

## **YOUR BENEFIT PLAN**

### **NYSUT MEMBER BENEFITS TRUST**

NYSUT Members,  
Associate Members prior to January 1, 2018,  
Members who elected 30 day Elimination Period  
prior to January 1, 2018, and Members who  
Enrolled in \$10 Monthly Benefit prior to  
January 1, 2018 residing in Montana

**Disability Income Insurance: Long Term Benefits**

**Certificate Date: January 1, 2018**

New York State United Teachers Member Benefits Trust  
800 Troy-Schenectady Road  
Latham, NY 12110

TO MEMBERS:

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.

New York State United Teachers Member Benefits Trust



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

## **CERTIFICATE OF INSURANCE**

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

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

**Policyholder:** New York State United Teachers Member Benefits Trust

**Group Policy Number:** 35370-2-G

**Type of Insurance:** Long Term Disability Income Insurance

**MetLife Toll Free Number(s):**  
**For Claim Information** FOR DISABILITY INCOME CLAIMS: 1-800-300-4296

### **THIS CERTIFICATE ONLY DESCRIBES LONG TERM DISABILITY INCOME INSURANCE.**

**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**

The MetLife Disability Plan is a NYSUT Member Benefits Trust (Member Benefits)-endorsed program. Member Benefits has an endorsement arrangement of 5% of gross premiums for this program. All such payments to Member Benefits are used solely to defray the costs of administering its various programs and, where appropriate, to enhance them. The Insurer pools the premiums of Member Benefits participants who are insured for the purposes of determining premium rates and accounting. Coverage outside of this plan may have rates and terms that are not the same as those obtainable through Member Benefits. The Insurer or Member Benefits may hold premium reserves that may be used to offset rate increases and/or fund such other expenses related to the plan as determined appropriate by Member Benefits. Member Benefits acts as your advocate; please contact Member Benefits at 800-626-8101 if you experience a problem with any endorsed program.

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

### **WORKERS' COMPENSATION**

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

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## SCHEDULE OF BENEFITS

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

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

### BENEFIT

### BENEFIT AMOUNT AND HIGHLIGHTS

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

For All Members who enrolled in the 30 day Elimination Period prior to January 1, 2018 residing in Montana

<b>Monthly Benefit</b> .....	An amount, elected by You, which is an increment of \$50 up to the Maximum Monthly Benefit of \$5,000, not to exceed 60% of Your Predisability Earnings, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.
<b>Maximum Monthly Benefit</b> .....	\$5,000
<b>Minimum Monthly Benefit</b> .....	\$500 subject to the Overpayments and Rehabilitation Incentive subsections of this certificate
<b>Elimination Period</b> .....	30 Days

**Note:** If You are insured for the benefit shown above and request any change to the amount Your Disability Income Insurance on or after January 1, 2018, You must elect a different option shown below.

**Maximum Benefit Period\*** is 12 months

\*The Maximum Benefit Period is subject to the DATE BENEFIT PAYMENTS END section.

Rehabilitation Incentives..... Yes



## SCHEDULE OF BENEFITS (continued)

For All Members who enrolled in the \$10 Monthly Benefit plan prior to January 1, 2018 residing in Montana

<b>Monthly Benefit</b> .....	An amount, elected by You, which is an increment of \$10 up to the Maximum Monthly Benefit of \$5,000, not to exceed 60% of Your Predisability Earnings, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.
<b>Maximum Monthly Benefit</b> .....	\$5,000
<b>Minimum Monthly Benefit</b> .....	\$100 subject to the Overpayments and Rehabilitation Incentive subsections of this certificate
<b>Elimination Period</b> .....	30 Days

**Note:** If You are insured for the benefit shown above and request any change to the amount Your Disability Income Insurance on or after January 1, 2018, You must elect a different option shown below.

**Maximum Benefit Period\*** is 12 months

\*The Maximum Benefit Period is subject to the DATE BENEFIT PAYMENTS END section.

Rehabilitation Incentives..... Yes

## SCHEDULE OF BENEFITS (continued)

For All Actively At Work NYSUT Members; and Associate Members insured prior to January 1, 2018 residing in Montana

<b>Monthly Benefit</b> .....	An amount, elected by You, which is an increment of \$50 up to the Maximum Monthly Benefit of \$5,000, not to exceed 60% of Your Predisability Earnings, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.
<b>Maximum Monthly Benefit</b> .....	\$5,000
<b>Minimum Monthly Benefit</b> .....	\$500 subject to the Overpayments and Rehabilitation Incentive subsections of this certificate

### Elimination Period, elected by You

<b>Option 1</b> .....	60 Days
<b>Option 2</b> .....	90 Days
<b>Option 3</b> .....	120 Days
<b>Option 4</b> .....	150 Days
<b>Option 5</b> .....	180 Days

**Maximum Benefit Period\*** is 12 months

\*The Maximum Benefit Period is subject to the DATE BENEFIT PAYMENTS END section.

Rehabilitation Incentives..... Yes

## DEFINITIONS

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

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

- the employer's place of business;
- an alternate place approved by the employer; or
- a place 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.

**Associate Member** means a person who is a dues paying member of NYSUT and who is in good standing with Member requirements.

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

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

**Contributory Insurance** means insurance for which the employer requires You to pay any part of the premium. The following insurance is Contributory: Long Term Disability Income Insurance for You.

If You enroll for certain Contributory Insurance, a portion of Your contributions for such insurance will be allocated to fund the premium for certain Noncontributory Insurance under the Group Policy.

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

- You are receiving Appropriate Care and Treatment and complying with the requirements of such treatment; and
- You are unable to earn more than 80% of your Predisability Earnings at Your Own Occupation from any employer in Your Local Economy.

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

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

- Your Predisability Earnings times the lesser of:

## DEFINITIONS (continued)

- 7%; or
- the annual rate of increase in the Consumer Price Index for the prior calendar year.

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

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

**Domestic Partner** means each of two people, one of whom is a Member or an Associate Member, who:

- have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
  1. 18 years of age or older;
  2. unmarried;
  3. the sole domestic partner of the other person and have been so for the immediately preceding 6 months;
  4. sharing a primary residence with the other person and have been so sharing for the immediately preceding 6 months; and
  5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

A Domestic Partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and Signed by the Member or Associate Member.

**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.

**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.

**Local Economy** means the geographic area:

- within which You reside; and
- which offers suitable employment opportunities within a reasonable travel distance.

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

## DEFINITIONS (continued)

**Member** means a person who is a dues paying member of NYSUT and who is in good standing with Member requirements.

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

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

**The term does not include:**

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

**Predisability Earnings** means Your average monthly gross salary or wages You received from Your employer for the twelve month period ending just prior to Your last day of Active Work before Your Disability began. We calculate this amount on a monthly basis.

**The term includes:**

- commissions You earned averaged over the 12 month period before Disability began, or over the period of Your employment, if less;
- bonuses You earned averaged over the 12 month period before Disability began, or over the period of Your employment, if less; and
- 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:**

- awards;
- 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.

## DEFINITIONS (continued)

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

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

Proof must be provided at the claimant's expense.

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

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

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

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

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

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

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

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

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

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

**Class 1:** All Members of NYSUT who enrolled in the 30 day Elimination Period plan prior to January 1, 2018 residing in Montana.

**Class 2:** All Actively At Work NYSUT Members, excluding Associate Members, who are under the age of 65 and in good standing with Member requirements and work at least 20 hours per week residing in Montana.

**Class 3:** All Associate Members of NYSUT who were insured under the group Policy prior to January 1, 2018 residing in Montana.

**Class 4:** All Members of NYSUT who enrolled in the \$10 Monthly Benefit plan prior to January 1, 2018 residing in Montana.

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

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

**For Class 1, 3 and 4,** if You are in an eligible class on January 1, 2018, You will be eligible for the insurance described in this certificate on that date.

**For Class 2,** if You are in an eligible class on January 1, 2018, You will be eligible for the insurance described in this certificate on that date; and

If You enter an eligible class after January 1, 2018, You will be eligible for insurance on the first day of the calendar month coincide with or next following the date You enter that class.

### **ENROLLMENT PROCESS**

If You are eligible for insurance, You may enroll for such insurance by completing the required form. In addition, You must give evidence of Your Insurability satisfactory to Us at Your expense if You are required to do so under the section entitled EVIDENCE OF INSURABILITY. If You enroll for Contributory Insurance, You must also give the employer Written permission to deduct premiums from Your pay for such insurance. You will be notified how much You will be required to contribute. If You enroll for certain Contributory Insurance, a portion of Your contributions for such insurance will be allocated to fund the premium for certain Noncontributory Insurance under the Group Policy.

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

#### **Rules for Contributory Insurance**

If you complete the enrollment process for Contributory Insurance **before** the date You become eligible for such insurance, You must give evidence of Your insurability satisfactory to us. You must give such evidence at Your expense. If We determine that You are insurable, such insurance will take effect on the date We state in Writing, if You are Actively at Work on that date.

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

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

### **DATE YOUR INSURANCE ENDS**

Your insurance will end on the earliest of:

1. the date the Group Policy ends; or
2. the date insurance ends for Your class; or
3. the end of the period for which the last premium has been paid for You; or
4. the 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. the date Your employment ends; or
6. the date You retire in accordance with the date Your employment ends; or
7. the premium due date coinciding with or next following the date You attain age 66.

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

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

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

1. If Your insurance ends because:

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

You become a member of an eligible class again within 60 days of the date Your insurance ended, You will not have to complete a new Waiting Period or provide evidence of Your insurability.

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

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

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

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



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

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

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

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

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

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

- **"If You are Actively at Work on the day before the Replacement Date**, You will become insured for Disability Income Insurance under this certificate on the Replacement Date subject to any condition exclusions applicable to Your insurance under the Prior Plan on the day before the Replacement Date.
- **If You are not Actively at Work on such date because You are Disabled**, and the Prior Plan that You were covered under on the day before the Replacement Date was an insured plan, You will become insured -for Disability Income Insurance under this certificate on the Replacement Date. However, if the Prior Plan that You were covered under on the day before the Replacement Date was a self-funded plan, You will become insured for Disability Income Insurance under this certificate on the date You return to Active Work. In each case, the Disability Income Insurance under this certificate will be subject to any condition exclusions applicable to Your insurance under the Prior Plan on the day before 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 such date for any other reason, You will become insured for Disability Income Insurance under this certificate on the date You return to Active Work, provided however, if You are on an employer approved leave of absence on the Replacement Date, You will become insured for Disability Income Insurance on the Replacement Date. In each case, the Disability Income Insurance under this certificate will be subject to any condition exclusions applicable to Your insurance under the Prior Plan on the day before the Replacement Date. However, Your insurance under this certificate will end on the date Your approved leave of absence ends if You do not return to Active Work on such date."**

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

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

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

### **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 YOUR OPTION**

You may elect to continue insurance by paying premiums if You are not Disabled and cease Active Work in an eligible class for any of the reasons specified below.

Disability Income Insurance will continue for the following periods:

1. for the period You cease Active Work in an eligible class due to injury or sickness, up to 3 months;
2. for the period You cease Active Work in an eligible class due to an employer approved leave of absence, through the end of the month that immediately follows the month You cease Active Work;
3. for the period You cease Active Work in an eligible class due to an employer approved layoff, through the end of the month that immediately follows the month You cease Active Work;
4. for Disability Income Insurance: Long Term Benefits, for the period You cease Active Work in an eligible class due to any other employer approved leave of absence up to 1 month and will end at the end of the following month.

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

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

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;

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

## **EVIDENCE OF INSURABILITY**

We require evidence of insurability satisfactory to Us as follows:

1. For Contributory Disability Income Insurance: Long Term Benefits.

If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, You will not be covered for Disability Income Insurance: Long Term Benefits.

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

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

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

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

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

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

### **BENEFIT PAYMENT**

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

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

While You are receiving Monthly Benefits, You will not be required to pay premiums for the cost of any disability income insurance defined as Contributory Insurance.

### **RECOVERY FROM A DISABILITY**

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

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

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

##### **If Your Elimination Period is less than 60 days**

If You return to Active Work before completing Your Elimination Period for a period of 10 days or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. We will count those days towards the completion of Your Elimination Period.

If You return to Active Work for a period of more than 10 days, and then become Disabled again, You will have to complete a new Elimination Period.

##### **If Your Elimination Period is 60 days or more but less than 90 days**

If You return to Active Work before completing Your Elimination Period 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. We will count those days towards the completion of Your Elimination Period.

If You return to Active Work for a period of more than 20 days, and then become Disabled again, You will have to complete a new Elimination Period.

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

### **If Your Elimination Period is 90 days or more but less than 120 days**

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

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

### **If Your Elimination Period is 120 days or more but less than 150 days**

If You return to Active Work before completing Your Elimination Period for a period of 40 days or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. We will count those days towards the completion of Your Elimination Period.

If You return to Active Work for a period of more than 40 days, and then become Disabled again, You will have to complete a new Elimination Period.

### **If Your Elimination Period is 150 days or more but less than 180 days**

If You return to Active Work before completing Your Elimination Period for a period of 50 days or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. We will count those days towards the completion of Your Elimination Period.

If You return to Active Work for a period of more than 50 days, and then become Disabled again, You will have to complete a new Elimination Period.

### **If Your Elimination Period is 180 days or longer**

If You return to Active Work before completing Your Elimination Period for a period of 60 days or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. We will count those days towards the completion of Your Elimination Period.

If You return to Active Work for a period of more than 60 days, and then become Disabled again, You will have to complete a new Elimination Period.

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

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

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

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

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

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

### **REHABILITATION INCENTIVES**

#### **Rehabilitation Program Incentive**

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

#### **Family Care Incentive**

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

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

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

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

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

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

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

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

1. any disability or retirement benefits which You, Your Spouse or child(ren) receive or are eligible to receive because of Your disability or retirement under:
  - Federal Social Security Act;
  - Railroad Retirement Act;
  - any state or public employee retirement or disability plan; or
  - any pension or disability plan of any other nation or political subdivision thereof.
2. any income received for disability or retirement under the Employer's Retirement Plan, to the extent that it can be attributed to the employer's contributions.
3. any income received for disability under:
  - a group insurance policy to which the employer has made a contribution, such as:
    - benefits for loss of time from work due to disability;
    - installment payments for permanent total disability;
  - 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;
  - workers' compensation or a similar law which provides periodic benefits;
  - occupational disease laws;
  - laws providing for maritime maintenance and cure;
  - unemployment insurance law or program.
4. any income that You receive from working while Disabled to the extent that such income reduces the amount of Your Monthly Benefit as described in REHABILITATION INCENTIVES. This includes but is not limited to salary, commissions, overtime pay, bonus or other extra pay arrangements from any source.

### **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 following 12 consecutive months of Disability for which You were entitled to receive Monthly benefit payments while You are living outside of the United States or Canada; or
- the date You fail to provide required Proof of continuing Disability.

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

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

## **DISABILITY INCOME INSURANCE: EXCLUSIONS**

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

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

## FILING A CLAIM

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

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

## CLAIMS FOR DISABILITY INSURANCE BENEFITS

**When 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 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

For Disability Income Insurance benefits, 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 as soon as is reasonably possible.

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

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

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

## **FILING A CLAIM (continued)**

- any and all medical information, including but not limited to:
  - x-ray films; and
  - photocopies of medical records, including:
    - histories,
    - physical, mental or diagnostic examinations; and
    - treatment notes; and
- the names and addresses of all:
  - physicians and medical practitioners who have provided You with diagnosis, treatment or consultation;
  - hospitals or other medical facilities which have provided You with diagnosis, treatment or consultation; and
  - pharmacies which have filled Your prescriptions within the past three years.

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

## **GENERAL PROVISIONS**

### **Assignment**

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

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

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

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

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

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

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

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

### **Entire Contract**

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

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

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

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

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

We will not use Your statements which relate to insurability to contest disability income insurance after it has been in force for 2 years during Your life. In addition, We will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during Your life.

### **Misstatement of Age**

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

## **GENERAL PROVISIONS (continued)**

### **Conformity with Law**

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

### **Physical Exams**

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

### **Autopsy**

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

### **Overpayments for Disability Income Insurance**

#### **Recovery of Overpayments**

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

An overpayment occurs if We determine that:

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

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

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

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

We may recover the overpayment from You by:

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

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

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

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE NEW YORK STATE UNITED TEACHERS MEMBER BENEFITS TRUST DISABILITY INSURANCE 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 AND ADDRESS OF POLICYHOLDER

New York State United Teachers Member Benefits Trust  
800 Troy-Schenectady Road  
Latham, NY 12110

### NAME AND ADDRESS OF PLAN ADMINISTRATOR

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC.  
P.O. Box 9186  
Des Moines, IA 50306-9186

**POLICYHOLDER IDENTIFICATION NUMBER:** 22-2480854

PLAN NUMBER	COVERAGE	PLAN NAME
503	Disability Income Insurance: Long Term Benefits	New York State United Teachers Member Benefits Trust

### TYPE OF ADMINISTRATION

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

MetLife is liable for any benefits under the Plan. The group policy specifies the time when and the circumstances under which MetLife is liable for Disability Income Insurance: Long Term Benefits.

### 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 the insurance provided by MetLife under the Plan.

### PLAN TERMINATION OR CHANGES

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



The Policyholder reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the insurance described herein for the duration of your membership. 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 insurance ends in accordance with the DATE YOUR INSURANCE ENDS subsection 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 TO PREMIUM**

If you enroll for Disability Income Insurance: Long Term Benefits coverage, you are required to make contributions to premiums.

Premium rates are set by MetLife.

There are benefits insured under the group insurance coverages or the group insurance policy or policies which are combined for experience. This means that the costs of these coverages are determined on a combined basis, and the costs are accumulated from year to year. As a result, favorable experience under one or more coverage in a particular year may offset unfavorable experience on other coverages in the same year, or offset unfavorable experience of coverage in prior years.

## **PLAN YEAR**

The Plan's fiscal records are kept on a plan year basis as follows:

For Disability Income Insurance: Long Term Benefits: Beginning each January 1 and ending each December 31.

## **CLAIMS INFORMATION**

### **Disability Benefits Claims**

#### **Routine Questions**

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

#### **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 "Filing A Claim" section of the certificate.

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

#### **Initial Determination**

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

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

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

### **Appealing the Initial Determination**

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

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

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

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

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

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

## **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.

## **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.

## **FUTURE OF THE PLAN**

It is hoped that This Plan will be continued indefinitely, but New York State United Teachers Member Benefits Trust reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Trustees of New York State United Teachers Member Benefits Trust shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.

**YOUR BENEFIT PLAN**

**NYSUT Member Benefits Trust**

**Members enrolled in Long Term Disability Insurance who are  
residents of Mississippi**

**Voluntary Accidental Death and Dismemberment Insurance**

**Certificate Date: January 1, 2018**

New York State United Teachers Member Benefits Trust  
800 Troy-Schenectady Road  
Latham, NY 12110

TO MEMBERS:

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.

New York State United Teachers Member Benefits Trust



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

## **CERTIFICATE OF INSURANCE**

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

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

**Policyholder:** New York State United Teachers Member Benefits Trust

**Group Policy Number:** 35370-2-G

**Type of Insurance:** Accidental Death and Dismemberment Insurance

**MetLife Toll Free Number(s):**  
**For Claim Information** FOR LIFE CLAIMS: 1-800-638-6420

**THIS CERTIFICATE ONLY DESCRIBES ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE. THE INSURANCE DESCRIBED DOES NOT PROVIDE BENEFITS FOR LOSS CAUSED BY SICKNESS.**

## **IMPORTANT NOTICE**

The MetLife Disability Plan is a NYSUT Member Benefits Trust (Member Benefits)-endorsed program. Member Benefits has an endorsement arrangement of 5% of gross premiums for this program. All such payments to Member Benefits are used solely to defray the costs of administering its various programs and, where appropriate, to enhance them. The Insurer pools the premiums of Member Benefits participants who are insured for the purposes of determining premium rates and accounting. Coverage outside of this plan may have rates and terms that are not the same as those obtainable through Member Benefits. The Insurer or Member Benefits may hold premium reserves that may be used to offset rate increases and/or fund such other expenses related to the plan as determined appropriate by Member Benefits. Member Benefits acts as your advocate; please contact Member Benefits at 800-626-8101 if you experience a problem with any endorsed program.

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## SCHEDULE OF BENEFITS

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

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

**The amount of Insurance that We will pay for any insurance to which You make contributions will be decreased by the amount of Your contributions due and unpaid to Us for that insurance.**

### BENEFIT

### BENEFIT AMOUNTS AND HIGHLIGHTS

#### How We Will Pay Benefits

Unless the Beneficiary requests payment by check, when the Certificate states that We will pay benefits in "one sum" or a "single sum", We may pay the full benefit amount:

- by check;
- by establishing an account that earns interest and provides the Beneficiary with immediate access to the full benefit amount; or
- by any other method that provides the Beneficiary with immediate access to the full benefit amount.

Other modes of payment may be available upon request. For details, call Our toll free number shown on the Certificate Face Page.

#### Accidental Death and Dismemberment Insurance (AD&D) For You

##### Full Amount for Voluntary AD&D

For Members..... \$25,000

##### Additional Benefits:

Seat Belt Benefit .....	Yes
Air Bag Use Benefit.....	Yes
Child Care Benefit.....	Yes
Child Education Benefit.....	Yes
Spouse Education Benefit.....	Yes
Hospital Confinement Benefit.....	Yes
Common Carrier Benefit .....	Yes

The Common Carrier Benefit is an amount equal to the Full Amount.

##### Schedule of Covered Losses for Voluntary Accidental Death and Dismemberment Insurance

All amounts listed are stated as percentages of the Full Amount.

##### Covered Losses

Loss of life .....	100%
Loss of a hand permanently severed at or above the wrist but below the elbow.....	50%

## SCHEDULE OF BENEFITS (continued)

Loss of a foot permanently severed at or above the ankle but below the knee .....	50%
Loss of an arm permanently severed at or above the elbow.....	75%
Loss of a leg permanently severed at or above the knee.....	75%
Loss of sight in one eye .....	50%

**Loss of sight** means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.

Loss of any combination of hand, foot, or sight of one eye, as defined above .....	100%
Loss of the thumb and index finger of same hand.....	25%

**Loss of thumb and index finger of same hand** means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.

Loss of speech and loss of hearing .....	100%
Loss of speech or loss of hearing .....	50%

**Loss of speech** means the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury.

**Loss of hearing** means the entire and irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury.

Paralysis of both arms and both legs.....	100%
Paralysis of both legs.....	50%
Paralysis of the arm and leg on either side of the body.....	50%
Paralysis of one arm or leg .....	25%

**Paralysis** means loss of use of a limb, without severance. A Physician must determine the paralysis to be permanent, complete and irreversible.

Brain Damage .....	100%
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**Brain Damage** means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least 5 days and persists for 12 consecutive months after the date of the accidental injury.

Coma.....	1% monthly beginning on the 7th day of the Coma for the duration of the Coma to a maximum of 60 months
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**Coma** means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for 7 consecutive days.

Third-degree burn(s) .....	A percentage of the Full Amount equal to the percentage of body surface suffering third-degree burns
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## 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.

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

**Common Carrier** means a government regulated entity that is in the business of transporting fare paying passengers.

### The term does not include:

- chartered or other privately arranged transportation;
- taxis; or
- limousines.

**Contributory Insurance** means insurance for which the Policyholder requires You to pay any part of the premium. Contributory Insurance includes: Voluntary Accidental Death and Dismemberment Insurance.

If You enroll for certain Contributory Insurance, a portion of Your contributions for such insurance will be allocated to fund the premium for certain Noncontributory Insurance under the Group Policy.

**Domestic Partner** means each of two people, one of whom is a Member, who:

- have registered as each other's domestic partner, civil union partner, or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
  1. 18 years of age or older;
  2. unmarried;
  3. the sole domestic partner of the other person and have been so for the immediately preceding 6 months;
  4. sharing a primary residence with the other person and have been so sharing for the immediately preceding 6 months; and
  5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

A Domestic Partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and Signed by the Member.

**Hospital** means a facility which is licensed as such in the jurisdiction in which it is located and:

- provides a broad range of medical and surgical services on a 24 hour a day basis for injured and sick persons by or under the supervision of a staff of Physicians; and
- provides a broad range of nursing care on a 24 hour a day basis by or under the direction of a registered professional nurse.

**Member** means a person who is a dues paying member of NYSUT and who is in good standing with member requirements.

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

**NYSUT** means New York State United Teachers.

## DEFINITIONS (continued)

**Physician** means:

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

**The term does not include:**

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

**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.

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

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

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

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

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

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

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

**All Members enrolled in Long Term Disability Insurance and who are residents of Mississippi.**

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

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

If You are in an eligible class on January 1, 2018, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after January 1, 2018, You will be eligible for insurance on the first day of the calendar month coinciding with or next following the date You enter that class.

### **ENROLLMENT PROCESS**

If You have already enrolled for Long Term Disability Insurance, You do not have to enroll for Voluntary Accidental Death and Dismemberment Insurance.

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

#### **Rules for Contributory Insurance**

Voluntary Accidental Death and Dismemberment Insurance will take effect on the date Your Long Term Disability Insurance takes effect.

### **DATE YOUR INSURANCE ENDS**

Your Voluntary Accidental Death and Dismemberment 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 date You cease to be in an eligible class; or
4. the end of the period for which the last premium has been paid for You; or
5. the premium due date coinciding with or next following the date You attain age 66.

## **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.

## **EVIDENCE OF INSURABILITY**

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



## ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

If You sustain an accidental injury that is the Direct and Sole Cause of a Covered Loss described in the SCHEDULE OF BENEFITS, Proof of the accidental injury and Covered Loss must be sent to Us. When We receive such Proof We will review the claim and, if We approve it, will pay the insurance in effect on the date of the injury.

**Direct and Sole Cause** means that the Covered Loss occurs within 12 months of the date of the accidental injury and was a direct result of the accidental injury, independent of other causes.

We will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

### PRESUMPTION OF DEATH

You will be presumed to have died as a result of an accidental injury if:

- the aircraft or other vehicle in which You were traveling disappears, sinks, or is wrecked; and
- the body of the person who has disappeared is not found within 1 year of:
  - the date the aircraft or other vehicle was scheduled to have arrived at its destination, if traveling in an aircraft or other vehicle operated by a Common Carrier; or
  - the date the person is reported missing to the authorities, if traveling in any other aircraft or other vehicle.

### EXCLUSIONS

We will not pay benefits under this section for any loss caused or contributed to by:

1. physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
2. infection, other than infection occurring in an external accidental wound or from food poisoning;
3. suicide or attempted suicide;
4. intentionally self-inflicted injury;
5. service in the armed forces of any country or international authority. However, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the national guard of any other country;
6. any incident related to:
  - travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
  - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
  - parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
  - travel in an aircraft or device used:
    - for testing or experimental purposes;
    - by or for any military authority; or
    - for travel or designed for travel beyond the earth's atmosphere;
7. committing or attempting to commit a felony;
8. the voluntary intake or use by any means of:
  - any drug, medication or sedative, unless it is:
    - taken or used as prescribed by a Physician; or

## **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)**

- an "over the counter" drug, medication or sedative taken as directed;
  - alcohol in combination with any drug, medication, or sedative; or
  - poison, gas, or fumes; or
9. war, whether declared or undeclared; or act of war, insurrection, rebellion or active participation in a riot.

### **Exclusion for Intoxication**

We will not pay benefits under this section for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

**Intoxicated** means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

### **BENEFIT PAYMENT**

For loss of Your life, We will pay benefits to Your Beneficiary.

For any other loss sustained by You We will pay benefits to You.

If You sustain more than one Covered Loss due to an accidental injury, the amount We will pay, on behalf of any such injured person, will not exceed the Full Amount.

We will pay benefits in one sum. Other modes of payment may be available upon request. For details call Our toll free number shown on the Certificate Face Page.

### **APPLICABILITY OF PROVISIONS**

The provisions set forth in this ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section apply to all Accidental Death and Dismemberment Insurance – Additional Benefit sections included in this certificate except as may otherwise be provided in such Additional Benefit sections.

## **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)**

### **ADDITIONAL BENEFIT: SEAT BELT USE**

If You die as a result of an accidental injury, We will pay this additional Seat Belt Use benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that the deceased person:
  - was in an accident while driving or riding as a passenger in a Passenger Car;
  - was wearing a Seat Belt which was properly fastened at the time of the accident; and
  - died as a result of injuries sustained in the accident.

A police officer investigating the accident must certify that the Seat Belt was properly fastened. A copy of such certification must be submitted to Us with the claim for benefits.

**Passenger Car** means any validly registered four-wheel private passenger car, four-wheel drive vehicle, sports-utility vehicle, pick-up truck or mini-van. It does not include any commercially licensed car, any private car being used for commercial purposes, or any vehicle used for recreational or professional racing.

**Seat Belt** means any restraint device that:

- meets published United States Government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

**The term includes** any child restraint device that meets the requirements of state law.

### **BENEFIT AMOUNT**

The Seat Belt Use benefit is an additional benefit equal to 10% of the Full Amount shown in the SCHEDULE OF BENEFITS. However, the amount We will pay for this benefit will not be less than \$1,000 or more than \$25,000.

### **BENEFIT PAYMENT**

For loss of Your life, We will pay benefits to Your Beneficiary.

## **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)**

### **ADDITIONAL BENEFIT: AIR BAG USE**

If You die as a result of an accidental injury, We will pay this additional benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that the deceased person:
  - was in an accident while driving or riding as a passenger in a Passenger Car equipped with an Air Bag(s);
  - was riding in a seat protected by an Air Bag;
  - was wearing a Seat Belt which was properly fastened at the time of the accident; and
  - died as a result of injuries sustained in the accident.

A police officer investigating the accident must certify that the Seat Belt was properly fastened and that the Passenger Car in which the deceased was traveling was equipped with Air Bags. A copy of such certification must be submitted to Us with the claim for benefits.

**Passenger Car** means any validly registered four-wheel private passenger car, four-wheel drive vehicle, sports-utility vehicle, pick-up truck or mini-van. It does not include any commercially licensed car, any private car being used for commercial purposes, or any vehicle used for recreational or professional racing.

**Seat Belt** means any restraint device that:

- meets published United States government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

**The term includes** any child restraint device that meets the requirements of state law.

**Air Bag** means an inflatable restraint device that:

- meets published United States government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

### **BENEFIT AMOUNT**

The Air Bag Use Benefit is an additional benefit equal to 5% of the Full Amount shown in the SCHEDULE OF BENEFITS. However, the amount We will pay for this benefit will not be less than \$1,000 or more than \$10,000.

### **BENEFIT PAYMENT**

For loss of Your life, We will pay benefits to Your Beneficiary.

## **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)**

### **ADDITIONAL BENEFIT: CHILD CARE**

If You die as a result of an accidental injury, We will pay this additional Child Care benefit if:

1. We pay a benefit for loss of Your life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that:
  - on the date of death a child was enrolled in a Child Care Center; or
  - within 12 months after the date of death a child was enrolled in a Child Care Center.

**Child Care Center** means a facility that:

- is operated and licensed according to the law of the jurisdiction where it is located; and
- provides care and supervision for children in a group setting on a regularly scheduled and daily basis.

### **BENEFIT AMOUNT**

For each child who qualifies for this benefit, We will pay an amount equal to the Child Care Center charges incurred for a period of up to 4 consecutive years, not to exceed:

- an annual maximum of \$5,000; and
- an overall maximum of 12% of the Full Amount shown in the SCHEDULE OF BENEFITS.

We will not pay for Child Care Center charges incurred after the date a child attains age 13.

We may require Proof of the child's continued enrollment in a Child Care Center during the period for which a benefit is claimed.

### **BENEFIT PAYMENT**

We will pay this benefit quarterly when We receive Proof that Child Care Center charges have been paid. Payment will be made to the person who pays such charges on behalf of the child.

If this benefit is in effect on the date You die and there is no child who could qualify for it, We will pay \$1,000 to Your Beneficiary in one sum.

## **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)**

### **ADDITIONAL BENEFIT: CHILD EDUCATION**

If You die as a result of an accidental injury, We will pay this additional Child Education benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that on the date of death a child was:
  - enrolled as a full-time student in an accredited college, university or vocational school above the 12th grade level; or
  - at the 12th grade level and, within one year after the date of death, enrolls as a full-time student in an accredited college, university or vocational school.

### **BENEFIT AMOUNT**

For each child who qualifies for this benefit, We will pay an amount equal to the tuition charges incurred for a period of up to 4 consecutive academic years, not to exceed:

- an academic year maximum of \$10,000; and
- an overall maximum of 20% of the Full Amount shown in the SCHEDULE OF BENEFITS.

We may require Proof of the child's continued enrollment as a full-time student during the period for which a benefit is claimed.

### **BENEFIT PAYMENT**

We will pay this benefit semi-annually when We receive Proof that tuition charges have been paid. Payment will be made to the person who pays such charges on behalf of the child.

If this benefit is in effect on the date of death and there is no child who could qualify for it, We will pay \$1,000 to Your Beneficiary in one sum.

## **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)**

### **ADDITIONAL BENEFIT: SPOUSE EDUCATION**

If You die as a result of an accidental injury, We will pay this additional Spouse Education benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that:
  - on the date of Your death, Your Spouse was enrolled as a full-time student in an accredited school; or
  - within 12 months after the date of Your death, Your Spouse enrolls as a full-time student in an accredited school.

### **BENEFIT AMOUNT**

We will pay an amount equal to the tuition charges incurred for a period of up to 1 academic year, not to exceed:

- an academic year maximum of \$5,000; and
- an overall maximum of 5% of the Full Amount shown in the SCHEDULE OF BENEFITS.

We may require Proof of the Spouse's continued enrollment as a full-time student during the period for which a benefit is claimed.

### **BENEFIT PAYMENT**

We will pay this benefit semi-annually when We receive Proof that tuition charges have been paid. Payment will be made to the Spouse.

If this benefit is in effect on the date You die and there is no Spouse who could qualify for it, We will pay \$1,000 to Your Beneficiary in one sum.

## **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)**

### **ADDITIONAL BENEFIT: HOSPITAL CONFINEMENT**

Subject to the provisions of the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE, We will pay this additional benefit if:

1. We receive Proof that You are confined in a Hospital as a result of an accidental injury which is the direct cause of such confinement independent of other causes; and
2. this benefit is in effect on the date of the injury.

### **BENEFIT AMOUNT**

We will pay \$250 for each full month of Hospital Confinement.

We will pay this benefit on a monthly basis beginning on the 5th day of confinement, for up to 12 months of continuous confinement. This benefit will be paid on a pro-rata basis for any partial month of confinement.

We will only pay benefits for one period of continuous confinement for any accidental injury. That period will be the first period of confinement that qualifies for payment.

### **BENEFIT PAYMENT**

Benefit payments will be made monthly. Payment will be made to You.



## **ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)**

### **ADDITIONAL BENEFIT: COMMON CARRIER**

If You die as a result of an accidental injury, We will pay this additional benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that the injury resulting in the deceased's death occurred while traveling in a Common Carrier.

### **BENEFIT AMOUNT**

The Common Carrier Benefit is shown in the SCHEDULE OF BENEFITS.

### **BENEFIT PAYMENT**

For loss of Your life, We will pay benefits to Your Beneficiary.

## FILING A CLAIM

### CLAIMS FOR ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

When there has been a Covered Loss, notify Us. This notice should be given to Us within 30 days after the date when such Covered Loss occurred. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. The claim form will be sent to You or the beneficiary or beneficiaries of record.

The claim form should be completed and sent along with Proof of the Covered Loss to Us as instructed on the claim form. If You or the beneficiary have not received a claim form within 15 days of giving notice of the claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

The claimant must give us Proof no later than 90 days after the date of the Covered Loss.

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 or Proof are given as soon as is reasonably possible.

When We receive the claim form and Proof, We will review the claim and, if We approve it, We will pay benefits, subject to the terms and provisions of this certificate and the Group Policy, within twenty-five (25) days after Our receipt of a clean claim submitted electronically, or within thirty-five (35) days after Our receipt of a clean claim submitted in paper format. For purposes of this provision, a "clean claim" means a claim for benefits under this certificate that requires no further information, adjustment, or alteration by You or by a Physician in order for Us to process and pay it. A clean claim does not include claims which are submitted fraudulently or that are based upon material misrepresentations.

The benefit amount may be reduced by the amount of any due and unpaid contributions to premium outstanding at the time We make payment.

If We do not deny payment of benefits under this certificate by the end of the respective 25 day or 35 day period for clean claims, and such benefits remain due and payable to You, interest will accrue on the amount of such benefits at the rate of one and one half-percent (1 ½ %) per month until such benefits are finally settled. Subject to the Time Limit on Legal Actions provisions, if We do not pay such benefits to You when due and payable, You may bring action to recover such benefits and any interest which has accrued with respect to such benefits and any other damages which may be allowed by law.

**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.

### **Beneficiary**

You may designate a Beneficiary in Your application or enrollment form. You may change Your Beneficiary at any time. To do so, You must send a Signed and dated, Written request to the Policyholder using a form satisfactory to Us. Your Written request to change the Beneficiary must be sent to the Policyholder within 30 days of the date You Sign such request.

You do not need the Beneficiary's consent to make a change. When We receive the change, it will take effect as of the date You Signed it. The change will not apply to any payment made in good faith by Us before the change request was recorded.

If two or more Beneficiaries are designated and their shares are not specified, they will share the insurance equally.

If there is no Beneficiary designated or no surviving Beneficiary at Your death, We will determine the Beneficiary 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;
4. Your sibling(s), if there is no surviving parent; or
5. Your estate, if there is no surviving sibling.

Any payment made in good faith will discharge our liability to the extent of such payment.

If a Beneficiary or a payee is a minor or incompetent to receive payment, We will pay that person's guardian.

### **Entire Contract**

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

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

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

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

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

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

## **GENERAL PROVISIONS (continued)**

### **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 the laws of the state in which the insured resides on the effective date of this certificate, this certificate shall be interpreted to so conform.

### **Physical Exams**

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

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE NEW YORK STATE UNITED TEACHERS MEMBER BENEFITS TRUST ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE 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 AND ADDRESS OF POLICYHOLDER

New York State United Teachers Member Benefits Trust  
800 Troy-Schenectady Road  
Latham, NY 12110

### NAME AND ADDRESS OF PLAN ADMINISTRATOR

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC  
P.O Box 9186  
Des Moines, IA 50306-9186

**POLICYHOLDER IDENTIFICATION NUMBER:** 22-2480854

PLAN NUMBER	COVERAGE	PLAN NAME
503	Voluntary Accidental Death and Dismemberment Insurance	New York State United Teachers Member Benefits Trust

### TYPE OF ADMINISTRATION

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

MetLife is liable for all life and accidental death and dismemberment insurance.

### 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 the insurance provided by MetLife under the Plan.

### PLAN TERMINATION OR CHANGES

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

The Policyholder reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the insurance 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 insurance ends in accordance with the DATE YOUR INSURANCE ENDS subsection 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 TO PREMIUM**

Premium rates are set by MetLife.

There are benefits insured under the group insurance coverages or the group insurance policy or policies which are combined for experience. This means that the costs of these coverages are determined on a combined basis, and the costs are accumulated from year to year. As a result, favorable experience under one or more coverage in a particular year may offset unfavorable experience on other coverages in the same year, or offset unfavorable experience of coverage in prior years.

## **PLAN YEAR**

The Plan's fiscal records are kept on a plan year basis as follows:

For Voluntary Accidental Death and Dismemberment Insurance: Beginning each January 1st and ending each December 31st.

## **CLAIMS INFORMATION**

### **Procedures for Presenting Claims for Accidental Death and Dismemberment Benefits**

All claim forms needed to file for benefits under the group insurance program can be obtained from the Plan Administrator who will also be ready to answer questions about the insurance benefits and to assist the claimant in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

### **Routine Questions**

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

### **Claim Submission**

In submitting claims for accidental death and dismemberment benefits ("Benefits"), the claimant must complete the appropriate claim form and submit the required Proof as described in the certificate.

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

### **Initial Determination**

After MetLife receives a claim for Benefits, MetLife will review the claim and notify the claimant of its decision to approve or deny the claim.

Such notification will be provided to the claimant within a reasonable period, not to exceed 90 days from the date we received the claim, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies the claim in whole or in part, the notification of the claims decision will state the reason why the 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. The notification will also include a description of the Plan review procedures and time limits, including a statement of the claimant's right to bring a civil action if the claim is denied after an appeal.

## **Appealing the Initial Determination**

In the event a claim has been denied in whole or in part, the claimant can request a review of the claim by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after the claimant received notice of denial of the claim. When requesting a review, the claimant should state the reason the claimant believes the claim was improperly denied and submit in writing any written comments, documents, records or other information the claimant deems appropriate. Upon the claimant's written request, MetLife will provide the claimant free of charge with copies of relevant documents, records and other information.

MetLife will re-evaluate all the information, will conduct a full and fair review of the claim, and the claimant will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received the request for review, unless MetLife notifies the claimant within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send the claimant a final written decision that states the reason(s) why the appealed claim is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of the claimant's right to bring a civil action if the claim is denied after an appeal. Upon written request, MetLife will provide the claimant free of charge with copies of documents, records and other information relevant to the claim.

## **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, 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, 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 your 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 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.

## **FUTURE OF THE PLAN**

It is hoped that This Plan will be continued indefinitely, but New York State United Teachers Member Benefits Trust reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Trustees of New York State United Teachers Member Benefits Trust shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.