

**YOUR EMPLOYEE
BENEFIT PLAN**

MIAMI-DADE COUNTY PUBLIC SCHOOLS

Life and Accidental Death or Dismemberment Benefits
For Active Employees



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

CERTIFICATE RIDER

Group Policy No.: 24400-G
Policyholder: Miami-Dade County Public Schools
Effective Date: August 1, 2007

The certificate is changed as follows:

In the Schedule of Benefits, replace **IF YOU ARE AGE 70 OR OLDER** with the following:

“IF YOU ARE AGE 70 OR OLDER

The amount of your Basic Life and Optional Life Benefits on and after age 70 will be determined by applying the appropriate percentage from the following table to the amount of such benefits, rounded up to the next higher \$1,000, which would otherwise have been applicable had you not become age 70:

<u>Age of Employee</u>	<u>Percentage</u>
70 but less than 75	65%
75 but less than 80	45%
80 or older	30%”

This rider is to be attached to and made part of the certificate.

Form G.8480



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

CERTIFICATE RIDER

Group Policy No.: 24400-G
Policyholder: Miami-Dade County Public Schools
Effective Date: January 1, 2008

The certificate is changed as follows:

In **SCHEDULE OF BENEFITS, APPLICABLE TO ADMINISTRATORS AND CONFIDENTIAL EXEMPT EMPLOYEES, NON-CONTRIBUTORY BENEFITS**, replace with the following:

“BASIC LIFE

- Option 1..... \$50,000
- Option 2..... An amount equal to 2 times your basic annual earnings, as determined by your Employer, rounded to the next higher \$1,000
- Minimum Basic Life Benefit \$10,000
- Maximum Basic Life Benefit \$500,000”

This rider is to be attached to and made part of the certificate.

Form G.8480

Miami-Dade County Public Schools
1500 Biscayne Blvd.
Miami, FL 33132

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.

Benefits are provided through a group policy issued to Miami-Dade County Public Schools by Metropolitan Life Insurance Company.

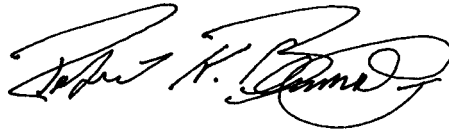
Miami-Dade County Public Schools

MetLife®

Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

Certifies that the benefits as described herein are provided under and subject to the terms and conditions of the Group Policy issued to the Employer.

The Employee named below is covered for the Personal Benefits on the effective date set forth below.



Robert H. Benmosche
Chairman, President and Chief Executive Officer

Employer: **Miami-Dade County Public Schools**

Group Policy No.: **6024400-G**

PLEASE AFFIX THE STICKER
SHOWING THE EMPLOYEE'S
NAME AND EFFECTIVE DATE
IN THIS SPACE

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

North Dakota Residents: Free Look Period for Life Insurance: If You are not satisfied with your certificate, You may return it to Us within 20 days after You receive it, unless a claim has previously been received by Us under your certificate. We will refund within 30 days of our receipt of the returned certificate any Premium that has been paid and the certificate will then be considered to have never been issued. You should be aware that, if you elect to return the certificate for a refund of

premiums, losses which otherwise would have been covered under your certificate will not be covered.

For West Virginia Residents: You have the right to return this certificate within ten days of its receipt and to have your premium refunded if, after examination of the certificate, you are not satisfied for any reason.

Accelerated Benefits may be taxable. If so, you or your Beneficiary may incur a tax obligation. As with all tax matters, you should consult your personal tax advisor to assess the impact of this Benefit.

Texas Residents: Please Read the Notice Pages for Texas Residents Carefully

If any prior certificate relating to the coverage set forth herein has been given to the Employee, such certificate is void.

Form G.23000-Cert.

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-638-5433

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 - 475-1771

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.

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-638-5433

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

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS:

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

UNA ESTE AVISO A SU CERTIFICADO: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

For Texas Residents:

IMPORTANT NOTICES

DEATH BENEFITS WILL BE REDUCED IF AN ACCELERATION-OF-LIFE-INSURANCE BENEFIT IS PAID.

DISCLOSURE: The acceleration-of-life-insurance benefits offered under this certificate are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If the acceleration-of-life-insurance benefits qualify for such favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to acceleration-of-life insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration-of-life-insurance benefits excludable from income under the federal law.

DISCLOSURE: Receipt of acceleration-of-life-insurance benefits may affect your, your spouse's or your family's eligibility for public assistance programs such as Medical Assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary Social Security Income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such payment will affect your, your spouse and your family's eligibility for public assistance.

Arkansas residents please be advised of the following:

IMPORTANT NOTICE

IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:

1-800-638-5433

IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER AND METLIFE, YOU SHOULD FEEL FREE TO CONTACT:

**ARKANSAS INSURANCE DEPARTMENT
CONSUMER SERVICES DIVISION
1200 WEST THIRD
LITTLE ROCK, ARKANSAS 72201-1904**

California residents please be advised of the following:

IMPORTANT NOTICE

**TO OBTAIN ADDITIONAL INFORMATION, OR
TO MAKE A COMPLAINT, CONTACT METLIFE
AT:**

**METROPOLITAN LIFE INSURANCE
COMPANY
1 MADISON AVENUE
NEW YORK, NY 10010
ATTN: CORPORATE CONSUMER RELATIONS
DEPARTMENT
1-800-638-5433**

**IF, AFTER CONTACTING METLIFE
REGARDING A COMPLAINT, YOU FEEL THAT
A SATISFACTORY RESOLUTION HAS NOT
BEEN REACHED, YOU MAY FILE A
COMPLAINT WITH THE CALIFORNIA
INSURANCE DEPARTMENT AT:**

**CALIFORNIA DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1-800-927-4357 (within California)
1-213-897-8921 (outside California)**

Georgia residents please be advised of the following:

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.

IMPORTANT NOTICE

NOTICE FOR RESIDENTS OF MONTANA

If a claim on your life becomes payable under this certificate, settlement of the claim shall be made within 60 days of the date that we receive proof of death that is satisfactory to us. The settlement shall include interest from the 30th day after we receive such proof until settlement. Such interest shall be paid at the rate required by law in Montana.

Utah residents please be advised of the following:

NOTICE TO POLICYHOLDERS

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

PEOPLE ENTITLED TO COVERAGE

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

POLICIES COVERED

- ULHIGA provides coverage for certain life, health and annuity insurance policies.

EXCLUSIONS AND LIMITATIONS

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.

- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

LIMITS ON AMOUNT OF COVERAGE

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or \$500,000 — whichever is lower. Other caps also apply:

- \$100,000 in net cash surrender values.
- \$500,000 in life insurance death benefits (including cash surrender values).
- \$500,000 in health insurance benefits.
- \$200,000 in annuity benefits — if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- \$5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).
- Interest rates on some policies may be adjusted downward.

DISCLAIMER

PLEASE READ CAREFULLY:

· **COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.**

· **COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.**

· **THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.**

· **INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.**

· **THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.**

Utah Life and Health Insurance
Guaranty Association
955 E. Pioneer Rd.
Draper, Utah 84114

Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

Virginia residents please be advised of the following:

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:

Metropolitan Life Insurance Company
1 Madison Avenue
New York, New York 10010
Attn: Corporate Customer Relations Department

To phone in a claim related question, you may call Claims Customer Service at:

1-800-638-5433

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:

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209

1-800-552-7945 - In-state toll-free
1-804-786-3741 - Out-of-state

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.

Wisconsin residents please be advised of the following:

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.

Metropolitan Life Insurance Company
Corporate Consumer Relations Department
1 Madison Avenue
New York, NY 10010
1-800-638-5433

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

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

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SCHEDULE OF BENEFITS
(Also see SCHEDULE SUPPLEMENT)

The following Benefits are provided subject to the provisions below.

**APPLICABLE TO ALL EMPLOYEES OTHER THAN
ADMINISTRATORS AND CONFIDENTIAL EXEMPT EMPLOYEES**

NON-CONTRIBUTORY BENEFITS
(EMPLOYEE ONLY)

AMOUNT

BASIC LIFE An amount equal to the greater of \$10,000 or 1 times your basic annual earnings, as determined by your Employer, rounded to the next higher \$1,000

Minimum Basic Life Benefit \$10,000

Maximum Basic Life Benefit \$250,000

**BASIC ACCIDENTAL DEATH OR
DISMEMBERMENT**

An amount equal to your Basic Life Benefits

OPTIONAL CONTRIBUTORY BENEFITS
(EMPLOYEE ONLY)

AMOUNT

OPTIONAL LIFE

All Employees who elect:

Option 1 An amount equal to 1 times your basic annual earnings, as determined by your Employer, rounded to the next higher \$1,000

- Option 2 An amount equal to 2 times your basic annual earnings, as determined by your Employer, rounded to the next higher \$1,000
- Option 3 An amount equal to 3 times your basic annual earnings, as determined by your Employer, rounded to the next higher \$1,000
- Option 4 An amount equal to 4 times your basic annual earnings, as determined by your Employer, rounded to the next higher \$1,000
- Maximum Optional Life Benefit..... \$750,000

OPTIONAL ACCIDENTAL DEATH OR DISMEMBERMENT

An amount equal to your Optional Life Benefits

**APPLICABLE TO ALL ADMINISTRATORS AND
CONFIDENTIAL EXEMPT EMPLOYEES**

<u>NON-CONTRIBUTORY BENEFITS (EMPLOYEE ONLY)</u>	<u>AMOUNT</u>
BASIC LIFE	An amount equal to 2 times your basic annual earnings, as determined by your Employer, rounded to the next higher \$1,000
Minimum Basic Life Benefit	\$10,000
Maximum Basic Life Benefit	\$500,000

BASIC ACCIDENTAL DEATH OR DISMEMBERMENT An amount equal to your Basic Life Benefits

<u>OPTIONAL CONTRIBUTORY BENEFITS (EMPLOYEE ONLY)</u>	<u>AMOUNT</u>
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OPTIONAL LIFE

All Employees who elect:

Option 1	An amount equal to 1 times your basic annual earnings, as determined by your Employer, rounded to the next higher \$1,000
Option 2	An amount equal to 2 times your basic annual earnings, as determined by your Employer, rounded to the next higher \$1,000

Option 3 An amount equal to 3 times your basic annual earnings, as determined by your Employer, rounded to the next higher \$1,000

Maximum Optional Life Benefit..... \$500,000

OPTIONAL ACCIDENTAL DEATH OR DISMEMBERMENT An amount equal to your Optional Life Benefits

Only your Life Benefits will be reduced if Accelerated Benefits are paid. Any amount of Accidental Death or Dismemberment Benefits will be based on the amount of your earnings used to determine the amount of your Life Benefits in effect at the date payment of the Accelerated Benefit is made subject to any change in your earnings as described in the Increase and Decrease provisions in this SCHEDULE OF BENEFITS.

See pages hereof entitled ACCELERATED BENEFITS (On Your Own Account).

You may request payment of an Accelerated Benefit from your Basic or Optional Life Benefits or from both. If you elect payment from both your Basic and Optional Life Benefits, the Accelerated Benefits payment will be determined in accordance with the pages hereof entitled ACCELERATED BENEFITS (On Your Own Account), but not more than \$250,000 will be payable for Basic Life and not more than \$250,000 for Optional Life.

**INCREASES AND DECREASES IN AMOUNTS OF
BASIC AND OPTIONAL LIFE BENEFITS, BASIC ACCIDENTAL
DEATH OR DISMEMBERMENT BENEFITS AND OPTIONAL
ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS**

Your earnings on the date you become covered under This Plan will determine your benefits on that date. If your earnings or class changes, your benefits will be those for your new earnings or class. Any increase or decrease in your benefits will take place on January 1 each year provided you are Actively at Work on that date. If you are not Actively at Work on that date, the change in your benefits will take place when you return to Active Work.

**APPLICABLE TO EMPLOYEES WITH A PERSONAL ELIGIBILITY
DATE ON OR AFTER APRIL 1, 1997**

**PROVISIONS APPLICABLE TO BASIC LIFE BENEFITS AND
OPTIONAL LIFE BENEFITS IN TOTAL AMOUNTS GREATER THAN
3 TIMES YOUR BASIC ANNUAL EARNINGS**

1. You must, at your expense, give us evidence of your good health in order to become covered by This Plan for a total amount of Life Benefits greater than 3 times your basic annual earnings; or
2. If we accept the evidence of your good health as satisfactory, such amount of Life Benefits or such increase in the amount of Life Benefits will become effective:
 - a. with respect to Basic Life Benefits, on the later of: (i) the date we accept the evidence of your good health if you are Actively at Work on that date or (ii) on the date you return to Active Work if you are not Actively at Work on that date; and
 - b. with respect to Optional Life Benefits, on the later of: (i) the date we accept the evidence of your good health or (ii) the effective date of your Personal Benefits provided, on such later date, you have satisfied the Work Requirements. If you have not satisfied the Work Requirements, such amount of Optional Life Benefits or such increase in the amount of Optional Life Benefits will become effective on the first day after you satisfy the Work Requirements.

3. If you do not give us evidence of your good health, or if such evidence of good health is not accepted by us as satisfactory, the amount of your Life Benefits will not be more than the greater of:
 - a. the amount of Life Benefits for which you were covered immediately prior to the date on which any such increase would have become effective; or
 - b. 3 times your basic annual earnings.

**APPLICABLE TO EMPLOYEES WITH A PERSONAL BENEFITS
ELIGIBILITY DATE PRIOR TO APRIL 1, 1997**

IF YOU CHANGE YOUR OPTIONAL LIFE BENEFITS COVERAGE

- A. **Increase in Coverage:** If you are covered for Optional Life Benefits and make written application to increase coverage, you must give us evidence of good health at your expense. If we accept your evidence of good health as satisfactory, the increase in Optional Life Benefits will take effect as of the date we accept it if you have satisfied the Work Requirements. If you are required to submit evidence of good health and do not; or if you submit evidence of good health and we do not accept it; or if you fail to satisfy the Work Requirements at the time you submit your application or the time we accept your evidence of good health, whichever is later; the amount of your Optional Life Benefits will not change.
- B. **Decrease in Coverage:** If you are covered for Optional Life Benefits and make a written application to decrease your coverage under one of the options of the Plan, that decrease will take effect as of the date of your application.

IF YOU ARE AGE 70 OR OLDER

The amounts of your Basic Life and Optional Life Benefits on and after age 70 will be determined by applying the appropriate percentage from the following table to the amount of such benefits which would otherwise have been applicable had you not become age 70:

<u>Age of Employee</u>	<u>Percentage</u>
70 but less than 75	65%
75 but less than 80	45%
80 or older	30%

No Basic Accidental Death or Dismemberment or and Optional Accidental Death or Dismemberment Benefits are provided for you under This Plan on and after your 70th birthday.

**AMOUNT OF CONTINUED DEATH BENEFITS
DURING TOTAL DISABILITY**

The amount of your Death Benefits will be the amount of your Life Benefits on the date your Life Benefits ended and will be subject to the same reduction as would apply had you not become disabled.

Your Death Benefits will be reduced if Accelerated Benefits are paid.

WHEN YOU RETIRE

Refer to your Retired Employees Booklet Certificate for details.



Please call 800-638-6420 for assistance regarding claims and information about coverage.

Form G.23000-B

SCHEDULE SUPPLEMENT

A. Statements Made by You Which Relate to Insurability

Any statement made by you will be deemed a representation and not a warranty.

No such statement made by you which relates to insurability will be used:

1. in contesting the validity of the benefits with respect to which such statement was made; or
2. to reduce the benefits;

unless the conditions listed in items (a) and (b) below have been met:

- a. The statement must be contained in a written application which has been signed by you.
- b. A copy of the application has been furnished to you or to your Beneficiary.

No such statement made by you will be used at all after such benefits have been in force prior to the contest for a period of two years during the lifetime of the person to whom the statement applies.

B. Assignment

This certificate may not be assigned by you. Your benefits may not be assigned prior to a loss.

C. Additional Provisions

1. The benefits under This Plan do not at any time provide paid-up insurance, or loan or cash values.
2. No agent has the authority:
 - a. to accept or to waive the required notice or proof of a claim; nor
 - b. to extend the time within which a notice or a proof must be given to us.

Form G.23000-B1

DEFINITIONS OF CERTAIN TERMS USED HEREIN

"Actively at Work" or **"Active Work"** means that you are performing all of the material duties of your job with the Employer where these duties are normally carried out or you are on an approved leave of absence. If you were Actively at Work on your last scheduled working day, you will be deemed Actively at Work:

1. on a scheduled non-working day;
2. provided you are not disabled.

"Covered Person" means an Employee on whose account benefits are in effect under This Plan.

"Doctor" means a person who is legally licensed to practice medicine. A licensed practitioner will be considered a Doctor if:

1. there is a law which applies to This Plan and that law requires that any service performed by such a practitioner must be considered for benefits on the same basis as if the service were performed by a Doctor; and

2. the service performed by the practitioner is within the scope of his or her license.

The term Doctor also includes any mental health professional as licensed by the Florida Department of Professional Regulation.

"Employee" means a person who is employed and paid for services by the Employer on a full-time basis.

"Hospitalized" means that you have received:

1. inpatient care in a hospital; or
2. care in:
 - a. a hospice facility; or
 - b. an intermediate facility; or
 - c. a long term care facility; or
3. chemotherapy; or
4. radiation therapy; or
5. dialysis treatment.

"Personal Benefits" mean the benefits which are provided on account of an Employee under This Plan.

"This Plan" means the Group Policy which is issued by us to provide Personal Benefits.

"Total Disability" or **"Totally Disabled"** means that because of a sickness or an injury:

1. you can not do your job; and
2. you can not do any other job for which you are fit by your education, your training or your experience.

"We", **"us"** and **"our"** mean Metropolitan.

"Work Requirements" means that you have:

1. worked as an Employee at least 20 hours during the last 7 consecutive calendar days; and
2. worked at either your usual place of business or away from your usual place of business at your Employer's convenience.

"You" and **"your"** mean the Employee who is a Covered Person for Personal Benefits.

Form G.23000-A

ELIGIBILITY FOR BENEFITS

Personal Benefits Eligibility Date

If you are an Employee on October 1, 2003, that is your Personal Benefits Eligibility Date.

If you become an Employee after October 1, 2003, your Personal Benefits Eligibility Date is the date you become an Employee of the Employer.

Form G.23000-C

EFFECTIVE DATES OF PERSONAL BENEFITS

This Plan provides one or more Non-Contributory Benefit(s) and one or more Contributory Benefit(s). The applicable provisions set forth below will be applied separately to each benefit.

APPLICABLE TO NON-CONTRIBUTORY BENEFITS (Basic Life and Basic Accidental Death or Dismemberment Benefits)

Your Personal Benefits will become effective on your Personal Benefits Eligibility Date provided you are then Actively at Work as an Employee. If you are not then Actively at Work as an Employee, your Personal Benefits will become effective on the date of your return to Active Work as an Employee.

APPLICABLE TO CONTRIBUTORY BENEFITS (Optional Life and Optional Accidental Death or Dismemberment Benefits)

A. Request Forms

You must make a written request to the Employer for Personal Benefits. The request forms will be given to the Employer by us.

B. If Timely Request Is Made

A timely request is one that is made on or prior to the date thirty-one days after your Personal Benefits Eligibility Date. If you are not Actively at Work as an Employee on your Personal Benefits Eligibility Date, a request will be timely if it is made on or prior to the date thirty-one days after the date you return to Active Work as an Employee.

If you make a timely request for Personal Benefits, your Personal Benefits will become effective on the later of:

1. your Personal Benefits Eligibility Date; and
2. the date of your request;

subject to the Work Requirements.

If, on the date you would have become covered under This Plan for Personal Benefits, you:

1. were Hospitalized in the ninety days prior to the date you make a request for Personal Benefits under This Plan; or
2. are then Hospitalized;

then evidence of your good health must be given to us.

C. If Late Request Is Made

If a request is not a timely request, it is a late request.

If you make a late request for Personal Benefits, evidence of your good health must be given to us.

D. Evidence of Good Health

The evidence of good health is to be given at your expense.

Your Personal Benefits will become effective on the date such evidence of good health is accepted by us as satisfactory, subject to the Work Requirements.

If the evidence of your good health is not accepted by us as satisfactory, you will not be covered for any Personal Benefits.

E. Work Requirements

You must satisfy the Work Requirements in order for your Personal Benefits to become effective. If you have not satisfied the Work Requirements on the date when your Personal Benefits would otherwise become effective, these benefits will become effective on the first day after you satisfy the Work Requirements.

F. Reinstatement of Benefits

If your Personal Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them. Such a request will be treated as if it were a late request in order to determine the effective date of your Personal Benefits.

Form G.23000-D1

**LIFE BENEFITS
(On Your Own Account)**

A. Coverage

If you die while you are covered for Life Benefits, we will pay to the Beneficiary the amount of Life Benefits that is in effect on your life on the date of your death.

B. Optional Types of Payment

Payment of any amount of Life Benefits may be made in installments. Details on the payment options may be obtained from the Employer.

Form G.23000-1

**ACCELERATED BENEFITS
(On Your Own Account)**

A. Definitions

"Meet the Requirements" means:

1. your life span is drastically limited; and
2. you are expected to die within 6 months; and
3. you are not expected to recover.

These must be certified by a Doctor and accepted by us.

B. Coverage

We will pay Accelerated Benefits to you if:

1. you apply for Accelerated Benefits while your Life Benefits or Death Benefits are in effect; and
2. you Meet the Requirements while you are covered for Life Benefits or Death Benefits; and
3. you or your legal representative requests payment of Accelerated Benefits while your Life Benefits or Death Benefits are in effect.

Accelerated Benefits are payable only once.

Payment of Accelerated Benefits will reduce your Life Benefits or Death Benefits and the amount available for you to convert to a personal policy of life insurance under RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE.

C. Proof

Accelerated Benefits will be payable when we receive proof that you Meet the Requirements.

Proof must be given to us. The proof must be in a form that is satisfactory to us. We have no duty to ask for any proof. Any delay in submitting proof will not cause a claim to be denied so long as the proof is given as soon as reasonably possible.

At the time that such proof is given, we may have you examined by Doctors of our choice, at our expense.

D. Amount

The amount of Accelerated Benefits payable is:

1. up to 50% of your Life Benefits or Death Benefits shown in the SCHEDULE OF BENEFITS; and
2. determined as of the date we accept certification that you Meet the Requirements; and
3. no more than \$250,000 for Basic Life Insurance and \$250,000 for Optional Life Insurance.

If your Life Benefits or Death Benefits will reduce within 6 months of such certification date, the Accelerated Benefits payable will be up to 50% of such reduced amount.

Accelerated Benefits will be payable if you are living when payment is made.

For Texas Residents: Upon receipt of your claim form we will send you a Preadjudication letter containing specific information on the payment you requested. Such information will include the amount of payment which will be made to you and the amount of death benefit remaining after payment of the Accelerated Benefit.

E. Exclusions

Accelerated Benefits will not be payable if:

1. you have assigned your Life Benefits (see Assignment provision under SCHEDULE SUPPLEMENT); or
2. the amount of your Life Benefits or Death Benefits is less than \$10,000.

Form G.23000-36

**CONTINUED DEATH BENEFITS
DURING TOTAL DISABILITY**

A. Coverage

If you cease to be Actively at Work as an Employee due to Total Disability, your Life Benefits may be continued for up to 12 months. For this to occur, your Employer must deem you to be Actively at Work and must continue to make premium payments for your Life Benefits. Your Life Benefits will end once you have ceased to be Actively at Work as an Employee due to Total Disability for 12 months. Death Benefits may be payable after your Life Benefits end in certain cases of Total Disability. We will pay Death Benefits to your Beneficiary if:

1. you become Totally Disabled before your Life Benefits end; and
2. your Total Disability starts for Basic Life Benefits while you are covered for such benefits and for Optional Life Benefits after you have been covered for such benefits for one year; and
3. you are less than 60 years old when you become Totally Disabled; and

4. you continue to be Totally Disabled after your Life Benefits end and until the date of your death; and
5. the required proof is submitted to us.

However, no Death Benefits are payable if a death benefit is payable under RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE.

B. Proof of Claim

The Death Benefits will be payable when we receive proof of your death if:

1. we have received proof of your Total Disability no later than 12 months after the date you ceased to be Actively at Work because of Total Disability. This proof must establish that your Total Disability had continued for at least nine months from the date you were last Actively at Work; and
2. you submit further proof, when we ask for it, that you continue to be Totally Disabled. We will not ask for such proof more than once a year; and
3. upon your death proof that Total Disability continued to the date of your death is given to us.

If you die within a year after your Life Benefits ended and before any proof has been given, then proof that your Total Disability continued to the date of your death must be given to us. This proof must be given within one year of your death.

All proofs must be given to us. The proofs must be in a form that is satisfactory to us. We have no duty to ask for any proof. If any proof is not given on time, the delay will not cause a claim to be denied so long as the proof is given as soon as reasonably possible.

At any time that proof of your Total Disability is given, we may have you examined by Doctors of our choice, at our expense.

C. Amount

The amount of Death Benefits is the amount shown in the SCHEDULE OF BENEFITS.

D. Termination

Your Death Benefits will end on:

1. the date you are no longer Totally Disabled; or
2. the date you do not give us proof of Total Disability when required; or
3. the last day in which you were Totally Disabled for 36 consecutive months.

E. One Payment Only

If we have issued a personal policy under RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE, we will pay Death Benefits only if that policy is returned to us without any claim. In such case an amount equal to the premiums paid on the personal policy will be given to the Beneficiary.

Form G.23000-1B1-A

**RIGHT TO OBTAIN A PERSONAL POLICY
OF LIFE INSURANCE ON YOUR OWN LIFE**

A. Application

We will issue a personal policy of life insurance without disability or accidental death benefits to you if you apply for it in writing during the Application Period. The Application Period is the 31 day period after:

1. the date your Life Benefits end because your employment ends or because you are no longer in a class which remains eligible for Life Benefits; or
2. the date your Life Benefits end because This Plan ends, but only if your Life Benefits under This Plan have been in effect for at least 5 years; or
3. the date This Plan is changed to end the Life Benefits for your class, but only if your Life Benefits under This Plan have been in effect for at least 5 years; or
4. the date your Death Benefits end under CONTINUED DEATH BENEFITS DURING TOTAL DISABILITY if you do not then again become eligible for Life Benefits under This Plan.

For New Hampshire residents. If you are not given notice, in writing, of the Right To Obtain A Personal Policy of Life Insurance On Your Own Life at least 15 days before the end of the Application Period, you will have additional time in which to apply. You will then have 15 days from the date you are given the notice in which to apply.

Proof that you are insurable is not required by us.

B. Conditions

The personal policy will be issued to you subject to these conditions:

1. it will be on one of the forms then usually issued by us, except term insurance; and
2. it will not take effect until after the Application Period ends; and
3. the premium for the policy will be based on:
 - a. the class of risk to which you belong; and
 - b. your age on the effective date of the policy; and
 - c. the form and amount of the policy; and
4. if item A(1) applies to you, the amount of the policy will not be more than the amount of your Life Benefits on the date the Life Benefits end; and
5. if item A(2) or item A(3) applies to you, the amount of the policy will not be more than the lesser of:
 - a. the amount of your Life Benefits on the date the Life Benefits end, less any amount of life insurance for which you may be eligible under any group policy which takes effect within 31 days after your Life Benefits end; and
 - b. \$10,000.
6. if item A(4) applies to you, the amount of the policy will not be more than the amount of your Death Benefits on the date the Life Benefits end.

C. If You Die During the Application Period

If you die during the Application Period, we will pay a death benefit to the Beneficiary. The amount of the death benefit will be the highest amount of life insurance pursuant to item B(4) or B(5) or B(6) for which a personal policy could have been issued. This death benefit will be paid even if you did not apply for a personal policy.

If you could have applied for a policy under item A(4) and you die within one year after your Life Benefits end, we must, within one year after your death, be given proof that:

1. your Total Disability had continued from the date your Life Benefits ended to within 31 days of the date of your death; and
2. your death occurred during the Application Period which applies to item A(4).

Form G.23000-1A

ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

A. Coverage

We will pay Accidental Death or Dismemberment Benefits for a Covered Loss shown in Section C if you are injured in an accident which occurs while you are covered for Accidental Death or Dismemberment Benefits; and if:

1. that accident is the sole cause of the injury; and
2. that injury is the sole cause of that Covered Loss; and
3. that Covered Loss occurs not more than 90 days after the date of that accident.

In addition, we will pay Accidental Death or Dismemberment Benefits for a Covered Loss shown below:

4. Exposure Benefit

We will pay an amount equal to the Full Amount, shown in section B, for the loss of your life if:

- a. such loss of life results from unavoidable exposure to the elements; and
- b. after one year, your body has not been found after the conveyance in which you were traveling:
 - i. disappeared;
 - ii. made a forced landing;
 - iii. sank; or
 - iv. was wrecked.

B. Maximum Benefit for All Covered Losses in Each Accident

For all Covered Losses caused by all injuries which you sustain in one accident not more than the Full Amount will be paid.

Full Amount means the amount of Accidental Death or Dismemberment Benefits for which you are covered on the date of your accident.

C. Table of Covered Losses and Benefit Amounts

Covered Losses (Subject to Exclusions)	Benefit Amounts
Life	Full Amount
A hand	One-half of the Full Amount
A foot	One-half of the Full Amount
Sight of an eye	One-half of the Full Amount
Loss of more than one of the above in any one accident	Full Amount

Loss of sight of an eye means that the eye is entirely blind and that no sight can be restored in that eye.

Loss of a hand means that all of the hand is cut off at or above the wrist.

Loss of a foot means that all of the foot is cut off at or above the ankle.

D. Exclusions

We will not pay for any Covered Loss shown in Section C if it in any way results from, or is caused or contributed to by:

1. physical or mental illness, diagnosis of or treatment for the illness; or
2. suicide or attempted suicide; or
3. injuring oneself on purpose; or
4. the use of any drug or medicine; or

5. a war, or a warlike action in time of peace, including terrorist acts; or
6. committing or trying to commit a felony or other serious crime or an assault.

E. Payment of Benefits

The Accidental Death or Dismemberment Benefits for a Covered Loss will be paid when we receive notice and satisfactory proof of that loss.

Accidental Death or Dismemberment Benefits will be paid:

1. to your Beneficiary for the loss of your life; and
2. to you for any other Covered Loss sustained by you.

F. Optional Types of Payment

Payment of any amount of Accidental Death or Dismemberment Benefits for loss of life may be made in installments. Details on the payment options may be obtained from the Employer.

Form G.23000-4L

BENEFICIARY

A. Your Beneficiary

The "Beneficiary" is the person or persons you choose to receive any benefit payable because of your death.

You make your choice in writing on a form approved by us. This form must be filed with the records for This Plan.

You may change the Beneficiary at any time by filing a new form with the Employer. You do not need the consent of the Beneficiary to make a change. When the Employer receives a form changing the Beneficiary, the change will take effect as of the date you signed it. The change of Beneficiary will take effect even if you are not alive when it is received.

A change of Beneficiary will not apply to any payment made by us prior to the date the form was received by the Employer.

Your choice of a Beneficiary for a personal policy issued under RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE will be effective for This Plan.

B. More Than One Beneficiary

If, when you die, more than one person is your Beneficiary, they will share in the benefits equally, unless you have chosen otherwise.

C. Death of a Beneficiary

A person's rights as a Beneficiary end if:

1. that person dies before your death occurs; or
2. that person dies at the same time your death occurs; or
3. that person dies within 24 hours of your death.

The share for that person will be divided among the surviving persons you have named as Beneficiary, unless you have chosen otherwise.

D. No Beneficiary at Your Death

If there is no Beneficiary at your death for any amount of benefits payable because of your death, that amount will be paid to your estate. However, we may instead pay all or part of that amount to one or more of the following persons who are related to you and who survive you:

- 1. spouse;
- 2. child;
- 3. parent;
- 4. brother and sister.

Any payment will discharge our liability for the amount so paid.

Form G.23000-G

**CLAIM PROCEDURE FOR
ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS**

A. When Notice of Claim Must be Given

Written notice of a claim must be given to us for Accidental Death or Dismemberment Benefits within 20 days after the date of the accident which caused the loss.

B. Claim Forms

When we receive written notice of a claim, we may furnish printed forms for filing proof of the claim. If we do not furnish printed forms within 15 days after you give us notice, you must furnish your own form of proof in writing.

Proof must describe the event, the nature and the extent of the cause for which a claim is made; it must be satisfactory to us.

C. When Proof of Claim Must Be Given

Written proof of a claim must be given to us not later than 90 days after the date of the loss, in the case of Accidental Death or Dismemberment Benefits.

D. Late Notice or Proof

If notice or proof is not given on time, the delay will not cause a claim to be denied or reduced as long as the notice or proof is given as soon as possible.

E. Time Limits on Starting Lawsuits

No lawsuit may be started to obtain benefits until 60 days after proof is given.

No lawsuit may be brought after the expiration of the applicable statute of limitations from the time proof must be given.

F. Medical Examinations

While a claim is pending, we, at our expense, have the right to have you examined by Doctors of our choice when and as often as we reasonably choose.

G. Autopsy

If Accidental Death or Dismemberment Benefits are claimed, we, at our expense, have, in the case of death, the right to have an autopsy made where it is not against the law.

Form G.23000-H3

WHEN BENEFITS END

- A.** All of your benefits will end on the last day of the calendar month in which your employment ends. Your employment ends when you cease Active Work as an Employee. However, for the purpose of benefits, the Employer may deem your employment to continue for certain absences. See CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE.
- B.** If This Plan ends in whole or in part, your benefits which are affected will end.
- C.** If a Covered Person does not make a payment which is required by the Employer to the cost of any benefits, those benefits will end; they will end on the last day of the period for which a payment required by the Employer was made.

The end of any type of benefits on account of a Covered Person will not affect a claim which is incurred before those benefits ended.

PORTABILITY

For purposes of this subsection, the term "Portability Eligible Insurance for you" refers to Optional Life Insurance.

You may request in writing during the Request Period specified below to continue Portability Eligible Insurance for you 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 for portability 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 Employer 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 the section entitled RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE; and
- The person making the request resides in a jurisdiction that permits portability.

Request Period

To continue Portability Eligible Insurance for you 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 for you 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 for you 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 for you 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.

Amount of the New Certificate

The maximum amount of Optional Life Insurance which may be continued is the lesser of:

- The total amount of all such insurance for you in effect immediately prior to the date it ends; and
- **\$1,000,000.**

Right to Convert Life Insurance Amounts Not Continued

Any amount of Life Insurance not continued under this subsection may be converted under the section entitled RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE.

Premiums for the New Certificate

When a request to continue Portability Eligible Insurance for you is made under this subsection, the first premium must be paid during the Request Period. All premium payments must be made directly to us. When we issue the new certificate, we will also provide a schedule of premiums and payment instructions.

If You Die Within 31 Days of the Date Your Life Insurance Ends

If you die within 31 days of the date your life insurance ends and we have not received an application for a new certificate under this section, we will pay Life Insurance in accordance with the section entitled RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE. If an application for a new certificate was received by us during such time period, we will only pay benefits for the Portability Eligible Insurance for which you applied for in accordance with this subsection.

If You are Totally Disabled on the Date Your Employment Ends.

If you are Totally Disabled on the date your employment ends and you elect to continue Portability Eligible Insurance for you as provided in this subsection, you may at a later date become approved for the continuation of such insurance under the section entitled CONTINUED DEATH BENEFITS DURING TOTAL DISABILITY. If you are so approved, any insurance described in, applied for, or issued under this subsection will end and we will return any premium paid by you for such insurance.

OPTION TO CONVERT

In addition to the continuation of insurance option described above, you may have the right to convert to a policy of individual life insurance. We urge you to read the section entitled RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE.

Form G.23000-F

END-EPORT

**CONDITIONS UNDER WHICH YOUR ACTIVE
WORK IS DEEMED TO CONTINUE**

If you are not Actively at Work as an Employee because of a situation set forth below, the Employer may deem you to be in Active Work as an Employee only for the purpose of continuing your employment and only for the periods specified below in order that certain of your benefits under This Plan may be continued.

All such benefits will be subject to prior cessation as set forth in WHEN BENEFITS END.

In any case, the benefits will end on:

1. the date the Employer notifies us that your benefits are not to be continued; or
2. the end of the last period for which the Employer has paid premiums to us for your benefits.

Your Sickness or Injury, Your Leave of Absence, Your Lay Off

With respect to all Personal Benefits, the period determined in accordance with the Employer's general practice for an Employee in your job class.

However, in the event the leave qualifies under the Family and Medical Leave Act of 1993 (FMLA), the period cannot be longer than 12 weeks in any 12 month period following the date the leave of absence begins.

Form G.23000-L

NOTICES

This certificate is of value to you. It should be kept in a safe place. Your Beneficiary should know where the certificate is kept.

As soon as your benefits end, you should consult your Employer to find out what rights, if any, you may have to continue your protection.

If you had coverage under a prior plan of benefits, please consult your Employer to determine if there are any additional provisions which affect your benefits under This Plan.

Our Home Office is located at One Madison Avenue, New York, New York 10010.

Form G.23000-E

THIS IS THE END OF THE CERTIFICATE.