

# **YOUR BENEFIT PLAN**

**County of San Bernardino**

**Exempt Employees**

**Disability Income Insurance: Short Term Benefits and Long Term Benefits**

**Certificate Date: July 18, 2020**

County of San Bernardino  
157 West Fifth Street, 1st Floor  
San Bernadino, CA 92415

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

County of San Bernardino



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

### 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.

<b>Policyholder:</b>	County of San Bernardino
<b>Group Policy Number:</b>	226815-1-G
<b>Type of Insurance:</b>	Disability Income Insurance: Short Term Benefits
<b>MetLife Toll Free Number(s): For Claim Information</b>	FOR DISABILITY INCOME CLAIMS: 1-877-638-8269

### **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:

1-877-638-8269

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)

Email: [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:

1-877-638-8269

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)

Email: [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 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.

## **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 METLIFE AT:**

**METROPOLITAN LIFE INSURANCE COMPANY  
ATTN: CONSUMER RELATIONS DEPARTMENT  
500 SCHOOLHOUSE ROAD  
JOHNSTOWN, PA 15904**

**1-800-438-6388**

**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 DEPARTMENT OF INSURANCE DEPARTMENT AT:**

**DEPARTMENT OF INSURANCE  
CONSUMER SERVICES  
300 SOUTH SPRING STREET  
LOS ANGELES, CA 90013**

**WEBSITE: <http://www.insurance.ca.gov/>**

**1-800-927-4357 (within California)  
1-213-897-8921 (outside California)**

## **NOTICE FOR RESIDENTS OF CONNECTICUT**

### **MANDATORY REHABILITATION**

This certificate contains a mandatory rehabilitation provision, which may require you to participate in vocational training or physical therapy when appropriate.



## **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 Policyholder. 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:

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 (for calls placed within Idaho) or 208-334-4250 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**

**1-800-438-6388**

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/idoi](http://www.in.gov/idoi)

## **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 for 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 or any person authorized to act on Your behalf 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 MASSACHUSETTS RESIDENTS**

### **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 OF INSURANCE 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 THE STATE OF VERMONT

Vermont law provides that the following apply to Your certificate:

**Domestic Partner** means each of two people, one of whom is an Employee of the Policyholder, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

Wherever the term "**Spouse**" appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

## **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, New York 10166  
1-800-438-6388

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.

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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;
- which You elect, if subject to election; and
- which are in effect.

### BENEFIT

### BENEFIT AMOUNT AND HIGHLIGHTS

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

Weekly Benefit.....	55% of the first \$3,369 of Your Predisability Earnings, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section
Maximum Weekly Benefit.....	\$1,853
Minimum Weekly Benefit.....	\$25, subject to the Overpayments and Rehabilitation Incentive subsections of this certificate
Elimination Period.....	<b>For Injury</b> <ul style="list-style-type: none"> <li>• 7 days of Disability</li> </ul> <b>For Sickness</b> <ul style="list-style-type: none"> <li>• 7 days of Disability</li> </ul>
Maximum Benefit Period.....	180 days
Rehabilitation Incentives.....	Yes

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

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 subsections of this certificate.
Elimination Period.....	The greater of the Short Term Disability Maximum Benefit Period or 180 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
Age 60 but less than age 65	60 months
Age 65 but less than age 68	To age 70
Age 68 or older	24 months

## SCHEDULE OF BENEFITS

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

Rehabilitation Incentives..... Yes

### **Additional Benefits:**

Cost of Living Adjustment..... Yes

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

Portability..... 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. This must be done at:

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

You will be deemed to be Actively at Work during regularly scheduled days off or Policyholder approved vacations, holidays or business closures if You were Actively at Work on the last scheduled workday preceding such time off.

**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.

**Disability or Disabled** The definition of "Disability or Disabled" is outlined on a separate page which can be found at the end of the Definitions section.

**Domestic Partner** means each of two people, one of whom is an Employee of the Policyholder, who:

- have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
  1. 18 years of age or older;
  2. unmarried;
  3. the sole domestic partner of the other;
  4. sharing a primary residence with the other; and
  5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

A Domestic Partner declaration attesting to the relationship between the employee and the employee's domestic partner must be completed and Signed by the Employee. The declaration must establish that each person has either a substantial interest in the other engendered by love and affection; or a lawful and substantial economic interest in the continued life, health or bodily safety of each other, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the other person.

**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.

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

**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 he performs

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**def as amended by GCR09-08 dp**



## DEFINITIONS (continued)

the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.

### The term does not include:

- You;
- 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.

### Policyholder's Retirement Plan means a plan which:

- provides retirement benefits to employees; and
- is funded in whole or in part by Policyholder 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 Policyholder as of Your last day of Active Work before Your Disability began. We calculate this amount on a weekly basis.

### The term includes:

- contributions You were making through a salary reduction agreement with the Policyholder 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.

### 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 Policyholder's contributions on Your behalf to any deferred compensation arrangement or pension plan; or
- any other compensation from the Policyholder.

## DEFINITIONS (continued)

**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.

**Spouse** means Your lawful spouse. Wherever the term "Spouse" appears in the certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

**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.

## DEFINITIONS (continued)

**Disability** or **Disabled** means that as a result of Sickness or injury You are either Totally Disabled or Partially Disabled.

**Totally Disabled** or **Total Disability** means:

For Disability Income Insurance: Short Term Benefits,

You are unable to perform with reasonable continuity the Substantial and Material Acts necessary to pursue Your Usual Occupation and You are not working in Your Usual Occupation.

For Disability Income Insurance: Long Term Benefits,

- During the Elimination Period and the next 24 months, You are unable to perform with reasonable continuity the Substantial and Material Acts necessary to pursue Your Usual Occupation in the usual and customary way.
- After such period, You are not able to engage with reasonable continuity in any occupation in which You could reasonably be expected to perform satisfactorily in light of Your:
  - age;
  - education;
  - training;
  - experience;
  - station in life; and
  - physical and mental capacity

that exists within any of the following locations:

- a reasonable distance or travel time from Your residence in light of the commuting practices of Your community;
- a distance of travel time equivalent to the distance or travel time You traveled to work before becoming disabled; or
- the regional labor market, if You reside or resided prior to becoming disabled in a metropolitan area.

**Partially Disabled** or **Partial Disability** means while actually working in an occupation, You are unable to earn 80% or more of Your Predisability Earnings.

For Disability Income Insurance: Short Term Benefits, If You are Partially Disabled and have received a Weekly Benefit for 26 weeks or for Disability Income Insurance: Long Term Benefits, If You are Partially Disabled and have received a Monthly Benefit for 24 months, We will adjust Your Predisability Earnings only for the purposes of determining whether You continue to be Partially Disabled and for calculating the Return to Work Incentive, if any. We will make the initial adjustment as follows:

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

- Your Predisability Earnings times
- 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.**

For purposes of determining whether a Disability is the direct result of an injury, the Disability must have occurred within 90 days of the injury and not as a result of Sickness.

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

## **DEFINITIONS (continued)**

**Substantial and Material Acts** means the important tasks, functions and operations generally required by employers from those engaged in Your Usual Occupation that cannot be reasonably omitted or modified. In determining what substantial and material acts are necessary to pursue Your Usual Occupation, We will first look at the specific duties required by Your job. If You are unable to perform one or more of these duties with reasonable continuity, We will then determine whether those duties are customarily required of other employees engaged in Your Usual Occupation. If any specific, material duties required of You by Your job differ from the material duties customarily required of other employees engaged in Your Usual Occupation, then We will not consider those duties in determining what substantial and material acts are necessary to pursue Your Usual Occupation.

**Usual Occupation** means any employment, business, trade or profession and the Substantial and Material Acts of the occupation You were regularly performing for the employer when the Disability began. Usual Occupation is not necessarily limited to the specific job that You performed for the employer.

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## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU**

### **ELIGIBLE CLASS(ES)**

All Full-Time exempt employees or members of another employee group which has been expressly approved for this coverage by the County Board of Supervisors working in a regular County position who are budgeted to work at least 40 hours per pay period.

The Policyholder's determination of eligibility shall be made in a fair and equitable manner among persons in like situations and in accordance with applicable law.

### **DATE YOU ARE ELIGIBLE FOR INSURANCE**

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

You will be eligible for the insurance described in this certificate on the later of:

1. July 18, 2020; and
2. the day after the date You complete the Waiting Period of 1 pay period following the date You enter an eligible class.

**Waiting Period** means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

### **ENROLLMENT PROCESS**

If You are eligible for insurance, You will be automatically enrolled for such insurance on the date You enter an eligible class.

### **DATE YOUR INSURANCE TAKES EFFECT**

#### **Rules for Noncontributory Insurance**

Your Noncontributory insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

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

#### **Increase in Insurance**

An increase in insurance due to an increase in Your earnings will take effect on the date of the increase in Your earnings.

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.

#### **Decrease in Insurance**

A decrease in insurance due to a decrease in Your earnings will take effect on the date of change.

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

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

## **ELIGIBILITY PROVISIONS: INSURANCE FOR YOU**

### **DATE YOUR INSURANCE ENDS**

Your insurance will end on the earliest of:

1. the date the Group Policy ends; or
2. the date insurance ends for Your class; or
3. the end of the period for which the last premium has been paid for You; or
4. the last day of the pay period coincident with or next following the date You cease to be in an eligible class. You will cease to be in an eligible class on the last day of the calendar month in which You cease Active Work in an eligible class, if You are not Disabled on that date; or
5. the last day of the pay period coincident with or next following the date Your employment ends; or
6. the date You retire in accordance with the last day of the calendar month coincident with or next following the date Your employment ends.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

### **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 premium 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 Policyholder 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.

## **SPECIAL RULES FOR GROUPS PREVIOUSLY INSURED UNDER A PLAN OF DISABILITY INCOME INSURANCE**

To prevent a loss of insurance because of a change in insurance carriers, the following rules will apply if this Disability Income Insurance:

- replaces a plan of group disability income insurance provided to You by the Policyholder; or
- replaces a Prior Plan of group disability income insurance provided to You by a former employer; when the replacement results from the Policyholder's acquisition of, merger with or other combination with that employer.

**Prior Plan** means the plan of group disability income insurance provided to You by the Policyholder through another carrier on the day before the Replacement Date.

**Replacement Date** means the effective date of the Disability Income Insurance under the Group Policy.

### **Rules for When Insurance Takes Effect if You were Insured Under the Prior Plan on the Day Before the Replacement Date:**

- **If You are Actively at Work on the day before the Replacement Date**, You will become insured for Disability Income Insurance under this certificate on the Replacement Date.
- **If You are not Actively at Work on such date because you are Disabled, and the Prior Plan that You were covered under on the day before the Replacement Date was an insured plan**, You will become insured for Disability Income Insurance under this certificate on the Replacement Date. However, if the Prior Plan that You were covered under on the day before the Replacement Date was a self-funded plan, You will become insured for Disability Income Insurance under this certificate on the date You return to Active Work.

We will credit any time You accumulated toward the Elimination Period under the Prior Plan to the satisfaction of the Elimination Period required to be met under this certificate.

Any benefits paid for such Disability will be equal to those that would have been payable to You under the Prior Plan less any amount for which the prior carrier is liable.

Benefit payments for such Disability will end on the earliest of:

- the date that payments end under the subsection DATE BENEFIT PAYMENTS END in this certificate; or
- the date that payments would have ended under the provisions of the Prior Plan of Insurance.
- **If You are not Actively at Work on such date for any other reason**, You will become insured for Disability Income Insurance under this certificate on the date you return to Active Work, provided however, if You are on a Policyholder approved leave of absence on the Replacement Date, You will become insured for Disability Income Insurance on the Replacement Date. However, Your insurance under this certificate will end on the date Your approved leave of absence ends if You do not return to Active Work on such date.

### **Rules for When Insurance Takes Effect if You were Not Insured Under the Prior Plan on the Day Before the Replacement Date:**

- You will be eligible for Disability Income Insurance under this certificate when you meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOU; and
- We will credit any time You accumulated under the Prior Plan toward the eligibility waiting period under the Prior Plan to the satisfaction of the eligibility waiting period required to be met under this certificate.

### **Rules for Pre-existing Conditions**

In determining whether a Disability is due to a Pre-existing Condition, We will credit You for any time You were insured under the Prior Plan. If Your Disability is due to a Pre-existing Condition as described in this

## **SPECIAL RULES FOR GROUPS PREVIOUSLY INSURED UNDER A PLAN OF DISABILITY INCOME INSURANCE (continued)**

certificate, but would not have been due to a pre-existing condition under the Prior Plan, We will pay a benefit equal to the lesser of:

- the benefit amount under this certificate; or
- the disability income insurance benefit that would have been payable to You under the Prior Plan.

If Your Disability would have been due to a pre-existing condition under the Prior Plan, it will be treated as having been caused by a Pre-existing Condition under this certificate.

### **Rules for Temporary Recovery from a Disability under the Prior Plan**

We will waive the Elimination Period that would otherwise apply to a Disability under this certificate if You:

- received benefits for a disability that began under the Prior Plan (“Prior Plan’s disability”);
- returned to work as an active Full-Time employee prior to the Replacement Date;
- become Disabled, as defined in this certificate, after the Replacement Date and within 90 days of Your return to work due to a sickness or accidental injury that is the same as or related to the Prior Plan’s disability;
- are no longer entitled to benefit payments for the Prior Plan’s disability since You are no longer insured under such Plan; and
- would have been entitled to benefit payments with no further elimination period under the Prior Plan, had it remained in force.



## **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 Policyholder for information regarding such legally mandated leave of absence laws.

### **AT YOUR OPTION: PORTABILITY**

You may request in Writing during the Request Period specified below to continue Portability Eligible Insurance under another group policy if such insurance ends because:

- Your employment ends; or
- You cease to be in a class that is eligible for such insurance.

If a request is made under this subsection, We will issue a new certificate of insurance which will explain the new insurance benefits. The insurance benefits under the new certificate may not be the same as those that ended under the Group Policy.

A request under this subsection may be made if, on the date of the request, the following requirements are met:

- the Group Policy is in effect;
- We have not received notice from the Policyholder of its intent to end the Group Policy;
- no application has been made to convert the insurance that is to be continued to an individual policy of life insurance as provided in; and
- the person making the request resides in a jurisdiction that permits portability.

### **Request Period**

To continue Portability Eligible Insurance under a different group policy, We must receive a completed request form within the Request Period described below.

If written notice of the option to continue Portability Eligible Insurance is given within 15 days before or after the date such insurance ends, the Request Period begins on the date the insurance ends and expires 31 days after such date.

If written notice of the option to continue Portability Eligible Insurance is given more than 15 days after but within 90 days of the date such insurance ends, the Request Period begins on the date the insurance ends and expires 45 days after the date of the notice.

If written notice of the option to continue Portability Eligible Insurance is not given within 90 days after the date such insurance ends, the Request Period begins on the date the insurance ends and expires at the end of such 90 day period.

### **For Disability Income Insurance**

For purposes of this subsection the term "Portability Eligible Disability Income Insurance" refers to Disability Income Insurance: Long Term Benefits.

You may request in Writing during the Request Period specified below to continue Your Portability Eligible Disability Income Insurance under another group policy issued by MetLife if such insurance ends because You cease to be in an eligible class or Your employment ends.

If You make a request under this subsection, evidence of Your insurability will not be required. We will issue a new certificate of insurance which will explain Your new insurance benefits. Your insurance benefits under the new certificate may not be the same as those that ended under the Group Policy.

## **CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (continued)**

A request under this subsection may be made, if, on the date of Your request, the following requirements are met:

- the Group Policy is in effect;
- We have not received notice from the Policyholder of its intent to end the Group Policy;
- You reside in a jurisdiction that permits portability;
- You have been insured for at least 12 months prior to the date that Your employment ends;
- Your employment did not end as a result of Your retirement;
- You are not Disabled; and
- You have not become insured under any other disability insurance plan within 31 days after the date Your Portability Eligible Disability Income Insurance ends under the Group Policy.

### **Request Period**

To continue Your Portability Eligible Disability Income Insurance under a different group policy, We must receive a completed request form from You within 31 days after the date such insurance ends under this certificate.

Your new certificate will take effect on the day after Your Portability Eligible Disability Income Insurance ends under this Certificate.

### **Premiums for the New Certificate**

When You request to continue Portability Eligible Disability Income Insurance under this subsection, the first premium must be paid within 31 days after Your insurance ends under this certificate. All premiums must be paid directly to Us. When We issue the new certificate, We will also provide You with a schedule of premiums and payment instructions.

### **AT YOUR OPTION: CONTINUATION OF YOUR DISABILITY INCOME INSURANCE DURING A LABOR DISPUTE**

You may elect to continue Your Disability Income Insurance if You cease to be Actively at Work as the result of a labor dispute. Your Disability Income Insurance will continue for up to 6 months if the following conditions are met:

- at least 75% of the Employees eligible to continue their Disability Income Insurance elect to continue this insurance for such time period; and
- You pay the required premium for Your Disability Income Insurance.

If continued, Your Disability Income Insurance will end if:

- Premium payment is required and You fail to pay premiums for such insurance;
- the number of Employees who elect to continue such insurance falls below 75% of all employees eligible to continue this insurance for such time period; or
- You cease to be eligible to continue Your Disability Income Insurance under this section and You do not immediately resume Active Work in a class that is eligible for Disability Income Insurance.

### **AT THE POLICYHOLDER'S OPTION**

The Policyholder 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.

Disability Income Insurance will continue for the following periods:

1. for the period You cease Active Work in an eligible class due to injury or sickness, up to 3 months;

## CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (continued)

2. for Disability Income Insurance: Short Term Benefits, for the period You cease Active Work in an eligible class due to any other Policyholder approved leave of absence, up to 3 months.
3. for Disability Income Insurance: Long Term Benefits, for the period You cease Active Work in an eligible class due to any other Policyholder approved leave of absence, up to 90 days.

For purposes of this provision, leave of absence does not include a furlough. Furlough means an employer-mandated leave of absence.

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.

## **DISABILITY INCOME INSURANCE: SHORT 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 Weekly 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 of the Disability claim, 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 Weekly 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.

### **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 Weekly Benefit one week after the date benefits begin to accrue. We will make subsequent payments weekly thereafter so long as You remain Disabled. Payment will be based on the number of days You are Disabled during each week. For any partial week of Disability, payment will be made at the daily rate of 1/7<sup>th</sup> of the Weekly Benefit payable.

We will pay Weekly 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**

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

The provisions of this subsection will not apply if Your insurance has ended and You are eligible for coverage under another group short 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 and then become Disabled, You will have to complete a new Elimination Period.

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

If You return to Active Work after You begin to receive Weekly Benefits, We will consider You to have recovered from Your Disability.

If You return to Active Work for a period of 60 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.

### **REHABILITATION INCENTIVES**

#### **Rehabilitation Program Incentive**

If You participate in a Rehabilitation Program, We will increase Your Weekly Benefit by an amount equal to 10% of the Weekly Benefit. We will do so before We reduce Your Weekly Benefit by any Other Income.

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

### **Work Incentive**

If You work while You are Disabled and receiving Weekly Benefits, Your Weekly Benefit will be adjusted as follows:

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

Your Weekly Benefit as adjusted above will not be reduced by the amount You earn from working, except to the extent that such adjusted Weekly 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 Weekly Benefit will not apply.

### **Family Care Incentive**

If You work or participate in a Rehabilitation Program while You are Disabled, We will reimburse You for up to \$100 for weekly 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 or living in Your residence.

- care to 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 weekly basis starting with the 4<sup>th</sup> Weekly Benefit payment. 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.

### **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: 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 60 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 60 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 Incentive, 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 return to work, 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 or living in Your residence.

- care to 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 first Monthly Benefit payment until You have received 12 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: SHORT TERM BENEFITS INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT**

We will reduce Your Disability benefit by the amount of all Other Income that was actually paid to You for the same disability for which You are claiming benefits under this certificate. Other Income includes the following:

1. any disability benefits under:
  - the Jones Act;
  - any government compulsory/statutory benefit law;
  - any government retirement system, including but not limited to the California State Teachers Retirement System (CalSTRS) and/or the California Public Employee Retirement System (CalPERS); and/or the 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;
  - the Policyholder's Retirement Plan;
2. third party liability payments by judgment, settlement or otherwise (minus attorneys' fees);
3. sick pay;
4. amounts from compromise or settlement of any claim for any of the Other Income sources shown in this provision (minus attorneys' fees);
5. any salary continuation, personal time off, and annual leave pay; and
6. return to work earnings as set forth in the Work Incentive and Limit on Work Incentive sub-provisions, in the REHABILITATION INCENTIVES provision.

### **REDUCING YOUR DISABILITY BENEFIT BY THE ESTIMATED AMOUNT OF YOUR GOVERNMENT COMPULSORY BENEFIT PLAN OR PROGRAM OR CalSTRS, CalPERS OR FERS OR OTHER PUBLIC EMPLOYEE RETIREMENT OR DISABILITY BENEFIT PLAN OR PROGRAM**

If We have a reasonable, good faith belief that You are entitled to disability benefits under a government compulsory plan or program or a federal, state or other public employee retirement or disability plan or program, including a CalSTRS, CalPERS or FERS Retirement System, We expect You to apply for such benefits.

1. **With respect to Government Compulsory Benefit Plans or Programs or CalSTRS, CalPERS, FERS Benefit Plans or Programs**, to apply means to pursue such benefits through the initial appeal level provided under such benefit plans or programs. You must send Us Proof that You have applied for benefits under such plans or programs and are pursuing such benefits with reasonable diligence. You must also 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 and if there is a reasonable means of estimating the amount of such benefits payable to You, We will reduce Your Disability benefit by the amount of such government compulsory benefit plan or program benefit, or CalSTRS, CalPERS or FERS benefit that We estimate You are eligible to receive. We will start to do this with the first Disability benefit payment under this certificate coincident with the date You were eligible to receive such government compulsory benefit plan or program benefit, or Cal STRS, Cal PERS or FERS benefits under any such plan or programs.

If Your application for such benefits is approved, We will reduce Your Disability benefit by the amount actually paid to You from the above sources.

2. With respect to a government compulsory benefit plan or program, or 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: SHORT TERM BENEFITS 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: LONG TERM BENEFITS INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT**

We will reduce Your Disability benefit by the amount of all Other Income that was actually paid to You for the same disability for which You are claiming benefits under this certificate. Other Income includes the following:

1. any disability benefits for You, Your Spouse or child(ren) under:
  - Federal Social Security Act;
  - Canadian Pension Plan;
  - Quebec Pension Plan;
  - Railroad Retirement Act; or
  - any similar plan or act;
2. temporary disability benefits under a workers' compensation law;
3. amounts under any other occupational disease law, Longshoremen's and Harbor Worker's Act, Maritime Doctrine of Maintenance, Wages and Cure or similar act;
4. any disability benefits under:
  - the Jones Act;
  - any government compulsory/statutory benefit law;
  - any government retirement system, including but not limited to the California State Teachers Retirement System (CalSTRS) and/or the California Public Employee Retirement System (CalPERS); and/or the 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;
  - the Policyholder's Retirement Plan;
5. any retirement benefits for You under:
  - Federal Social Security Act;
  - Canadian Pension Plan;
  - Quebec Pension Plan;
  - Railroad Retirement Act;
  - the Policyholder's Retirement Plan; or
  - any similar plan or act;
6. third party liability payments by judgment, settlement or otherwise (minus attorneys' fees);
7. sick pay;
8. amounts from compromise or settlement of any claim for any of the Other Income sources shown in this provision (minus attorneys' fees);
9. any salary continuation, personal time off, and annual leave pay; and
10. return to work earnings as set forth in the Work Incentive and Limit on Work Incentive sub-provisions, in the REHABILITATION INCENTIVES provision.

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

If We have a reasonable, good faith belief that You are entitled to disability benefits under the Federal Social Security Act, a government compulsory plan or program or a federal, state or other public employee retirement or disability plan or program, including a CalSTRS, CalPERS or FERS Retirement System, We expect You to apply for such benefits.

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 We estimate that You are eligible to receive because of Your retirement, if We have a reasonable, good faith belief that You are entitled to

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

such benefits, and there is a reasonable basis for estimating the amount of such benefits payable to You. We will start to do this with the first Disability benefit payment coincident with the date You were eligible to receive such benefits, if:

- You have not applied for such benefits, or, You have failed to pursue such benefits with reasonable diligence;
- Your claim for Federal Social Security benefits is approved, and You do not notify Us of such approval; or
- You have not received a notice of denial of such benefits indicating that all levels of appeal have been exhausted, and You did not notify Us of such approval.

2. You must also:

- 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; or

If Your application for such benefits is approved, We will reduce Your Disability benefit by the amount actually paid to You from the Federal Social Security Administration.

3. With respect to Government Compulsory Benefit Plans or Programs or CalSTRS, CalPERS, FERS Benefit Plans or Programs to apply means to pursue such benefits through the initial level of appeal provided for under such benefit plans or programs. You must send Us Proof that You have applied for benefits under such plans or programs and are pursuing such benefits with reasonable diligence. You must also 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, and if there is a reasonable means of estimating the amount of such benefits payable to You, We will reduce Your Disability benefit by the amount of such government compulsory benefit plan or program benefit, or CalSTRS, CalPERS or FERS benefit that We estimate You are eligible to receive. We will start to do this with the first Disability benefit payment under this certificate coincident with the date You were eligible to receive such government compulsory benefit plan or program benefit or CalSTRS, CalPERS or FERS benefits under any such plan or programs.

If Your application for such benefits is approved, We will reduce Your Disability benefit by the amount actually paid to You from the above sources.

4. With respect to benefits You have applied for under the Federal Social Security Act, a government compulsory benefit plan or program or a federal, state or other public employee retirement or disability plan or program, including a CalSTRS, CalPERS 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: LONG TERM BENEFITS 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 any Other Income that is not shown in Income Which Will Reduce Your Disability Benefit.

## **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 section 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;
- for Disability Income Insurance: Long Term Benefits: the date following 12 consecutive months of Disability for which You were entitled to receive Monthly benefit payments while You are living outside of the United States or Canada; or
- 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: COST OF LIVING ADJUSTMENT**

If You have been receiving Monthly Benefits under this certificate, We will adjust Your benefit amount on the date following the date the 12th Monthly Benefit is payable. As limited by the Maximum Benefit Period, further adjustments will take effect on each anniversary of the first adjustment. The total number of adjustments may not exceed 60.

The adjustments do not apply to amounts We pay under this certificate for Rehabilitation Incentives or any Additional Benefits shown in the Schedule of Benefits.

### **BENEFIT AMOUNT**

To calculate Your cost of living adjustment, We will multiply the amount of Your Monthly Benefit for the month prior to the date the cost of living adjustment is to take effect by 3%. We will add this amount to each subsequent Monthly Benefit payment.



## **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 4 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: LONG TERM BENEFITS PRE-EXISTING CONDITIONS**

Pre-existing Condition means You:

- received medical treatment, care, or services for a diagnosed condition; or
- took prescribed medication for a diagnosed condition;

in the 3 months immediately prior to the effective date of coverage under this certificate; and the Disability caused or substantially contributed to by the condition begins in the first 12 consecutive months after the effective date of coverage under this certificate.

You are not covered for a Disability caused or substantially contributed to by a Pre-existing Condition or medical or surgical treatment of a Pre-existing Condition.

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

### **For Disability Due to Alcohol, Drug or Substance Abuse or Addiction**

If You are Disabled due to alcohol, drug or substance abuse or addiction, We will limit Your Disability benefits during your lifetime. During Your Disability, We require You to participate in an alcohol, drug or substance abuse or addiction recovery program recommended by a Physician.

We will end Disability benefit payments at the earliest of:

- the date You receive 24 months of Disability benefit payments;
- the date You cease or refuse to participate in the recovery program referred to above; or
- the date You complete such recovery program.

### **For Disability Due to Mental or Nervous Disorders or Diseases**

If You are Disabled due to a Mental or Nervous Disorder or Disease, We will limit Your Disability benefits to a lifetime maximum equal to the lesser of:

- 24 months; or
- the Maximum Benefit Period.

If You are confined in a Hospital or Mental Health Facility at the end of the period shown above for which benefits are to be paid, We will continue Your Monthly Benefits until the end of Your Hospital or Mental Health Facility confinement.

We will determine if a Disability is the result of a Mental or Nervous Disorder or Disease.

This limitation will not apply to a Disability resulting from:

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

For purposes of this provision, Mental Health Facility means a facility licensed in the jurisdiction in which it is located to provide care and treatment for a Mental or Nervous Disorder or Disease. Such facility must provide care on a 24 hour a day basis under the supervision of a staff of Physicians, and must provide a broad range of nursing care on a 24 hour a day basis by or under the direction of a registered professional nurse.

**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.

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

### **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 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 a felony.

We will not pay Short Term Benefits for any Disability caused or contributed to by elective treatment or procedures, such as:

1. cosmetic surgery or treatment primarily to change appearance;
2. reversal of sterilization;
3. liposuction;
4. visual correction surgery; and
5. in vitro fertilization; embryo transfer procedure; or artificial insemination.

However, pregnancies and complications from any of these procedures will be treated as a Sickness.

## FILING A CLAIM

The Policyholder should have a supply of claim forms. Obtain a claim form from the Policyholder and fill it out carefully. Return the completed claim form with the required Proof to the Policyholder. The Policyholder will certify Your insurance under the Group Policy and send the certified claim form and Proof to Us.

When We receive the claim form and Proof, We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this certificate and the Group Policy.

### CLAIMS FOR DISABILITY INSURANCE BENEFITS

**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 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**

For Disability Income Insurance benefits, You must give Us Proof not later than 30 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 as soon as is reasonably possible but, in no event, other than for lack of legal capacity, may Proof be given later than one year after the date it is otherwise required.

### 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 Income;
    - 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 Income;

## FILING A 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.

### Regular Care of a Physician Requirement

In addition, You must be under the Regular Care of a Physician unless Regular Care:

1. will not improve the condition(s) causing Your Disability; or
2. will not prevent a worsening of the condition(s) causing Your Disability.

**Regular care** means:

1. You personally visit a Physician(s) as frequently as is medically required to effectively manage and treat the condition(s) causing Your Disability; and
2. You are receiving appropriate treatment and care which conforms with generally accepted medical standards for the condition(s) causing Your Disability.

Prior to the initial payment of benefits, provided You are receiving appropriate treatment and care which conforms with generally accepted medical standards for the condition(s) causing Your Disability, if the time period between Your visits to a Physician(s) is reasonable, You will be deemed to have satisfied the Regular Care of a Physician requirement, even if this results in a visit to a Physician(s) occurring after the end of the Elimination Period.

**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. 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 Beneficiary at Your death, We will pay any benefit that is or becomes due, according to the following order:

1. Your Spouse or Domestic Partner, if alive;
2. Your unmarried child(ren) under age 25; if there is no surviving Spouse or Domestic Partner; or
3. Your estate, if there is no such surviving child.

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 Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Policyholder'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.



## **GENERAL PROVISIONS (continued)**

### **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.

### **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 for Disability Income Insurance**

#### **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.

**THE PRECEDING PAGE IS THE END OF THE CERTIFICATE.  
THE FOLLOWING IS ADDITIONAL INFORMATION.**

# **SPECIAL SERVICES**

## **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 National 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.

## **SPECIAL SERVICES**

### **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.

### **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.

# **SPECIAL SERVICES**

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

As soon as you are approved 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 provides 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.

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.