



TRANSIT EMPLOYEES' HEALTH AND WELFARE PLAN
 2701 WHITNEY PLACE • SUITE 100 • FORESTVILLE, MARYLAND 20747
 PHONE: (301) 568-2294 • FAX: (240) 745-3956
 WEBSITE: WWW.TEHW.ORG • EMAIL: INFO@TEHW.ORG



LONG-TERM DISABILITY (LTD)

Long-Term Disability Claim Process

Dear Valued Member,

Before submitting an LTD claim, please ensure that you have a detailed timeline of being out of work. Having additional documentation will help with understanding your claim better.

How do I qualify for Long-term disability?



1. You **MUST** be out of work for 6 consecutive months, (either on Short-Term Disability or on Workers Compensation).
2. You **MUST** be out of work because you are not able to meet the on-duty obligations with WMATA, because of an Injury or workplace injury or Illness.

How can you determine if you need a Hartford application or a MetLife application?

3. You qualify for a **Hartford** application if you were out of work **before** January 1, 2024.
4. You qualify for a **MetLife** application if you were out of work **after** January 1, 2024.

How much money will I get?



1. The maximum Monthly amount is \$5,000. (Page 9 in Hartford Booklet)
2. The minimum Monthly amount is \$100 or 10% of the gross monthly benefit. (Gross monthly benefit is calculated by MetLife or Hartford)

How Long will it take before I receive Long-Term Disability benefits?

1. Long-Term Disability can take between 6 to 20 weeks before you receive an approval.

What can delay my Long-Term Disability application process?

Long-Term Disability decisions may take longer based on 3 factors:

1. Members did not send sufficient information for their claim.
2. MetLife Claim Specialist has not conducted an interview with members yet.
3. MetLife Claim Specialist is still waiting for the Physician or Nurse to respond.

Once approved what is next?

1. Once a member is approved, the member will receive all documentation and payments from MetLife directly.
2. MetLife will periodically contact the member and the member's Physicians to get a status update on your treatment plan and functional abilities.

Friendly Reminder: All decisions are determined by The Hartford ONLY!





YOUR LONG TERM DISABILITY BENEFIT PLAN

TRANSIT EMPLOYEES' HEALTH AND WELFARE PLAN



The benefits and provisions described in this booklet apply to the Transit Employees' Health and Welfare Plan Long Term Disability coverage adopted on July 1, 2011 and provided by Hartford Life and Accident Insurance Company.

Questions or Complaints about Your Coverage

In the event You have questions or complaints regarding any aspect of Your coverage, You should contact The Policyholder or You may write to us at:

The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999

Or call Us at: 1-800-523-2233

When calling, please give Us the following information:

- 1) the policy number; and
- 2) the name of the policyholder (employer or organization), as shown in Your Certificate of Insurance.

Or You may contact Our Sales Office:

Hartford Life and Accident Insurance Company
Group Sales Department
4480 Cox Road
Suite 200
Glen Allen, VA 23060-3325
TOLL FREE: 800-552-3429

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

For residents of:	Write	Telephone
Arkansas	Arkansas Insurance Department Consumer Services Division 1200 West Third Street Little Rock, AR 72201-1904	1(800) 852-5494 1(501) 371-2640 (in the Little Rock area)
California	State of California Insurance Department Consumer Communications Bureau 300 South Spring Street, South Tower Los Angeles, CA 90013	1(800) 927-HELP
Idaho	Idaho Department of Insurance Consumer Affairs 700 W State Street, 3rd Floor PO Box 83720 Boise, ID 83720-0043	1-800-721-3272 or www.DOI.Idaho.gov
Illinois	Illinois Department of Insurance Consumer Services Station Springfield, Illinois 62767	Consumer Assistance: 1(866) 445-5364 Officer of Consumer Health Insurance: 1(877) 527-9431
Indiana	Public Information/Market Conduct Indiana Department of Insurance 311 W. Washington St. Suite 300 Indianapolis, IN 46204-2787	Consumer Hotline: 1(800) 622-4461 1(317) 232-2395 (in the Indianapolis Area)
Virginia	Life and Health Division Bureau of Insurance P.O. Box 1157 Richmond, VA 23209	1(804) 371-9741 (inside Virginia) 1(800) 552-7945 (outside Virginia)
Wisconsin	Office of the Commissioner of Insurance Complaints Department P.O. Box 7873	1(800) 236-8517 (outside of Madison) 1(608) 266-0103 (in Madison) to request a complaint form.

Madison, WI 53707-7873

The following states require that We provide these notices to You about Your coverage:

For residents of:

Arizona

This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read This certificate carefully.

Florida

The benefits of the policy providing you coverage are governed primarily by the law of a state other than Florida.

STATE OF DELAWARE
The Civil Union and Equality Act of 2011
Effective January 1, 2012

In accordance with Delaware law, insurers are required to provide the following notice to applicants of insurance policies issued in Delaware.

The Civil Union and Equality Act of 2011 ("the Act") creates a legal relationship between two persons of the same sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Delaware to spouses in a legal marriage. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Delaware law. This includes the terms "marriage" or "married," or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of same sex civil unions or marriages legally entered into in other jurisdictions.

For more information regarding the Act, refer to Chapter 2 of Title 13 of the Delaware Code or the State of Delaware website at www.delaware.gov/CivilUnions.

Georgia

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family abuse.

STATE OF ILLINOIS
The Religious Freedom Protection and Civil Union Act
Effective June 1, 2011

In accordance with Illinois law, insurers are required to provide the following notice to applicants of insurance policies issued in Illinois.

The Religious Freedom Protection and Civil Union Act ("the Act") creates a legal relationship between two persons of the same or opposite sex who form a civil union. The Act provides that the parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married," or variations thereon. Insurance policies are required to provide identical benefits and protections to both civil unions and marriages. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions.

**IMPORTANT TERMINATION
INFORMATION**

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

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

**PRE-EXISTING LIMITATION
READ CAREFULLY**

NO BENEFITS WILL BE PAYABLE UNDER THIS PLAN FOR PRE-EXISTING CONDITIONS WHICH ARE NOT COVERED UNDER THE PRIOR PLAN. PLEASE READ THE LIMITATIONS IN THIS CERTIFICATE.

READ YOUR CERTIFICATE CAREFULLY.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call The Hartford's toll-free telephone number for information or to make a complaint at:

1-800-523-2233

You may also write to The Hartford at:
P.O. Box 2999
Hartford, CT 06104-2999

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:
P.O. Box 149104
Austin, TX 78714-9410
Fax # (512) 475-1771

Web: <http://www.tdi.state.tx.us>

E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact the agent or The Hartford first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

Texas

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de The Hartford para informacion o para someter una queja al:

1-800-523-2233

Usted tambien puede escribir a The Hartford:
P.O. Box 2999
Hartford, CT 06104-2999

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:
P.O. Box 149104
Austin, TX 78714-9410
Fax # (512) 475-1771

Web: <http://www.tdi.state.tx.us>

E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o The Hartford primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

For more information regarding the Act, refer to 750 ILCS 75/1 *et seq.* Examples of the interaction between the Act and existing law can be found in the Illinois Insurance Facts, Civil Unions and Insurance Benefits document available on the Illinois Department of Insurance's website at www.insurance.illinois.gov.

Maine

1. The benefits under this policy are subject to reduction due to other sources of income.

This means that your benefits will be reduced by the amount of any other benefits for loss of time provided to you or for which you are eligible as a result of the same period of disability for which you claim benefits under this policy.

Other sources of income are plans or arrangements of coverage that provide disability-related benefits such as Worker's Compensation or other similar governmental programs or laws, or disability-related benefits received from your employer or as the result of your employment, membership or association with any group, union, association or other organization. Other sources of income include disability-related benefits under the United States Social Security Act or an alternate governmental plan, the Railroad Retirement Act, and other similar plans or acts. Other sources of income may also include certain disability-related or retirement benefits that you receive because of your retirement unless you were receiving them prior to becoming disabled.

What comprises other sources of income under this policy is determined by the nature of the policyholder. Therefore, we strongly urge you to **Read Your Certificate Carefully**. A full description of the plans and types of plans considered to be other sources of income under this policy will be found in the definition of "Other Income Benefits" located in the Definitions section of your certificate.

2. The laws of the State of Maine require notification of the right to designate a third party to receive notice of cancellation, to change the designation and, policy reinstatement if the insured suffers from organic brain disease and the ground for cancellation was the insured's nonpayment of premium or other lapse or default on the part of the insured.

Within 10 days after a request by an insured, a Third Party Notice Request Form shall be mailed or personally delivered to the insured.

Maryland

The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

Montana

Conformity with Montana statutes: The provisions of this certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this certificate.

North Carolina

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

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



CERTIFICATE OF INSURANCE

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Simsbury, Connecticut
(A stock insurance company)

Policyholder: TRANSIT EMPLOYEES' HEALTH AND WELFARE PLAN
Policy Number: GLT-402264
Policy Effective Date: July 1, 2011
Policy Anniversary Date: July 1, 2014

We have issued The Policy to the Policyholder. Our name, the Policyholder's name and The Policy Number are shown above. The provisions of The Policy, which are important to You, are summarized in this certificate consisting of this form and any additional forms which have been made a part of this certificate. This certificate replaces any other certificate We may have given to You earlier under The Policy. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with Us at Our home office. The Policy may be inspected at the office of the Policyholder.

Signed for the Company

Terence Shields, Secretary

Ronald R. Gendreau, President

A note on capitalization in this certificate:

Capitalization of a term, not normally capitalized according to the rules of standard punctuation, indicates a word or phrase that is a defined term in The Policy or refers to a specific provision contained herein.

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SCHEDULE OF INSURANCE

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

The benefits described herein are those in effect as of June 12, 2014

Cost of Coverage:

You do not contribute toward the cost of coverage.

Eligible Class(es) for Coverage: All Active Full-time Employees and Active Part-time Employees who are participating members of the Transit Employees' Health and Welfare Plan and who are represented by the Amalgamated Transit Union Local 689, including employees on leave of absence while holding office in, or performing duties for the Union or its International Office, the Transit Employees' Federal Credit Union or a State or Local AFL-CIO Central Body, or as a staff member of the Transit Employees Health and Welfare Plan. This Eligible Class excludes Re-Hired Retired Employees.

Eligibility Waiting Period for Coverage:

First day of the month in which you complete your 90 day probationary period.

The time period(s) referenced above are continuous. The Eligibility Waiting Period for Coverage will be reduced by the period of time You were a Full-time or Part-time Active Employee with the Employer under the Prior Policy.

Elimination Period: 180 day(s)

Maximum Monthly Benefit: \$5,000

Minimum Monthly Benefit: the greater of:

- 1) \$100; or
- 2) 10% of the gross monthly benefit.

If you return to work at your employer and are earning 100% of pre-disability earnings while meeting the definition of disability, no minimum benefit will be paid.

Benefit Percentage: 60%

Maximum Duration of Benefits

Maximum Duration of Benefits Table

Age When Disabled	Benefits Payable
Prior to Age 63	To Normal Retirement Age or 42 months, if greater
Age 63	To Normal Retirement Age or 36 months, if greater
Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

Normal Retirement Age means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act. It is determined by Your date of birth as follows:

Year of Birth	Normal Retirement Age
1937 or before	65

1938	65 + 2 months
1939	65 + 4 months
1940	65 + 6 months
1941	65 + 8 months
1942	65 + 10 months
1943 thru 1954	66
1955	66 + 2 months
1956	66 + 4 months
1957	66 + 6 months
1958	66 + 8 months
1959	66 + 10 months
1960 or after	67

Additional Benefit

Family Care Credit Benefit

see Benefit

Survivor Income Benefit

The Survivor Income Benefit is calculated as 6 times the gross monthly benefit, and is payable as a lump sum.
see Benefit

Workplace Modification Benefit

see Benefit

ELIGIBILITY AND ENROLLMENT

Eligible Persons: *Who is eligible for coverage?*

All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.
GBD-1200 D01

Eligibility for Coverage: *When will I become eligible?*

You will become eligible for coverage on the later of:

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

GBD-1200 D02

Enrollment: *How do I enroll for coverage?*

All eligible Active Employees will be enrolled automatically by the Policyholder.
GBD-1200 D03

PERIOD OF COVERAGE

Effective Date: *When does my coverage start?*

Your coverage will start on the date You become eligible.
GBD-1200 E01

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*

If You are absent from work due to:

- 1) accidental bodily injury;
- 2) sickness;
- 3) Mental Illness;
- 4) Substance Abuse; or

5) pregnancy;

on the date Your insurance, or increase in coverage, would otherwise have become effective, Your insurance, or increase in coverage will not become effective until You are Actively at Work one full day. Other Policyholder approved absences will not cause your effective date to be deferred if you were Actively at Work on the preceding scheduled workday.
GBD-1200 E05 (MD)

Continuity From A Prior Policy: *Is there continuity of coverage from a Prior Policy?*

If You were:

- 1) insured under the Prior Policy; and
- 2) not eligible to receive benefits under the Prior Policy;

on the day before the Policy Effective Date, the Deferred Effective Date provision will not apply.

Is my coverage under The Policy subject to the Pre-existing Condition Limitation?

If You become insured under The Policy on the Policy Effective Date and were covered under the Prior Policy on the day before the Policy Effective Date, the Pre-existing Conditions Limitation will end on the earliest of:

- 1) the Policy Effective Date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
- 2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.

The Pre-existing Conditions Limitation will apply after the Policy Effective Date to the amount of a benefit increase which results from a change from the Prior Policy to The Policy, a change in benefit options, a change of class or a change in The Policy.

Do I have to satisfy an Elimination Period under The Policy if I was Disabled under the Prior Policy?

If You received Monthly benefits for disability under the Prior Policy, and You returned to work as a Active Employee before The Policy Effective Date, then, if within 6 months of Your return to work:

- 1) You have a recurrence of the same disability while covered under The Policy; and
- 2) there are no benefits available for the recurrence under the Prior Policy;

the Elimination Period, which would otherwise apply, will be waived if the recurrence would have been covered without any further elimination period under the Prior Policy.

GBD-1200 E08

Termination: *When will my coverage end?*

Your coverage will end on the earliest of the following:

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

unless continued in accordance with any of the Continuation Provisions. However, if Your coverage terminates, benefits will be payable for any Disability that begins while coverage is still in force.

GBD-1200 E10 (MD)

Continuation Provisions: *Can my coverage be continued beyond the date it would otherwise terminate?*

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

- 1) is subject to any reductions in The Policy;
- 2) is subject to payment of premium by the Policyholder; and
- 3) terminates if:
 - a) The Policy terminates; or
 - b) coverage for Your class terminates.

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

Family Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to 12 weeks, or 26 weeks if You

qualify for Family Military Leave, or longer if required by other applicable law, following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.
GBD-1200 E13

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

If You are Disabled and You cease to be an Active Employee, Your insurance will be continued:

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

GBD-1200 E14

Waiver of Premium: *Am I required to pay Premiums while I am Disabled?*

No premium will be due for You:

- 1) during the Elimination Period; and
- 2) for as long as benefits are payable.

GBD-1200 E19

Extension of Benefits for Total Disability: *Do my benefits continue if The Policy terminates?*

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

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

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

GBD-1200 E21

BENEFITS

Disability Benefit: *What are my Disability Benefits under The Policy?*

We will pay You a Monthly Benefit if You:

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

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

GBD-1200 F01

Mental Illness And Substance Abuse Benefits: *Are benefits limited for Mental Illness or Substance Abuse?*

If You are Disabled because of:

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

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

Benefits will be payable:

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

GBD-1200 F05

Recurrent Disability: *What happens if I recover but become Disabled again?*

Any day within such period of Recovery, will count toward the Elimination Period. After the Elimination Period, if You return to work as an Active Employee and then become Disabled and such Disability is:

- 1) due to the same cause; or
- 2) due to a related cause; and
- 3) within 6 month(s) of the return to work; the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability.

If You return to work as an Active Employee for 6 months or more, any recurrence of a Disability due to the same or

related cause to the prior Disability will be treated as a new Disability. The new Disability is subject to a new Elimination Period and a new Maximum Duration of Benefits.

Period of Disability means a continuous length of time during which You are Disabled under The Policy.

Recover or Recovery means that You are no longer Disabled and have returned to work with the Employer and premiums are being paid for You.
GBD-1200 F07 (MD)

Calculation of Monthly Benefit: Return to Work Incentive: *How are my Disability benefits calculated?*

If You remain Disabled after the Elimination Period, but work while You are Disabled, We will determine Your Monthly Benefit for a period of up to 36 consecutive months as follows:

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

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

After the 36 consecutive month period, We will determine Your Monthly Benefit as follows:

- 1) from Your gross monthly long term disability benefit, we will deduct Other Income Benefits;
- 2) then, deduct 50% of Your Current Monthly Earnings. The result is Your Monthly Benefit.

The 36 consecutive month period will start on the last to occur of:

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

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

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

GBD-1200 F12

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

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

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

GBD-1200 F14

Rehabilitative Employment Benefit: *What happens to my benefits if I participate in a Rehabilitation Program?*

If you participate in a Rehabilitation Program, We will increase Your Monthly Benefit by an amount equal to 10% of the Monthly Benefit. We will do so before We reduce Your Monthly Benefit by any other income.

Minimum Monthly Benefit: *Is there a Minimum Monthly Benefit?*

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

GBD-1200 F15

Partial Month Payment: *How is the benefit calculated for a period of less than a month?*

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

GBD-1200 F16

Termination of Payment: *When will my benefit payments end?*

Benefit payments will stop on the earliest of:

- 1) the date You are no longer Disabled;
- 2) the date You fail to furnish Proof of Loss;
- 3) the date You are no longer under the Regular Care of a Physician;
- 4) the date You refuse Our request that You submit to an examination by a Physician or other qualified medical professional;
- 5) the date of Your death;
- 6) the last day benefits are payable according to the Maximum Duration of Benefits Table;
- 7) the date Your Current Monthly Earnings exceed:
 - a) 80% of Your Indexed Pre-disability Earnings if You are receiving benefits for being Disabled from Your Job; or
 - b) 80% of Your Indexed Pre-disability Earnings if You are receiving benefits for being Disabled from Any Occupation;
- 8) the date no further benefits are payable under any provision in The Policy that limits benefit duration.

GBD-1200 F18 (MD)

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

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

- 1) Family Care means the care or supervision of:
 - a) Your children under age 13; or
 - b) a member of Your household who is mentally or physically handicapped and dependent upon You for support and maintenance;
- 2) the maximum monthly deduction allowed for each qualifying child or family member is \$350 but in no event may the deduction exceed the amount of Your monthly earnings;
- 3) Family Care Credits may not exceed a total of \$2,500 during a calendar year;
- 4) the deduction will be reduced proportionally for periods of less than a month;
- 5) the charges for Family Care must be documented by a receipt from the caregiver;
- 6) the credit will cease when You are no longer in a Rehabilitation program; and
- 7) no Family Care provided by someone Related to the family member receiving the care will be eligible as a deduction under this provision.

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

GBD-1200 F25

Survivor Income Benefit: *Will my survivors receive a benefit if I die while receiving Disability Benefits?*

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

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

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

We will pay the Survivor Income Benefit:

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

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

The Survivor Income Benefit is shown in the Schedule of Insurance.

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

Surviving Children means Your unmarried children, step children, legally adopted children who, on the date You die, are primarily dependent on You for support and maintenance and who are under age 25.

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

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

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

GBD-1200 F27

Workplace Modification Benefit: *Will the Rehabilitation program provide for modifications to my workplace to accommodate my return to work?*

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

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

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

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

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

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

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

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

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

GBD-1200 F29

EXCLUSIONS AND LIMITATIONS

Exclusions: *What Disabilities are not covered?*

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

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

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

- 1) was sponsored by Your Employer; the Policyholder or the Transit Employees' Retirement Plan; and
- 2) was terminated before the Effective Date of The Policy;

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

GBD-1200 G01 (MD)

Pre-Existing Conditions Limitation: *Are benefits limited for Pre-existing Conditions?*

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

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

Pre-existing Condition means:

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

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

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

Medical Care is received when a physician or other health care provider:

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

Treatment includes, but is not limited to:

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

GBD-1200 G04 (MD)

GENERAL PROVISIONS

Notice of Claim: *When should I notify the Company of a claim?*

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

GBD-1200 H01 (MD)

Claim Forms: *Are special forms required to file a claim?*

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

GBD-1200 H02

Proof of Loss: *What is Proof of Loss?*

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

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

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

GBD-1200 H03

Additional Proof of Loss: *What additional proof of loss is the Company entitled to?*

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

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

Any such interview, meeting or examination will be:

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

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

GBD-1200 H04

Sending Proof of Loss: *When must proof of Loss be given?*

Written Proof of Loss must be sent to Us within 90 days after the start of the period for which We are liable for payment. If proof is not given by the time it is due, it will not affect the claim if:

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

We may request Proof of Loss throughout Your Disability at reasonable intervals.

GBD-1200 H05 (MD)

Claim Payment: *When are benefit payments issued?*

When We determine that You;

- 1) are Disabled; and
- 2) eligible to receive benefits;

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

GBD-1200 H06

Claims to be Paid: *To whom will benefits for my claim be paid?*

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

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

then We may pay up to \$5,000 to a person who is Related to You and who, at Our sole discretion, is entitled to it. Any such payment shall fulfill Our responsibility for the amount paid.

GBD-1200 H08 (MD)

Claim Denial: *What notification will I receive if my claim is denied?*

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

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

GBD-1200 H09

Claim Appeal: *What recourse do I have if my claim is denied?*

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

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

We will respond to You in writing with Our final decision on the claim.
GBD-1200 H10

Social Security: *When must I apply for Social Security Benefits?*

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

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

GBD-1200 H11

Benefit Estimates: *How does the Company estimate Disability benefits under the United States Social Security Act?*

We reserve the right to reduce Your Monthly Benefit by estimating the Social Security disability benefits You may be eligible to receive.

When We determine that You may be eligible for benefits, We may estimate the amount of these benefits. We may reduce Your Monthly Benefit by the estimated amount.

Your Monthly Benefit will not be reduced by estimated Social Security disability benefits if:

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

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

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

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

GBD-1200 H12

Overpayment: *When does an overpayment occur?*

An overpayment occurs:

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

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

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

GBD-1200 H13

Overpayment Recovery: *How does the Company exercise the right to recover overpayments?*

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

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

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

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

GBD-1200 H14

Subrogation: *What are the Company's subrogation rights?*

If You:

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

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

GBD-1200 H15

Reimbursement: *What are the Company's Reimbursement Rights?*

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

If You recover payment from a Third Party as:

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

You must reimburse Us for the lesser of:

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

GBD-1200 H16 (MD)

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

Legal Actions: *When can legal action be taken against Us?*

Legal action cannot be taken against Us:

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

GBD-1200 H17 (MD)

Insurance Fraud: *How does the Company deal with fraud?*

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

GBD-1200 H18

GBD-1200 H19 (MD)

Final Dispute Resolution Procedure: If there is a dispute as to whether you are Disabled and it is not resolved under the Claims Appeal process, We agree, to participate in the resolution procedure described below.

A doctor, who has been mutually agreed upon, will review your case. The determination by the doctor will be final and binding on the insurance company. We will pay the full cost of the review. A determination in your favor will not:

- 1) Limit Our right to make future determinations as to whether You continue to be Disabled; or
- 2) Subject Us to any claims for damages arising from benefits not being paid during the period of dispute.

DEFINITIONS

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

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

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

GBD-1200 C01 (MD)
GBD-1200 C01

Active Employee means an Employee who works for the Employer on a regular basis in the usual course of the Employer's business.

GBD-1200 C03

Any Occupation means any occupation for which You are qualified by education, training or experience.

GBD-1200 C05

Current Monthly Earnings means monthly earnings You receive from:

- 1) Your Employer; and
- 2) other employment;

while You are Disabled, not counting bonuses, commissions, tips and tokens, overtime pay or any other fringe benefits or extra compensation.

GBD-1200 C09

Disability or Disabled means You are unable to earn:

- 1) during the Elimination Period and the 36 month(s) following the Elimination Period, more than 80% of Your Indexed Pre-disability Earnings at Your Own Job; and
- 2) after that, more than 80% of Your Indexed Pre-disability Earnings from any employer in Your Local Economy at Any Occupation.

If You have been assigned to and are performing a Light Duty Assignment during the Elimination Period, such assignment will count towards the satisfaction of the Elimination Period, whether or not You have satisfied the 80% of Your Pre-disability Earnings test set forth above.

Your Disability must result from:

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

For an employee whose occupation requires a license, "loss of license" for any reason does not, in itself, constitute Disability, except for the suspension of an employee's CDL as following: When an employee's CDL (License) is suspended, in accordance with Department of Transportation Guidelines, and the suspension is the result of a disabling condition resulting in a Disability approved by Us, We may extend Disability benefits beyond an employee's return to work date. The extension cannot exceed one year from the license suspension date, unless the employee is deemed Disabled under the definition of Disability.

Light Duty Assignment means any work or assignment approved by Your Employer, which occurs during a period of Disability with a goal of returning You to your own job. A Light Duty Assignment may include:

- 1) a reduction in the number of hours or work days;
- 2) restriction to performing some, but not all, of Your Essential Duties; and/or
- 3) placement by the Employer to another job.

Local Economy means the geographic area:

GBD-1200 C15 (MD) (402264)

- 1) within which You reside; and
- 2) which offers suitable employment opportunities within a reasonable travel distance

If you move on or after the date you become Disabled, We may consider both Your former and current residence to be your Local Economy.

Own Job means the specific job You are performing for the Employer at a specific location.
GBD-1200 C14 (MD)

Elimination Period means the number of consecutive days at the beginning of any one period of Disability which must elapse before benefits are payable.
GBD-1200 C16

Employer means Washington Metropolitan Area Transit Authority.
GBD-1200 C17

Essential Duty means a duty that:

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

GBD-1200 C18

Indexed Pre-disability Earnings means Your Pre-disability Earnings adjusted annually by 7%.

This adjustment is made January 1st each year after You have been Disabled for 12 consecutive month(s), provided You are receiving benefits at the time the adjustment is made.
GBD-1200 C19 (MD)

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

For the purpose of The Policy, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

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

GBD-1200 C21

Monthly Benefit means a monthly sum payable to You while You are Disabled, subject to the terms of The Policy.
GBD-1200 C22

Monthly Income Loss means Your Pre-disability Earnings minus Your Current Monthly Earnings.
GBD-1200 C23

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

- 1) temporary disability, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
- 2) governmental law or program that provides disability or unemployment benefits as a result of Your Own Job with Your Employer;
- 3) plan or arrangement of coverage, whether insured or not, which is received from Your Employer as a result of employment by or association with Your Employer;

However, for the first 12 months from the date Long Term Disability benefits become payable, We will not offset any fractional sick pay you receive from the Employer to the extent that fractional sick pay plus Disability benefits do not exceed 100% of Pre-disability Earnings. After this period, you may elect to reserve the remaining sick pay, meaning, you are not required to exhaust any remaining accumulated days.

- 4) disability benefits under the United States Social Security Act that You are eligible to receive because of Your Disability.

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

- 1) disability benefit under Your Employer's Retirement plan;
- 2) portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings;
- 3) retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
 - a) You were receiving it prior to becoming Disabled; or
 - b) You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement;
(Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by Your after-tax contributions.); or
- 4) retirement benefits under the United States Social Security Act that You receive because of Your retirement, unless You were receiving them prior to becoming Disabled.

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

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

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

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

- 1) takes effect after the date benefits become payable under The Policy;
- 2) is a general increase which applies to all persons who are entitled to such benefits; and
- 3) benefits will not be reduced due to any increase in Social Security benefits.

GBD-1200 C24 (MD)

Physician means a person who is:

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

GBD-1200 C27

Pre-disability Earnings means Your regular monthly pay, including overtime, spread premium and shift differential averaged over the 12 month period immediately prior to the date You became Disabled.

If you have been employed for less than 12 months: Pre-disability Earnings means Your regular monthly pay, including overtime, spread premium and shift differential averaged over the number of calendar months you worked for the Employer prior to becoming Disabled.

Pre-disability Earnings may include contributions You make through a salary reduction agreement with your Employer to any of the following:

- 1) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 eligible deferred compensation arrangement;
- 2) an executive nonqualified deferred compensation arrangement; and
- 3) amounts contributed to your fringe benefits according to a salary reduction agreement under an IRC Section 125 plan.

GBD-1200 C33

Prior Policy means the long term disability insurance carried by the Transit Employees' Retirement Plan on the day before the Policy Effective Date.

GBD-1200 C34

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

- 1) whose medical training and clinical experience are suitable to treat Your disabling condition; and
- 2) whose treatment is:
 - a) consistent with the diagnosis of the disabling condition;
 - b) according to guidelines established by medical, research, and rehabilitative organizations; and
 - c) administered as often as needed;to achieve the maximum medical improvement.

GBD-1200 C35

Rehabilitation means a process of Our working together with You in order for Us to plan, adapt, and put into use options and services to meet Your return to work needs. A Rehabilitation program, for which there is no charge to You, may include, when We consider it to be appropriate, any necessary and feasible:

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

GBD-1200 C36 (MD)

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

GBD-1200 C38

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

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

GBD-1200 C39

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

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

Substance includes alcohol and drugs but excludes tobacco and caffeine.

GBD-1200 C42

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

GBD-1200 C43

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

GBD-1200 C48

Your Occupation means Your Own Job.

GBD-1200 C49

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

GBD-1200 C50



AMENDATORY RIDER

This rider is attached to all certificates given in connection with The Policy and is effective on The Policy Effective Date.

This rider is intended to amend Your certificate, as indicated below, to comply with the laws of Your state of residence. Only those references to benefits, provisions or terms actually included in Your certificate will affect Your coverage.

For Arkansas residents:

The provision titled **Policy Interpretation** is deleted in its entirety.

For Colorado residents:

The **Complications of Pregnancy** definition is replaced by the following:

Complications of Pregnancy means a condition whose diagnosis is distinct from pregnancy but adversely affected or caused by pregnancy, such as:

- 1) acute nephritis or nephrosis;
- 2) cardiac decompensation;
- 3) missed abortion; and
- 4) similar medical and surgical conditions of comparable severity.

Complications of Pregnancy will also include:

- 1) pre-eclampsia;
- 2) placenta previa;
- 3) physician prescribed bed rest for intra-uterine growth retardation, funneling, incompetent cervix;
- 4) termination of ectopic pregnancy;
- 5) spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible;
- 6) non-elective cesarean section; and
- 7) similar medical and surgical conditions of comparable severity.

However, the term Complications of Pregnancy will not include:

- 1) elective cesarean section;
- 2) false labor, occasional spotting, or morning sickness;
- 3) hyperemesis gravidarum; or
- 4) similar conditions associated with the management of a difficult pregnancy not consisting of a nosologically distinct Complications of Pregnancy.

For Delaware residents:

- 1) The definition of **Spouse** is amended to include the following:

Spouse will include Your party to a civil union, provided You:

- 1) have established that You and Your partner are parties to a civil union for purposes of The Policy; or
- 2) have registered as parties to a civil union with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.

You will continue to be considered parties to a civil union provided You continue to meet the requirements required by law.

- 2) The definition of **Surviving Spouse** in the **Survivor Income Benefit** is amended to read as follows:
Surviving Spouse means Your spouse who was not legally separated or divorced from You when You died. "Spouse" will include Your domestic partner, provided You have executed a Domestic Partner Affidavit acceptable to us, establishing that You and Your partner are domestic partners for purposes of this Policy. You will continue to be considered domestic partners provided You continue to meet the requirements described in the Domestic Partner Affidavit.
- 3) The **Change in Family Status** provision is replaced with the following:
Change in Family Status: What constitutes a Change in Family Status?
A Change in Family Status means:

- 1) You get married or enter into a civil union;
- 2) You and Your spouse divorce or You terminate a civil union;
- 3) Your child is born or You adopt or become the legal guardian of a child;
- 4) Your spouse or civil union partner dies;
- 5) Your child is emancipated or dies;
- 6) Your spouse or civil union partner is no longer employed, which results in a loss of group insurance; or
- 7) You have a change in classification from part-time to full-time or from full-time to part-time.

For Hawaii residents:

- 1) The definition of **Spouse** is amended to include the following:
Spouse will include Your party to a civil union, provided You:
 - 1) have established that You and Your partner are parties to a civil union for purposes of The Policy; or
 - 2) have registered as parties to a civil union with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.
 You will continue to be considered parties to a civil union provided You continue to meet the requirements required by law.

- 2) The definition of **Surviving Spouse** in the **Survivor Income Benefit** provision is replaced with the following:
Surviving Spouse means Your wife or husband who was not legally separated or divorced from You when You died. Spouse will include Your party to a civil union, provided You:
 - 1) have established that You and Your partner are parties to a civil union for purposes of The Policy; or
 - 2) have registered as parties to a civil union with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.
 You will continue to be considered parties to a civil union provided You continue to meet the requirements required by law.

- 3) The **Change in Family Status** provision is replaced with the following:
Change in Family Status: *What constitutes a Change in Family Status?*
A Change in Family Status means:
 - 1) You get married or enter into a civil union;
 - 2) You and Your spouse divorce or You terminate a civil union;
 - 3) Your child is born or You adopt or become the legal guardian of a child;
 - 4) Your spouse or civil union partner dies;
 - 5) Your child is emancipated or dies;
 - 6) Your spouse or civil union partner is no longer employed, which results in a loss of group insurance; or
 - 7) You have a change in classification from part-time to full-time or from full-time to part-time.

For Illinois residents:

- 1) The definition of **Spouse** is amended to include the following:
Spouse will include Your party to a civil union, provided You:
 - 1) have established that You and Your partner are parties to a civil union for purposes of The Policy; or
 - 2) have registered as parties to a civil union with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.
 You will continue to be considered parties to a civil union provided You continue to meet the requirements required by law.

- 2) The definition of **Surviving Spouse** in the **Survivor Income Benefit** provision is replaced with the following:
Surviving Spouse means Your wife or husband who was not legally separated or divorced from You when You died. Spouse will include Your party to a civil union, provided You:
 - 1) have established that You and Your partner are parties to a civil union for purposes of The Policy; or
 - 2) have registered as parties to a civil union with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.
 You will continue to be considered parties to a civil union provided You continue to meet the requirements required by law.

- 3) The **Change in Family Status** provision is replaced with the following:
Change in Family Status: *What constitutes a Change in Family Status?*
A Change in Family Status means:
 - 1) You get married or enter into a civil union;
 - 2) You and Your spouse divorce or You terminate a civil union;

- 3) Your child is born or You adopt or become the legal guardian of a child;
- 4) Your spouse or civil union partner dies; .
- 5) Your child is emancipated or dies;
- 6) Your spouse or civil union partner is no longer employed, which results in a loss of group insurance; or
- 7) You have a change in classification from part-time to full-time or from full-time to part-time.

For Indiana residents:

The last sentence in the **Policy Interpretation** provision is deleted and replaced by the following:

This provision applies only where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA), 29 U.S.C. 1001 et seq.

For Louisiana residents, the following provision is added:

Reinstatement after Military Service: *Can my coverage be reinstated after return from active military service?*

If:

- 1) Your coverage terminates because You enter active military service; and
- 2) You are rehired within 12 months of the date You return from active military service;

then coverage may be reinstated, provided You request such reinstatement within 31 days of the date you return to work.

The reinstated coverage will:

- 1) be the same coverage amounts in force on the date coverage terminated; and
- 2) not be subject to any Waiting Period for Coverage, Evidence of Insurability or Pre-existing Conditions Limitations; and
- 3) be subject to all the terms and provisions of The Policy.

For Maine residents, the following provision is added:

Reinstatement: *Can my coverage be reinstated after it ends?*

We will reinstate The Policy upon receipt of all current and late premiums if:

- 1) You, any person authorized to act on Your behalf, or any of Your dependents may request reinstatement of The Policy within 90 days following cancellation of The Policy for nonpayment of premium provided You suffered from cognitive impairment or functional incapacity at the time the contract cancelled; and
- 2) all current and late premium payments are received within 15 days of Our request.

We may request a medical demonstration, at Your expense, that You suffered from cognitive impairment or functional incapacity at the time of cancellation of The Policy.

For Massachusetts residents:

- 1) the following is added to the **Continuation Provisions:**

In accordance with Massachusetts state law, if Your insurance terminates because Your employment terminates or You cease to be a member of an eligible class, Your insurance will automatically be continued until the end of a 31 day period from the date Your insurance terminates or the date You become eligible for similar benefits under another group plan, whichever occurs first.

Additionally, if Your insurance terminates because Your employment is terminated as a result of a plant closing or covered partial closing, Your insurance may be continued. You must elect in writing to continue insurance and pay the required premium for continued coverage. Coverage will cease on the earliest to occur of the following dates:

- 1) 90 days from the date You were no longer eligible for coverage as a Full-time Active Employee;
- 2) the date You become eligible for similar benefits under another group plan;
- 3) the last day of the period for which required premium is made;
- 4) the date the group insurance policy terminates; or
- 5) the date Your Employer ceases to be a Participant Employer, if applicable.

Continued coverage is subject to all other applicable terms and conditions of The Policy.

- 2) The **Surviving Children** definition in the **Survivor Income Benefit** will also include a child in the process of adoption.

For Michigan residents, the **Policy Interpretation** provision is deleted in its entirety.

For Minnesota residents:

- 1) the definition of **Any Occupation** is amended by the addition of the phrase "or may reasonably become qualified" to the first line;
- 2) The first two paragraphs of the **Pre-Existing Conditions Limitation** provision are deleted and replaced by the following:

No benefit will be payable under The Policy for any Disability that is due to, contributed to by, or results from a Pre-Existing Condition, unless such Disability or loss is incurred:

- 1) After the lesser of the last day of:
 - a) the number of days stated in Your certificate; or
 - b) 730 consecutive days; while insured, during which you receive no medical care for the Pre-Existing Condition; or
- 2) After the lesser of the last day of:
 - a) the number of days stated in Your certificate; or
 - b) 730 consecutive days; during which you have been continuously insured under The Policy.

The amount of a benefit increase, which results from a change in benefit options, a change of class or a change in The Policy, will not be paid for any disability that is due to, contributed to by, or results from a Pre-Existing Condition, unless such Disability begins:

- 1) After the lesser of the last day of :
 - a) the number of days stated in Your certificate; or
 - b) 730 consecutive days; while insured for the increased benefit amount during which you receive no medical care for the Pre-Existing Condition; or
- 2) After the lesser of the last day of :
 - a) the number of days stated in Your certificate; or
 - b) 730 consecutive days; during which you have been continuously insured for the increased benefit amount.

- 3) The definition of **Pre-existing Condition** in the **Pre-Existing Conditions Limitation** provision is deleted and is replaced by the following:

Pre-existing Condition means any accidental bodily injury, sickness, Mental Illness, pregnancy, or episode of Substance Abuse for which You received Medical Care during the lesser of:

- 1) the period of time stated in Your certificate; or
- 2) the 730 day period; that ends the day before;
- 3) Your effective date of coverage; or
- 4) the effective date of a Change in Coverage.

- 4) The definition of **Surviving Spouse** in the **Survivor Income Benefit** is amended to read as follows:
Surviving Spouse means Your spouse who was not legally separated or divorced from You when You died. "Spouse" will include Your domestic partner, provided You have executed a Domestic Partner Affidavit acceptable to us, establishing that You and Your partner are domestic partners for purposes of this Policy. You will continue to be considered domestic partners provided You continue to meet the requirements described in the Domestic Partner Affidavit.

For Missouri residents intentionally self-inflicted Injury, suicide or attempted suicide, while sane.

For Montana residents, pregnancy will be covered, the same as any other Sickness, anything in the Policy to the contrary notwithstanding.

For New Hampshire residents:

- 1) The definition of **Other Income Benefits** is amended by the deletion of 'mandatory "no-fault" automobile insurance plan';
- 2) LTD The time period, stated in the **Recurrent Disability** provision, within which a Disability must recur in order to be considered the same Period of Disability is changed to 6 months, if less than 6 months.
- 3) The **Policy Interpretation** provision is deleted and replaced by the following:
 Under ERISA, the Company is hereby designated by the plan sponsor as a claim fiduciary with discretionary authority to determine eligibility for benefits and to interpret and construe the terms and provisions of the policy. As claim fiduciary, the Company has a duty to administer claims solely in the interest of the participants and beneficiaries of the employee benefit plan and in accordance with the documents and instruments governing the plan. This assignment of discretionary authority does not prohibit a participant or beneficiary from seeking judicial review of the Company's benefit eligibility determination after exhausting administrative remedies. The assignment of discretionary authority made under this provision may affect the

standard of review that a court will use in reviewing the appropriateness of the Company's determination. In order to prevail, a plan participant or beneficiary may be required to prove that the Company's determination was arbitrary and capricious or an abuse of discretion.

- 4) The time periods stated in the **Claim Appeal** provision are changed to 180 days, if less than 180 days.

For New Jersey residents:

- 1) The **Change in Family Status** provision is replaced with the following:
Change in Family Status: What constitutes a Change in Family Status?
A Change in Family Status means:
 - 1) You get married or enter into a civil union;
 - 2) You and Your spouse divorce or You terminate a civil union;
 - 3) Your child is born or You adopt or become the legal guardian of a child;
 - 4) Your spouse or civil union partner dies;
 - 5) Your child is emancipated or dies;
 - 6) Your spouse or civil union partner is no longer employed, which results in a loss of group insurance;
or
 - 7) You have a change in classification from part-time to full-time or from full-time to part-time.
- 2) The definition of **Surviving Spouse** in the **Survivor Income Benefit** provision is replaced with the following:
Surviving Spouse means Your spouse who was not legally separated or divorced from You when You died.

Spouse will include Your party to a civil union, provided You have registered as parties to a civil union with a government agency or office where such registration is available. You will continue to be considered parties to a civil union provided You continue to meet the requirements required by law.
- 3) The second paragraph of the **Surviving Children** definition in the **Survivor Income Benefit** provision is replaced with the following:
The term **Surviving Children** will also include any other children related to You by blood or marriage or civil union and who:
 - 1) lived with You in a regular parent-child relationship; and
 - 2) were eligible to be claimed as dependents on Your federal income tax return for the last tax year prior to Your death.

For North Carolina residents:

- 1) The definition of **Other Income Benefits** is amended by the deletion of 'mandatory "no-fault" automobile insurance plan';
- 2) The last sentence of the first paragraph of the **Disability Benefit** is amended by the addition of the following clause: "unless qualified medical professionals have determined that further medical care and treatment would be of no benefit to you."
- 3) The exclusion regarding Workers' Compensation benefits is replaced by the following in the **Exclusions** provision:
for which the final adjudication or a Workers' Compensation claim determines that benefits are paid, or may be paid, if duly claimed;
- 4) The **Subrogation** provision is deleted.

For Oregon residents:

- 1) The **Spouse** definition is amended to include the following:
Spouse will include Your domestic partner provided You:
 - 1) have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy; or
 - 2) have registered as domestic partners with a government agency or office where such registration is available.
You will continue to be considered domestic partners provided You continue to meet the requirements of the law or as described in the domestic partner affidavit.
- 2) The definition of **Surviving Spouse** in the **Survivor Income Benefit** section is replaced with the following:
Survivor Income Benefit: Will my survivors receive a benefit if I die while receiving Disability Benefits?
Surviving Spouse means Your wife or husband who was not legally separated or divorced from You when You died.
Spouse will include Your domestic partner provided You:

- 1) have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy; or
- 2) have registered as domestic partners with a government agency or office where such registration is available.

You will continue to be considered domestic partners provided You continue to meet the requirements of the law or as described in the domestic partner affidavit.

- 3) The **Change in Family Status** provision is replaced by the following:
Change in Family Status: *What constitutes a Change in Family Status?*

A Change in Family Status means:

- 1) You get married or register as domestic partners or You execute a domestic partner affidavit;
- 2) You and Your spouse divorce or You terminate a domestic partnership;
- 3) Your child is born or You adopt or become the legal guardian of a child;
- 4) Your spouse or domestic partner dies;
- 5) Your child is emancipated or dies;
- 6) Your spouse or domestic partner is no longer employed, which results in a loss of group insurance; or
- 7) You have a change in classification from part-time to full-time or from full-time to part-time.

- 4) The **Continuation Provisions** section is amended to include the following for Employers with 10 or more employees:

Jury Duty: If You are scheduled to serve or are required to serve as a juror, Your coverage may be continued until the last day of Your Jury Duty, provided You:

- 1) elected to have Your coverage continued; and
- 2) provided notice of the election to Your employer in accordance with Your employer's notification policy.

For Puerto Rico residents, the **Policy Interpretation** provision is deleted in its entirety.

For Rhode Island residents:

- 1) The definition of **Spouse** is amended to include the following:

Spouse will include Your party to a civil union, provided You:

- 1) have established that You and Your partner are parties to a civil union for purposes of The Policy; or
- 2) have registered as parties to a civil union with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.

You will continue to be considered parties to a civil union provided You continue to meet the requirements required by law.

- 2) The definition of **Surviving Spouse** in the **Survivor Income Benefit** is amended to read as follows:
Surviving Spouse means Your spouse who was not legally separated or divorced from You when You died. "Spouse" will include Your domestic partner, provided You have executed a Domestic Partner Affidavit acceptable to us, establishing that You and Your partner are domestic partners for purposes of this Policy. You will continue to be considered domestic partners provided You continue to meet the requirements described in the Domestic Partner Affidavit.

- 3) The **Change in Family Status** provision is replaced with the following:
Change in Family Status: *What constitutes a Change in Family Status?*

A Change in Family Status means:

- 1) You get married or enter into a civil union;
- 2) You and Your spouse divorce or You terminate a civil union;
- 3) Your child is born or You adopt or become the legal guardian of a child;
- 4) Your spouse or civil union partner dies;
- 5) Your child is emancipated or dies;
- 6) Your spouse or civil union partner is no longer employed, which results in a loss of group insurance; or
- 7) You have a change in classification from part-time to full-time or from full-time to part-time.

- 4) The provision titled **Policy Interpretation** is deleted in its entirety.

For South Carolina residents:

- 1) The first paragraph of the **Continuity from a Prior Policy** provision is replaced by the following:

If You become insured under The Policy on the Policy Effective Date and **within 30 days of being covered under the Prior Policy**, the Pre-existing Conditions Limitation will end on the earliest of:

- 1) the Policy Effective Date, if Your coverage for the Disability was not limited by a pre-existing condition restriction under the Prior Policy; or
- 2) the date the restriction would have ceased to apply had the Prior Policy remained in force, if Your coverage was limited by a pre-existing condition limitation under the Prior Policy.
- 2) The time period in the Notice of Claim provision is changed to 20 days, if not already 20 days.
- 3) The following is added to the Physical Examinations and Autopsy provision: "Such autopsy must be performed during the period of contestability and must take place in the state of South Carolina."

For South Dakota residents:

- 1) The definition of **Physician** is deleted and replaced by the following:
Physician means a legally qualified physician or surgeon other than a physician or surgeon who is related to You by blood or marriage or a physician or surgeon who is a partner of S-Corp Shareholder working with You in the same business. This does not apply in areas in which the immediate family member is the only physician in the area and acting within the scope of their normal employment.
- 2) The definition of **Other Income Benefits** is amended by the deletion of all references to **Your family, Your spouse and/or children.**
- 3) The provision titled **Policy Interpretation** is deleted in its entirety.

For Texas residents, the provision titled **Policy Interpretation** is deleted in its entirety.

For Utah residents:

- 1) The time period during which You must be continuously insured in order to exercise the **Conversion Right** is changed to 6 consecutive months, if not already 6 consecutive months.
- 2) The time period in the **Sending Proof of Loss** provision is changed to 90 days, if not already 90 days.
- 3) The **Policy Interpretation** provision is deleted and replaced by the following:
Benefits under this plan will be paid only if We, the plan administrator, decides in Our discretion that you are entitled to them. We also have discretion to determine eligibility for benefits and to interpret the terms of conditions of the benefit plan. Determinations made by Us, the plan administrator, pursuant to this reservation of discretion does not prohibit or prevent a claimant from seeking judicial review in federal court or Our determinations.

The reservation of discretion made under this provision only establishes the scope of review that a federal court will apply when you seek judicial review of our determination of eligibility for benefits, the payment of benefits, or interpretation of the terms and conditions applicable to the plan.

We are an insurance company that provides insurance of this plan and the federal court will determine the level of discretion that it will accord Our determination.

For Vermont residents:

Purpose: Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons.

Definitions, Terms, Conditions and Provisions: The definitions, terms, conditions or any other provisions of the policy, contract, certificate and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

- 1) Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage", "spouse", "husband", "wife", "dependent", "next of kin", "relative", "beneficiary", "survivor", "immediate family" and any other such terms, include the relationship created by a civil union established according to Vermont law.
- 2) Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage", "divorce decree", "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Vermont law.
- 3) Terms that mean or refer to family relationships arising from a marriage, such as "family", "immediate family", "dependent", "children", "next of kin", "relative", "beneficiary", "survivor" and any other such terms include family relationships created by a civil union established according to Vermont law.
- 4) "Dependent" means a spouse, a party to a civil union established according to Vermont law, and a child or children (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

- 5) "Child or covered child" means a child (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

CAUTION: FEDERAL LAW RIGHTS MAY OR MAY NOT BE AVAILABLE

Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law, the Employee Income Retirement Security Act of 1974 known as "ERISA", controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer health benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a civil union in an ERISA employee welfare benefit plan. However, governmental employers (not federal government) are required to provide health benefits to the dependents of a party to a civil union if the public employer provides health benefits to the dependents of married persons. Federal law also controls group health insurance continuation rights under COBRA for employers with 20 or more employees as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under this policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

For Washington residents:

- 1) The definition of **Surviving Spouse** in the **Survivor Income Benefit** is amended to read as follows:

Surviving Spouse means Your spouse who was not legally separated or divorced from You when You died.

"Spouse" will include Your domestic partner, provided You:

- 1) have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy or;
- 2) have registered as domestic partners with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.

You will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit or required by law.

- 2) The definition of **Spouse** is amended to include the following:

Spouse will include Your domestic partner provided You:

- 1) have executed a domestic partner affidavit satisfactory to Us, establishing that You and Your partner are domestic partners for purposes of The Policy or;
- 2) have registered as domestic partners with a government agency or office where such registration is available and provide proof of such registration unless requiring proof is prohibited by law.

You will continue to be considered domestic partners provided You continue to meet the requirements described in the domestic partner affidavit or required by law.

For Wisconsin residents, the time periods stated in the **Claim Appeal** provision are removed.

In all other respects, the Policy and certificates remain the same.

Signed for Hartford Life and Accident Insurance Company

**The Plan Described in this Booklet
is Insured by the**

**Hartford Life and Accident Insurance Company
Simsbury, Connecticut
Member of The Hartford Insurance Group**

Long-Term Disability

Transit Employees Health & Welfare Plan



ATU Local 689 members who are active WMATA employees are covered by a group long-term disability (LTD) plan. The LTD plan is underwritten by Hartford Life Insurance Company and provides benefits in the event you are disabled and cannot work due to an injury, illness, accident or pregnancy. Under the current collective bargaining agreement, the cost of the LTD plan is paid for by the authority.

Plan Features

Elimination Period

This is the time you must wait until benefits are payable.
Your elimination period under the plan is 180 calendar days.

Benefit Percentage

Your monthly benefit is equal to 60% of your pre-disability earnings, subject to reductions for other income such as social security benefits and workers compensation benefits.

Definition of Disability – **ENHANCED!**

Disability is defined as being unable to do your own job at WMATA during the first 36 months of your disability. Benefits are payable after this period if you remain totally disabled, as defined by the plan.

Benefit Duration – **ENHANCED!**

In the event you are totally disabled, as defined by the plan, benefits are payable until your social security normal retirement age.

Minimum Monthly Benefit – **ENHANCED!**

The LTD plan includes a minimum monthly benefit of \$100 or 10% of your gross monthly benefit, whichever is greater.

Social Security Offset – **ENHANCED!**

Your monthly LTD benefit is reduced by social security benefits you (not your spouse or dependents) are entitled to receive.

24-Hour Coverage

Both on and off the job disabilities are covered.

Survivor Benefit

The LTD plan provides your eligible survivor with a benefit equal to 6 times your gross monthly LTD benefit.

Effective July 1, 2011
Enhanced Benefits!
New Insurance Company -
Hartford Life

Long-Term Disability

Service / Claims



Hartford Life

Effective July 2011, Hartford Life is the insurance company for the Transit Employees Health & Welfare LTD program. Participants with a date of disability on or after July 1, 2011 are insured under the Hartford Life plan.

Hartford Life Insurance Company

(800) 752-9713

Fax: (877) 454-7217

Send all claims paperwork and correspondence to:

Hartford Life & Accident Company

Disability Claims Office

P.O. Box 14305

Lexington, KY 40512-4305

Transit Employees Health & Welfare Plan

After you have been out of work for 13 weeks, the Health & Welfare office will notify you of the opportunity to apply for Long-Term Disability. You will receive an application and a form for your attending physician to complete. You will need to send these forms to Hartford Life's claims office for processing. Upon receipt, a Hartford Life claims analyst will call you to discuss your claim.

Please keep a copy of your LTD claim paperwork. The claim form is designed to have a carbon copy that you can keep for your records.

Please be aware that receipt of workers' compensation benefits does not disqualify you for Long-Term Disability benefits. Contact the Health & Welfare Fund office if you have any questions.

Transit Employees Health & Welfare Plan

(301) 568-2294

Fax: (301) 568-7302

2701 Whitney Place
Forestville, MD 20747



Please fax or mail the completed application to:

The Hartford
P.O. Box 14301
Lexington, KY. 40512-4301
Fax Number: 877-454-7217
Phone Number: 800-752-9713
Employee's Statement

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS



To be completed by the Employee (BE SURE TO ANSWER ALL QUESTIONS - FAILURE TO DO SO MAY DELAY YOUR CLAIM)

A. Information about you

Last Name: _____ First Name: _____ Middle Initial: _____ Date of Birth: _____ Social Security Number: _____ ID Number: _____

Address: (Street, City, State & Zip Code) _____ Gender: Male Female

E-Mail Address: _____ E-Mail is used to provide The Hartford At Work registration instructions and important status updates.

Personal Cell Telephone Number: (_____) _____ Alternate Telephone Number: (_____) _____
May we have your authorization to leave confidential medical and benefit information on your personal cell phone? Yes No

Signature _____ Date _____

Marital Status: Married Single Divorced Widowed Occupation: _____

Policy Holder: (include division, if applicable) **Transit Employees Health & Welfare Plan** Employer: **WMATA** Policy Number: **GLT 402264**

When your disability began, did you have more than one employer (includes self-employment)? Yes No If "Yes," please provide the name, address and phone number of that employer. Indicate the dates when you worked (or were self-employed).

Please indicate the extent of your formal education: (Check one)
 HS/GED Trade School/Certification Program AA/AS BA/BS Masters Doctorate Some college
 Other List all licenses, certifications, majors _____

Have you served in the military? Yes No

Briefly describe your past work experience for the last 20 years (Begin with your most recent job.)

Dates Employed	Employer	Job Title	Duties

Now, or at some time in the future, would you be interested in seeking rehabilitation to some other kind of work? Yes No

Have you contacted your State Department of Vocational Rehabilitation? Yes No If "Yes," please include the name, address and telephone number of your counselor.

B. Information About your Family (required to determine your eligibility for Social Security Benefits)

Legal Spouse's Name: (Last, First) _____

Legal Spouse's Social Security Number: _____ Date of Birth: (Month/Day/Year) _____ Is your legal spouse employed? Yes No Retired? Yes No

Do you have any children under Age 19? Yes No If "Yes," please provide the information requested below for each child.

Name: _____ Date of Birth: _____ Social Security Number: _____

Name: _____ Date of Birth: _____ Social Security Number: _____

Name: _____ Date of Birth: _____ Social Security Number: _____

Do you have any children with disabilities (regardless of age)? Yes No If "Yes," please provide the information requested below for each child

Name: _____ Date of Birth: _____ Social Security Number: _____

Name: _____ Date of Birth: _____ Social Security Number: _____

C. Information About the Condition Causing Your Disability
1a. For illness, answer the following questions:

What were your first symptoms? _____

When did you first notice them? _____ Have you had this illness before? Yes No If so, when? _____

C. Information About the Condition Causing Your Disability (cont'd...)

1b. Next to any Activity of Daily Living (ADL), please place the number shown next to the statement that most accurately reflects your ability/inability to perform each: 1 = I can perform this activity independently; 2 = I can perform this activity with the use of equipment or adaptive devices; 3 = I cannot perform this activity.

- () Bathe (tub, shower, or sponge) () Transfer from Bed to Chair
- () Dress () Voluntary bladder and bowel control or ability to maintain a reasonable level of personal hygiene.
- () Toilet () Feed yourself with food that has been prepared and made available to you.

If you indicated (3) for any of the above activities, please describe the impairment and restrictions to your functionality that preclude you from performing this activity.

Height: _____ Weight: _____

Have you suffered a severe Cognitive Impairment that renders you unable to perform common tasks, such as using the phone, money management, or medication management? Yes No If "Yes," describe:

2. For an injury, answer the following questions:

When, where and how did the injury occur?

3. For illness, injury or pregnancy, answer the following questions:

Date you were first treated by a Healthcare Provider? (Month/Day/Year)	Name of Healthcare Provider:
	Address of Healthcare Provider:

Before you stopped working, did your condition require you to change your job, or the way you did your job? Yes No
If "Yes," explain:

What aspect of your condition made you unable to work?

Is your condition related to work activities or your workplace? Yes No If "Yes," explain:

Have you filed, or do you intend to file a Workers' Compensation claim? Yes No

D. Information About the Disability

Last day you worked before the disability: _____
(Month/Day/Year)

Did you work a full day? Yes No If "No," explain.

Since that date, have you done any work? Yes No If "Yes," please indicate dates worked, name of employer, and amount earned.

Date you were first unable to work: _____
(Month/Day/Year)

If you have not returned to work, do you expect to? Yes No Part time _____ Full time _____
(date) (date)

E. Information About Healthcare Providers and Hospitals

First medical attention for the current disability was given by (complete below)

Healthcare Provider's Name:	Telephone: () Fax: ()	Specialty:
Address: (Street, City, State & Zip)		Dates seen: _____ to _____

List all Healthcare Providers and Hospitals you have seen for this condition (attach separate sheet, if needed)

Healthcare Provider's Name:	Telephone: () Fax: ()	Specialty:
Address: (Street, City, State & Zip)		Dates seen: _____ to _____
Hospital:		
Address: (Street, City, State & Zip)		Dates of Confinement: _____ to _____

APPLICATION FOR LONG TERM DISABILITY INCOME BENEFITS

E. Information About Healthcare Providers and Hospitals (Cont...)

Have you consulted any other Healthcare Provider or been hospitalized in the past three years? Yes No
 If "Yes," complete the following concerning your past treatment (attach separate sheet, if needed)

Healthcare Provider's Name:	Telephone ()	Specialty
	Fax: ()	
Address (Street, City, State, Zip)		Dates seen to
Hospital		
Address (Street, City, State, Zip)		Dates of Confinement to

F. Other Income

Check the other income benefits you have received/are receiving, or are eligible to receive during your disability (complete the information requested).

Source of Income	Amount (week /month)	Date Claim was filed	Date Payments began	Date Payments ended
Social Security: Retirement	\$ _____ / _____	_____	_____	_____
Social Security: Disability	\$ _____ / _____	_____	_____	_____
Sick Leave	\$ _____ / _____	_____	_____	_____
Income from Work	\$ _____ / _____	_____	_____	_____
Workers' Compensation	\$ _____ / _____	_____	_____	_____
Pension/Retirement	\$ _____ / _____	_____	_____	_____
Pension/Disability	\$ _____ / _____	_____	_____	_____
Short Term Disability	\$ _____ / _____	_____	_____	_____
Other (include individual Group Benefits or Veteran's Benefits)	\$ _____ / _____	_____	_____	_____

Are you paying for Medicare Part D? Yes No If "Yes," please enter amount: _____ . 00.

G. Information about Tax Withholding

Federal law requires us to withhold federal income tax from your check if you request us to do so. We are also required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld, if any, and your social security number. If you want us to withhold tax, please indicate on the line below the dollar amount to be withheld per benefit check. Whole dollars only (minimum is \$88.00 per month): \$ _____ .00. **IMPORTANT:** If you pay the entire cost of the LTD premium, but on a Post-tax basis per Section I, Part D of the Employer's Statement, you will not be able to request any federal income tax withholding from your check. Puerto Rico residents may not request withholding.

Note to residents of Iowa and the District of Columbia: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed state Tax Withholding Certificate from you. Please contact your employer or state Tax Department to obtain the proper withholding form.

Note to residents of Nebraska, Rhode Island and South Carolina: Should you choose federal income tax withholding, your state requires us to withhold state income tax. We must withhold at a state mandated rate (which may be higher than you need) until we receive a signed federal Form W-4, Employee's Withholding Allowance Certificate, from you. You may go to www.irs.gov to obtain the proper withholding form.

Signature - Please read the statement that applies to your state of residence and sign the bottom of the page.

With the exception of any source(s) of income reported above in this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my disability benefits from this plan. Further, I understand that should I receive income of any kind or perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately. If I receive disability income benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. The Hartford has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For Residents of California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maine, Tennessee, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit and who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

For residents of Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

The statements contained in this form are true and complete to the best of my knowledge and belief.

Signature _____

Date _____

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.



To: Any health care provider, pharmaceutical provider, pharmacy benefits manager, employer, benefit plan, insurer, service provider, financial institution, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. I AUTHORIZE you to disclose to The Hartford a complete copy of, and to communicate telephonically or electronically with The Hartford's representatives about, any and all of the following personal, private, or privileged information, records, or documents relative to:

Insured's Name (Please print)

Date of Birth

Last 4 Digits of Social Security Number

Any and all medical information or records, including medical histories, physical, mental, or diagnostic examinations, pharmaceutical records, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health; work and performance information and history, including job duties and earnings; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; financial information, including pension benefits and bank records; business transaction billing and payment records; academic transcripts; and any and all information concerning Social Security benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used by The Hartford (including subsidiaries and affiliates) for the purpose of evaluating and administering my claim(s) for benefits and/or leave request and/or request for accommodation. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford.

I UNDERSTAND that once My Information has been disclosed to The Hartford as permitted under this Authorization, it may be re-disclosed by The Hartford as permitted by law or my further authorization. I authorize The Hartford to use or disclose My Information (i) to my employer for a) functions related to accommodating my restrictions/limitations, including in accordance with law; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim or condition; c) responding to complaints by me or my representative relating to benefits or leave or accommodation; d) responding to any litigation, agency or regulatory proceeding, or lawful subpoena (including regarding employment claims); e) federal, state, or other leave administration; f) fulfilling fiduciary obligations under my benefit plan; or (g) claim or other audits or reviews; (ii) to the administrator or other service providers, including health and wellness vendors, of my employer's benefit plan(s) and/or programs, including leave management, for plan, benefit, or program related functions or data aggregation and analysis; (iii) to any electronic claim systems or programs or third party vendors used for claims administration or processing or to any insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business, medical, or legal services related to my claim; (vi) for other insurance or reinsurance purposes, including workers' compensation insurance, Social Security Disability insurance, or subrogation or reimbursement purposes; (vii) as may be lawfully required; (viii) as may be reasonably necessary to protect the personal safety of others; (ix) as may be reasonably necessary to respond to regulatory complaints; and (x) as may be reasonably necessary to prevent or detect perpetration of a fraud.

I ALSO UNDERSTAND that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures The Hartford may make, unless The Hartford has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to The Hartford. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing The Hartford to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy(ies) or benefit plan or program, except as may be reasonably necessary to prevent or detect perpetration of a fraud, respond to regulatory complaints, or protect the personal safety of others. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Authorized Representative

Date (Valid for 2 years)

Relationship to Insured (if signed by Authorized Representative)

The Hartford® is underwriting companies Hartford Life and Accident Insurance Company and Hartford Life Insurance Company. The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Please fax the completed form to:
 Fax Number: 877-454-7217
 The Hartford
 P.O.Box 14301
 Lexington, KY 40512-4301
 Phone Number: 800-752-9713

ATTENDING PHYSICIAN'S STATEMENT - INITIAL REPORT



To be completed by the Employee

Patient Name:	Date of Birth:	Social Security Number:	Insured ID Number:
Patient Address: (Street, City, State & Zip Code)			

Policy Holder Name: Transit Employees Health & Welfare Plan	Employer's Name: WMATA	Policy Number: 402264
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To be completed by the Provider - Use current information from your patient's most recent office visit or examination to complete this form. (The patient is responsible for the completion of this form without expense to the Company.)

Patient's condition is the result of: Sickness Injury Pregnancy

If pregnancy, what is the expected date of delivery?
 _____ Month _____ Day _____ Year

Is condition due to illness or an injury that is related to: Work Activity Motor Vehicle Accident

Medical Conditions Impacting Activity

Primary condition: _____ ICD-9 Code: _____
 ICD-10 Code: _____

Secondary condition(s): _____ ICD-9 Code: _____
 ICD-10 Code(s): _____

Subjective symptoms: _____

Objective Physical Findings (Please include office notes for date(s): _____ to _____)

Pertinent Test Results (list all results or attach test results):

Test: _____ Date: _____ Results: _____

Test: _____ Date: _____ Results: _____

Condition(s) Specific Medications, Dosage and Frequency:

Treatments

Date your patient reported stopping work: _____ Date of disability: _____ Expected Return to Work Date: _____

Date you first treated this patient: _____ Date you first treated this patient for this condition: _____

Date of reported onset of this condition: _____ Date of most recent treatment: _____

How often has patient been seen/treated for this condition? _____ Date of next office visit: _____

Current Treatment Plan: _____

Has surgery been performed? Yes No Is surgery planned? Yes No If "Yes," Date: _____

Procedure: _____ CPT Code: _____

Was patient hospitalized for this condition? Yes No If "Yes," Date(s) admitted: _____ Date(s) Discharged: _____

Name of Hospital: _____ Telephone Number of Hospital: () _____

Has patient been referred to any other physician? Yes No If "Yes," Date(s) of Referral: _____

Other Physician Name: _____ Phone Number: () _____ Specialty: _____

Other Physician Name _____ Phone Number: () _____ Specialty: _____

The Hartford® is underwriting companies Hartford Life and Accident Insurance Company and Hartford Life Insurance Company. The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

Patient Name:

Date of Birth:

Insured ID Number:

Complete this section to the best of your ability. Generalized comments such as "unable to work" may delay your patient's disability benefits.

Based on your medical findings and opinion, address the full range of restrictions/limitations at the time patient stopped working, reduced their work schedule or initially visited your office for this condition, noting that we will conclude there are no restrictions on function unless specified below.

Restrictions/Limitations based on office visit dated:

In an 8 hour period the patient is able to: (select either continuous or intermittent)

	Continuously with standard breaks	or	Intermittently with standard breaks	If intermittent circle time for each section below															
				Hours at one time								Total hours/8 hours							
Sit	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Stand	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Walk	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8

Provide medical findings/rationale for your opinion if patient is unable to continuously sit, stand or walk:

Activity Ability (with normal breaks)	Never 0 hours	Occasionally up to 2.5 hours	Frequently 2.5 to 5.5 hours	Constantly 5.5 to 8 hours	Please indicate diagnosis, symptoms, exam findings, and/or imaging that supports the restrictions/limitations
Bend at waist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneel/crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lift - Indicate weight in pounds		lbs.	lbs.	lbs.	
Other Restrictions (if any)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Hand Dominance: Right Left

Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral

Fine manipulation (fingering, keyboard)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gross manipulation (grip/grasp, handle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach (extend arms) above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach (extend arms) below shoulder at desk or workbench level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please attach copies of imaging results/tests

Expected duration of any restriction(s) or limitation(s) listed above:

Current Status (Please check one): Recovered Improved Unchanged Retrogressed

Additional Comments (If Necessary):

Does the patient have a psychiatric / cognitive impairment? Yes No If "Yes," please describe the extent of the impairment and its etiology:

In your opinion is the patient competent to endorse checks and direct the use of the proceeds? Yes No

Provider's Name: (please print or type)

EIN Number:

License Number:

Telephone Number: ()

Fax Number: ()

Degree:

Specialty:

Street Address (Street, City, State & Zip Code):

Office Contact and Telephone Number:

Provider's Signature:

Date signed: