



Metropolitan Life Insurance Company  
200 Park Avenue, New York, New York 10166-0188

**CERTIFICATE OF INSURANCE**

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

Policyholder: Washington Technology Industry Association  
Participating Entity: Arizona Technology Council  
Group Policy Number: TS 05347628-G  
Type of Insurance: Disability Income Insurance: Long Term Benefits  
MetLife Toll Free Number(s):  
For General Information 1-800-275-4638

**THIS CERTIFICATE ONLY DESCRIBES DISABILITY INSURANCE.**

**THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.**

**THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.**

**For New Hampshire Residents: 30 Day Right to Examine Certificate.** Please read this Certificate. You may return the Certificate to Us within 30 days from the date You receive it. If you return it within the 30 day period, the Certificate will be considered never to have been issued and We will refund any premium paid for insurance under this Certificate.

**WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.**

## IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-275-4638

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:

P.O. Box 149104  
Austin, TX 78714-9104  
Fax: (512) 490-1007

Web: [www.tdi.texas.gov](http://www.tdi.texas.gov)

E-mail: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

**PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim, you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

**ATTACH THIS NOTICE TO YOUR CERTIFICATE:**

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

## AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de MetLife's para obtener información o para presentar una queja al:

1-800-275-4638

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104  
Austin, TX 78714-9104  
Fax: (512) 490-1007

Sitio web: [www.tdi.texas.gov](http://www.tdi.texas.gov)

E-mail: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)

**DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:** Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con MetLife primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

**ADJUNTE ESTE AVISO A SU CERTIFICADO:**

Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

## **NOTICE FOR RESIDENTS OF ARKANSAS**

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, Arkansas 72201  
(501) 371-2640 or (800) 852-5494

## **NOTICE FOR RESIDENTS OF CALIFORNIA**

### **IMPORTANT NOTICE**

**TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR THE METLIFE CLAIM OFFICE SHOWN ON THE EXPLANATION OF BENEFITS YOU RECEIVE AFTER FILING A CLAIM.**

**IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:**

**DEPARTMENT OF INSURANCE  
300 SOUTH SPRING STREET  
LOS ANGELES, CA 90013  
1 (800) 927-4357**

## **NOTICE FOR RESIDENTS OF GEORGIA**

### **IMPORTANT NOTICE**

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 violence.

## **NOTICE FOR RESIDENTS OF IDAHO**

If You have a question concerning Your coverage or a claim, first contact the Employer. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Employer and MetLife, You should feel free to contact:

Idaho Department of Insurance  
Consumer Affairs  
700 West State Street, 3<sup>rd</sup> Floor  
PO Box 83720  
Boise, Idaho 83720-0043  
1-800-721-3272 or [www.DOI.Idaho.gov](http://www.DOI.Idaho.gov)

# NOTICE FOR RESIDENTS OF ILLINOIS

## IMPORTANT NOTICE

To make a complaint to MetLife, You may write to:

MetLife  
200 Park Avenue  
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance  
Public Services Division  
Springfield, Illinois 62767

## **NOTICE FOR RESIDENTS OF INDIANA**

**Questions regarding your policy or coverage should be directed to:**

**Metropolitan Life Insurance Company  
1-800-275-4638**

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance  
Consumer Services Division  
311 West Washington Street, Suite 300  
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaint can be filed electronically at *[www.in.gov/doi](http://www.in.gov/doi)*



## **NOTICE FOR RESIDENTS OF MAINE**

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as nonpayment of a contribution that is due. The intent is to allow reinstatements where the default is due to the insured person's suffering from cognitive impairment or functional incapacity. You may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third-Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this certificate to obtain a Third-Party Notice Request Form. Within 90 days after cancellation of coverage for nonpayment of premium, You, any person authorized to act on Your behalf, or any covered Dependent may request reinstatement of the certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

# NOTICE FOR RESIDENTS OF MASSACHUSETTS

## CONTINUATION OF DISABILITY INCOME INSURANCE

1. If Your Disability Income Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.
2. If Your Disability Income Insurance ends because:
  - You cease to be in an Eligible Class; or
  - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your Disability Income Insurance under the CONTINUATION WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

**Plant Closing** and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

## **NOTICE FOR RESIDENTS OF TEXAS**

**THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**

## NOTICE FOR RESIDENTS OF UTAH

### Notice of Protection Provided by Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association (“the Association”) and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - o \$500,000 in death benefits
  - o \$200,000 in cash surrender or withdrawal values
- Health Insurance
  - o \$500,000 in hospital, medical and surgical insurance benefits
  - o \$500,000 in long-term care insurance benefits
  - o \$500,000 in disability income insurance benefits
  - o \$500,000 in other types of health insurance benefits
- Annuities
  - o \$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 IA, Chapter 28.

**Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.**

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association’s website at [www.utlifega.org](http://www.utlifega.org) or contact:

Utah Life and Health Insurance Guaranty Assoc.  
60 East South Temple, Suite 500  
Salt Lake City UT 84111  
(801) 320-9955

Utah Insurance Department  
3110 State Office Building  
Salt Lake City UT 84114-6901  
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

## **NOTICE FOR RESIDENTS OF VIRGINIA**

### **IMPORTANT INFORMATION REGARDING YOUR INSURANCE**

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife  
200 Park Avenue  
New York, New York 10166  
Attn: Corporate Consumer Relations Department

To phone in a claim related question, You may call Claims Customer Service at:  
1-800-275-4638

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Bureau of Insurance  
Life and Health Division  
P.O. Box 1157  
Richmond, VA 23218-1157  
1-804-371-9691 - phone  
1-877-310-6560 - toll-free  
1-804-371-9944 – fax  
[www.scc.virginia.gov](http://www.scc.virginia.gov) - web address  
[BureauOfInsurance@scc.virginia.gov](mailto:BureauOfInsurance@scc.virginia.gov) - email

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.

## NOTICE FOR RESIDENTS OF WISCONSIN

### **KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS**

**PROBLEMS WITH YOUR INSURANCE?** - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

MetLife  
Attn: Corporate Consumer Relations Department  
200 Park Avenue  
New York, NY 10166-0188  
1-800-638-5433

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance  
Complaints Department  
P.O. Box 7873  
Madison, WI 53707-7873  
1-800-236-8517 outside of Madison or 608-266-0103 in Madison.

## **NOTICE FOR RESIDENTS OF ALL STATES**

### **WORKERS' COMPENSATION**

This certificate does not replace or affect any requirement for coverage by workers' compensation insurance.

### **MANDATORY DISABILITY INCOME BENEFIT LAWS**

#### **For Residents of California, Hawaii, New Jersey, New York, Rhode Island and Puerto Rico**

This certificate does not affect any requirement for any government mandated temporary disability income benefits law.

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## SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You will only be insured for the benefits:

- for which You become and remain eligible, and
- which You elect, if subject to election; and
- which are in effect.

### BENEFIT BENEFIT AMOUNT AND HIGHLIGHTS

#### Disability Income Insurance For You: Long Term Benefits

##### For All Active Full-Time Employees Electing LongTerm Disability Plan 6:

Monthly Benefit.....	60% of the first \$16,667 of Your Predisability Earnings, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.
Maximum Monthly Benefit.....	\$10,000
Minimum Monthly Benefit.....	\$100 subject to the Overpayments and Rehabilitation Incentive subsection of this certificate.
Elimination Period.....	The greater of the Short Term Disability Maximum Benefit Period or 90 days.

#### Maximum Benefit Period\*

the later of:

- Your Normal Retirement Age;

or

- the period shown below:

Age on Date of Your Disability	Benefit Period
Less than 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

## SCHEDULE OF BENEFITS (continued)

\*The Maximum Benefit Period is subject to the LIMITED DISABILITY BENEFITS and DATE BENEFIT PAYMENTS END sections.

Rehabilitation Incentives..... Yes

### **Additional Benefits:**

Single Sum Payment in  
the Event of Your Death..... Yes

Alternative Benefit Payment,  
At Our Option..... Yes

## DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

**Actively at Work or Active Work** means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:

- the Employer's place of business;
- an alternate place approved by the Employer; or
- a location to which the Employer's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Employer-approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

**Appropriate Care and Treatment** means medical care and treatment that is:

- given by a Physician whose medical training and clinical specialty are appropriate for treating Your Disability;
- consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;
- consistent with a Physician's diagnosis of Your Disability; and
- intended to maximize Your medical and functional improvement.

**Beneficiary** means the person(s) to whom We will pay insurance as determined in accordance with the General Provisions section.

**Consumer Price Index** means the CPI-W, the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the CPI-W is discontinued or replaced, We reserve the right to substitute any other comparable index.

**Contributory Insurance** means insurance for which the Employer requires You to pay any part of the premium.

**Disabled or Disability** means that, due to Sickness or as a direct result of accidental injury:

- You are receiving Appropriate Care and Treatment and complying with the requirements of such treatment; and
- You are unable to earn during the Elimination Period and the next 24 months of Sickness or accidental injury, more than 80% of Your Predisability Earnings at Your Own Occupation for any employer in Your Local Economy; and
- unable to perform each of the material duties of Your Own Occupation; and
- after such period, unable to earn more than 80% of Your Predisability Earnings at any gainful occupation for any employer in Local Economy; and
- unable to perform the duties of any gainful occupation for which You are reasonably qualified taking into account Your training, education and experience.

For purposes of determining whether a Disability is the direct result of an accidental injury, the Disability must have occurred within 90 days of the accidental injury and resulted from such injury independent of other causes.

If Your occupation requires a license, the fact that You lose Your license for any reason will not, in itself, constitute Disability.

If You are Disabled and have received a Monthly Benefit for 12 months, We will adjust Your Predisability Earnings only for the purposes of determining whether You continue to be Disabled and for calculating the Return to Work Incentive, if any. We will make the initial adjustment as follows:

## DEFINITIONS (continued)

We will add to Your Predisability Earnings an amount equal to the product of:

- Your Predisability Earnings times the lesser of:
  - 7%; or
  - the annual rate of increase in the Consumer Price Index for the prior calendar year.

Annually thereafter, We will add an amount to Your adjusted Predisability Earnings calculated by the method set forth above but substituting Your adjusted Predisability Earnings from the prior year for Your Predisability Earnings. **This adjustment is not a cost of living benefit.**

**Domestic Partner** means each of two people, of the same or opposite sex, one of whom is an Employee of the Employer, who represent themselves publicly as each other's domestic partner and have:

- registered as domestic partners, with a government agency or office where such registration is available; or
- submitted a domestic partner declaration to the Employer.

The domestic partner declaration must establish that:

- each person is 18 years of age or older;
- neither person is married;
- neither person has had another domestic partner within 6 months prior to the date they enrolled for insurance for the Domestic Partner under the Group Policy;
- they have shared the same residence for at least 6 months prior to the date they enrolled for insurance for the Domestic Partner under the Group Policy;
- they are not related by blood in a manner that would bar their marriage in the jurisdiction in which they reside;
- they have an exclusive mutual commitment to share the responsibility for each other's welfare and financial obligations which commitment existed for at least 6 months prior to the date they enrolled for insurance for the Domestic Partner under the Group Policy, and such commitment is expected to last indefinitely; and
- 2 or more of the following exist as evidence of joint responsibility for basic financial obligations:
  - a joint mortgage or lease;
  - designation of the Domestic Partner as beneficiary for life insurance or retirement benefits;
  - joint wills or designation of the Domestic Partner as executor and/or primary beneficiary;
  - designation of the Domestic Partner as durable power of attorney or health care proxy;
  - ownership of a joint bank account, joint credit cards or other evidence of joint financial responsibility; or
  - other evidence of economic interdependence.

The Employer will review the declaration and determine whether to accept the request to insure the Domestic Partner.

The Employer will inform the employee of its decision.

**Elimination Period** means the period of Your Disability during which We do not pay benefits. The Elimination Period begins on the day You become Disabled and continues for the period shown in the SCHEDULE OF BENEFITS.

**Full-Time** means Active Work on the Employer's regular work schedule for the class of employees to which You belong. The work schedule must be at least 20 hours a week. Full-Time does not include temporary or seasonal employees.

**Local Economy** means the geographic area:

- within which You reside; and
- 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.

## DEFINITIONS (continued)

**Noncontributory Insurance** means insurance for which the Employer does not require You to pay any part of the premium.

**Normal Retirement Age** means that as defined by the federal Social Security Administration on the date Your Disability starts.

**Own Occupation** means the essential functions You regularly perform that provide Your primary source of earned income.

**Physician** means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where the service is performed and must act within the scope of that license. Such person must also be certified and/or registered if required by such jurisdiction.

**The term does not include:**

- You, or
- Your Spouse, or
- any member of Your immediate family including Your and/or Your Spouse's parents; children (natural, step or adopted); siblings; grandparents; or grandchildren.

**Employer's Retirement Plan** means a plan which:

- provides retirement benefits to employees; and
- is funded in whole or in part by Employer contributions.

**The term does not include:**

- profit sharing plans;
- thrift or savings plans;
- non-qualified plans of deferred compensation;
- plans under IRC Section 401(k) or 457;
- individual retirement accounts (IRA);
- tax sheltered annuities (TSA) under IRC Section 403(b);
- stock ownership plans; or
- Keogh (HR-10) plans.

**Predisability Earnings** means gross salary or wages You were earning from the Employer as of Your last day of Active Work before Your Disability began. We calculate this amount on a monthly basis.

If you do not have regular work hours, your Predisability Earnings are based on the average number of hours you worked per month during the preceding 12 calendar months (or during your period of employment if less than 12 months).

**The term includes:**

- contributions You were making through a salary reduction agreement with the Employer to any of the following:
- an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
- an executive non-qualified deferred compensation arrangement; and
- Your fringe benefits under an IRC Section 125 plan.

## DEFINITIONS (continued)

### The term does not include:

- commissions;
- awards and bonuses;
- overtime pay;
- the grant, award, sale, conversion and/or exercise of shares of stock or stock options;
- the Employer's contributions on Your behalf to any deferred compensation arrangement or pension plan;  
or
- any other compensation from the Employer.

**Proof** means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

**Rehabilitation Program** means a program that has been approved by Us for the purpose of helping You return to work. It may include, but is not limited to, Your participation in one or more of the following activities:

- return to work on a modified basis with a goal of resuming employment for which You are reasonably qualified by training, education, experience and past earnings;
- on-site job analysis;
- job modification/accommodation;
- training to improve job-seeking skills;
- vocational assessment;
- short-term skills enhancement;
- vocational training; or
- restorative therapies to improve functional capacity to return to work.

**Sickness** means illness, disease or pregnancy, including complications of pregnancy.

**Signed** means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

**We, Us and Our** mean MetLife.

**Written or Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

**You and Your** mean an employee who is insured under the Group Policy for the insurance described in this certificate.

## ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

### ELIGIBLE CLASS(ES)

All Active Full-Time Employees Electing LongTerm Disability Plan 6

### DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance available for Your class as shown in the SCHEDULE OF BENEFITS.

If You are in an eligible class on January 1, 2020, You will be eligible for insurance on that date.

If You enter an eligible class after January 1, 2020, You will be eligible for insurance on the first day of the month coincident with or next following the date You enter that class.

### ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing the required form. In addition, You must give evidence of Your insurability satisfactory to Us at Your expense if You are required to do so under the section entitled EVIDENCE OF INSURABILITY.

### DATE YOUR INSURANCE TAKES EFFECT

#### Rules for Noncontributory Insurance

When You complete the enrollment process for Noncontributory Insurance, such insurance will take effect as follows:

- if You are **not required** to give evidence of Your insurability, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date; or
- if You are **required** to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the date We state in Writing, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the Noncontributory Insurance benefit would otherwise take effect, the insurance will take effect on the day You resume Active Work.

#### Rules for Contributory Insurance

If You request Contributory Insurance **before** the date You become eligible for such insurance, such insurance will take effect as follows:

- if You are **not required** to give evidence of Your insurability, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.
- if You are **required** to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the date We state in Writing, provided You are Actively at Work on that date.

If You request Contributory Insurance **within 31 days of** the date You become eligible for such insurance, such insurance will take effect as follows:

- if You are **not required** to give evidence of Your insurability, such insurance will take effect on the later of:
  - the date You become eligible for such insurance; and
  - the date You enroll provided You are Actively at Work on that date.
- if You are **required** to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the date We state in Writing, provided You are Actively at Work on that date.

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)**

If You request Contributory Disability Income Insurance **more than 31 days after** the date You become eligible for such insurance, You must give evidence of Your insurability satisfactory to us. You must give such evidence at Your expense. If We determine that You are insurable, such insurance will take effect on the date We state in Writing, if You are Actively at Work on that date.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

See the DEFINITIONS section of this certificate for a complete list of Contributory Insurance benefits.

### **Increase in Insurance**

You are not required to give evidence of insurability for an increase in insurance due to a change in class of employee, an increase in Your earnings, or a requested increase in insurance. The increase will take effect on the later of:

- the first day of the month coincident with or next following the date of Your request; or
- the date of the increase in Your earnings, provided You are Actively at Work on that date.

### **Decrease in Insurance**

A decrease in insurance due to a change in class of employee or a decrease in Your earnings will take effect on the first day of the month coincident with or next following the date of change.

If You make a Written application to decrease Your insurance, that decrease will take effect as of the date of Your application.

Changes in Your Disability Income Insurance will only apply to Disabilities commencing on or after the date of the change.

### **DATE YOUR INSURANCE ENDS**

Your insurance will end on the earliest of:

1. the date the Group Policy ends;
2. the date insurance ends for Your class;
3. the end of the period for which the last premium has been paid for You; or
4. for Disability Income Insurance: Long Term Benefits, the date You cease to be in an eligible class. You will cease to be in an eligible class on the date You cease Active Work in an eligible class, if You are not disabled on that date; or
5. for Disability Income Insurance: Long Term Benefits, the date You retire in accordance with the date Your employment ends; or
6. for Disability Income Insurance: Long Term Benefits, date Your employment ends.



## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)**

### **Reinstatement of Disability Income Insurance**

If Your insurance ends, You may become insured again as follows:

1. If Your insurance ends because:

- You cease to be in an eligible class; or
- Your employment ends; and

You become a member of an eligible class again within 3 months of the date Your insurance ended, You will not have to complete a new Waiting Period or provide evidence of Your insurability.

2. If Your insurance ends because You cease making the required contribution while on an approved Family and Medical Leave Act (FMLA) or other legally mandated leave of absence and You become a member of an eligible class within 31 days of the earlier of:

- The end of the period of leave You and the Employer agreed upon; or
- The end of the eligible leave period required under the FMLA or other similar legally mandated leave of absence law,

You will not have to complete a new Waiting Period or provide evidence of Your insurability.

3. In all other cases where Your insurance ends because the required premium for Your insurance has ceased to be paid, You will be required to provide evidence of Your insurability.

If You become insured again as described in either item 1 or 2 above, the limitation for Pre-existing Conditions will be applied as if Your insurance had remained in effect with no interruption.

## **CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT**

### **FOR FAMILY AND MEDICAL LEAVE**

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Employer for information regarding such legally mandated leave of absence laws.

### **AT THE EMPLOYER'S OPTION**

The Employer has elected to continue insurance by paying premiums for employees who are not Disabled and cease Active Work in an eligible class for any of the reasons specified below:

- for the period You cease Active Work in an eligible class due to injury or Sickness, up to 3 months;
- for the period You cease Active Work in an eligible class due to an Employer's approved leave of absence, up to the end of the month You cease Active Work.

For purposes of this provision, leave of absence does not include a furlough.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

## **EVIDENCE OF INSURABILITY**

We require evidence of insurability satisfactory to Us as follows:

1. For Noncontributory Insurance, no evidence of insurability is required.

The evidence of insurability is to be given at Your expense.

## **DISABILITY INCOME INSURANCE: LONG TERM BENEFITS**

If You become Disabled while insured, Proof of Disability must be sent to Us. When We receive such Proof, We will review the claim. If We approve the claim, We will pay the Monthly Benefit up to the Maximum Benefit Period shown in the SCHEDULE OF BENEFITS, subject to THE DATE BENEFIT PAYMENTS END section.

To verify that You continue to be Disabled without interruption after Our initial approval, We may periodically request that You send Us Proof that You continue to be Disabled. Such Proof may include physical exams, exams by independent medical examiners, in-home interviews or functional capacity exams, as needed.

While You are Disabled, the Monthly Benefit described in this certificate will not be affected if:

- Your insurance ends; or
- the Group Policy is amended to change the plan of benefits for Your class.

### **BENEFIT PAYMENT**

If We approve Your claim, benefits will begin to accrue on the day after the day You complete Your Elimination Period. We will pay the first Monthly Benefit one month after the date benefits begin to accrue. We will make subsequent payments monthly thereafter so long as You remain Disabled. Payment will be based on the number of days You are Disabled during each month and will be pro-rated for any partial month of Disability.

We will pay Monthly Benefits to You. If You die, We will pay the amount of any due and unpaid benefits as described in the GENERAL PROVISIONS subsection entitled Disability Income Benefit Payments: Who We Will Pay.

### **RECOVERY FROM A DISABILITY**

If You return to Active Work, We will consider You to have recovered from Your Disability.

The provisions of this subsection will not apply if Your insurance has ended and You are eligible for coverage under another group long term disability plan.

#### **If You Return to Active Work Before Completing Your Elimination Period**

If You return to Active Work before completing Your Elimination Period for a period of 30 days or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. We will count those days towards the completion of Your Elimination Period.

If You return to Active Work for a period of more than 30 days, and then become Disabled again, You will have to complete a new Elimination Period.

For purposes of this provision, the term Active Work only includes those days You actually work.

#### **If You Return to Active Work After Completing Your Elimination Period**

If You return to Active Work after completing Your Elimination Period for a period of 180 days or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. For the purpose of determining Your benefits, We will consider such Disability to be a part of the original Disability and will use the same Predisability Earnings and apply the same terms, provisions and conditions that were used for the original Disability.

If You return to Active Work for a period of more than 180 days, and then become Disabled again, You will have to complete a new Elimination Period.

For purposes of this provision, the term Active Work includes all of the continuous days which follow Your return to work for which You are not Disabled.

## **DISABILITY INCOME INSURANCE: LONG TERM BENEFITS (continued)**

### **REHABILITATION INCENTIVES**

#### **Rehabilitation Program Incentive**

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.

#### **Work Incentive**

While You are Disabled, We encourage You to work. If You work while You are Disabled and receiving Monthly Benefits, Your Monthly Benefit will be adjusted as follows:

- Your Monthly Benefit will be increased by Your Rehabilitation Program, if any; and
- reduced by Other Income as defined in the DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.

Your Monthly Benefit as adjusted above will not be reduced by the amount You earn from working, except to the extent that such adjusted Monthly Benefit plus the amount You earn from working and the income You receive from Other Income exceeds 100% of Your Predisability Earnings as calculated in the definition of Disability.

In addition, the Minimum Monthly Benefit will not apply.

#### **Limit on Work Incentive**

After the first 24 months following Your Elimination Period, We will reduce Your Monthly Benefit by 50% of the amount You earn from working while Disabled.

#### **Family Care Incentive**

If You work or participate in a Rehabilitation Program while You are Disabled, We will reimburse You for up to \$400 for monthly expenses You incur for each family member to provide:

- care for Your or Your Spouse's child, legally adopted child, or child for whom You or Your Spouse are legal guardian and who is:
  - living with You as part of Your household;
  - dependent on You for support; and
  - under age 13.

The child care must be provided by a licensed child care provider who may not be a member of Your immediate family.

- care for Your family member who is:
  - living with You as part of Your household;
  - chiefly dependent on You for support; and
  - incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.

Care to Your family member may not be provided by a member of Your immediate family.

We will make reimbursement payments to You on a monthly basis starting with the 1<sup>st</sup> Monthly Benefit payment until You have received 24 Monthly Benefit Payments. Payments will not be made beyond the Maximum Benefit Period. We will not reimburse You for any expenses for which You are eligible for payment from any other source. You must send Proof that You have incurred such expenses.

## **DISABILITY INCOME INSURANCE: LONG TERM BENEFITS (continued)**

### **Moving Expense Incentive**

If You participate in a Rehabilitation Program while You are Disabled, We may reimburse You for expenses You incur in order to move to a new residence recommended as part of such Rehabilitation Program. Such expenses must be approved by Us in advance.

You must send Proof that You have incurred such expenses for moving.

We will not reimburse You for such expenses if they were incurred for services provided by a member of Your immediate family or someone who is living in Your residence.

## **DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT**

We will reduce Your Disability benefit by the amount of all Other Income. Other Income includes the following:

1. any disability or retirement benefits which You, Your Spouse or child(ren) receive or are eligible to receive because of Your disability or retirement under:
  - Federal Social Security Act;
  - Railroad Retirement Act;
  - any state, public or federal employee retirement or disability plan, including State Teachers Retirement System (STRS), Public Employee Retirement System (PERS) or Federal Employee Retirement System (FERS). You must apply for such benefits through the highest appeal level that is applicable to such benefits and available under the plan;
  - any pension or disability plan of any other nation or political subdivision thereof;
2. any income received for disability or retirement under the Employer's Retirement Plan, to the extent that it can be attributed to the Employer's contributions;
3. any income received for disability under:
  - a group insurance policy to which the Employer has made a contribution, such as:
    - benefits for loss of time from work due to disability; and
    - installment payments for permanent total disability.
  - a no-fault auto law for loss of income, excluding supplemental disability benefits;
  - a government compulsory benefit plan or program which provides payment for loss of time from Your job due to Your disability, whether such payment is made directly by the plan or program, or through a third party;
  - a self-funded plan, or other arrangement if the Employer contributes toward it or makes payroll deductions for it;
  - any sick pay, vacation pay or other salary continuation that the Employer pays to You;
  - Unemployment insurance law or program; and/or
4. any income that You receive from working while Disabled. This includes but is not limited to salary, commissions, overtime pay, bonus or other extra pay arrangements from any source.
5. recovery amounts that You receive for loss of income as a result of claims against a third party by judgment, settlement or otherwise, including future earnings.

### **REDUCING YOUR DISABILITY BENEFIT BY THE ESTIMATED AMOUNT OF YOUR FEDERAL SOCIAL SECURITY BENEFIT OR GOVERNMENT COMPULSORY BENEFIT PLAN OR PROGRAM OR STRS, PERS, OR FERS OR OTHER PUBLIC EMPLOYEE RETIREMENT OR DISABILITY BENEFIT PLAN OR PROGRAM**

If there is a reasonable basis for You to apply for benefits under the Federal Social Security Benefit or , a government compulsory plan or program or a federal, state or other public employee retirement or disability plan or program, including a STRS, PERS or FERS Retirement System, We expect You to apply for such benefits.

## **DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT (continued)**

1. **With respect to benefits under the Federal Social Security Act**, to apply means to pursue such benefits until You receive approval from the Federal Social Security Administration, or a notice of denial of benefits from an administrative law judge. We will reduce the amount of Your Disability benefit by the amount of Federal Social Security benefits We estimate that You Your Spouse or child(ren) are eligible to receive because of Your Disability or retirement. We will start to do this after You have received 24 months of Disability benefit payments, unless We have received:

- approval of Your claim for Federal Social Security benefits; or
- a notice of denial of such benefits indicating that all levels of appeal have been exhausted.

You must, within 6 months following the date You became Disabled:

- send Us Proof that You have applied for Federal Social Security benefits;
- sign a reimbursement agreement in which You agree to repay Us for any overpayments We may make to You under this insurance; and
- sign a release that authorizes the Federal Social Security Administration to provide information directly to Us concerning Your Federal Social Security benefits eligibility.

If You do not satisfy the above requirements, We will reduce Your Disability benefits by such estimated Federal Social Security benefits starting with the first Disability benefit payment coincident with the date You were eligible to receive Federal Social Security benefits.

2. **With respect to Government Compulsory Benefit Plans or Programs, or STRS, PERS or FERS Benefit Plans or Programs**, to apply means to pursue such benefits through all applicable levels of appeal provided for under such benefit plans or programs. You must, within 1 month following the date You became Disabled:

- send Us Proof that You have applied for benefits under such plans or programs;
- sign a reimbursement agreement in which You agree to repay Us for any overpayments We may make to You under this insurance; and
- sign a release that authorizes such benefit plans or programs to provide information directly to Us concerning Your benefits eligibility under such plans or programs.

If You do not satisfy the above requirements, We will reduce Your Disability benefit by the amount of such government compulsory benefit plan or program benefit, or STRS, PERS or FERS benefit that We estimate You are eligible to receive, provided that We have the reasonable means to make such an estimate. We will start to do this with the first Disability benefit payment under this certificate coincident with the date You were eligible to receive government compulsory benefit plan or program benefit, or STRS, PERS or FERS benefits under any such plans or programs.

3. With respect to benefits You have applied for under the Federal Social Security Act or , a government compulsory benefit plan or program or a federal, state or other public employee retirement or disability plan or program, including a STRS, PERS or FERS Retirement System plan or program, if You do receive approval or final denial of Your claim for such benefits, You must notify Us immediately. We will adjust the amount of Your Disability benefit. You must promptly repay Us for any overpayment.



## **DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT (continued)**

### **SINGLE SUM PAYMENT**

If You receive Other Income in the form of a single sum payment, You must, within 10 days after receipt of such payment, give Written Proof satisfactory to Us of:

- the amount of the single sum payment;
- the amount to be attributed to income replacement; and
- the time period for which the payment applies.

When We receive such Proof, We will adjust the amount of Your Disability benefit.

If We do not receive the Written Proof described above, and We know the amount of the single sum payment, We may reduce Your Disability benefit by an amount equal to such benefit until the single sum has been exhausted.

If We adjust the amount of Your Disability benefit due to a single sum payment, the amount of the adjustment will not result in a benefit amount less than the minimum amount, except in the case of an Overpayment.

If You receive Other Income in the form of a single sum payment and We do not receive the Written Proof described above within 10 days after You receive the single sum payment, We will adjust the amount of Your Disability benefit by the amount of such payment.

## **DISABILITY INCOME INSURANCE: INCOME WHICH WILL NOT REDUCE YOUR DISABILITY BENEFIT**

We will not reduce Your Disability benefit to less than the Minimum Benefit shown in the SCHEDULE OF BENEFITS, or by:

- cost of living adjustments that are paid under any of the above sources of Other Income;
- reasonable attorney fees included in any award or settlement. If the attorney fees are incurred because of Your successful pursuit of Social Security disability benefits, such fees are limited to those approved by the Social Security Administration;
- group credit insurance;
- mortgage disability insurance benefits;
- early retirement benefits that have not been voluntarily taken by You;
- veteran's benefits;
- individual disability income insurance policies;
- benefits received from an accelerated death benefit payment; or
- amounts rolled over to a tax qualified plan unless subsequently received by You while You are receiving benefit payments.

## **DISABILITY INCOME INSURANCE: DATE BENEFIT PAYMENTS END**

Your Disability benefit payments will end on the earliest of:

- the end of the Maximum Benefit Period;
- the date benefits end as specified in the section entitled LIMITED DISABILITY BENEFITS;
- the date You are no longer Disabled;
- the date You die except for benefits paid under sections entitled ADDITIONAL LONG TERM BENEFIT: SINGLE SUM PAYMENT IN THE EVENT OF YOUR DEATH;
- the date You cease or refuse to participate in a Rehabilitation Program that We require;
- the date You fail to have a medical exam requested by Us as described in the Physical Exams subsection of the GENERAL PROVISIONS section;
- the date You fail to provide required Proof of continuing Disability.

While You are Disabled, the benefits described in this certificate will not be affected if:

- Your insurance ends ; or
- the Group Policy is amended to change the plan of benefits for Your class.

## **DISABILITY INCOME INSURANCE**

### **ADDITIONAL LONG TERM BENEFIT: SINGLE SUM PAYMENT IN THE EVENT OF YOUR DEATH**

If You die while You are Disabled and You were entitled to receive Monthly Benefits under this certificate, Proof of Your death must be sent to Us. When We receive such Proof, We will pay the benefit described in this section.

#### **BENEFIT AMOUNT**

The benefit amount will be equal to 3 times the lesser of:

- the Monthly Benefit You receive for the calendar month immediately preceding Your death;
- the Monthly Benefit You were entitled to receive for the month You die, if You die during the first month that Disability benefits are payable.

We will reduce the benefit amount by any overpayment We are entitled to recover.

#### **BENEFIT PAYMENT**

Benefit payments will be made as described in the GENERAL PROVISIONS subsection entitled Disability Income Benefit Payments: Who We Will Pay.

## **DISABILITY INCOME INSURANCE**

### **ADDITIONAL LONG TERM BENEFIT: ALTERNATIVE BENEFIT PAYMENT OFFER, AT OUR OPTION**

If We approve Your claim for benefits under this certificate in accordance with the Long Term Benefit provisions of this certificate, We may offer to pay You a Disability benefit in the form of a lump sum benefit payment as an alternative to the Monthly Benefit payments described in the DISABILITY INCOME INSURANCE: LONG TERM BENEFITS provision of this certificate. If We determine on the basis of objective criteria applied to the particular facts and circumstances of Your claim that a lump sum payment is an appropriate option for Us to offer to You, We will make an offer of a lump sum payment to You. If You accept Our offer in Writing, Signed by You, and We make such lump sum benefit payment to You, no further Disability benefit payments will be made to You under this certificate. If You do not accept Our offer of a lump sum benefit payment, We will continue to administer Your claim in accordance with the terms and conditions of this certificate.

## **DISABILITY INCOME INSURANCE: PRE-EXISTING CONDITIONS**

**Pre-existing Condition** means a Sickness or accidental injury for which You:

- received medical treatment, consultation, care, or services; or
- took prescription medication or had medications prescribed;

in the 3 months before Your insurance under this certificate takes effect.

We will not pay benefits for a Disability that results from a Pre-existing Condition, if You have been Actively at Work for less than 12 consecutive months after the date Your Disability insurance takes effect under this certificate.

## **DISABILITY INCOME INSURANCE: LIMITED DISABILITY BENEFITS**

### **For Disabilities Due to: Alcohol, Drug or Substance Abuse or Addiction Mental or Nervous Disorders or Diseases**

If You are Disabled due to:

- alcohol;
- drug or substance addiction;
- Mental or Nervous Disorders or Diseases.

We will limit Your Disability benefits to a combined lifetime maximum for any and all of the above equal to the lesser of:

- 24 months; or
- the Maximum Benefit Period.

### **For Disability Due to Alcohol and Drug Addiction or Chemical Dependency**

If Your Disability is due to alcohol, drug or substance addiction, We require You to participate in an alcohol, drug or substance addiction recovery program recommended by a Physician. We will end Disability benefit payments at the earliest of the period described above or the date You cease, refuse to participate, or complete such recovery program.

This limitation will not apply to a Disability resulting from:

- schizophrenia;
- dementia; or
- organic brain disease.

**Mental or Nervous Disorder or Disease** means a medical condition which meets the diagnostic criteria set forth in the most recent edition of the Diagnostic And Statistical Manual Of Mental Disorders as of the date of Your Disability. A condition may be classified as a Mental or Nervous Disorder or Disease regardless of its cause.

### **For Occupational Disabilities**

We will not pay benefits for any Disability:

- which happens in the course of any work performed by You for wage or profit; or
- for which You are eligible to receive benefits under workers' compensation or a similar law.

## **DISABILITY INCOME INSURANCE: EXCLUSIONS**

We will not pay for any Disability caused or contributed to by:

1. war, whether declared or undeclared, or act of war, insurrection, rebellion, or terrorist act;
2. Your active participation in a riot;
3. intentionally self-inflicted injury;
4. attempted suicide; or
5. commission of or attempt to commit or taking part in a felony.



## FILING A DISABILITY INCOME CLAIM

The Employer should have a supply of claim forms. Obtain a claim form from the Employer and fill it out carefully. Return the completed claim form with the required Proof to the Employer.

If You are unable to report for Active Work due to a Sickness or accidental injury, and You think that You may be Disabled, You should contact MetLife or Your benefits representative to initiate a claim. We recommend that You do so no later than 30 days after the first day You are unable to report for Active Work so that Your claim can be processed in a timely manner.

When You file an initial claim for Disability Income insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to us within 90 days after the end of the Elimination Period.

Notice of claim and Proof for Disability Income Insurance may also be given to Us by following the steps set forth below:

### **Step 1**

You may give Us notice by calling Us at the toll free number shown in the Certificate Face Page within 20 days of the date of a loss.

### **Step 2**

We will send a claim form to You and explain how to complete it. You should receive the claim form within 15 days of giving Us notice of claim.

### **Step 3**

When You receive the claim form, You should fill it out as instructed and return it with the required Proof described in the claim form.

If You do not receive a claim form within 15 days after giving Us notice of claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

### **Step 4**

You must give Us Proof not later than 90 days after the end of the Elimination Period.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given within 90 days after the end of the Elimination Period or if it is not reasonably possible to give notice of claim or Proof within such period, they are given as soon as is reasonably possible thereafter.

### **Items to be Submitted for a Disability Income Insurance Claim**

When submitting Proof on an initial or continuing claim for Disability Income insurance, the following items may be required:

- documentation which must include, but is not limited to, the following information:
  - the date Your Disability started;
  - the cause of Your Disability;
  - the prognosis of Your Disability;
  - the continuity of Your Disability; and
- Your application for:
  - Other Benefit Sources;
  - Federal Social Security disability benefits; and
  - Workers' compensation benefits or benefits under a similar law.
- Written authorization for Us to obtain and release medical, employment and financial information and any other items We may reasonably require to document Your Disability or to determine Your receipt of or eligibility for Other Benefit Sources;

## FILING A DISABILITY INCOME CLAIM (continued)

- any and all medical information, including but not limited to:
  - x-ray films; and
  - photocopies of medical records, including:
    - histories;
    - physical, mental or diagnostic examinations; and
    - treatment notes; and
- the names and addresses of all:
  - physicians and medical practitioners who have provided You with diagnosis, treatment or consultation;
  - hospitals or other medical facilities which have provided You with diagnosis, treatment or consultation; and
  - pharmacies which have filled Your prescriptions within the past three years; and
- additional proof elements as required and described within the additional plan provisions for which you are filing a claim for benefits.

**Time Limit on Legal Actions.** A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

## **GENERAL PROVISIONS**

### **Assignment**

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment.

### **Disability Income Benefit Payments: Who We Will Pay**

We will make any benefit payments during Your lifetime to You or Your legal representative as Beneficiary. Any payment made in good faith will discharge Us from liability to the extent of such payment.

Upon Your death, We will pay any amount that is or becomes due to Your designated Beneficiary. If there is no Beneficiary designated or no surviving designated Beneficiary at Your death We may determine the Beneficiary for any amount that is or becomes due according to the following order:

1. Your Spouse, including Your Domestic Partner, if alive;
2. Your child(ren), if there is no surviving Spouse, or Domestic Partner;
3. Your parent(s), if there is no surviving child(ren);
4. Your sibling(s), if there is no surviving parent(s);
5. Your estate, if there is no such surviving sibling(s).

If more than one person is eligible to receive payment, We will divide the benefit amount in equal shares.

Payment to a minor or incompetent will be made to such person's guardian. The term "children" or "child" includes natural and adopted children.

Any periodic payments owed to Your estate may be paid in a single sum. Any payment made in good faith will discharge Us from liability to the extent of such payment.

### **Entire Contract**

Your insurance is provided under a contract of group insurance with the Employer. The entire contract with the Employer is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Employer's application; and
3. any amendments and/or endorsements to the Group Policy.

### **Incontestability: Statements Made by You**

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. You have Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to You or Your Beneficiary.

We will not use Your statements which relate to insurability to contest Disability Insurance after it has been in force for 2 years during Your life, unless the statement is fraudulent. In addition, we will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during Your life, unless the statement is fraudulent.

### **Misstatement of Age**

If Your age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

### **Conformity with Law**

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

## **GENERAL PROVISIONS (continued)**

### **Physical Exams**

If a claim is submitted for insurance benefits, We have the right to ask the insured to be examined by a Physician(s) of Our choice as often as is reasonably necessary to process the claim. We will pay the cost of such exam.

### **Autopsy**

We have the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons We are requesting the autopsy.

### **Overpayments**

#### **Recovery of Overpayments**

We have the right to recover any amount that We determine to be an overpayment.

An overpayment occurs if We determine that:

- the total amount paid by Us on Your claim is more than the total of the benefits due to You under this certificate; or
- payment We made should have been made by another group plan.

If such overpayment occurs, You have an obligation to reimburse Us. Our rights and Your obligations in this regard are described in the reimbursement agreement that You are required to sign when You submit a claim for benefits under this certificate. This agreement:

- confirms that You will reimburse Us for all overpayments; and
- authorizes Us to obtain any information relating to sources of Other Income.

#### **How We Recover Overpayments**

We may recover the overpayment from You by:

- stopping or reducing any future Disability benefits, including the Minimum Benefit, payable to You or any other payee under the Disability sections of this certificate;
- demanding an immediate refund of the overpayment from You; and
- taking legal action.

If the overpayment results from Our having made a payment to You that should have been made under another group plan, We may recover such overpayment from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

## **GENERAL PROVISIONS (continued)**

### **Lien and Repayment**

If You become Disabled and You receive Disability benefits under this certificate and You receive payment from a third party for loss of income with respect to the same loss of income for which You received benefits under this certificate (for example, a judgment, settlement, payment from Federal Social Security or payment pursuant to Workers' Compensation laws), You shall reimburse Us from the proceeds of such payment up to an amount equal to the benefits paid to You under this certificate for such Disability. Our right to receive reimbursement from any such proceeds shall be a claim or lien against such proceeds and Our right shall provide Us with a first priority claim or lien over any such proceeds up to the full amount of the benefits paid to You under this certificate for such Disability. You agree to take all action necessary to enable Us to exercise Our rights under this provision, including, without limitation:

- notifying Us as soon as possible of any payment You receive or are entitled to receive from a third party for loss of income with respect to the same loss of income for which You received benefits under this certificate;
- furnishing of documents and other information as requested by Us or any person working on Our behalf; and
- holding in escrow, or causing Your legal representative to hold in escrow, any proceeds paid to You or any party by a third party for loss of income with respect to the same loss of income for which You received benefits under this certificate, up to an amount equal to the benefits paid to You under this certificate for such Disability, to be paid immediately to Us upon Your receipt of said proceeds.

You shall cooperate and You shall cause Your legal representative to cooperate with Us in any recovery efforts and You shall not interfere with Our rights under this provision. Our rights under this provision apply whether or not You have been or will be fully compensated by a third party for any Disability for which You received or are entitled to receive benefits under this certificate.

**"THIS IS THE END OF THE CERTIFICATE. THE FOLLOWING IS ADDITIONAL INFORMATION"**

## **SPECIAL SERVICES**

### **Social Security Assistance Program**

If your claim for Disability benefits under this plan is approved, MetLife provides you with assistance in applying for Social Security disability benefits. Before outlining the details of this assistance, you should understand why applying for Social Security disability benefits is important.

### **Why You Should Apply For Social Security Disability Benefits**

Both you and your Employer contribute payroll taxes to Social Security. A portion of those tax dollars are used to finance Social Security's program of disability protection. Since your tax dollars help fund this program, it is in your best interest to apply for any benefits to which you may be entitled. Your spouse and children may also be eligible to receive Social Security disability benefits due to your Disability. There are several reasons why it may be to your financial advantage to receive Social Security disability benefits. Some of them are:

#### **1. Avoids reduced retirement benefits**

Should you become disabled and approved for Social Security disability benefits, Social Security will freeze your earnings record as of the date Social Security determines that your disability has begun. This means that the months/years that you are unable to work because of your disability will not be counted against you in figuring your average earnings for retirement and survivors benefit.

#### **2. Medicare Protection**

Once you have received 24 months of Social Security disability benefits, you will have Medicare protection for hospital expenses. You will also be eligible to apply for the medical insurance portion of Medicare.

#### **3. Trial Work Period**

Social Security provides a trial work period for the rehabilitation efforts of disabled workers who return to work while still disabled. Full benefit checks can continue for up to 9 months during the trial work period.

#### **4. Cost of Living Increases Awarded by Social Security Will Not Reduce Your Disability Benefits**

MetLife will not decrease your Disability benefit by the periodic cost of living increases awarded by Social Security. This is also true for any cost of living increases awarded by Social Security to your spouse and children.

This is called a Social Security "freeze." It means that only the Social Security benefit awarded to you and your dependents will be used by MetLife to reduce your Disability benefit; with the following exceptions:

- a) an error by Social Security in computing the initial amount;
- b) a change in dependent status; or
- c) your Employer submitting updated earnings records to Social Security for earnings received prior to your Disability.

Over a period of years, the net effect of these cost of living increases can be substantial.

### **How MetLife Assists You in the Social Security Approval Process**

As soon as you apply for Disability benefits, MetLife begins assisting you with the Social Security approval process.

#### **1. Assistance Throughout the Application Process**

MetLife has a dedicated team of Social Security Specialists. These Specialists, many of whom have worked for the Social Security Administration, are also located within our Claim Department. They provide

expert assistance up front, offer support while you are completing the Social Security forms, and help guide you through the application process.

## **2. Guidance Through Appeal Process by Social Security Specialists**

Social Security disability benefits may be initially denied, but are often approved following an appeal. If your benefits are denied, our dedicated team of Social Security Specialists provide expert assistance on an appeal if your situation warrants continuing the appeal process. They guide you through each stage of the appeal process. These stages may include:

- a) Reconsideration by the Social Security Administration
- b) Hearing before an Administrative Law Judge
- c) Review by an Appeals Council established within the Social Security Administration in Washington, D.C.
- d) A civil suit in Federal Court

## **3. Social Security Attorneys**

Depending on your individual needs, MetLife may provide a referral to an attorney who specializes in Social Security law. The Social Security approved attorney's fee is credited to the Long Term Disability Overpayment, which results upon your receipt of the retroactive Social Security benefits. The attorney's fee, which is capped by Social Security law, will be deducted from the lump sum social security disability benefits award and will not be used to further reduce your Long Term Disability benefit.

## **Return To Work Program**

### **Goal of Rehabilitation**

The goal of MetLife is to focus on Employees' abilities, instead of disabilities. This "abilities" philosophy is the foundation of our Return to Work Program. By focusing on what Employees can do versus what they can't, we can assist you in returning to work sooner than expected.

### **Incentives For Returning To Work**

Your Disability plan is designed to provide clear advantages and financial incentives for returning to work either full-time or part-time, while still receiving a Disability benefit. In addition to financial incentives, there may be personal benefits resulting from returning to work. Many Employees experience higher self-esteem and the personal satisfaction of being self-sufficient and productive once again. If it is determined that you are capable but you do not participate in the Return to Work Program, your Disability benefits may cease.

### **Return-to-Work Services**

As a covered Employee you are automatically eligible to participate in our Return-to-Work Program. The Program aims to identify the necessary training and therapy that can help you return to work. In many cases, this means helping you return to your former occupation, although rehabilitation can also lead to a new occupation which is better suited to your condition and makes the most of your abilities. There is no additional cost to you for the services we provide, and they are tailored to meet your individual needs. These services include, but are not limited to, the following:



## **1. Vocational Analyses**

Assessment and counseling to help determine how your skills and abilities can be applied to a new or a modified job with your Employer.

## **2. Labor Market Surveys**

Studies to find jobs available in your Local Economy that would utilize your abilities and skills. Also identify your earning potential for a specific occupation.

## **3. Retraining Programs**

Programs to facilitate return to your previous job, or to train you for a new job.

## **4. Job Modifications/Accommodations**

Analyses of job demands and functions to determine what modifications may be made to maximize your employment opportunities.

This also includes changes in your job or accommodations to help you perform the previous job or a similar vocation, as required of your employer under the Americans With Disabilities Act (ADA).

## **5. Job Seeking Skills and Job Placement Assistance**

Special training to identify abilities, set goals, develop resumes, polish interviewing techniques, and provide other career search assistance.

### **Return-to-Work Program Staff**

The Case Manager handling your claim will coordinate return-to-work services. You may be referred to a clinical specialist, such as a Nurse Consultant, Psychiatric Clinical Specialist, or Vocational Rehabilitation Consultant, who has advanced training and education to help people with disabilities return to work. One of our clinical specialists will work with you directly, as well as with local support services and resources. They have returned hundreds of individuals to meaningful, gainful employment.

### **Rehabilitation Vendor Specialists**

In many situations, the services of independent vocational rehabilitation specialists may be utilized. Services are obtained at no additional cost to you; MetLife pays for all vendor services. Selecting a rehabilitation vendor is based on:

1. Attending physician's evaluation and recommendations;
2. Your individual vocational needs; and
3. Vendor's credentials, specialty, reputation, and experience.

When working with vendors, we continue to collaborate with you and your doctor to develop an appropriate return-to-work plan.

Metropolitan Life Insurance Company  
Metropolitan Tower Life Insurance Company  
SafeGuard Health Plans, Inc.  
Delaware American Life Insurance Company  
MetLife Health Plans, Inc.  
SafeHealth Life Insurance Company

## Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. “Personal information” as used here means anything we know about you personally.

### 1. Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, “you” refers to these individuals.

### 2. Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

### 3. Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a legal plans company, and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

### 4. How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a “consumer report” about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. (“MIB”). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901, or by contacting MIB at [www.mib.com](http://www.mib.com).

### 5. Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what

products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

## 6. Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our “Using Your Information” section above

## 7. HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act (“HIPAA”) protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at [www.MetLife.com](http://www.MetLife.com). For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at [HIPAAprivacyAmericasUS@metlife.com](mailto:HIPAAprivacyAmericasUS@metlife.com), or call us at telephone number (212) 578-0299.

## 8. Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

## 9. Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. When you write, include your name, address, and policy or account number.

**Send privacy questions to:**

MetLife Privacy Office  
P. O. Box 489  
Warwick, RI 02887-9954  
[privacy@metlife.com](mailto:privacy@metlife.com)

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.



THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

## **ERISA INFORMATION**

### **NAME OF THE PLAN**

Washington Technology Industry Association Welfare Benefit Plan, ("Plan")

### **NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR**

Washington Technology Industry Association  
1721 8th ave N  
seattle, WA 98109-3015  
(206) 707-0332

### **EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER**

911427013

501

### **TYPE OF PLAN**

Employee Welfare Plan including:

Long Term Disability Benefits

### **TYPE OF ADMINISTRATION**

The above listed benefits are insured by Metropolitan Life Insurance Company, ("MetLife").

### **AGENT FOR SERVICE OF LEGAL PROCESS**

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. For disputes arising under those portions of the Plan insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

### **ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS**

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan. It also includes a detailed description of insurance provided by MetLife under the Plan.

### **PLAN TERMINATION OR CHANGES**

The group policy sets forth those situations in which the Employer and/or MetLife have the right to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the benefits described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event your coverage ends in accord with the "Termination of Coverage" provision of your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in your MetLife certificate.

## **CONTRIBUTIONS**

No contribution is required for Long Term Disability Benefits.

The total premium rate for insurance provided under the Plan by MetLife is set by MetLife.

## **PLAN YEAR**

The Plan's fiscal records are kept on a Plan year basis beginning each December 1 and ending on the following November 30.

## **CLAIMS INFORMATION**

### **Procedures for Presenting Claims for Benefits**

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who will also be ready to answer questions and to assist you or, if applicable, your beneficiary in filing claims.

#### **Claim Submission**

For claims for disability benefits, the claimant must report the claim to MetLife and, if requested complete the appropriate claim form. The claimant must also submit the required proof as described in the "Claims" section of the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

#### **Initial Determination**

After you submit a claim for disability benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed.

## **Appealing the Initial Determination**

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

## **Routine Questions**

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

## **Discretionary Authority of Plan Administrator and Other Plan Fiduciaries**

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

## STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, all copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.



## **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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## **FUTURE OF THE PLAN**

It is hoped that the Plan will be continued indefinitely, but Washington Technology Industry Association reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.