



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

### CERTIFICATE OF INSURANCE

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

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

Employer: Goodwill of Western Missouri and Eastern  
KS

Group Policy Number: KM 05941020-G

Type of Insurance: Disability Income Insurance: Short Term  
Benefits

MetLife Toll Free Number(s):  
For General Information 1-800-275-4638

#### **THIS CERTIFICATE ONLY DESCRIBES DISABILITY INSURANCE.**

**FOR CALIFORNIA RESIDENTS: REVIEW THIS CERTIFICATE CAREFULLY. IF YOU ARE 65 OR OLDER ON YOUR EFFECTIVE DATE OF THIS CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS FROM THE DATE YOU RECEIVE IT AND WE WILL REFUND ANY PREMIUM YOU PAID. IN THIS CASE, THIS CERTIFICATE WILL BE CONSIDERED TO NEVER HAVE BEEN ISSUED.**

**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.**

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

## IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-275-4638

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

1-800-252-3439

You may write the Texas Department of Insurance:

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

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

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

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

**ATTACH THIS NOTICE TO YOUR CERTIFICATE:** This notice is for information only and does not become a part or condition of the attached document.

## AVISO IMPORTANTE

Para obtener información o para presentar una queja:

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

1-800-275-4638

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

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

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

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

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

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

**ADJUNTE ESTE AVISO A SU CERTIFICADO:** Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

## **NOTICE FOR RESIDENTS OF ARKANSAS**

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

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

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

## **NOTICE FOR RESIDENTS OF CALIFORNIA**

### **IMPORTANT NOTICE**

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

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

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

## **NOTICE FOR RESIDENTS OF GEORGIA**

### **IMPORTANT NOTICE**

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

## **NOTICE FOR RESIDENTS OF IDAHO**

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

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

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

## **NOTICE FOR RESIDENTS OF ILLINOIS**

### **IMPORTANT NOTICE**

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

MetLife  
200 Park Avenue  
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance  
Public Services Division  
Springfield, Illinois 62767

## **NOTICE FOR RESIDENTS OF INDIANA**

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

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

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

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

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

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

## NOTICE FOR RESIDENTS OF MASSACHUSETTS

### CONTINUATION OF DISABILITY INCOME INSURANCE

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

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

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

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

## **NOTICE FOR RESIDENTS OF TEXAS**

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

## NOTICE FOR RESIDENTS OF UTAH

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

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

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

The basic protections provided by the Association are:

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

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

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

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

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

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

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

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

## NOTICE FOR RESIDENTS OF VIRGINIA

### IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

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

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

The Office of the Managed Care Ombudsman  
Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23209  
1-877-310-6560 - toll-free  
1-804-371-9032 - locally  
[www.scc.virginia.gov](http://www.scc.virginia.gov) - web address  
[ombudsman@scc.virginia.gov](mailto:ombudsman@scc.virginia.gov) - email

Or:

The Virginia Department of Health (The Center for Quality Health Care Services and Consumer Protection)  
3600 West Broad St  
Suite 216  
Richmond, VA 23230  
1-800-955-1819

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.

## CIVIL UNION NOTICE FOR RESIDENTS OF VERMONT

Vermont law provides that the following definitions apply to your certificate:

- Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," "wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family" and any other such terms include the relationship created by a Civil Union established according to Vermont law.
- Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage" and any other such terms include the inception or dissolution of a Civil Union established according to Vermont law.
- Terms that mean or refer to family relationships arising from a marriage, such as "family," "immediate family," "dependent," "children," "next of kin," "relative," "beneficiary," "survivor" and any other such terms include family relationships created by a Civil Union established according to Vermont law.
- "Dependent" includes a spouse, a party to a Civil Union established according to Vermont law, and a child or children (natural, step-child, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.
- "Child" includes a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.
- "'Civil Union'" means a civil union established pursuant to Act 91 of the 2000 Vermont Legislative Session, entitled "'Act Relating to Civil Unions'".

All references in this notice to Civil Unions are limited to Civil Unions in which the parties are residents of Vermont.

If dependent insurance for a spouse and/or child is not provided under your certificate, such insurance is not added by virtue of this notice.

For purposes of dependent insurance, any person who meets the definition of "'dependent'" as set forth in this notice is required to meet all other applicable requirements in order to qualify for such insurance.

This notice does not limit any definitions or terms included in your certificate. It broadens definitions and terms only to the extent required by Vermont law.

### **DISCLOSURE:**

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

## NOTICE FOR RESIDENTS OF WISCONSIN

### KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

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

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

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

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

### **WORKERS' COMPENSATION**

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

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

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

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



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The bottom left of each page of this certificate has a unique coding which describes the section of the certificate that the page contains (fp = Certificate Face Page, sch = Schedule of Benefits).

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## SCHEDULE OF BENEFITS

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

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

<b>BENEFIT</b>	<b>BENEFIT AMOUNT AND HIGHLIGHTS</b>
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### Disability Income Insurance For You: Short Term Benefits

**For All Active Full-Time Employees:**

Weekly Benefit.....	Multiples of \$50 with a \$100 minimum, as elected by You, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.
Maximum Weekly Benefit.....	The lesser of \$1,000 and 60% of Your Predisability Earnings, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.
Minimum Weekly Benefit.....	15% of the Weekly Benefit before reductions for Other Income Benefits or \$50 whichever is greater. The Minimum Weekly Benefit will not apply if you are in an Overpayment situation or are receiving income from employment.
Elimination Period.....	<p><b>For Injury</b></p> <ul style="list-style-type: none"> <li>• 14 days of Disability</li> </ul> <p><b>For Sickness</b></p> <ul style="list-style-type: none"> <li>• 14 days of Disability</li> </ul>
Maximum Benefit Period.....	11 weeks
Rehabilitation Incentives.....	Yes
<b>Additional Benefits</b>	
Organ Donor Benefit.....	Yes

## DEFINITIONS

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

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

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

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

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

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

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

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

Contributory Insurance includes: Disability Income Insurance: Short Term Benefits.

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

- You are receiving Appropriate Care and Treatment determined by Your Physician as necessary to treat the Sickness or injury;
- You are complying with the requirements of such treatment; and
- You are unable to earn more than 80% of Your Predisability Earnings at Your Own Occupation for any employer.

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

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

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

**Full-Time** means Active Work on the Employer's regular work schedule for the class of employees to which You belong. The work schedule must be at least 30 hours a week. Full-Time does not include temporary or seasonal employees.

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

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## DEFINITIONS

**Organ Transplant Procedure** means the surgical removal of any one or more of Your organs for the purpose of transplanting to another person.

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

**Physician** means:

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

**The term does not include:**

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

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

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

**The term does not include:**

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

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

If you do not have regular work hours, your Predisability Earnings are based on the average number of hours you worked per month during the preceding 12 calendar months (or during your period of employment if less than 12 months). In no event will the number of hours be more than 173 hours.

**The term includes:**

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

**The term does not include:**

- commissions;
- awards and bonuses;

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## DEFINITIONS

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

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

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

Proof must be provided at the claimant's expense.

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

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

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

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

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

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

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

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

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

All Active Full-Time Employees

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

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

You will be eligible for insurance on the later of:

1. January 01, 2017; and
2. the first day of the month coincident with or next following the date You complete the Waiting Period of 60 days.

If You enter an eligible class after January 01, 2017, You will be eligible for insurance on the first day of the month coincident with or next following the date You complete the Waiting Period of 60 days.

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

#### **Enrollment When First Eligible**

If You complete the enrollment process within 31 days of becoming eligible for insurance, such insurance will take effect on the date You become eligible for such insurance if You are Actively at Work on that date.

If You do not complete the enrollment process within 31 days of becoming eligible, You will not be able to enroll for insurance until the next annual enrollment period, as determined by the Employer, following the date You first became eligible.

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.

#### **Enrollment During First Annual Enrollment Period Following the Date You Became Eligible**

If You complete the enrollment process during the first annual enrollment period following the date You became eligible for such insurance, You may enroll for \$100 of Weekly Benefits. Such insurance will take effect on the first day of the month following the annual enrollment period, provided You are Actively at Work on that day.

#### **Subsequent Annual Enrollment Period**

If You enrolled for insurance during the initial enrollment period You may request an increase in Your Weekly Benefit during any annual enrollment period as determined by the Employer, You may enroll for an increase of \$50 of insurance. The increase in insurance, made during an annual enrollment period, will take effect on the first day of the month following the annual enrollment period, provided You are Actively at Work on that day.

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

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

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

### **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. for Disability Income Insurance: Short Term Benefits, the date You cease to be in an eligible class. You will cease to be in an eligible class on the date You cease Active Work in an eligible class, if You are not disabled on that date; or
5. for Disability Income Insurance: Short Term Benefits, the date Your employment ends.

Please refer to the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT for information concerning Continuation For Family and Medical Leave.

### **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 the required premium for Your insurance has ceased to be paid due to Your being on an approved Family Medical Leave Act (FMLA) 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 12-week period following the date Your leave began,

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 can be become insured for \$100 of Weekly Benefit by enrolling during the next annual enrollment period.

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

## **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 the Disability Income Insurance described in this certificate replaces a plan of group disability income insurance provided to You by the Employer:

**Prior Plan** means the plan of group disability income insurance provided to You by the Employer 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 the day before the Replacement Date because You are Disabled**, You will become insured for Disability Income Insurance under this certificate on the Replacement Date.

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 the day before the Replacement Date for any other reason**, You will become insured for Disability Income Insurance under this certificate on the date You return to Active Work.

**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 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; and
- the disability income insurance benefit that would have been payable to You under the Prior Plan.



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

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 Employer for information regarding such legally mandated leave of absence laws.

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

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

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

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

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

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

## **EVIDENCE OF INSURABILITY**

No evidence of insurability is required for the insurance described in this certificate.

## **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 a 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.

While You are receiving Weekly Benefits, You will be required to continue to pay for the cost of any disability income insurance defined as Contributory Insurance.

### **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 20 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.

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

### **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.

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

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

We will make reimbursement payments to You on a 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**

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

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

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

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

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

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

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

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

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

1. **With respect to Government Compulsory Benefit Plans or Programs, or STRS, PERS or FERS Benefit Plans or Programs**, to apply means to pursue such benefits through all applicable levels of appeal provided for under such benefit plans or programs. You must, within 4 weeks following the date You became Disabled:
  - send Us Proof that You have applied for benefits under such plans or programs;

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

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

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

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

### **SINGLE SUM PAYMENT**

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

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

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

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

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

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



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

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

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

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

Your Disability benefit payments will end on the earliest of:

- the end of the Maximum Benefit Period;
- the date You are no longer Disabled;
- the date You die;
- the date You cease or refuse to participate in a Rehabilitation Program that We require;
- the date You fail to have a medical exam requested by Us as described in the Physical Exams subsection of the GENERAL PROVISIONS section;
- the date You fail to provide required Proof of continuing Disability.

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

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

## **DISABILITY INCOME INSURANCE**

### **ADDITIONAL SHORT TERM BENEFIT: ORGAN DONOR**

If You become Disabled as a result of an Organ Transplant Procedure while insured, Proof of the 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 Organ Donor benefit shown below.

If We pay this benefit, You will not have to complete an Elimination Period and You will not be subject to the PRE-EXISTING CONDITIONS section for purposes of such organ transplant procedure.

### **BENEFIT AMOUNT**

We will increase Your Weekly Benefit by an additional amount equal to 10% of Your Weekly Benefit. This increase will be applied to the first Weekly Benefit payment and continue while You remain Disabled, up to the Maximum Benefit Period.

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

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

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

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

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

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

### **For Occupational Disabilities**

We will not pay benefits for any Disability:

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

## **DISABILITY INCOME INSURANCE: EXCLUSIONS**

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

1. war, whether declared or undeclared, or act of war, insurrection, rebellion, or terrorist act;
2. Your active participation in a riot;
3. intentionally self-inflicted injury;
4. attempted suicide; while sane or
5. commission of or attempt to commit or taking part in 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. sex-change surgery;
3. reversal of sterilization;
4. liposuction;
5. visual correction surgery; and
6. 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 DISABILITY INCOME CLAIM

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

If You are unable to report for Active Work due to a Sickness or accidental injury, and You think that You may be Disabled, You should contact MetLife or Your benefits representative to initiate a claim. We recommend that You do so no later than 14 days after the first day You are unable to report for Active Work so that Your claim can be processed in a timely manner.

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

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

### Step 1

A claimant 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 the claimant and explain how to complete it. The claimant should receive the claim form within 15 days of giving Us notice of claim.

### Step 3

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

If the claimant does 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

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

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

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

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

- documentation which must include, but is not limited to, the following information:
  - the date Your Disability started;
  - the cause of Your Disability;
  - the prognosis of Your Disability;
  - the continuity of Your Disability; and
- Your application for:
  - Other Benefit Sources;
  - Federal Social Security disability benefits; and
  - Workers' compensation benefits or benefits under a similar law.

## FILING A DISABILITY INCOME CLAIM

- Written authorization for Us to obtain and release medical, employment and financial information and any other items We may reasonably require to document Your Disability or to determine Your receipt of or eligibility for Other Benefit Sources;
- any and all medical information, including but not limited to:
  - x-ray films; and
  - photocopies of medical records, including:
    - histories;
    - physical, mental or diagnostic examinations; and
    - treatment notes; and
- the names and addresses of all:
  - physicians and medical practitioners who have provided You with diagnosis, treatment or consultation;
  - hospitals or other medical facilities which have provided You with diagnosis, treatment or consultation; and
  - pharmacies which have filled Your prescriptions within the past three years; and
- additional proof elements as required and described within the additional plan provisions for which you are filing a claim for benefits.

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



## **GENERAL PROVISIONS**

### **Assignment**

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

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

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

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

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

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

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

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

### **Entire Contract**

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

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

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

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

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

### **Misstatement of Age**

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

### **Conformity with Law**

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

## **GENERAL PROVISIONS (CONTINUED)**

### **Physical Exams**

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

### **Autopsy**

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

### **Overpayments**

#### **Recovery of Overpayments**

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

An overpayment occurs if We determine that:

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

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

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

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

We may recover the overpayment from You by:

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

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

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

### **Lien and Repayment**

If You become Disabled and You receive Disability benefits under this certificate and You receive payment from a third party for loss of income with respect to the same loss of income for which You received benefits under this certificate (for example, a judgment, settlement, payment from Federal Social Security or payment pursuant to Workers' Compensation laws), You shall reimburse Us from the proceeds of such payment up to

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## GENERAL PROVISIONS (CONTINUED)

an amount equal to the benefits paid to You under this certificate for such Disability. Our right to receive reimbursement from any such proceeds shall be a claim or lien against such proceeds and Our right shall provide Us with a first priority claim or lien over any such proceeds up to the full amount of the benefits paid to You under this certificate for such Disability. You agree to take all action necessary to enable Us to exercise Our rights under this provision, including, without limitation:

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

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

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

## **SPECIAL SERVICES**

### **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 locale that would utilize your abilities and skills. Also identify one's earning potential for a specific occupation.

##### **3. Retraining Programs**

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

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

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

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

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

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

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

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

### **Rehabilitation Vendor Specialists**

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

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

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

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

## **ERISA INFORMATION**

### **NAME OF THE PLAN**

Goodwill of Western Missouri and Eastern KS Welfare Benefit Plan, ("Plan")

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

Goodwill of Western Missouri and Eastern KS  
1817 Campbell  
Kansas City, MO 64108  
(816) 842-7425

### **EMPLOYER IDENTIFICATION NUMBER**

431125281

### **TYPE OF PLAN**

Employee Welfare Plan including:

Short Term Disability Benefits

### **TYPE OF ADMINISTRATION**

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

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

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

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

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

### **PLAN TERMINATION OR CHANGES**

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

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

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

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

## **CONTRIBUTIONS**

You must make a contribution to the cost of Short Term Disability Benefits.

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

## **PLAN YEAR**

The Plan's fiscal records are kept on a Plan year basis beginning each January 01 and ending on the following December 31.

## **CLAIMS INFORMATION**

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

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

### **Claim Submission**

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

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



## **Initial Determination**

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

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

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

## **Appealing the Initial Determination**

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

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

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

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

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an

extension is required, MetLife will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

### **Routine Questions**

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

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

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

### **STATEMENT OF ERISA RIGHTS**

The following statement is required by federal law and regulation.

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

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

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

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

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

## **Prudent Actions by Plan Fiduciaries**

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

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

## **Enforce Your Rights**

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

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

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

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

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

## **Assistance with Your Questions**

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

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## **FUTURE OF THE PLAN**

It is hoped that the Plan will be continued indefinitely, but Goodwill of Western Missouri and Eastern KS reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.



## 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.

### Plan Sponsors and Group Insurance Contract Holders

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

### Protecting Your Information

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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.

### Collecting Your Information

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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 bank, a legal plans company, and securities broker-dealers. In the future, we may also have affiliates in other businesses.

### How We Get Your Information

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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.

### Using Your Information

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

### Sharing Your Information With Others

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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

## HIPAA

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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). Select “Privacy Policy” at the bottom of the home page. 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.

## Accessing and Correcting Your Information

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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 retrievable and within our control. 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.

## Questions/More Information

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We want you to understand how we protect your privacy. If you have any questions 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 these MetLife companies:

**Metropolitan Life Insurance Company**  
**MetLife Insurance Company USA**  
**SafeGuard Health Plans, Inc.**

**MetLife Health Plans, Inc.**  
**General American Life Insurance Company**  
**SafeHealth Life Insurance Company**