

Offered by Life Insurance Company of North America

## Employer-Paid TERM LIFE INSURANCE

### Summary of Benefits

Prepared for: City of Carson

#### Eligibility:

All active, Full-time Employees of the Employer classified as AFSCME Local 809 regularly working a minimum of 30 hours per week, and Employees classified as CPT AFSCME Local 809 of the Employer regularly working a minimum of 30 hours per week in the United States, who are citizens or permanent resident aliens of the United States.

**Employee:** You will be eligible for coverage the first of the month on or coinciding with 30 days of hire.

#### Available Coverage:

	Benefit Amount	Maximum	Guaranteed Issue Amount
Employee	\$100,000	\$100,000	\$100,000

#### Additional Features:

**Continuation of Disability** – If your active service ends due to disability, at age 60 or over, your life insurance coverage will continue while you are disabled. Benefits will remain in force until the earliest of: the date you are no longer disabled, the date the policy terminates, the date you are Disabled for 12 consecutive months, or the day after the last period for which premiums are paid. You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your Regular Occupation, or you are receiving disability benefits under your Employer’s plan.

**Extended Death Benefit with Waiver of Premium** – The extended death benefit continues your coverage without payment of premium, before you’re eligible to qualify for Waiver of Premium, if you are continuously Disabled for 9 months prior to age 60. “Disabled” means, because of injury or sickness, you are unable to perform all the material duties of your regular occupation, or you are receiving disability benefits under a program sponsored by your Employer. Regular Occupation means the occupation you routinely performed at the time your Disability began. We/the insurance company will consider the duties of your occupation as those that are normally performed in the general labor market in the national economy. If you qualify for this benefit and have insured your spouse or children, the insurance company will also extend their coverage if applicable.

**Waiver of Premium** – If you become Disabled prior to age 60, and you remain Disabled continuously for a 9 month period and thereafter, you won’t need to pay premiums for your life insurance coverage, provided we/the Insurance Company determine(s) you are Disabled. “Disabled” for this coverage means, because of injury or sickness, you are unable to perform the material duties of your regular occupation, or are receiving disability benefits under a program sponsored by your employer, for the first 12 months after your Disability began. Thereafter, you must be unable to perform the material duties of any occupation that you are or may reasonably become qualified based on your education, training or experience. If you qualify for this coverage and have insured your spouse or children, the insurance company will also waive their premium if applicable. After premiums have been waived for 12 months, they will be waived for future periods of 12 months if you remain Disabled. This benefit will remain active until age 65 subject to proof of continuing disability each year.

**Accelerated Death Benefit – Terminal Illness** – if two unaffiliated doctors diagnose you as terminally ill while the coverage is active, with a life expectancy of 12 months or less, the benefit for Terminal Illness provides up to:

Employee: 100% of your Term Life Insurance coverage amount or \$100,000, whichever is less.

**Portability** – If your employment is terminated, you can continue your life insurance on a direct-bill basis. Premiums will increase at this time.

Coverage can be continued to age 70, unless the insurance company terminates portability for all insured persons. Refer to your certificate for details.

**Conversion** – To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends.

*Actual per pay period premiums may differ slightly due to rounding. Benefits will reduce based on age (see Benefits Reduction Schedule for details).*

#### Important Definitions and Policy Provisions:

**When Your Coverage Begins and Ends** – Coverage becomes effective on the later of the program’s effective date, the date you become eligible, the date your enrollment elections are received if applicable, or the date you authorize any necessary payroll deductions if applicable. Your coverage will not begin unless you are actively at work on the effective date. Dependent coverage, if applicable, will not begin for any spouse or child who on the effective date is an inpatient in a facility or is home confined and under the care of a physician. Coverage will end on the earliest of the date you are eligible for coverage under a plan intended to replace this coverage, you or your dependents if applicable, are no longer eligible, the group policy is no longer in force, or required premiums are not paid.

#### Benefit Reductions, Exclusions and Limitations:

**Benefit Reduction Schedule** – If you are still employed, your benefits will reduce to 65% at age 70, 45% at age 75 and 30% at age 80.

**Limitations** – The Accelerated Death Benefit is payable only once. Using this benefit reduces the life insurance death benefit. The amount payable under the Accelerated Death Benefit may be reduced by the amount of other benefits already paid to the insured under the policy. See your certificate for details. Benefits will be extended without premium payment until the earlier of the date you are no longer disabled, or the date you fail to qualify for Waiver of Premium or fail to provide proof of Disability.

**THIS POLICY PROVIDES LIMITED COVERAGE. IT PAYS A FIXED BENEFIT AND DOES NOT COVER MEDICAL EXPENSES AS INCURRED. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE OR MAJOR MEDICAL HEALTH INSURANCE. THIS COVERAGE DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT BECAUSE THE COVERAGE DOES NOT MEET THE REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.**

Terms and conditions of coverage for Term Life insurance are set forth in Group Policy No. FLX 967822. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, eligible conditions, their respective payments and policy exclusions and limitations are contained in the Policy. Please see your Plan Sponsor to obtain a copy of the Policy. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability, costs, benefits, riders, covered conditions and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 51 Madison Avenue New York, NY 10010.

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## Employee-Paid TERM LIFE INSURANCE

### Summary of Benefits

Prepared for: City of Carson

#### Eligibility:

All active, Full-time Employees of the Employer classified as AFSCME Local 809 regularly working a minimum of 30 hours per week, and Employees classified as CPT AFSCME Local 809 of the Employer regularly working a minimum of 30 hours per week in the United States, who are citizens or permanent resident aliens of the United States.

**Employee:** You will be eligible for coverage the first of the month on or coinciding with 30 days of hire.

**Spouse\*:** Is eligible as long as you apply for and are approved for coverage yourself.

**Child(ren):** Birth to age 26, as long as you apply for and are approved for coverage yourself.

\*Domestic Partner is defined in the Group Policy. For purposes of this brochure, wherever the term Spouse appears, it shall also include Domestic Partner registered under any state which legally recognizes Domestic Partnerships or Civil Unions. Additional information is available from your Benefit Services Representative.

#### Available Coverage:

	Benefit Amount	Maximum	Guaranteed Issue Amount
Employee	Units of \$5,000	Lesser of 5 times salary or \$300,000	\$200,000
Spouse	\$10,000	\$10,000	\$10,000
Children	\$5,000	\$5,000	All amounts

Guaranteed Issue means that you may be able to purchase coverage without medical exams or health questions. See "Guaranteed Issue" below for more information.

#### Additional Features:

**Continuation of Disability** – If your active service ends due to disability, at age 60 or over, your life insurance coverage will continue while you are disabled. Benefits will remain in force until the earliest of: the date you are no longer disabled, the date the policy terminates, the date you are Disabled for 12 consecutive months, or the day after the last period for which premiums are paid. You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your Regular Occupation, or you are receiving disability benefits under your Employer's plan.

**Extended Death Benefit with Waiver of Premium** – The extended death benefit continues your coverage without payment of premium, before you're eligible to qualify for Waiver of Premium, if you are continuously Disabled for 9 months prior to age 60. "Disabled" means, because of injury or sickness, you are unable to perform all the material duties of your regular occupation, or you are receiving disability benefits under a program sponsored by your Employer. Regular Occupation means the occupation you routinely performed at the time your Disability began. We/the insurance company will consider the duties of your occupation as those that are normally performed in the general labor market in the national economy. If you qualify for this benefit and have insured your spouse or children, the insurance company will also extend their coverage if applicable.

**Waiver of Premium** – If you become Disabled prior to age 60, and you remain Disabled continuously for a 9 month period and thereafter, you won't need to pay premiums for your life insurance coverage, provided we/the Insurance Company determine(s) you are Disabled. "Disabled" for this coverage means, because of injury or sickness, you are unable to perform the material duties of your regular occupation, or are receiving disability benefits under a program sponsored by your employer, for the first 12 months after your Disability began. Thereafter, you must be unable to perform the material duties of any occupation that you are or may reasonably become qualified based on your education, training or experience. If you qualify for this coverage and have insured your spouse or children, the insurance company will also waive their premium if applicable.

**Accelerated Death Benefit** – Terminal Illness – if two unaffiliated doctors diagnose you or your spouse as terminally ill while the coverage is active, with a life expectancy of 12 months or less, the benefit for Terminal Illness provides up to:  
Employee: 100% of your Term Life Insurance coverage amount or \$300,000, whichever is less.  
Spouse: 100% of your Term Life Insurance coverage amount or \$10,000, whichever is less.

**Portability** – If your employment is terminated, you can continue your life insurance on a direct-bill basis. Coverage may also be continued for your spouse/children. Premiums will increase at this time. Coverage can be continued to age 70, unless the insurance company terminates portability for all insured persons. Refer to your certificate for details.

**Conversion** – To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends.

#### Employee's Monthly Cost of Coverage:

Employee Cost Per \$1,000 = \$0.490

Spouse and Child Cost Per Family Unit = \$2.40

*Actual per pay period premiums may differ slightly due to rounding. The rates above reflect the total cost. Rates may be subject to change in the future.*

## **How to Calculate Your Monthly Cost:**

**Step 1:** Find the above **Monthly** rate.

**Step 2:** Multiply this rate by your desired coverage amount, in units. Reference the information above to find the appropriate unit amounts for employee and/or dependents.

**Step 3:** The result is the Per Paycheck cost.

## **Important Definitions and Policy Provisions:**

**When Your Coverage Begins and Ends** – Coverage becomes effective on the later of the program's effective date, the date you become eligible, the date your enrollment elections are received if applicable, or the date you authorize any necessary payroll deductions if applicable. Your coverage will not begin unless you are actively at work on the effective date. Dependent coverage, if applicable, will not begin for any spouse or child who on the effective date is an inpatient in a facility or is home confined and under the care of a physician. Coverage will end on the earliest of the date you are eligible for coverage under a plan intended to replace this coverage, you or your dependents if applicable, are no longer eligible, the group policy is no longer in force, or required premiums are not paid.

## **Benefit Reductions, Exclusions and Limitations:**

**Exclusions** - Voluntary life insurance will not be paid if you commit suicide, while sane or insane, within the first two years of coverage.

**Limitations** - The Accelerated Death Benefit is payable only once. Using this benefit reduces the life insurance death benefit. The amount payable under the Accelerated Death Benefit may be reduced by the amount of other benefits already paid to the insured under the policy. See your certificate for details. Benefits will be extended without premium payment until the earlier of the date you are no longer disabled, or the date you fail to qualify for Waiver of Premium or fail to provide proof of Disability. After premiums have been waived for 12 months, they will be waived for future periods of 12 months if you remain Disabled. This benefit will remain active until age 65 subject to proof of continuing disability each year.

## **Guaranteed Issue:**

If you are a new hire and you apply within 31 days after you are eligible to elect coverage for yourself, you are entitled to choose any coverage offered up to the Guaranteed Issue Amount, without providing proof of good health. If you apply for an amount of coverage greater than the Guaranteed Issue Amount, coverage in excess of the Guaranteed Issue Amount will not be issued until the insurance company approves acceptable proof of good health. If you apply for coverage yourself more than 31 days from the date you become eligible to elect coverage under this plan, the Guaranteed Issue Amount will not apply, unless Guaranteed Issue has been approved by your employer for a specific period of time. Coverage will not be issued until the insurance company approves acceptable proof of good health.

These are summarized definitions only. To be eligible for coverage, the covered illness or event must meet the definitions and other terms and conditions set forth in the group policy.

**THIS POLICY PROVIDES LIMITED COVERAGE. IT PAYS A FIXED BENEFIT AND DOES NOT COVER MEDICAL EXPENSES AS INCURRED. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE OR MAJOR MEDICAL HEALTH INSURANCE. THIS COVERAGE DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT BECAUSE THE COVERAGE DOES NOT MEET THE REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.**

Terms and conditions of coverage for Term Life insurance are set forth in Group Policy No. FLX 967822. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, eligible conditions, their respective payments and policy exclusions and limitations are contained in the Policy. Please see your Plan Sponsor to obtain a copy of the Policy. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability, costs, benefits, riders, covered conditions and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 51 Madison Avenue New York, NY 10010.

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**Offered by Life Insurance Company of North America**

**Employer-Paid  
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE**

**Summary of Benefits**

**Prepared for:** City of Carson

**Eligibility:**

All active, full-time Employees of the Employer classified as AFSCME Local 809 regularly working a minimum of 30 hours per week, and Employees classified as CPT AFSCME Local 809 of the Employer regularly working a minimum of 30 hours per week in the United States, who are citizens or permanent resident aliens of the United States.

**Employee:** You will be eligible for coverage the first of the month on or coinciding with 30 days of hire.

**Available Coverage: You will receive equal amounts of Term Life and Accidental Death and Dismemberment insurance.**

	<b>Benefit Amount</b>	<b>Maximum</b>
Employee	\$100,000	\$100,000

**Benefit Details:**

<b>If, within 365 days of a Covered Accident, bodily injuries result in:</b>	<b>We'll pay this % of the Benefit Amount:</b>
Loss of life; Quadriplegia; Loss of two or more hands or feet; Loss of sight in both eyes; or Loss of speech and hearing (both ears)	100%
Paraplegia	75%
Hemiplegia; Loss of one hand, one foot, sight in one eye, speech, or hearing in both ears; or Severance and Reattachment of one hand or foot	50%
Uniplegia; Loss of all four fingers of the same hand; or Loss of thumb and index finger of the same hand	25%
Loss of all toes of the same foot	20%

**For Comas** – You will receive 1% of the full benefit amount each month, for up to a maximum of 11 months, if you or an insured family member are in a coma for 30 days or more as a result of a Covered Accident. If the covered person is still in a coma after 11 months, or dies, the full benefit amount will be paid.

**Additional Features:**

**For Wearing a Seatbelt & Protection by an Airbag** – You will receive an additional 25% benefit but not more than \$25,000 if the covered person dies in a covered automobile accident and law enforcement-certified to be wearing a seatbelt or approved child restraint. We will increase the benefit by an additional 10% but not more than \$5,000 if the insured person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

**For Exposure & Disappearance** – Benefits are payable if you or an insured family member suffer a covered loss due to unavoidable exposure to the elements as a result of a Covered Accident. If your or an insured family member's body is not found within one year of the disappearance, wrecking or sinking of the conveyance in which you or an insured family member were riding, on a trip otherwise covered, it will be presumed that you sustained loss of life as a result of a Covered Accident.

**For Furthering Education and Spouse Training**

The education benefit provides training or education as follows:

**For your children** – If you die in a covered accident, we will pay an extra benefit for each insured child under age 25 who enrolls in a school of higher learning within one year of your death. We will increase your benefit by 5% or \$5,000, whichever is less, for each qualifying child, each year for 4 consecutive years as long as your child continues his/her education.

**For your spouse** – If you die in a covered accident and your insured spouse enrolls in an accredited school to gain skills needed for employment within one year of your death, we will pay 3% of the actual cost of this education or training program for not more than 4 years after enrollment begins, up to a maximum of \$3,000.

If you have no spouse or child who qualifies within one year of your death, we will pay an additional \$1,000 to your beneficiary.

**Conversion** – If group accident coverage ends (except due to nonpayment of premium), your employment is terminated, membership in an eligible class is terminated, or insurance coverage is reduced based on attained age, you can convert to an individual non-term policy. To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends. Dependents may convert their coverage as well if applicable. Premiums may change at this time, and terms of coverage will be subject to change. You can also convert to an individual policy of up to \$10,000 if you have been insured for at least 5 years and the policy is terminated or amended, provided coverage is not replaced and you are not covered under a different conversion policy issued by Life Insurance Company of North America. Refer to your certificate for details.

## **Important Definitions and Policy Provisions:**

**When your coverage begins** - Coverage begins on the later of the program's effective date, the date you become eligible, the date we receive your completed enrollment form if applicable, or the date you authorize any necessary payroll deductions if applicable. Your coverage will not begin unless you are actively at work on the effective date. Dependent coverage, if applicable, will not begin for any dependent who on the effective date is hospital or home confined; receiving chemotherapy or radiation treatment; or disabled and under the care of a physician.

**When your coverage ends** - Coverage ends on the earliest of the date you or your dependents, if applicable, are no longer eligible, the date the group policy is no longer in force, or the date for the last period for which required premiums are paid. (Under certain circumstances, your coverage may be continued if you stop working. Be sure to read the Continuation of Insurance provisions in your Certificate.)

## **Benefit Reductions, Exclusions and Limitations**

**Benefit Reduction Schedule:** If you are still employed, your benefits will reduce to 65% at age 70, 45% at age 75 and 30% at age 80. Your premiums will also reduce to match your benefits.

**Exclusions** - Self-inflicted injuries or suicide while sane or insane • commission or attempt to commit a felony or an assault • any act of war, declared or undeclared • any active participation in a riot, insurrection or terrorist act • bungee jumping • parachuting • skydiving • parasailing • hang-gliding • sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food • voluntarily using any drug, narcotic, poison, gas or fumes except one prescribed by a licensed physician and taken as prescribed • operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the covered person has been provided a written warning against operating a vehicle while taking it • a Covered Accident that occurs while the covered person is engaged in the activities of active duty service in the military, navy or air force of any country or international organization (this does not include Reserve or National Guard training, unless it extends beyond 31 days) • traveling in an aircraft that is owned, leased or controlled by the sponsoring organization or any of its subsidiaries or affiliates • air travel, except as a passenger on a regularly scheduled commercial airline or in an aircraft being used by the Air Mobility Command or its foreign equivalent • flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface being flown by the covered person or in which the covered person is a member of the crew.

**Limitations** - For multiple covered losses, benefits are paid for the single largest benefit available. For loss of life, the benefit amount shown will be reduced by the amount of any dismemberment benefits that were previously paid or payable.

**THIS POLICY PROVIDES LIMITED ACCIDENT-ONLY COVERAGE. IT PAYS A FIXED BENEFIT AND DOES NOT COVER MEDICAL EXPENSES AS INCURRED. IT DOES NOT COVER LOSSES CAUSED BY SICKNESS. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE OR MAJOR MEDICAL HEALTH INSURANCE.**

Terms and conditions of coverage for Accidental Death and Dismemberment insurance are set forth in Group Policy No. OK 969324. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, eligible injuries, their respective payments and policy exclusions and limitations are contained in the Policy Certificate. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 51 Madison Avenue New York, NY 10010.

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## Employer-Paid SHORT TERM DISABILITY INSURANCE

### Summary of Benefits

Prepared for: City of Carson

#### Eligibility:

All active, Full-time Employees of the Employer regularly working a minimum of 30 hours per week in the United States who are citizens or permanent resident aliens of the United States, and Participating Elected or Appointed Officials who are citizens or permanent resident aliens of the United States.

**Employee:** You will be eligible for coverage the first of the month on or coinciding with 30 days of hire.

#### Available Coverage:

Gross Weekly Benefit <sup>1</sup>	Maximum Gross Weekly Benefit	Benefit Waiting Period	Maximum Benefit Period
66.67% of your weekly covered earnings	\$1,154	0 Days for accident 7 Days for sickness	13 Weeks for accident 12 Weeks for sickness

#### Important Definitions and Policy Provisions:

**Disability** - "Disability" or "Disabled" means if 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.

**Covered Earnings - Covered Earnings (Non AFSCME Local 809):** "Covered Earnings" means an Employee's wage or salary as reported by the Employer for work performed for the Employer. Total monthly earnings include deductions made for pre-tax contributions made to a qualified Deferred Compensation Plan, Section 125 Plan or Flexible Spending Account as in effect just prior to the date Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the first of the month following the change, if the Employer gives us written notice of the change and the required premium is paid. It does not include amounts received as bonus, commissions, stock options, stock bonuses, overtime pay or other extra compensation.

**Covered Earnings (AFSCME Local 809):** "Covered Earnings" means an Employee's wage or salary as reported by the Employer for work performed for the Employer. Total monthly earnings includes shift differential pay, uniform pay, bi-lingual pay, longevity pay, A/B License Pay, Certification Pay and deductions made for pre-tax contributions made to a qualified Deferred Compensation Plan, Section 125 Plan or Flexible Spending Account as in effect just prior to the date Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the first of the month following the change, if the Employer gives us written notice of the change and the required premium is paid. It does not include amounts received as bonus, commissions, stock options, stock bonuses, overtime pay or other extra compensation.

**When Benefits Begin** - You must be continuously Disabled for 0 Days for an accident and 7 Days for a sickness before benefits will be paid for a covered Disability.

**How Long Benefits Last** - Once you qualify for benefits under this plan, the maximum number of weekly Disability benefits is 13 Weeks for an accident and 12 Weeks for a sickness. Disability benefits will end sooner if you no longer qualify for benefits.

**When Coverage Takes Effect** - Your coverage takes effect on the later of the policy's effective date, the date you become eligible, the date we receive your completed enrollment form if required, or the date you authorize any necessary payroll deductions if applicable. If you're not actively at work on the date your coverage would otherwise take effect, your coverage will take effect on the date you return to work. If you have to submit proof of good health, your coverage takes effect on the date we agree, in writing, to cover you.

#### Benefit Reductions, Conditions, Limitations and Exclusions:

**Effects of Other Income Benefits** - This plan is structured to prevent your total benefits and post-disability earnings from equaling or exceeding pre-disability earnings. Therefore, we reduce this plan's benefits by an amount equal to any Social Security retirement and/or disability benefits payable to you, your dependents, or a qualified third party on behalf of you or your dependents. 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. Disability benefits will be reduced by amounts received through other government programs, sick pay, employer funded retirement benefits, workers' compensation, franchise/group insurance, auto no-fault, and damages for wage loss. For details, see your Certificate of Insurance.

**Termination of Disability Benefits** - Your benefits will terminate when your Disability ceases, when your benefit duration period is exceeded, you earn more than your allowable Covered Earnings, or the date benefits end because you did not comply with the terms and conditions of the policy.

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

- Suicide, attempted suicide, or intentionally self-inflicted injury while sane or insane.
- 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 an Employee's license, permit or certification necessary to perform the duties of his or her occupation unless due solely to Injury or Sickness otherwise covered by the Policy.
- any cosmetic surgery or surgical procedure that is not Medically Necessary.
- an Injury or Sickness for which the Employee is entitled to benefits from Workers' Compensation or occupational disease law.
- an Injury or Sickness that is work related.

In addition, the plan does not pay disability benefits any period of Disability during which you are incarcerated in a penal or corrections institution.

Terms and conditions of coverage for Short Term Disability insurance are set forth in Group Policy No. LK 752174. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, are contained in the Policy Certificate. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 51 Madison Avenue New York, NY 10010.

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Offered by Life Insurance Company of North America

## Employer-Paid LONG TERM DISABILITY INSURANCE

### Summary of Benefits

Prepared for: City of Carson

#### Eligibility:

All active, Full-time Employees of the Employer with 5 or more years of service, regularly working a minimum of 30 hours per week in the United States, who are citizens or permanent resident aliens of the United States, and Participating Elected or Appointed Officials with 5 or more years of service in the United States, who are citizens or permanent resident aliens of the United States.

**Employee:** You will be eligible for coverage the first of the month on or coinciding with 30 days of hire.

#### Available Coverage:

Gross Monthly Benefit <sup>1</sup>	Maximum Gross Monthly Benefit	Benefit Waiting Period	Maximum Benefit Period
66.67% of your monthly covered earnings	\$5,000	90 Days	Please refer to the "How Long Benefits Last" section below for more details.

#### Additional Features

**Family Survivor Benefit** – If you die while receiving benefits, we will pay a survivor benefit to your lawful spouse\*, eligible children, or estate. The plan will pay a single lump sum equal to 3 months of benefits.

#### Important Definitions and Policy Provisions:

**Disability** – "Disability" or "Disabled" means if 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 covered earnings from working in your regular occupation. We will require proof of earnings and continued disability.

**Covered Earnings** – Covered Earnings (Non AFSCME Local 809): "Covered Earnings" means an Employee's wage or salary as reported by the Employer for work performed for the Employer. Total monthly earnings include deductions made for pre-tax contributions made to a qualified Deferred Compensation Plan, Section 125 Plan or Flexible Spending Account as in effect just prior to the date Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the first of the month following the change, if the Employer gives us written notice of the change and the required premium is paid. It does not include amounts received as bonus, commissions, stock options, stock bonuses, overtime pay or other extra compensation.

Covered Earnings (AFSCME Local 809): "Covered Earnings" means an Employee's wage or salary as reported by the Employer for work performed for the Employer. Total monthly earnings includes shift differential pay, uniform pay, bi-lingual pay, longevity pay, A/B License Pay, Certification Pay and deductions made for pre-tax contributions made to a qualified Deferred Compensation Plan, Section 125 Plan or Flexible Spending Account as in effect just prior to the date Disability begins. Covered Earnings are determined initially on the date an Employee applies for coverage. A change in the amount of Covered Earnings is effective on the first of the month following the change, if the Employer gives us written notice of the change and the required premium is paid. It does not include amounts received as bonus, commissions, stock options, stock bonuses, overtime pay or other extra compensation.

**When Benefits Begin** – You must be continuously Disabled for 90 Days before benefits will be paid for a covered Disability.

**How Long Benefits Last** – Once you qualify for benefits under this plan, you continue to receive them until the end of the benefit or until you no longer qualify for benefits, whichever occurs first. Should you remain Disabled, your benefits continue according to the later of your Social Security Normal Retirement Age, or 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 42nd monthly benefit is payable, if later.	36	30	24	21	18	15	12

**When Coverage Takes Effect** - Your coverage takes effect on the later of the policy's effective date, the date you become eligible, the date we receive your completed enrollment form if required, or the date you authorize any necessary payroll deductions if applicable. If you're not actively at work on the date your coverage would otherwise take effect, your coverage will take effect on the date you return to work. If you have to submit proof of good health, your coverage takes effect on the date we agree, in writing, to cover you.

**Benefit Reductions, Conditions, Limitations and Exclusions:**

**\*Domestic Partner** - For purposes of this summary, wherever the term spouse appears it shall also include domestic partner/partner to a civil union. Your domestic partner is eligible for insurance if you have not been married to any person within the last 12 months and if he or she meets specific criteria stated in the group policy. Additional information is available from your benefit service representative.

**Effects of Other Income Benefits** - This plan is structured to prevent your total benefits and post-disability earnings from equaling or exceeding pre-disability earnings. Therefore, we reduce this plan's benefits by an amount equal to any Social Security retirement and/or disability benefits payable to you, your dependents, or a qualified third party on behalf of you or your dependents. 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. Disability benefits will be reduced by amounts received through other government programs, sick pay, employer funded retirement benefits, workers' compensation, franchise/group insurance, auto no-fault, and damages for wage loss. For details, see your outline of coverage, policy certificate, or your employer's summary plan description.

**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.

**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), Alcoholism, drug addiction or abuse. 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.

**Pre-existing Condition Limitation** - Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received medical treatment, care or services (including diagnostic measures), during the 3 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 insured under this plan for at least 12 months after your most recent effective date of insurance.

**Termination of Disability Benefits** - Your benefits will terminate when your Disability ceases, when your benefit duration period is exceeded, you earn more than your allowable Covered Earnings, or the date benefits end because you did not comply with the terms and conditions of the policy.

**Exclusions** - This plan does not pay benefits for a Disability which results, directly or indirectly, from any of the following: • Suicide, attempted suicide, or intentionally self-inflicted injury while sane or insane. • 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 an Employee's license, permit or certification necessary to perform the duties of his or her occupation unless due solely to Injury or Sickness otherwise covered by the Policy.

*In addition, the plan does not pay disability benefits any period of Disability during which you are incarcerated in a penal or corrections institution.*

Terms and conditions of coverage for Long Term Disability insurance are set forth in Group Policy No. LK 965343. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, are contained in the Policy Certificate. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability and/or features may vary by state.

Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company, 51 Madison Avenue New York, NY 10010.

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# INSURANCE ENROLLMENT FORM

**Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.**



Return completed form to New York Life Group Benefit Solutions  
 P.O. Box 20310  
 Lehigh Valley, PA 18003-9924  
 Phone: 1-800-732-1603  
 Fax: 1-800-440-0856

Offered by Life Insurance Company of North America

**Employer:** City of Carson

## ALL ABOUT YOU – THE EMPLOYEE

Your Name \_\_\_\_\_ Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Employee ID # \_\_\_\_\_ Gender: \_\_\_\_\_

## COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE OR DOMESTIC PARTNER\*

I am currently married and my date of marriage is: \_\_\_\_\_ or  I currently have an eligible Domestic Partner

**My Spouse/  
 Domestic Partner's  
 Information** Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Gender \_\_\_\_\_

*\*To be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or Affidavit on file with your employer, and accepted by the Insurance company. If not, an Affidavit should be requested from your employer.*

## YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employer-Paid (Basic) Term Life Insurance Policy # FLX 967822		
Applicant	The coverage below is provided by your employer at no cost to you.	
Employee	\$100,000	Guaranteed Coverage*: \$100,000

Employee-Paid (Voluntary) Term Life Insurance Policy # FLX 967822		
Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Units of \$5,000 up to the lesser of 5 times your salary, or \$300,000. Guaranteed Coverage: \$200,000	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$200,000* <input type="checkbox"/> \$300,000** <input type="checkbox"/> Other _____ <i>Amount must be a multiple of \$5,000.</i> <input type="checkbox"/> Decline Coverage
Spouse	<input type="checkbox"/> \$10,000 Guaranteed Coverage*: \$10,000	<input type="checkbox"/> Decline Coverage
Child	<input type="checkbox"/> \$5,000	<input type="checkbox"/> Decline Coverage

Employer-Paid (Basic) Accidental Death & Dismemberment Insurance Policy # OK 969324		
Applicant	The coverage below is provided by your employer at no cost to you.	
Employee	\$100,000	<input type="checkbox"/> Accept Coverage <input type="checkbox"/> Decline Coverage

Employer-Paid (Basic) Short-term Disability Insurance Policy # LK 752174		
Applicant	The coverage below is provided by your employer at no cost to you.	
Employee	66.67% of your weekly covered earnings, to a maximum of \$1,154 per week.	

Employer-Paid (Basic) Long-term Disability Insurance Policy # LK 965343		
Applicant	The coverage below is provided by your employer at no cost to you.	
Employee	66.7% of your monthly covered earnings, to a maximum of \$5,000 per month.	

**\*\*This is the maximum amount that you can choose under this plan.**  
 All coverage elected during this enrollment period will take effect on the latest of 03/01/2017, the date your election form is received by your employer, or if applicable the day your Evidence of Insurability Form is approved by the Insurance Company.

**SIGN HERE TO ACCEPT YOUR DEDUCTION FROM YOUR PAYCHECK**

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to New York Life Group Benefit Solutions' approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by CA: Life Insurance Company of North America.

**Pre-Existing Condition Limitation (applies to long-term disability insurance only):** "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance.

I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability coverage.

**Please Sign Here**  Signature \_\_\_\_\_ Date \_\_\_\_\_

**BENEFICIARY SECTION**

To specify a beneficiary, complete the section below. You will be the beneficiary for your spouse and child(ren). If you need additional space to indicate your beneficiary designations, attach a separate piece of paper using the below format including the appropriate policy number, the date, and your signature.

Basic Life Insurance			Policy No. FLX 967822	
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)

Voluntary Life Insurance			Policy No. FLX 967822	
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)

Basic Accidental Death & Dismemberment Insurance			Policy No. OK 969324	
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)

**Community Property Laws**—If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary payment of benefits may be delayed or disputed unless your spouse provides their signature in the space provided below.

Spouse Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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