEFIT ESTIMATES:**

How does the Company estimate Disability benefits under the United States Social Security Act?

We reserve the right to reduce Your Monthly Benefit by estimating the Social Security disability benefits You or Your spouse and children may be eligible to receive. When We determine that You or Your Dependent may be eligible for benefits, We may estimate the amount of these benefits. We may reduce Your Monthly Benefit by the estimated amount. Your Monthly Benefit will not be reduced by estimated Social Security disability benefits if:

1. You apply for Social Security disability benefits and pursue all required appeals in accordance with the Social Security provision; and
2. You have signed a form authorizing the Social Security Administration to release information about awards directly to Us; and
3. You have signed and returned Our reimbursement agreement, which confirms that You agree to repay all overpayments.

If We have reduced Your Monthly Benefit by an estimated amount and:

1. You or Your Dependent are later awarded Social Security disability benefits, We will adjust Your Monthly Benefit when We receive proof of the amount awarded, and determine if it was higher or lower than Our estimate; or
2. Your application for disability benefits has been denied, We will adjust Your Monthly Benefit when You provide Us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If Your Social Security Benefits were lower than we estimated, and We owe You a refund, We will make such refund in a lump sum. If Your Social Security Benefits were higher than we estimated, and If Your Monthly Benefit has been overpaid, You must make a lump sum refund to Us equal to all overpayments, in accordance with the Overpayment Recovery provision

## **OVERPAYMENT:**

When does an overpayment occur?

An overpayment occurs:

1. when We determine that the total amount We have paid in benefits is more than the amount that was due to You under The Policy; or
2. when payment is made by Us that should have been made under another group policy.

This includes, but is not limited to, overpayments resulting from:

1. retroactive awards received from sources listed in the Other Income Benefits definition;
2. failure to report, or late notification to Us of any Other Income Benefit(s) or earned income;
3. misstatement;
4. fraud; or
5. any error We may make.

### **Overpayment Recovery:**

How does the Company exercise the right to recover overpayments?

We have the right to recover from You any amount that We determine to be an overpayment. You have the obligation to refund to Us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under The Policy.

If benefits are overpaid on any claim, You must reimburse Us within 30 days.

If reimbursement is not made in a timely manner, We have the right to:

1. recover such overpayments from:
  - A. You;
  - B. any other organization;
  - C. any other insurance company;
  - D. any other person to or for whom payment was made; and
  - E. Your estate;
2. reduce or offset against any future benefits payable to You or Your survivors, including the Minimum Monthly Benefit, until full reimbursement is made. Payments may continue when the overpayment has been recovered;
3. refer Your unpaid balance to a collection agency; and
4. pursue and enforce all legal and equitable rights in court.

## **SUBROGATION:**

What are the Company's subrogation rights?

If You:

1. suffer a Disability because of the act or omission of a Third Party;
2. become entitled to and are paid benefits under The Policy in compensation for lost wages; and
3. do not initiate legal action for the recovery of such benefits from the Third Party in a reasonable period of time;

then We will be subrogated to any rights You may have against the Third Party and may, at Our option, bring legal action against the Third Party to recover any payments made by Us in connection with the Disability.

## **Reimbursement:**

What are the Company's Reimbursement Rights?

We have the right to request to be reimbursed for any benefit payments made or required to be made under The Policy for a Disability for which You recover payment from a Third Party.

If You recover payment from a Third Party as:

1. a legal judgment;
2. an arbitration award; or
3. a settlement or otherwise;

You must reimburse Us for the lesser of:

1. the amount of payment made or required to be made by Us; or
2. the amount recovered from the Third Party less any reasonable legal fees associated with the recovery.

**Third Party** means any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Policy.

## **LEGAL ACTIONS:**

When can legal action be taken against Us?

Legal action cannot be taken against Us:

1. sooner than 60 days after the date proof of loss is given; or
2. more than 3 years after the date Proof of Loss is required to be given according to the terms of The Policy.

## **INSURANCE FRAUD:**

How does the Company deal with fraud?

Insurance Fraud occurs when You and/or Your Employer provide Us with false information or file a claim for benefits that contains any false, incomplete or misleading information with the intent to injure, defraud or deceive Us. It is a crime if You and/or Your Employer commit Insurance Fraud. We will use all means available to Us to detect, investigate, deter and prosecute those who commit Insurance Fraud. We will pursue all available legal remedies if You and/or Your Employer perpetrate Insurance Fraud.

## **MISSTATEMENTS:**

What happens if facts are misstated?

If material facts about You were not stated accurately:

1. Your premium may be adjusted; and
2. the true facts will be used to determine if, and for what amount, coverage should have been in force.

No statement, except fraudulent misstatements, made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.

## **POLICY INTERPRETATION:**

Who interprets the terms and conditions of The Policy?

We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Policy.

## **DEFINITIONS**

**Actively at Work** means at work with the Employer on a day that is one of the Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:

1. in the usual way; and
2. for Your usual number of hours.

We will consider You Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.

**Active Employee** means an Employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Insurance.

**Any Occupation** means any occupation for which You are qualified by education, training or experience, and that has an earnings potential greater than the lesser of:

1. the product of Your Indexed Pre-disability Earnings and the Benefit Percentage;  
or
2. the Maximum Monthly Benefit.

**Current Monthly Earnings** means monthly earnings You receive from:

1. Your Employer; and
2. other employment;

while You are Disabled.

However, if the other employment is a job You held in addition to Your job with Your Employer, then during any period that You are entitled to benefits for being Disabled from Your Occupation, only the portion of Your earnings that exceeds Your average earnings from the other employer over the 6 month(s) period just before You became Disabled will count as Current Monthly Earnings.

Current Monthly Earnings also includes the pay You could have received for another job or a modified job if:

1. such job was offered to You by Your Employer, or another employer, and You refused the offer; and
2. the requirements of the position were consistent with:
  - A. Your education, training and experience; and
  - B. Your capabilities as medically substantiated by Your Physician.

**Disability or Disabled** means You are prevented from performing one or more of the Essential Duties of:

1. Your Occupation during the Elimination Period;
2. Your Occupation, for the 24 month(s) following the Elimination Period, and as a result Your Current Monthly Earnings are less than 80% of Your Indexed Pre-disability Earnings; and
3. after that, Any Occupation.

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, but Your Current Monthly Earnings are greater than 80% of Your Pre-disability Earnings, Your Elimination 19 Period will be extended for a total period of 12 months from the original date of Disability, or until such time as Your Current Monthly Earnings are less than 80% of Your Pre-disability Earnings, whichever occurs first.

For the purposes of extending Your Elimination Period, Your Current Monthly Earnings will not include the pay You could have received for another job or a modified job if such job was offered to You by Your Employer, or another employer, and You refused the offer.

Your Disability must result from:

1. accidental bodily injury;
2. sickness;
3. Mental Illness;
4. Substance Abuse; or
5. pregnancy.

Your failure to pass a physical examination required to maintain a license to perform the duties of Your occupation, alone, does not mean that You are Disabled.

**Elimination Period** means the longer of the number of consecutive days at the beginning of any one period of Disability which must elapse before benefits are payable or the expiration of any Employer sponsored short term Disability benefits or salary continuation program, excluding benefits required by state law.

**Employer** means the Policyholder.

**Essential Duty** means a duty that:

1. is substantial, not incidental;
2. is fundamental or inherent to the occupation; and
3. cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled work week is an Essential Duty.

**Indexed Pre-disability Earnings** means Your Pre-disability Earnings adjusted annually by adding the lesser of:

1. 10%; or
2. the percentage change in the Consumer Price Index (CPI-W).

The percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31, and the prior year's CPI-W as of July 31, divided by the prior year's CPI-W. The adjustment is made January 1st each year after You have been Disabled for 12 consecutive month(s), provided You are receiving benefits at the time the adjustment is made.

The term Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, We may use another nationally published index that is comparable to the CPI-W.

**Mental Illness** means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or

result in physical symptoms or manifestations. For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

1. Mental Retardation;
2. Pervasive Developmental Disorders;
3. Motor Skills Disorder;
4. Substance-Related Disorders;
5. Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
6. Narcolepsy and Sleep Disorders related to a General Medical Condition.

**Monthly Benefit** means a monthly sum payable to You while You are Disabled, subject to the terms of The Policy.

**Monthly Income Loss** means Your Pre-disability Earnings minus Your Current Monthly Earnings.

**Other Income Benefits** means the amount of any benefit for loss of income, provided to You or Your family, as a result of the period of Disability for which You are claiming benefits under The Policy. This includes any such benefits for which You or Your family are eligible or that are paid to You, or Your family or to a third party on Your behalf, pursuant to any:

1. temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
2. governmental law or program that provides disability or unemployment benefits as a result of Your job with Your Employer;
3. plan or arrangement of coverage, whether insured or not, which is received from Your Employer as a result of employment by or association with Your Employer or which is the result of membership in or association with any group, association, union or other organization;
4. mandatory "no fault" automobile insurance plan;
5. disability benefits under:
  - A. the United States Social Security Act or alternative plan offered by a state or municipal government;
  - B. the Railroad Retirement Act;
  - C. the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
  - D. similar plan or act; that You, Your spouse and/or children, are eligible to receive because of Your Disability; or
6. disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
  - A. that begins after You become Disabled; or
  - B. that You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means any payments that are made to You or to Your family, or to a third party on Your behalf, pursuant to any:

1. disability benefit under Your Employer's Retirement plan;
2. temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
3. portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings; or
4. retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
  - A. You were receiving it prior to becoming Disabled; or
  - B. You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement; (Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by Your after-tax contributions.); or
5. retirement benefits under:
  - A. the United States Social Security Act or alternative plan offered by a state or municipal government;
  - B. the Railroad Retirement Act;
  - C. the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan;
  - D. similar plan or act; that You, Your spouse and/or children receive because of Your retirement, unless You were receiving them prior to becoming Disabled.

If You are paid Other Income Benefits in a lump sum or settlement, You must provide proof satisfactory to Us of:

1. the amount attributed to loss of income; and
2. the period of time covered by the lump sum or settlement.

We will pro rate the lump sum or settlement over this period of time. If You cannot or do not provide this information, We will assume the entire sum to be for loss of income, and the time period to be 24 month(s). We may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of Your claim.

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:

1. takes effect after the date benefits become payable under The Policy; and
2. is a general increase which applies to all persons who are entitled to such benefits.

**Physician** means a person who is:

1. a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that We recognize or are required by law to recognize;
2. licensed to practice in the jurisdiction where care is being given;
3. practicing within the scope of that license; and
4. not Related to You by blood or marriage.

**Pre-disability Earnings** means Your regular monthly rate of pay, not counting bonuses, commissions and tips and tokens, overtime pay or any other fringe benefits or extra compensation in effect on the last day You were Actively at Work before You became Disabled.

However, if You are an hourly paid Employee, Pre-disability Earnings means the product of:

1. the average number of hours You worked per month, not including overtime, over the most recent 12 month period immediately prior to the last day You were Actively at Work before You became Disabled, multiplied by:
2. Your hourly wage in effect on the last day You were Actively at Work before You became Disabled.

**Prior Policy** means the long term disability insurance carried by the Employer on the day before the Policy Effective Date.

**Regular Care of a Physician** means that You are being treated by a Physician:

1. whose medical training and clinical experience are suitable to treat Your disabling condition; and
2. whose treatment is:
  - A. consistent with the diagnosis of the disabling condition;
  - B. according to guidelines established by medical, research, and rehabilitative organizations; and
  - C. administered as often as needed;

to achieve the maximum medical improvement.

**Rehabilitation** means a process of Our working together with You in order for Us to plan, adapt, and put into use options and services to meet Your return to work needs. A Rehabilitation program may include, when We consider it to be appropriate, any necessary and feasible:

1. vocational testing;
2. vocational training;
3. alternative treatment plans such as:
  - A. support groups;
  - B. physical therapy;
  - C. occupational therapy; or
  - D. speech therapy;
4. work-place modification to the extent not otherwise provided;
5. job placement;
6. transitional work; and
7. similar services.

**Related** means Your spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or similar relationship in law.

**Retirement Plan** means a defined benefit or defined contribution plan that provides benefits for Your retirement and which is not funded wholly by Your contributions. It does not include:

1. a profit sharing plan;
2. thrift, savings or stock ownership plans;
3. a non-qualified deferred compensation plan; or
4. an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan, 403(b) plan or 457 deferred compensation arrangement.

**Substance Abuse** means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1. impairments in social and/or occupational functioning;
2. debilitating physical condition;
3. inability to abstain from or reduce consumption of the substance; or
4. the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

**The Policy** means the Policy which We issued to the Policyholder under the Policy Number shown on the face page.

**We, Our, or Us** means the insurance company named on the face page of The Policy.

**Your Occupation** means Your Occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.

**You or Your** means the person to whom this certificate is issued.

Filename: LTD Booklet 01\_13\_09 01.doc  
Directory: U:\Counties\Rutherford County\Employee Benefits\2008  
Document Consolidation Project\Prototypes\January 12\_2009  
Template: C:\Documents and Settings\Jeremy\Application  
Data\Microsoft\Templates\Normal.dot  
Title: ARTICLE I – GENERAL INFORMATION  
Subject:  
Author: Jeremy  
Keywords:  
Comments:  
Creation Date: 01/13/2009 2:16:00 PM  
Change Number: 51  
Last Saved On: 01/20/2009 2:53:00 PM  
Last Saved By: Jeremy  
Total Editing Time: 504 Minutes  
Last Printed On: 01/20/2009 2:54:00 PM  
As of Last Complete Printing  
Number of Pages: 35  
Number of Words: 10,566 (approx.)  
Number of Characters: 53,681 (approx.)