Short-Term Disability Insurance

Cigna®

Developed for the Employees of
County of San Diego

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Protecting Your Family Securing Your Future

"As long as you've got your health …."

If you're physically healthy, you can work, play, take care of your family and enjoy life.

But, if something were to happen to you, all your hard work – and everything you have – could be lost unless you take steps to protect your income.

If asked to name your most valuable assets, you might list your home, your furnishings or your automobiles.

But what about your *paycheck?*

You insure your home and your auto. Shouldn't you insure your income as well?

After all, it's your income that enables you to buy and enjoy all of your other assets.

Having adequate insurance coverage is not only the basis for a sound financial blueprint, it helps to provide the protection you need to ensure that your family, your home and your finances will be protected.

By purchasing this disability insurance through your employer, you also benefit from:

- Affordable group rates
- Convenient payroll deduction

How This Program Protects You

If you suffer a covered disability while insured by this plan, you'll receive monetary benefits designed to help you maintain your normal lifestyle.

This program covers disabling injuries or sicknesses that last beyond the elimination period, whether they occur on or off the job.

Please take a few minutes now to read this program description and learn how this valuable program helps protect your income and your lifestyle.

Eligibility For Coverage

You must be an active, full-time Employee who is classified as Executive Management (EM), Non-Represented Administrator (NA), Elected Official (EO), Non-Represented Executive (NE), Chief Executive Officer (CEO)/Unclassified CERTIFICATE (CRX), Unclassified Management (UM or SD1), Deputy County Counsel (CC), County Counsel Supervisor (CS), Child Support Program Attorney Supervisor (AM), Child Support Program Attorney (AS), Deputy District Attorney (DA), Public Defender (PD), Public Defender Management (PM), Employees working at San Dieguito River Park (SDRP) and classified as Management (SR2) or Unclassified (SR1) or a member of the San Diego County Employees Retirement Association (SDCERA) and classified as (continued) Management (RTM) or Unclassified (RTU), Classified Management (CEM), Management (MA or SD2), Non-Represented Management (NM), or a member of the San Diego County Employees Retirement Associate (SDCERA) with classification code (SDB), Deputy (continued) Officer (CEO)/Unclassified (CRX), Unclassified Management (UM or SD1), Deputy County Counsel (CC), County Counsel Supervisor (CS), Child Support Program Attorney Supervisor (AM), Child Support Program Attorney (AS), Deputy District Attorney (DA), Public Defender (PD), Public Defender Management (PM), Employees working at San Dieguito River Park (SDRP) and classified as Management (SR2) or Unclassified (SR1) or a member of the San Diego County Employees Retirement Association (SDCERA) and classified as Management (RTM) or Unclassified (RTU), Classified Management (CEM), Management (MA or SD2), Non-Represented Management (NM), or a member of the San Diego County Employees Retirement Associate (SDCERA) with classification code (SDB), Deputy Sheriff (DS), Sheriff Management (SM), District Attorney Investigator (DI) or District Attorney lnvestigator Mid-management (DM), or an unrepresented Employee who is classified as Non-Represented Support (NS), regularly working a minimum of 20 hours per week to receive coverage under this plan.

Eligibility Waiting Period

All current employees who meet the eligibility requirements are eligible to participate in this program on the first of the month following the date of hire.

If you join the company after the date this program becomes effective, you are eligible to participate on the first of the month following the date of hire.

You can enroll any time within 31 days following the date you become eligible for coverage. If you decide to enroll later, you will have to provide acceptable evidence of good health. This may require a medical examination, at your cost.

You will be asked to complete an enrollment form, indicating your wish to participate and your authorization for payroll deductions.

When Coverage Takes Effect

If you meet these eligibility requirements, your coverage takes effect on the later of the program's effective date, the date you become eligible, the date we receive your completed enrollment form, or the date you authorize any necessary payroll deductions.

If you have to submit evidence of good health, your coverage takes effect on the date we agree, in writing, to cover you. If you're not actively at work on the date your coverage would otherwise take effect, you'll be covered on the date you return to work.

How Disability is Defined

To receive benefits under this plan, you must be disabled (as defined below) as a result of a covered injury or sickness, and you must be under the appropriate care of a licensed, practicing physician who is qualified to treat your disability.

Disabled means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular job and you are unable to earn 80% or more of your covered earnings from working in your regular job. We will require proof of earnings and continued disability.

Injury means any accidental loss or bodily harm that results directly and independently of all other causes from an accident.

Sickness means any physical or mental illness.

Accident means a sudden, unforeseeable event that causes bodily injury and occurs while you are covered under this plan.

Appropriate Care means the determination of an accurate and medically supported diagnosis of your disability, or ongoing medical treatment and care of your disability by a physician that conforms to generally accepted medical standards, including frequency of treatment and care.

Regular Job means you will be considered disabled if, because of Injury or Sickness, you are unable to perform all the material duties of your regular job. In evaluating the disability, the insurance company will consider the duties of the job as it is normally performed for the employer.

Physician means a licensed doctor practicing within the scope of his/her license and rendering care and treatment to an employee that is appropriate for the condition and locality. A physician cannot be the employee, his/her spouse, the immediate family of either the employee or spouse, or a person living in the employee's household.

Elimination Period

Before collecting benefits, you must satisfy the elimination period following your date of disability. For your plan, this period is the later of any accumulated vacation pay or 7 days of continuous disability from either accident or sickness.

Benefits

This plan pays a benefit up to 60% of your weekly covered earnings — to a maximum of $1,500 per week.

Your benefit amount will be reduced by any amounts payable to you by any of the sources listed under the "Effects of Other Income Benefits" section.

Covered earnings means your wages or salary, excluding overtime pay, bonuses, commissions and other extra compensation.

Return-To-Work Incentives

This plan encourages you to return to work as soon as medically feasible. It includes return-to-work incentives that offer you both the opportunity and the encouragement to successfully return to productive employment.

Return-to-Work Incentive Benefit

You may continue to receive benefits if you return to work but continue to meet the definition of disability.

For any week that the sum of your disability benefit, current earnings and any additional other income benefits exceed 100% of your weekly covered earnings, we may reduce the benefit by the excess amount.

Recurrent Disability Feature

If you return to work after receiving benefits under this plan, then again become disabled from the same or a related cause, you will *not* have to fulfill another elimination period, unless you have worked more than 14 days or you earn 80% or more of your covered earnings during at least one week. The disability would be considered a continuation of your initial claim. If the second disability recurs beyond this limit or results from a cause unrelated to the first, you must file a new claim and fulfill a new elimination period.

Rehabilitation Services

If you are offered a rehabilitative assistance program, we will work with you during the course of your elimination period or while benefits are payable. You will be expected to cooperate with the implementation of that assistance program. If you refuse such assistance without good cause (e.g., a medically substantiated reason), disability benefits will not be payable and coverage under this plan will end. Coverage may be reinstated, and benefits resumed, if, within 30 days of the termination date, you agree to participate in the rehabilitation efforts.

Effects of Other Income Benefits

Disability insurance is designed to help you meet your financial obligations if you cannot work as a result of a covered injury or sickness. The disability benefit provided by this plan is a total benefit; that is, it will be reduced by any disability benefits payable on behalf of you or your dependents, or a qualified third party on behalf of you or your dependents, whether or not you are actually receiving them. Your disability benefits will not be reduced by any Social Security disability benefits you are not receiving as long as you cooperate fully in efforts to obtain them and agree to repay any overpayment when and if you do receive them.

Other income sources that may reduce your benefits under this plan include:

- Any Social Security disability or retirement benefits you or any third party receive (or are assumed to receive) on your own behalf; or which your dependents receive (or are assumed to receive) because of your entitlement to such benefits.
- Benefits payable by a Canadian and/or Quebec provincial pension plan.
- Amounts payable under the Railroad Retirement Act.
- Amounts payable under any local, state, provincial or federal government disability or retirement plan or law as it pertains to the employer.
- Employer-paid portion of company retirement plan benefits.
- Amounts payable by company sponsored salary continuation plan.
- Amounts payable by any franchise or group insurance or similar plan.
- Benefits payable under work-loss provisions of any mandatory "no fault" auto insurance.
- Any amounts paid on account of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined.
- Amounts payable under any workers' compensation (including temporary or permanent disability benefits), occupational disease, and unemployment compensation. This includes damages, compromises or settlements paid in place of such benefits, whether or not liability is admitted.

Income sources that **WILL NOT** reduce your benefits under this plan are:

- Benefits paid by personal, individual disability income policies.
- Individual deferred compensation agreements.
- Employee savings plans, including thrift plans, stock options or stock bonuses.
- Individual retirement funds, such as IRA or 401(k) plans.
- Profit-sharing, investment or other retirement or savings plans maintained in addition to an employer-sponsored pension plan.

Minimum Disability Benefit

Your benefits from this plan will never be less than $100 per week. However, if there is an overpayment due, the minimum benefit may be reduced or not apply in order to recover the overpayment.

Example of Benefit Reductions:

Using the example below, follow these Steps to determine how Other Income sources would reduce your disability benefit amount.

Step 1. Your gross weekly pre-disability earnings = $1,000

Step 2. The benefit percentage provided under this plan = 60%

Step 3. Multiply Step 1 and 2 to determine your unreduced benefit amount (not to exceed the plan maximum) = $600

Step 4. Other income sources that may reduce your benefits under this plan, such as a monthly Social Security disability benefit = $150

Step 5. Subtract Step 4 from Step 3 to determine your total weekly disability benefit amount = $450

Benefit Period

Once you qualify for benefits under this plan, you continue to receive them until the end of the benefit period, or until you no longer qualify for benefits, whichever occurs first. (We will ask you to periodically furnish proof of your continuing disability.)

This plan offers 3 options for your benefit period.

Option 1 — the date the 3rd Disability Benefit is payable.

Option 2 — the date the 7th Disability Benefit is payable.

Option 3 — the date the 12th Disability Benefit is payable.

This plan pays short-term disability benefits weekly.

Benefits payable under this plan will terminate on the earliest of any date indicated below:

- The date we determine you are no longer disabled.
- The date you earn from any occupation more than the percentage of your covered earnings as defined in your definition of disability.
- The date the maximum benefit period ends.
- The date you cease to get appropriate care.
- The date you die.
- The date you refuse to participate without good cause in all required phases of the rehabilitation plan.
- The date you fail to cooperate with us in the administration of the claim.

Benefits may be resumed if you begin to cooperate in the rehabilitation plan within 30 days of the date benefits terminated.

Limitations

This plan provides only limited benefits for some conditions and excludes others from coverage, as listed below.

Pre-Existing Conditions

Pre-existing conditions are those for which you have incurred expenses, taken prescription drugs or medicines, received medical treatment, care or services (including diagnostic measures,) or for which a reasonable person would have consulted a physician during the 3 months immediately prior to the most recent effective date of insurance.

This plan does *not* pay benefits for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured under this plan for 12 consecutive months. If you were insured under the employer-sponsored disability plan with a pre-existing condition limitation immediately prior to the effective date of this plan, we will credit you for all time served toward that limitation period, for similar or lower benefit amounts. If benefits under this plan are higher than under your prior plan, you do not receive credit for the higher benefit levels. This limitation also applies to newly added or increased benefits.

Exclusions

This plan does not pay benefits for a disability which results, directly or indirectly, from any of the following:

- Suicide, attempted suicide, or whenever you injure yourself on purpose
- War or any act of war, whether or not declared
- Active participation in a riot
- Commission of a felony
- The revocation, restriction or non-renewal of your license, permit or certification necessary for you to perform the duties of your occupation, unless solely due to injury or sickness otherwise covered by the policy
- Cosmetic surgery or medically unnecessary surgical procedures

(**Medically necessary** means: prescribed by a licensed physician as required treatment for a sickness or injury *and* appropriate according to conventional medical practice in the locality where it is performed. Benefits are payable if the disability is caused by your donation of an organ in a non-experimental organ transplant procedure.)

In addition, we will not pay disability benefits for any period of disability during which you are incarcerated in a penal or corrections institution for any reason.

Changes To Existing Coverage

You can make changes to your existing coverage within 31 days after the following specific "life status changes."

- Marriage, divorce, annulment or legal separation.
- Birth or adoption of a child.
- Your spouse's death, termination of employment, or a change in benefit plans available to your spouse.
- Change in your or your spouse's employment affecting your benefits eligibility.

Termination of Coverage

Your coverage will end on the earliest of any of the following dates:

- the date you are no longer a member of an eligible class of employees.
- the date the plan is terminated by the insurer or the employer.
- the day after the last date for which premium has been paid by you or the employer.
- the date you become eligible for a plan of benefits intended to replace this coverage.
- the date you are no longer in active service.
- the date benefits end because you did not comply with the terms and conditions of the policy.

If you are receiving disability benefits when the policy terminates, disability benefits will continue if you remain disabled and meet the requirements for the insurance. Any later period of disability, regardless of cause, that begins when you are eligible under another disability coverage provided by any employer, will not be covered.

How Much Your Coverage Will Cost

The cost of this insurance program is paid for by you. Use the chart below to help you calculate the amount for your age group. Please indicate your disability plan choice (or your decision not to select coverage) on your enrollment form. You must authorize payroll deduction for premium payments.

Option 1

If you are between these ages:	Your cost per $10 of weekly benefit
Under 55	$.481
55 - 59	$.534
60 - 64	$.622
65 & Over	$.685

Costs are subject to change.

Option 2

If you are between these ages:	Your cost per $10 of weekly benefit
Under 55	$.786
55 - 59	$.875
60 - 64	$1.019
65 & Over	$1.118

Costs are subject to change.

Option 3

If you are between these ages:	Your cost per $10 of weekly benefit
Under 55	$.912
55 - 59	$1.013
60 - 64	$1.18
65 & Over	$1.295

Costs are subject to change.

To calculate the cost of your coverage, follow these steps:

Step 1. Enter your gross or pre-tax weekly pay (not counting commissions, bonus or overtime). $_____

Step 2. Multiply by .60 to determine your weekly benefit. Round to nearest dollar. This amount cannot exceed $1,500. $_____

Step 3. Enter the rate. $_____

Step 4. Multiply your weekly benefit (Step 2) by the rate (Step 3). $_____

Step 5. Divide by 10 to determine the amount of premium that will be deducted from your paycheck each month. $_____

(Please Note: All benefits in this plan are paid on a weekly basis, regardless of your regular pay period.)

Notes

LIFE INSURANCE COMPANY OF NORTH AMERICA

POLICYHOLDER
County of San Diego

POLICY NUMBER
VDT 961880

Short-Term Disability (STD) Enrollment Form

Name ____ Sex: ❑ Male ❑ Female
Last *First* *M. I.*

Date of Birth ____________________ Social Security No. ___/___/___ - ___/___ - ___/___/___/___

Address ____ Home Phone (_____)__________
Number and Street *City* *State* *Zip Code*

Date Hired__________________ Title or Occupation____________________ Annual Salary $____________

♦♦

Please check the appropriate box.

❑ I accept the STD insurance provided by the Company's Group Insurance Plan and authorize the deduction from my earnings of the required contribution toward the cost of the insurance.

❑ Option 1 ❑ Option 2 ❑ Option 3

❑ I have been offered STD insurance and decline to purchase it at this time. I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability at my own expense and that coverage is subject to the Insurance Company's approval.

Late entrants must complete an Evidence of Insurability Form. Coverage for late entrants is subject to the Insurance Company's approval.

If you are not in active service on the date your coverage would otherwise take effect, you will be covered on the date you return to active service.

Pre-Existing Condition Limitation: A pre-existing condition is any injury or illness for which you have consulted a physician (or for which a reasonable person would have consulted a physician), received medical treatment, care or services (including diagnostic measures), taken prescribed drugs or medicines, or incurred expenses during the 3 months prior to the effective date of your insurance. If you become disabled due to a pre-existing condition, you will not receive benefits unless your disability begins more than 12 consecutive months after the effective date of your coverage.

Signature of Applicant ______________________________________ Date________________

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TL-004038 (BME)

Return original to your employer and make a copy for your records.

This information is a brief description of the important features of this plan. It is not a contract. Terms and conditions of the coverage are set forth in Group Policy No. VDT-961880, on Policy Form TL-004700, issued in Delaware to the Group Insurance Trust for Employers in the Public Administration industry. The group policy is subject to the laws or jurisdiction in which it is issued. The availability of this offer may change. Please keep this material as a reference, and file it with your certificate, should you become insured.

Coverage is underwritten by
Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, PA 19192

08/17
Class 1

GO YOU℠

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