# Insurance & Benefits Trust *of* PORAC

## PREMIER PLUS Long Term Disability Program
### Summary of Benefits

| | |
|---|---|
| **How Benefits are Funded** | Funded and administered first 5 years and after age 65 for life by the **I&B Trust of PORAC** with assets in excess of $8 million*. Claims are funded by Standard Insurance Company - A.M. Best rated A (Excellent). Financial size category XII ($1 billion to $1.25 billion), from the sixth year of benefit eligibility to age 65. |
| **Percentage of Wages Protected** | **70%** of the first $12,857 Pre-Disability Earnings, reduced by deductible income |
| **Assisted Living Benefit** | During the Own Occupation Period it pays an additional **30%** of the first $12,857 of Pre-Disability Earnings, but not to exceed $3,857. This benefit is not reduced by deductible income. |
| **Maximum Monthly Benefit** | **$9,000** (70% of $12,857) before reduction by deductible income |
| **Maximum Benefit Period** | Safety Members: To age 65 for both Accident & Illness. Lifetime if severely disabled.<br>Non-Safety Members: 36 Months |
| **Own Occupation Period** | 24 months following the waiting period |
| **Waiting Period** | Non-Industrial: 30 days (Required use of sick leave may be frozen after 60 days)<br>Industrial: 0 days (Premiums waived after claim approval). |
| **Freeze of Sick Leave** | After 60 days |
| **Minimum Benefit** | **$200** per month while receiving sick leave for non-industrial disabilities |
| **Sick Leave Integration Benefit** | Receive **100%** of base pay through use of 50% leave time and 50% LTD benefit |
| **Cost of Living Benefit** (COLA) (Non-Industrial) | Based on increases in Consumer Price Index (CPI-W), up to 5% compounded annually |
| **Mental & Nervous Disorders** | Safety Members: Benefits are limited to 12 months each continuous period of disability, or as long as hospitalized.<br>Non-Safety Members: Benefits are limited to 6 months each occurrence, or as long as hospitalized. |
| **Musculoskeletal & Connective Tissue Disorders** | For certain conditions, benefits are limited to 24 months for each continuous period of disability |
| **Drug & Alcohol Use** | Benefits are limited to 12 months lifetime |
| **Pays Benefits During Disputed Worker's Compensation Cases** | After 30 days – **70%** of wages to a maximum monthly benefit of $9,000 (Repayable if determined to be an industrial disability)) |
| **Disability Pension Advance** | Up to **70%** of wages (max. $9,000 per month benefit) may be advanced during retirement processing |
| **Survivors Benefits** | Dependents will receive a lump sum benefit equal to 6 times the member's last LTD monthly benefit, after reductions by deductible income |
| **Death Benefit** | **$55,000** Death Benefit (accidental causes)<br>**$50,000** Death Benefit (natural causes) |

## Monthly Premium: $22.50

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*Reflects assets as of the most recent 5500 filing.

## What is deductible income?

Deductible income is income you receive or are eligible to receive while LTD benefits are payable. It is used to reduce the amount of your LTD benefits and includes, but is not limited to, the following:

- Sick pay and annual leave pay (including donated amounts), 4850 pay and other forms of salary continuation, but not including vacation pay, compensatory time off (CTO) pay, or lump sum buy-back of your sick leave and annual leave pay
- Benefits under any worker's compensation law (other than benefits for permanent disability), state disability income benefit law or similar law
- Social Security disability or retirement benefits, including benefits for your spouse and children
- Disability benefits from any other group insurance
- Any disability or retirement benefits you receive or are eligible to receive under your employer's retirement plan (such as PERS, STRS, or plan through a union or employee association) including a previous employers retirement plan through a peace officer's agency, unless receipt of such retirement benefits commenced prior to your date of disability under this LTD plan. Amounts you receive through the Deferred Retirement Option Program (D.R.O.P) also will be considered deductible income.
- Earnings from work activity while you are disabled
- Any amount you receive by compromise, settlement or other method as a result of a claim or any of the above

## What exclusions apply to this coverage?

You are not covered for a disability caused or contributed to by any of the following:

- Your committing or attempting to commit an assault or felony, or your active participation in a violent disorder or riot (except while performing your official duties)
- An intentionally self-inflicted injury, while sane or insane
- War or any act of war (declared or undeclared, and any substantial armed conflict between organized forces of a military nature)
- A condition for which you previously received a medical disability retirement from your position as a peace officer
- A pre-existing condition or the medical or surgical treatment of a pre-existing condition unless on the date you become disabled, you have been continuously covered under the plan for the 24-month exclusion period and actively at work for at least one full day after the end of the exclusion period

## What is a pre-existing condition?

A pre-existing condition is a mental or physical condition, whether or not diagnosed or misdiagnosed:

- Which was discovered or suspected as a result of any routine or other medical examination at any time during the pre-existing condition period or
- For which you have (or a reasonably prudent person would have) consulted a physician or other licensed medical professional, received medical treatment, services or advice, undergone diagnostic procedures, including self administered procedures, or taken prescribed drugs or medications at any time during the pre-existing condition period.

The pre-existing condition period is the 12-month period just before your LTD coverage becomes effective.

## What limitations apply to this coverage?

LTD benefits are not payable for any period of time when you are:

- Not under the ongoing care of a physician in the appropriate specialty
- Not participating in good faith in a plan, program or course of medical treatment or vocational training or education, unless your disability prevents you from participating
- Confined for any reason in a penal or correctional institution
- Scheduled to be away from work without pay

In addition, payment of LTD benefits is limited in duration:

- To 12 months during your entire lifetime for a disability caused or contributed to by your alcoholism, drug addiction, or use of any hallucinogens
- To 12 months for safety members (6 months for non-safety members) for each period of continuous disability caused or contributed to by a mental disorder (unless you are hospital-confined at the end of the 12 months)
- To 24 months for each period of continuous disability caused or contributed to by musculoskeletal for connective tissue disorders

## How is "disability" defined?

You will be considered to be "disabled" if you meet the following requirements.:

Own Occupation Definition:

- During the Benefit Waiting Period and the next 24 months of disability (Own Occupation Period) you are required to be Disabled only from your Own Occupation
- You are Disabled from your Own Occupation if, as a result of Physical Disease, Injury, Pregnancy, or Mental Disorder, you are unable to perform with reasonable continuity the Material Duties of your Own Occupation. However you will not be considered to be disabled from your Own Occupation if your employer is able to accommodate you in another position within the scope of your occupation for which you are reasonable fitted by education, training and experience. If you earn, in this position, more than or equal to 100% of your current base salary or there is no differential in salary, no benefits will be paid or payable

Any Occupation Definition:

- After the Own Occupation Period you are required to be Disabled from all occupations
- You are Disabled from all occupations if, as a result of Physical Disease, Injury, Pregnancy, or Mental Disorder, you are unable to perform with reasonable continuity the Material Duties of any gainful occupation for which you are reasonably fitted by education, training, and experience.

## How do I become covered?

To become insured under this plan, you must apply (complete and return the front page of the attached application form) and if required, submit and have approved evidence of good health (complete and return both the front and back of the attached application form). If you are required to submit evidence of good health, your coverage will not become effective until your evidence has been approved. Regardless, you also must be capable of active work on the day before the scheduled effective date of your coverage.

You will be required to provide satisfactory evidence of good health to become insured if:

- You apply for coverage more than 31 days after you become eligible for coverage
- You join PORAC more than one year after you first were eligible to join
- Fewer than 10 members in your participating unit are covered under the plan on the date you apply
- You were eligible under a prior LTD plan but were not covered
- You were covered previously and allowed your coverage to lapse

## What is a "Safety Member"?

A safety member is an employee who is entitled to Safety Employee Benefits under the County Retirement Act of 1937 or PERS of California, Safety Member Status, or the equivalent.

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# Group Long Term Disability Application

## PREMIER PLUS Long Term Disability Program

Please use this application to apply for Group Long Term Disability Plan during the specified enrollment period. Don't send money now. Your premiums will be paid through payroll deduction (if applicable), once coverage is issued.

*Please print clearly (black ink): Fax, Mail or Scan and E-Mail to:*

**Myers-Stevens & Toohey & Co., Inc.** | 26101 Marguerite Parkway | Mission Viejo | CA 92692
phone 800.827.4695 | fax 949.348.2630 | PORAC@myers-stevens.com | license #0425842

## Insurance & Benefits Trust of PORAC (Plan 610007-D)

Tell us about yourself:

| Members Name | | Sex<br>____Male ____Female | | SSN |
|---|---|---|---|---|
| Home Address | | | | |
| City | | | State | ZIP |
| E-mail Address | | Home Phone | | Work Phone |
| Full Name of Your Employer | | | | Date Employed |
| Association Name | | Association Number | | |
| Monthly Salary<br>$ | | Date of PORAC Membership<br>/ / | | PORAC # (if available) |

I am a: ___________ Safety Employee
___________ Non-safety Employee
___________ In the Academy graduation date: ________________________

As a member in good standing of PORAC and having read the attached brochure describing the benefits. I hereby apply for coverage under my association's disability plan which is subject to the provisions of the Insurance and Benefits Trust of the Peace Officers Research Association of California Group Long Term Disability Plan. I certify that I am working full-time and able to perform all the required duties of my occupation. Upon approval of this application, I authorize my employer to make the necessary deductions from my wages or salary to cover my contribution (if any) for the cost of this coverage.

**Member's Signature** ______________________________________________ **Date** ____________________

Check "yes" or "no" for each of these questions, and give details for any "yes" answers. *(Attach a separate sheet if more room is required.)*

| | YES | NO |
|---|---|---|
| 1. Are you now unable to work full-time because of any physical or mental condition, or injury? | ☐ | ☐ |
| 2. Has a medical professional ever treated you for, diagnosed you as having, or prescribed medication for you for any of the following: | | |
| *Disease of the liver, pancreas, kidney, ulcers, stomach, intestinal ailment, or digestive system disorder? | ☐ | ☐ |
| *Multiple sclerosis, epilepsy, stroke, paralysis, numbness, visual disturbance, blindness, deafness, or any other neurological disorders? | ☐ | ☐ |
| *Cancer, tumor, lesions, leukemia, lymphoma, blood clotting, or other malignancy or growth? | ☐ | ☐ |
| *Cardiovascular disease, heart ailment, abnormal pulse, high blood pressure, heart murmur, valve, circulatory or vascular disorders? | ☐ | ☐ |
| *Emphysema, asthma, bronchitis, sleep apnea, or other respiratory or lung disease? | ☐ | ☐ |
| *Lupus, scleroderma, vasculitis, connective tissue disease, or other immune system disorder not related to Human Immunodeficiency Disorder (HIV)? | ☐ | ☐ |
| *Osteoarthritis, rheumatoid arthritis, osteoporsis, pain in the joints, amputation, or other disease or disorder of the bones, joints, back, or spine, arthritic or disc condition? | ☐ | ☐ |
| *Diabetes, thyroid, gland, spleen, or nephritis? | ☐ | ☐ |
| *Drug or alcohol abuse, or have you used alcohol, drugs, or nicotine in a manner that has resulted in medical treatment? | ☐ | ☐ |
| *Psychiatric or mental condition, depression, adjustment disorder, affective disorder, anxiety disorder, or obsessive compulsive disorder? | ☐ | ☐ |
| 3. In the past 10 years have you had any illness or injury not listed above which resulted in the use of prescribed medication or physician visits? | ☐ | ☐ |
| 4. Has a medical professional ever diagnosed you as having or prescribed medication to you for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? | ☐ | ☐ |
| 5. Are you now pregnant? | ☐ | ☐ |

| HEIGHT | WEIGHT | PHYSICIAN OR MEDICAL FACILITY WITH APPLICANT'S COMPLETE MEDICAL RECORDS<br>Name and Full Mailing Address |
|---|---|---|
| | | |



Refer to Plan Documents for complete details. CA License Number 0425842
Standard Insurance Company I Medical Underwriting I 900 SW Fifth Avenue I Portland, OR 97204 I Please complete and sign application

## Describe below any yes answers to the Health Questionnaire (please provide the entire question number)

| Question No. | Description of Injuries, Disorders and Operations | Month/Year | Duration | Final Result | Physicians Consulted City and State |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Acknowledgement and Authorization for Release of Information.** *(Please read carefully.)*

- I represent that the statements contained herein, including those make in response to the Medical History Statement questions and any attachments, are true and complete, to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies). I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of mu insurance and/or denial of payment of a claim. I agree to notify Standard Insurance Company (The Standard) of any change in my medical condition while mu enrollment application if pending. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group policy(ies), including any applicable Active Work requirement. I agree that if my application is declined, The Standard's liability is limited to the return of any premium which may have been paid.
- To any health plan, physician, health care provider, hospital, clinic, laboratory, pharmacy, medical facility, insurance or reinsurance company, and the Medical Information Bureau Inc. (MIB), I instruct you to disclose my entire medical record and any other protected health information concerning me to The Standard or its reinsurers. This includes information on any disorder of the immune system, including Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, and any communicable or sexually transmitted disease or disorder. This also includes information of the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.
- By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any of the above to release and disclose my entire medical records without restriction.
- I understand that The Standard will use information obtained by authorization to determine my eligibility for group insurance coverage. I understand The Standard may release information it has about me to its reinsurers and to any person performing business or legal services for The Standard in connection with my application. I understand The Standard may release information it has about me to the MIB for the purpose of reporting to the MIB information exchange and for MIB to audit The Standard's reporting. I understand The Standard may release information it has about me to other insurance companies to which I have applied for insurance coverage or benefits.
- I understand that information disclosed to The Standard pursuant to authorization may be subject to redisclosure with my authorization or as otherwise permitted by law. Life and disability insurance coverages are not subject to the Privacy Rule under Health Insurance Portability and Accountability Act (HIPAA), and therefore release of information to The Standard is not protected under the Act.
- I understand that if my application is approved, premiums shall be paid in accordance with the provisions of the Group Policy(ies), any my coverage will be subject to all term and conditions of the Group Policy(ies) and state limitations.
- For Member/Employee: If I currently have a Life and/or Trust Life beneficiary designation of file with my plan administrator, I understand the designation(s) on file will also apply to any approved amounts. If I have no beneficiary designations) on file or I wish to change the name of the current beneficiary(ies), I will contact my plan administrator.
- I understand that insurance on a Spouse or other Dependent, if any, is payable to the Member/Employee, if living, or as provided under the terms of the Group Policy(ies).
- I acknowledge that I have read and received the Information Practices Notice and I have kept a copy of this Medical History statement.
- I understand that I am entitled to receive a copy of this authorization. This authorization will remain valid one year from the date of the signature below. A photocopy or facsimile of this authorization shall be considered as valid as the original.
- I understand that I have the right to refuse to sign this authorization. I further understand that I have a right to revoke this authorization at any time by sending a written statement to The Standard, except to the extent it had been relied upon to disclose requested records. I understand that the revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my application and may be a basis for denying my application for insurance coverage.

_______________________________________ Signature of Applicant

_______________________ Date

**Information Practices Notice**

- To help us determine your eligibility for group insurance we may request information about your from other persons and organizations. For example, we may request information from your doctor or hospital, other insurance companies, or MIB, Inc. (Medical Information Bureau). We will use the authorization you signed on this form when we seek this information.
- MIB (MEDICAL INFORMATION BUREAU) - Information regarding your insurability will be treated as confidential. Standard Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.
- Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: Post office Box 105, Essex Station, Boston, Massachusetts, 02112.
- Standard Insurance Company may release information in its file to its reinsurers, and Standard Insurance Company, or its reinsurers, may release information in its file to other insurance companies to whom yo may apply for life or health insurance, or to whom a claim for benefits may be submitted.
- DISCLOSURE TO OTHERS - The information collected about you is confidential. We will not release any information about you without your authorization, except to the extent necessary to conduct our business or as required or permitted by law.
- YOUR RIGHTS - You have a right to know what information we have about you in our underwriting file. You also have the right to ask us to correct any information you think is incorrect. We will carefully review your request and make changes when justified. If you would like more information about this right or our information practices please write to us at Medical Underwriting, Standard Insurance Company, 900 SW Fifth Avenue, Portland, Oregon, 97204 or call 800-843-7979.

Note: Declinations do not effect either Guarantee Issue Amounts not subjected to Evidence of Good Health (Insurability) or other coverages already in force with Standard Insurance Company.

Plans arranged and administered by:

**Myers-Stevens & Toohey & Co., Inc.**
26101 Marguerite Parkway | Mission Viejo, CA 92692
CA License No. 0425942 | 800-827-4695 | fax 949-348-2630