

Voluntary Long-term Disability Overview

Prepared for the employees of Williamson County



Voluntary Long-term Disability Insurance Coverage – *paid by you*

- Monthly Benefit** – This plan pays a benefit of up to 60% of your monthly covered earnings — to a maximum of \$5,000 per month. 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.
- Definition of Disability** – Disability means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation and you are unable to earn 80% or more of your indexed earnings from working in your regular occupation. After benefits have been payable for 24 months, you are considered disabled if solely due to your injury or sickness, you are unable to perform the material duties of any occupation for which you are (or may reasonably become) qualified by education, training or experience, and you are unable to earn 67% or more of your indexed earnings. We will require proof of earnings and continued disability.
- Covered Earnings** – Covered earnings means your wages or salary, not including bonuses, commissions and other extra compensation.
- Elimination Period** – You must be disabled for 90 days or the expiration of your sick leave, whichever is greater, before benefits may be payable.
- Benefit Duration** – Once you qualify for benefits under this plan, you continue to receive them until the end of the benefit period shown below, or until you no longer qualify for benefits, whichever occurs first.

Your benefit period begins on the first day after you complete your elimination period. And, should you remain disabled, your benefits continue according to the following schedule, depending on your age at the time you become disabled.

Age at Disability	Age 62 or younger	63	64	65	66	67	68	69+
Duration of Payments (months)	To age 65 or the date the 42 nd monthly benefit is payable, if later	36	30	24	21	18	15	12

Additional Plan Details

Earnings While Disabled

During the first 24 months that benefits are payable, benefits will be reduced if benefits plus income from employment exceeds 100% of pre-disability covered earnings. After that, benefits will be reduced by 50% of earnings from employment.

Termination of Disability Benefits

Your benefits will terminate when your disability ceases, when your benefit duration period is exceeded, or on the following events: (1) the date you earn from any occupation more than 80% of your indexed earnings. (refer to your plan's definition of disability), or (2) the date you fail to cooperate with us in a rehabilitation plan, or transitional work arrangement, or the administration of the claim.

Pre-existing Conditions

Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received medical treatment, care or services (including diagnostic measures,) or for which a reasonable person would have consulted a physician during the 6 months just prior to the most recent effective date of insurance.

Benefits are not payable for any disability resulting from a pre-existing condition unless the disability occurs after you have been in active service for a time of 6 consecutive months when you received no medical treatment, care, or services after you have been under this plan for at least 24 months after your most recent effective date of insurance.

Limited Benefit Period

Disabilities caused by or contributed to by any one or more of the following conditions are subject to a lifetime limit of 24 months for outpatient treatment: Anxiety-disorders, delusional (paranoid) or depressive disorders, eating disorders, mental illness, somatoform disorders (including psychosomatic illnesses).

Benefits are payable during periods of hospital confinement for these conditions for hospitalizations lasting more than 14 consecutive days that occur before the 24-month lifetime outpatient limit is exhausted. Once the 24-month outpatient benefits are exhausted, the plan pays no further benefits.

Disabilities caused by or contributed to by any one or more of the following conditions are subject to a lifetime limit of 24 months for outpatient treatment: Alcoholism, drug addiction or abuse.

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.

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.

When Coverage Takes Effect

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.

Family Survivor Benefit

If you die while receiving disability benefits, we will pay a survivor benefit based on 100% of the total of your last month's benefit plus the amount of any disability earnings by which this benefit had been reduced for that month. This plan pays a single lump sum equal to 3 months of benefits. We pay this benefit directly to your lawful spouse, or to your children in equal shares, if there is no lawful spouse. If you have no lawful spouse or children, we pay this benefit to your estate.

Programs Included at No Additional Cost

Cigna Healthy Rewards[®] Program

Program provides you and your covered family member's discounts on health programs and services like weight loss management, fitness,





WILLIAMSON COUNTY

LONG TERM DISABILITY (LTD) ENROLLMENT FORM Long Term Disability Policy Number #VDT 961068

<u>Employee Name:</u>	<u>Employee Date of Birth:</u>
<u>Address:</u>	<u>Annual Earnings:</u>
<u>City State, Zip:</u>	<u>Date of Hire:</u>
<u>Employee Social Security #:</u>	<u>Phone Number:</u>
<u>Gender:</u>	<u>Department/Location:</u>

Voluntary Long Term Disability Insurance –Employee Coverage Only

You have the opportunity to enroll in Williamson County's Voluntary Long Term Disability (LTD) insurance plan. LTD insurance helps to replace your income if you are sick or injured and cannot work and is designed to begin after you have been disabled for a predetermined waiting period, known as the elimination period, of 90 days. This plan provides you with income protection to replace up to 60% of your regular pay, to a maximum monthly benefit of \$5,000.

I understand the effective date of my coverage will be delayed if I am not in active employment because of an injury, sickness, temporary lay-off or leave of absence on the date this insurance would otherwise become effective. Use the calculation line below to determine your approximate monthly cost for this coverage. **

Please Note:
 *Enrollment at time of new hire does not require evidence of good health.
 *Pre-existing conditions could apply during the first 2 years of coverage on all enrollees as of effective date coverage. Pre-existing conditions are determined by Cigna.
 *To be eligible for coverage, employees must be regularly scheduled to work 30 hours per week.

Age	Under 30	30-34	35-39	40-44	45-49	50-54	55 +
Rate	\$0.270	\$0.270	\$0.378	\$0.531	\$0.738	\$1.04	\$1.59

I elect to **enroll** in the Voluntary LTD plan at the monthly cost below.

$$\frac{\text{Annual Salary}}{[Maximum=\$100,000]} \div 12 = \frac{\text{Monthly Salary}}{\text{Rate Above}} \div 100 = \text{Rate Above} \times \text{Rate Above} = \$ \text{Your Monthly Cost}^{**}$$

I elect to **decline** the Voluntary LTD plan and know that Evidence of Insurability will be required if I decline and then want to enroll at a later date. .

Employee Confirmation

I have been given the opportunity to enroll in Williamson County's Voluntary Long Term Disability program. I authorize my employer to make the appropriate payroll deductions from my wages on a post-tax basis.

Employee Signature: _____ **Date:** _____

The Beneficiary Designation Section must be completed at time of enrollment. Please Sign and return this form to the Williamson County Benefits Department



Beneficiary Designation -Supplemental Life, AD&D Insurance and LTD

Employee Name: _____
Address: _____
City, State, Zip: _____

Employee Social Security #: _____
Date of Birth: _____
Effective Date: _____
Department – Title: _____

This form must be completed in full and returned to the Williamson County Benefits Department when enrolling in the Supplemental Life, AD&D and/or LTD coverage's

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary (ies) please indicate their full name, address, social security number, relationship, date of birth and distribution percentage. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel. Following are examples of the most common designations:

Primary:

- Mary J. Doe, Wife (not Mrs. John Doe).

Contingent:

- Joseph W. Doe, Son and Jane Doe, Daughter, in equal shares (50%).
- Estate of the Insured.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

For Policy #: FLX 964518; OK 966107; VDT 961068; FLX 964517; OK 966106

	Full Name	Address	SSN	Relationship	D.O.B.	%
Primary						
Contingent						

The beneficiary for life insurance on the lives of your spouse and children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

Employee Signature: _____ **Date:** _____

