

**YOUR EMPLOYEE
BENEFIT PLAN**

STATE OF MARYLAND

State of Maryland
301 West Preston Street
Baltimore, MD 21201

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

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

Benefits are provided through a group policy issued to State of Maryland by Metropolitan Life Insurance Company.

State of Maryland

MetLife[®]

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

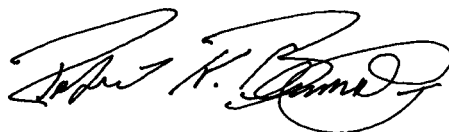
Certifies that, under and subject to the terms and conditions of the Group Policy issued to the Employer, coverage is provided for each Employee as defined herein.

The date when an Employee is eligible for coverage is set forth in the form with the title Eligibility for Benefits.

The date when an Employee's Personal Benefits become effective is set forth in the form with the title Effective Dates of Personal Benefits.

The date when an Employee's Dependent Benefits become effective is set forth in the form with the title Effective Dates of Dependent Benefits.

The amounts of coverage are determined by the form with the title Schedule of Benefits.



Robert H. Benmosche
Chairman, President and Chief Executive Officer

Employer: **State of Maryland**

Group Policy No.: **29992-G**

Florida Residents: The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

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

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

Form G.23000-Cert.-1

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-638-5433

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

1-800-252-3439

You may write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

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

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

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

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

1-800-638-5433

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

1-800-252-3439

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

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

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

Arkansas residents please be advised of the following:

IMPORTANT NOTICE

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

1-800-638-5433

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

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

California residents please be advised of the following:

IMPORTANT NOTICE

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

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

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

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

Georgia residents please be advised of the following:

IMPORTANT NOTICE

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

Utah residents please be advised of the following:

NOTICE TO POLICYHOLDERS

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

PEOPLE ENTITLED TO COVERAGE

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

POLICIES COVERED

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

EXCLUSIONS AND LIMITATIONS

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

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.
- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

LIMITS ON AMOUNT OF COVERAGE

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

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

DISCLAIMER

PLEASE READ CAREFULLY:

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

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

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

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

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

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

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

Virginia residents please be advised of the following:

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

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

1-800-638-5433

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

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

1-800-552-7945 - In-state toll-free

1-804-786-3741 - Out-of-state

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

Wisconsin residents please be advised of the following:

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

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

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

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

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SCHEDULE OF BENEFITS
(Also see SCHEDULE SUPPLEMENT)

The following Benefits are provided subject to the provisions below.

BENEFITS (EMPLOYEE ONLY) **AMOUNT**

ACCIDENTAL DEATH OR DISMEMBERMENT

All Employees who elect:

Option 1:	\$100,000
Option 2:	\$200,000
Option 3:	\$300,000

Spouse and Child(ren).....	An amount equal to: (a) 55% for your spouse; and (b) 15% for each child; of your Accidental Death or Dismemberment Benefits
Spouse Only	An amount equal to 65% of your Accidental Death or Dismemberment Benefits
Child(ren) Only.....	An amount equal to 25% of your Accidental Death or Dismemberment Benefits for each child

If you and your Dependent spouse die within one year of sustaining bodily injuries in the same accident, or separate accidents occurring within the same 24-hour period, the Accidental Death or Dismemberment Benefits amount which applies to your Dependent spouse will be increased to equal the amount set forth above which applies to you, the Employee.

WHEN YOU RETIRE

No benefits are provided under This Plan on or after the day you retire.

Form G.23000-B

SCHEDULE SUPPLEMENT

A. Statements Made by You Which Relate to Insurability

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

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

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

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

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

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

B. Assignment

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

C. Additional Provisions

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

NOTE: Please note evidence of insurability is not required.

Form G.23000-B1

DEFINITIONS OF CERTAIN TERMS USED HEREIN

“**Actively at Work**” or “**Active Work**” means that you will be considered at “Active Work”:

1. on any day in which you are performing in the usual way all the regular duties of your work; or
2. on any day in which you are absent from work for any reason other than:
 - a. your sickness; or
 - b. your injury; or
 - c. a medical leave of absence.

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

"Dependent" means your spouse (a husband or wife who is joined in marriage to an employee by a ceremony recognized by the laws of the State of Maryland) and a never-married child of an employee until the end of the calendar year in which the child becomes 19 years old (or 25th birthday if a full-time student).

An unmarried child means:

1. a blood descendent of the first degree (i.e., son or daughter),
2. a legally adopted child,
3. a step-child permanently residing with the employee, and supported 50% or more by the employee,
4. a child permanently residing in the employee's household, supported 50% or more by the employee, if the child is directly descendent from or placed in the legal guardianship of the employee,
5. a never-married child who is attending an accredited educational institution full-time until the end of the calendar year in which the child turns 25 or the end of the month in which the child ceases to be a full-time student, whichever occurs first.

A never-married child 19 years or older who is incapable of self-support because of mental or physical incapacity given that:

1. the condition leading to the incapacity began before the child's 19th birthday (or 25th if a full-time student),
2. the incapacity is permanent, and
3. The child resides permanently with the employee and is supported 50% or more by the employee.

No person may be covered as a Dependent of more than one Employee.

"Dependent Benefits" mean the benefits which are provided on account of a Dependent under This Plan.

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

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

"Employee" means a person who is employed and paid for services by the Employer and is eligible as determined by the Employer

1. Employee who is regularly paid salary or wages through an official State payroll center, including but not limited to:
 - a. Central Payroll Bureau;
 - b. Mass Transit Administration;
 - c. University of Maryland, including graduate assistants, and the Far East and European Division of

the University of Maryland;

2. Employee whose status is temporary pending an examination;
3. Elected official;
4. Register of wills or an employee of the office of register of wills;
5. Clerk of court or an employee of the office of clerk of court;
6. Board or commission member who is regularly paid salary or wages and who works at least 50 percent of a normal work week;
7. Employee of political subdivisions which participate in the State's health insurance program with the approval of the governing body;
8. Employee of agency, commission, or organization permitted to participate in the State's health insurance program by law;
9. Part-time employee working not less than 50 percent of the normal work week and his/her designated dependents in accordance with Regulation .4B(2) of COMAR 17.04.13.04; or
10. Contractual employee as defined in COMAR 17.04.13.03 and his/her designated dependents in accordance with Regulation .4B(2) of COMAR 17.04.13.04.

"Hospital" means a facility which:

1. is legally licensed; and
2. provides a broad range of 24 hour a day medical and surgical services for sick and injured persons by, or under the supervision of, a staff of Doctors; and
3. provides 24 hour a day nursing care by, or under the direction of, a registered professional nurse (R.N.).

For the purpose of determining benefits for:

- a. mental illnesses; or
- b. emotional disorders;

Hospital will also include any mental hospital or institution licensed for the treatment of mental illness.

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

"Qualifying Events" means a change of status, such as the birth of dependent, loss of eligibility of a dependent, your marriage or your divorce, change of employment status of yourself or a spouse, etc., under your Employer's Internal Revenue Code Section 125 Cafeteria Plan that allows a mid-year change in enrollment for AD&D coverage. Please contact your Employer's Benefits Division for more information regarding changes in status that may be Qualifying Events.

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

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

"You" and "your" mean the Employee who is a Covered Person for Personal Benefits. They do not include a Dependent of the Employee.

Form G.23000-A

ELIGIBILITY FOR BENEFITS

Personal Benefits Eligibility Date

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

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

Dependent Benefits Eligibility Date

Your Dependent Benefits Eligibility Date is the later of your Personal Benefits Eligibility Date and the date you first acquire a Dependent.

Form G.23000-C

EFFECTIVE DATES OF PERSONAL BENEFITS

A. Making a Request for Benefits

1. Your Employer has established a benefits plan. Under such a plan, you can choose the amount and types of benefits subject to the rules of the plan. Such rules include time frames during which you may make a request to be covered or to change your benefits under This Plan as set forth below. Such rules also establish a time frame for when changes in the amount of your benefits are made as a result of a change in your class or earnings. Your Employer can provide you with more information regarding the benefits plan. In order to become covered for Personal Benefits under This Plan, you must make a written request to the Employer on the benefits enrollment form furnished by the Employer.

In general, you can make choices for coverage for Personal Benefits:

- a. within 60 days from when you are first eligible for Personal Benefits; and
- b. during the annual enrollment period as designated by the Employer and reported to you.

Requests to be covered for Personal Benefits may only be made:

- a. during the first and any subsequent annual enrollment period, as designated by the Employer and reported to you, following your Personal Benefits Eligibility Date; or
- b. during the sixty day period following your Personal Benefits Eligibility Date; and
- c. within 60 days of the date of a Qualifying Event.

2. If you are already covered for Personal Benefits, requests for changes in Personal Benefits may only be made during the annual enrollment period, as designated by the Employer and reported to you, or within 60 days of the date of a Qualifying Event.
3. If you make a request to be covered for Personal Benefits within sixty days of your Personal Benefits Eligibility Date, your Personal Benefits will become effective on your Personal Benefits Eligibility Date in accordance with COMAR 17.04.13.04.
4. If you make a request to change your Personal Benefits during an annual enrollment period, your Personal Benefits will become effective on the first day of the calendar year following the annual enrollment period.

B. Active Work Requirement

You must be Actively at Work in order for your Personal Benefits to become effective. If you are not Actively at Work on the date when your Personal Benefits would otherwise become effective, your Personal Benefits will become effective on the first day after you return to Active Work.

C. Reinstatement of Benefits

If your Personal Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them, subject to the foregoing provisions.

Form G.23000-D1

EFFECTIVE DATES OF DEPENDENT BENEFITS

A. Making a Request for Benefits

1. In order to become insured for Dependent Benefits under This Plan, you must enroll through the process established by your Employer.

Requests to be insured for Dependent Benefits may only be made:

- a. during the sixty day period following your Dependent Benefits Eligibility Date; or
- b. during the first and any subsequent annual enrollment period, as designated by the Employer and reported to you, following your Dependent Benefits Eligibility Date; or
- c. within sixty days of a Qualifying Event, provided that the change in coverage is consistent with your new family status.

If you are already insured for Dependent Benefits, requests for changes in your Dependent Benefits may only be made:

- a. during the annual enrollment period, as designated by the Employer and reported to you; or
- b. within sixty days of a Qualifying Event, provided that the change in coverage is consistent with your new family status.

2. If you make a request to be insured for Dependent Benefits within sixty days of your Dependent Benefits Eligibility Date, your Dependent Benefits will become effective, on the latest of:
 - a. your Dependent Benefits Eligibility Date; and
 - b. the effective date of your Personal Benefits.
3. If you make a request to be insured for Dependent Benefits or a request for change(s) in Dependent Benefits within sixty days of a Qualifying Event, your Dependent Benefits or the change(s) in the Dependent Benefits will become effective following the completion of your enrollment form and in accordance with COMAR 17.04.13.04.

B. Reinstatement of Benefits

If your Dependent Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them, subject to the foregoing provisions.

C. New Dependents

If you are insured for Dependent Benefits and acquire a new Dependent, such event may be considered, subject to the provisions of the flexible benefits plan, as a Qualifying Event. The effective date of Dependent Benefits with respect to such person who becomes your Dependent would be determined in accordance with the foregoing provisions.

Form G.23000-D2

ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

A. Coverage

We will pay Accidental Death or Dismemberment Benefits for a Covered Loss shown in Section C if:

1. you are injured in an accident which occurs while you are covered for Accidental Death or Dismemberment Benefits; or
2. a Dependent is injured in an accident which occurs while Accidental Death or Dismemberment Benefits are in effect for that Dependent;

and if, in either case:

- a. that accident is the sole cause of the injury; and
- b. that injury is the sole cause of that Covered Loss; and
- c. that Covered Loss occurs not more than 365 days after the date of that accident.

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

1. Exposure Benefit

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

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

2. Seat Belt Benefit

We will pay an amount equal to 10% of the Full Amount shown in section B for the loss of a Covered Person's life that results from injuries sustained while driving or riding in a private Passenger Car if such Covered Person's Seat Belt was properly fastened; but the amount payable will not: (a) exceed \$25,000; nor (b) be less than \$1,000.

Passenger Car means any validly registered four-wheel private Passenger Car. It does not include:

- a.** any commercially licensed car; or
- b.** a private Passenger Car which is being used for commercial purposes.

"Seat Belt" means:

- a.** any child restraint device which meets the definition of the state law; or
- b.** any other restraint device which:
 - i.** meets published federal safety standards;
 - ii.** has been installed by the car manufacturer; and
 - iii.** has not been altered after such installation.

The correct position of the Seat Belt must be certified by the investigating officer. A copy of the police report must be submitted with the claim.

We will not pay a Seat Belt Benefit if the Covered Person was driving while under the influence of alcohol or drugs.

3. Hospital Benefit

If, as a result of an accident, a Covered Person is confined in a Hospital, we will pay during such confinement, after a four day waiting period a monthly amount equal to 1% of the Full Amount shown in section B, but not more than \$2,500 per month.

In no case will such benefit be payable for:

- a.** the first four days of a Hospital confinement; or
- b.** more than 12 months during a period of Hospital confinement.

Payments for periods less than a full month will be made on a pro-rata basis.

4. Training Benefit for a Dependent Spouse

If you die as a result of an accident while your Dependent spouse is enrolled in an accredited school for the purpose of training or refreshing skills needed for employment, we will pay the actual cost incurred for enrolling for one year in such school, up to a maximum of \$5,000.

5. Education Benefit for Dependent Children

If you die as a result of an accident, we will pay on account of each Dependent child an annual amount equal to 2% of the Full Amount shown in section B, but not more than \$5,000 per year, if such child, on the date of the accident, was:

- a.** enrolled as a full-time student in a college, university or vocational school above the 12th grade level; or
- b.** at the 12th grade level and subsequently enrolls as a full-time student in a college, university or vocational school within 365 days following the date of the accident.

The Education Benefit for Dependent Children is payable for a maximum of four consecutive years as long as the Dependent child remains such a full-time student.

If there are no Dependent children who qualify for the Education Benefit for Dependent Children on the date of your death, we will pay an additional benefit of \$1,000 to your Beneficiary.

6. Child Care Center Benefit

If you die as a result of an accident, we will pay on account of each Dependent child who:

- a.** is 12 years of age or under on the date of the accident; and
- b.** was enrolled in a Child Care Center on the date of the accident;

an annual amount equal to the lesser of:

- a.** 3% of the Full Amount shown in section B; and
- b.** the actual amount of Child Care Center Benefit costs incurred;

however, in no event will such amount be more than \$5,000 per year.

The Child Care Center Benefit is payable for a maximum of four consecutive years as long as the Dependent child remains:

- a.** enrolled in a Child Care Center; and
- b.** 12 years of age or under.

If there are no Dependent children who qualify for the Child Care Center Benefit on the date of your death, we will pay an additional benefit of \$1,000 to your Beneficiary.

Child Care Center means a facility which:

- a. is operated and licensed according to state law, and
- b. provided care and supervision for children in a group setting on a regular, daily basis.

Child Care Center Benefits will be paid to any person or persons who have incurred Child Care Center expenses on account of the Dependent child.

B. Maximum Benefit for All Covered Losses in Each Accident

For all Covered Losses caused by all injuries which:

1. you sustain in one accident; or
2. a Dependent sustains in one accident;

not more than the Full Amount will be paid.

Full Amount means the amount of Accidental Death or Dismemberment Benefits:

1. for which you are covered on the date of your accident; or
2. that is in effect for that Dependent on the date of that Dependent's accident.

C. Table of Covered Losses and Benefit Amounts

Covered Losses (Subject to Exclusions)	Benefit Amounts
Life	Full Amount
A hand	One-half of the Full Amount
A foot	One-half of the Full Amount
Sight of an eye	One-half of the Full Amount
Any combination of a hand, a foot or sight of an eye	Full Amount
Thumb and Index finger of same hand	One-quarter of the Full Amount
Speech and hearing	Full Amount
Speech or hearing in both ears	One-half of the Full Amount
Quadriplegia	Full Amount
Paraplegia	Three-fourths of the Full Amount
Hemiplegia	One-half of the Full Amount

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

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

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

Loss of thumb and index finger means actual severance 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 hearing means the entire and irrecoverable loss which has lasted continuously for 12 consecutive months following the injury.

Quadriplegia means total paralysis of both upper and lower limbs.

Paraplegia means total paralysis of both lower limbs.

Hemiplegia means total paralysis of upper and lower limbs on one side of the body.

Paralysis means loss of use, without severance, of a limb. Paralysis must be determined by competent medical authority to be permanent, complete and irreversible.

D. Exclusions

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

1. physical or mental illness, diagnosis of or treatment for the illness; or
2. an infection, unless it is caused by an external wound that can be seen and which was sustained in an accident; or
3. suicide or attempted suicide; or
4. injuring oneself on purpose; or
5. the use of any drug or medicine; or
6. a war, or a warlike action in time of peace, including terrorist acts; or
7. committing or trying to commit a felony or an assault; or
8. any poison or gas, voluntarily taken, administered or absorbed; or
9. service in the armed forces of any country or international authority, except the United States National Guard; or
10. operating, learning to operate, or serving as a member of a crew of an aircraft; or while in any aircraft operated by or under any military authority (other than the Military Airlift Command); or while in any aircraft being used for a test or experimental purposes; or while in any aircraft used or designed for use beyond the Earth's atmosphere; or while in any aircraft for the purpose of descent from such aircraft while in flight (except for self preservation); or
11. driving a vehicle while intoxicated as defined by the laws of the jurisdiction in which the vehicle was being operated.

E. Payment of Benefits

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

Accidental Death or Dismemberment Benefits will be paid:

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

3. to you for the loss of life of a Dependent, if you survive the Dependent; the benefits will be paid to your estate if:
 - a. that Dependent dies at the same time your death occurs; or
 - b. that Dependent dies within 24 hours of your death;in any other instance the benefits will be paid to that Dependent's estate; and
4. to you for any other Covered Loss sustained by a Dependent, if you survive that Dependent; otherwise the benefits will be paid to that Dependent.

Training Benefit for a Dependent Spouse will be paid to your Dependent Spouse.

Education Benefit for Dependent Children will be paid to each Dependent child.

Child Care Center Benefit will be paid to any person or persons who have incurred Child Care Center Benefits on account of the Dependent child.

The Child Care Center Benefit will be payable on a quarterly basis, with the first quarter beginning on the first day of the month following the date of your death, and with the first benefit being payable at the end of the first quarter.

F. Optional Types of Payment

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

Form G.23000-4L

BENEFICIARY

A. Your Beneficiary

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

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

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

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

B. More Than One Beneficiary

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

C. Death of a Beneficiary

A person's rights as a Beneficiary end if:

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

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

D. No Beneficiary at Your Death

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

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

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

Form G.23000-G

CLAIM PROCEDURE FOR ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

A. When Notice of Claim Must be Given

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

B. Claim Forms

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

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

C. When Proof of Claim Must Be Given

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

D. Late Notice or Proof

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

E. Time Limits on Starting Lawsuits

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

No lawsuit may be started more than 3 years after the time proof must be given.

F. Medical Examinations

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

G. Autopsy

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

Form G.23000-H4

WHEN BENEFITS END

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

The end of any type of benefits on account of a Covered Person will not affect a claim which is incurred on the date of the loss.

PORTABILITY

For purposes of this subsection, the term "Portability Eligible Insurance for you" refers to Accidental Death or Dismemberment Benefits.

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

- your coverage ends; or
- you cease to be in a class that is eligible for such insurance.

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

A request for portability may be made, if on the date of the request, the following requirements are met:

- the Group Policy is in effect;
- We have not received notice from the Employer of its intent to end the Group Policy;
- The person making the request resides in a jurisdiction that permits portability.

Request Period

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

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

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

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

Amount of the New Certificate

The maximum amount of Accidental Death or Dismemberment Benefits which may be continued is the lesser of:

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

Premiums for the New Certificate.

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

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

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

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

In any case, the benefits will end on:

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

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

With respect to all Personal Benefits and all Dependent Benefits, the period determined in accordance with the Employer's general practice for an Employee in your job class. Employees on unpaid leave of absence will be permitted to continue coverage amounts while on leave as long as premiums are paid to MetLife.

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

Form G.23000-L

NOTICES

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

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

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

Form G.23000-E

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

**YOUR EMPLOYEE
BENEFIT PLAN**

STATE OF MARYLAND

State of Maryland
301 West Preston Street
Baltimore, MD 21201

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

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

Benefits are provided through a group policy issued to State of Maryland by Metropolitan Life Insurance Company.

State of Maryland

MetLife®

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

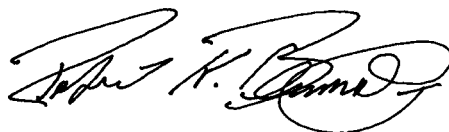
Certifies that, under and subject to the terms and conditions of the Group Policy issued to the Employer, coverage is provided for each Employee as defined herein.

The date when an Employee is eligible for coverage is set forth in the form with the title Eligibility for Benefits.

The date when an Employee's Personal Benefits become effective is set forth in the form with the title Effective Dates of Personal Benefits.

The date when an Employee's Dependent Benefits become effective is set forth in the form with the title Effective Dates of Dependent Benefits.

The amounts of coverage are determined by the form with the title Schedule of Benefits.



Robert H. Benmosche
Chairman, President and Chief Executive Officer

Employer: **State of Maryland**

Group Policy No.: **29992-G**

Florida Residents: The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

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

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

Form G.23000-Cert.-1

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-638-5433

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

1-800-252-3439

You may write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

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

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

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

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

1-800-638-5433

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

1-800-252-3439

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

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

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

Arkansas residents please be advised of the following:

IMPORTANT NOTICE

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

1-800-638-5433

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

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

California residents please be advised of the following:

IMPORTANT NOTICE

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

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

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

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

Georgia residents please be advised of the following:

IMPORTANT NOTICE

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

Utah residents please be advised of the following:

NOTICE TO POLICYHOLDERS

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

PEOPLE ENTITLED TO COVERAGE

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

POLICIES COVERED

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

EXCLUSIONS AND LIMITATIONS

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

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.
- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

LIMITS ON AMOUNT OF COVERAGE

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

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

DISCLAIMER

PLEASE READ CAREFULLY:

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

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

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

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

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

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

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

Virginia residents please be advised of the following:

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

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

1-800-638-5433

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

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

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

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

Wisconsin residents please be advised of the following:

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

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

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

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

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SCHEDULE OF BENEFITS
(Also see SCHEDULE SUPPLEMENT)

The following Benefits are provided subject to the provisions below.

BENEFITS (EMPLOYEE ONLY) **AMOUNT**

ACCIDENTAL DEATH OR DISMEMBERMENT

All Employees who elect:

Option 1:	\$100,000
Option 2:	\$200,000
Option 3:	\$300,000

Spouse and Child(ren).....	An amount equal to: (a) 55% for your spouse; and (b) 15% for each child; of your Accidental Death or Dismemberment Benefits
Spouse Only	An amount equal to 65% of your Accidental Death or Dismemberment Benefits
Child(ren) Only.....	An amount equal to 25% of your Accidental Death or Dismemberment Benefits for each child

If you and your Dependent spouse die within one year of sustaining bodily injuries in the same accident, or separate accidents occurring within the same 24-hour period, the Accidental Death or Dismemberment Benefits amount which applies to your Dependent spouse will be increased to equal the amount set forth above which applies to you, the Employee.

WHEN YOU RETIRE

No benefits are provided under This Plan on or after the day you retire.

Form G.23000-B

SCHEDULE SUPPLEMENT

A. Statements Made by You Which Relate to Insurability

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

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

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

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

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

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

B. Assignment

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

C. Additional Provisions

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

NOTE: Please note evidence of insurability is not required.

Form G.23000-B1

DEFINITIONS OF CERTAIN TERMS USED HEREIN

“**Actively at Work**” or “**Active Work**” means that you will be considered at “Active Work”:

1. on any day in which you are performing in the usual way all the regular duties of your work; or
2. on any day in which you are absent from work for any reason other than:
 - a. your sickness; or
 - b. your injury; or
 - c. a medical leave of absence.

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

"Dependent" means your spouse (a husband or wife who is joined in marriage to an employee by a ceremony recognized by the laws of the State of Maryland) and a never-married child of an employee until the end of the calendar year in which the child becomes 19 years old (or 25th birthday if a full-time student).

An unmarried child means:

1. a blood descendent of the first degree (i.e., son or daughter),
2. a legally adopted child,
3. a step-child permanently residing with the employee, and supported 50% or more by the employee,
4. a child permanently residing in the employee's household, supported 50% or more by the employee, if the child is directly descendent from or placed in the legal guardianship of the employee,
5. a never-married child who is attending an accredited educational institution full-time until the end of the calendar year in which the child turns 25 or the end of the month in which the child ceases to be a full-time student, whichever occurs first.

A never-married child 19 years or older who is incapable of self-support because of mental or physical incapacity given that:

1. the condition leading to the incapacity began before the child's 19th birthday (or 25th if a full-time student),
2. the incapacity is permanent, and
3. The child resides permanently with the employee and is supported 50% or more by the employee.

No person may be covered as a Dependent of more than one Employee.

"Dependent Benefits" mean the benefits which are provided on account of a Dependent under This Plan.

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

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

"Employee" means a person who is employed and paid for services by the Employer and is eligible as determined by the Employer

1. Employee who is regularly paid salary or wages through an official State payroll center, including but not limited to:
 - a. Central Payroll Bureau;
 - b. Mass Transit Administration;
 - c. University of Maryland, including graduate assistants, and the Far East and European Division of

the University of Maryland;

2. Employee whose status is temporary pending an examination;
3. Elected official;
4. Register of wills or an employee of the office of register of wills;
5. Clerk of court or an employee of the office of clerk of court;
6. Board or commission member who is regularly paid salary or wages and who works at least 50 percent of a normal work week;
7. Employee of political subdivisions which participate in the State's health insurance program with the approval of the governing body;
8. Employee of agency, commission, or organization permitted to participate in the State's health insurance program by law;
9. Part-time employee working not less than 50 percent of the normal work week and his/her designated dependents in accordance with Regulation .4B(2) of COMAR 17.04.13.04; or
10. Contractual employee as defined in COMAR 17.04.13.03 and his/her designated dependents in accordance with Regulation .4B(2) of COMAR 17.04.13.04.

"Hospital" means a facility which:

1. is legally licensed; and
2. provides a broad range of 24 hour a day medical and surgical services for sick and injured persons by, or under the supervision of, a staff of Doctors; and
3. provides 24 hour a day nursing care by, or under the direction of, a registered professional nurse (R.N.).

For the purpose of determining benefits for:

- a. mental illnesses; or
- b. emotional disorders;

Hospital will also include any mental hospital or institution licensed for the treatment of mental illness.

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

"Qualifying Events" means a change of status, such as the birth of dependent, loss of eligibility of a dependent, your marriage or your divorce, change of employment status of yourself or a spouse, etc., under your Employer's Internal Revenue Code Section 125 Cafeteria Plan that allows a mid-year change in enrollment for AD&D coverage. Please contact your Employer's Benefits Division for more information regarding changes in status that may be Qualifying Events.

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

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

"You" and "your" mean the Employee who is a Covered Person for Personal Benefits. They do not include a Dependent of the Employee.

Form G.23000-A

ELIGIBILITY FOR BENEFITS

Personal Benefits Eligibility Date

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

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

Dependent Benefits Eligibility Date

Your Dependent Benefits Eligibility Date is the later of your Personal Benefits Eligibility Date and the date you first acquire a Dependent.

Form G.23000-C

EFFECTIVE DATES OF PERSONAL BENEFITS

A. Making a Request for Benefits

1. Your Employer has established a benefits plan. Under such a plan, you can choose the amount and types of benefits subject to the rules of the plan. Such rules include time frames during which you may make a request to be covered or to change your benefits under This Plan as set forth below. Such rules also establish a time frame for when changes in the amount of your benefits are made as a result of a change in your class or earnings. Your Employer can provide you with more information regarding the benefits plan. In order to become covered for Personal Benefits under This Plan, you must make a written request to the Employer on the benefits enrollment form furnished by the Employer.

In general, you can make choices for coverage for Personal Benefits:

- a. within 60 days from when you are first eligible for Personal Benefits; and
- b. during the annual enrollment period as designated by the Employer and reported to you.

Requests to be covered for Personal Benefits may only be made:

- a. during the first and any subsequent annual enrollment period, as designated by the Employer and reported to you, following your Personal Benefits Eligibility Date; or
- b. during the sixty day period following your Personal Benefits Eligibility Date; and
- c. within 60 days of the date of a Qualifying Event.

2. If you are already covered for Personal Benefits, requests for changes in Personal Benefits may only be made during the annual enrollment period, as designated by the Employer and reported to you, or within 60 days of the date of a Qualifying Event.
3. If you make a request to be covered for Personal Benefits within sixty days of your Personal Benefits Eligibility Date, your Personal Benefits will become effective on your Personal Benefits Eligibility Date in accordance with COMAR 17.04.13.04.
4. If you make a request to change your Personal Benefits during an annual enrollment period, your Personal Benefits will become effective on the first day of the calendar year following the annual enrollment period.

B. Active Work Requirement

You must be Actively at Work in order for your Personal Benefits to become effective. If you are not Actively at Work on the date when your Personal Benefits would otherwise become effective, your Personal Benefits will become effective on the first day after you return to Active Work.

C. Reinstatement of Benefits

If your Personal Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them, subject to the foregoing provisions.

Form G.23000-D1

EFFECTIVE DATES OF DEPENDENT BENEFITS

A. Making a Request for Benefits

1. In order to become insured for Dependent Benefits under This Plan, you must enroll through the process established by your Employer.

Requests to be insured for Dependent Benefits may only be made:

- a. during the sixty day period following your Dependent Benefits Eligibility Date; or
- b. during the first and any subsequent annual enrollment period, as designated by the Employer and reported to you, following your Dependent Benefits Eligibility Date; or
- c. within sixty days of a Qualifying Event, provided that the change in coverage is consistent with your new family status.

If you are already insured for Dependent Benefits, requests for changes in your Dependent Benefits may only be made:

- a. during the annual enrollment period, as designated by the Employer and reported to you; or
- b. within sixty days of a Qualifying Event, provided that the change in coverage is consistent with your new family status.

2. If you make a request to be insured for Dependent Benefits within sixty days of your Dependent Benefits Eligibility Date, your Dependent Benefits will become effective, on the latest of:
 - a. your Dependent Benefits Eligibility Date; and
 - b. the effective date of your Personal Benefits.
3. If you make a request to be insured for Dependent Benefits or a request for change(s) in Dependent Benefits within sixty days of a Qualifying Event, your Dependent Benefits or the change(s) in the Dependent Benefits will become effective following the completion of your enrollment form and in accordance with COMAR 17.04.13.04.

B. Reinstatement of Benefits

If your Dependent Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them, subject to the foregoing provisions.

C. New Dependents

If you are insured for Dependent Benefits and acquire a new Dependent, such event may be considered, subject to the provisions of the flexible benefits plan, as a Qualifying Event. The effective date of Dependent Benefits with respect to such person who becomes your Dependent would be determined in accordance with the foregoing provisions.

Form G.23000-D2

ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

A. Coverage

We will pay Accidental Death or Dismemberment Benefits for a Covered Loss shown in Section C if:

1. you are injured in an accident which occurs while you are covered for Accidental Death or Dismemberment Benefits; or
2. a Dependent is injured in an accident which occurs while Accidental Death or Dismemberment Benefits are in effect for that Dependent;

and if, in either case:

- a. that accident is the sole cause of the injury; and
- b. that injury is the sole cause of that Covered Loss; and
- c. that Covered Loss occurs not more than 365 days after the date of that accident.

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

1. Exposure Benefit

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

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

2. Seat Belt Benefit

We will pay an amount equal to 10% of the Full Amount shown in section B for the loss of a Covered Person's life that results from injuries sustained while driving or riding in a private Passenger Car if such Covered Person's Seat Belt was properly fastened; but the amount payable will not: (a) exceed \$25,000; nor (b) be less than \$1,000.

Passenger Car means any validly registered four-wheel private Passenger Car. It does not include:

- a.** any commercially licensed car; or
- b.** a private Passenger Car which is being used for commercial purposes.

"Seat Belt" means:

- a.** any child restraint device which meets the definition of the state law; or
- b.** any other restraint device which:
 - i.** meets published federal safety standards;
 - ii.** has been installed by the car manufacturer; and
 - iii.** has not been altered after such installation.

The correct position of the Seat Belt must be certified by the investigating officer. A copy of the police report must be submitted with the claim.

We will not pay a Seat Belt Benefit if the Covered Person was driving while under the influence of alcohol or drugs.

3. Hospital Benefit

If, as a result of an accident, a Covered Person is confined in a Hospital, we will pay during such confinement, after a four day waiting period a monthly amount equal to 1% of the Full Amount shown in section B, but not more than \$2,500 per month.

In no case will such benefit be payable for:

- a.** the first four days of a Hospital confinement; or
- b.** more than 12 months during a period of Hospital confinement.

Payments for periods less than a full month will be made on a pro-rata basis.

4. Training Benefit for a Dependent Spouse

If you die as a result of an accident while your Dependent spouse is enrolled in an accredited school for the purpose of training or refreshing skills needed for employment, we will pay the actual cost incurred for enrolling for one year in such school, up to a maximum of \$5,000.

5. Education Benefit for Dependent Children

If you die as a result of an accident, we will pay on account of each Dependent child an annual amount equal to 2% of the Full Amount shown in section B, but not more than \$5,000 per year, if such child, on the date of the accident, was:

- a.** enrolled as a full-time student in a college, university or vocational school above the 12th grade level; or
- b.** at the 12th grade level and subsequently enrolls as a full-time student in a college, university or vocational school within 365 days following the date of the accident.

The Education Benefit for Dependent Children is payable for a maximum of four consecutive years as long as the Dependent child remains such a full-time student.

If there are no Dependent children who qualify for the Education Benefit for Dependent Children on the date of your death, we will pay an additional benefit of \$1,000 to your Beneficiary.

6. Child Care Center Benefit

If you die as a result of an accident, we will pay on account of each Dependent child who:

- a.** is 12 years of age or under on the date of the accident; and
- b.** was enrolled in a Child Care Center on the date of the accident;

an annual amount equal to the lesser of:

- a.** 3% of the Full Amount shown in section B; and
- b.** the actual amount of Child Care Center Benefit costs incurred;

however, in no event will such amount be more than \$5,000 per year.

The Child Care Center Benefit is payable for a maximum of four consecutive years as long as the Dependent child remains:

- a.** enrolled in a Child Care Center; and
- b.** 12 years of age or under.

If there are no Dependent children who qualify for the Child Care Center Benefit on the date of your death, we will pay an additional benefit of \$1,000 to your Beneficiary.

Child Care Center means a facility which:

- a. is operated and licensed according to state law, and
- b. provided care and supervision for children in a group setting on a regular, daily basis.

Child Care Center Benefits will be paid to any person or persons who have incurred Child Care Center expenses on account of the Dependent child.

B. Maximum Benefit for All Covered Losses in Each Accident

For all Covered Losses caused by all injuries which:

1. you sustain in one accident; or
2. a Dependent sustains in one accident;

not more than the Full Amount will be paid.

Full Amount means the amount of Accidental Death or Dismemberment Benefits:

1. for which you are covered on the date of your accident; or
2. that is in effect for that Dependent on the date of that Dependent's accident.

C. Table of Covered Losses and Benefit Amounts

Covered Losses (Subject to Exclusions)	Benefit Amounts
Life	Full Amount
A hand	One-half of the Full Amount
A foot	One-half of the Full Amount
Sight of an eye	One-half of the Full Amount
Any combination of a hand, a foot or sight of an eye	Full Amount
Thumb and Index finger of same hand	One-quarter of the Full Amount
Speech and hearing	Full Amount
Speech or hearing in both ears	One-half of the Full Amount
Quadriplegia	Full Amount
Paraplegia	Three-fourths of the Full Amount
Hemiplegia	One-half of the Full Amount

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

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

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

Loss of thumb and index finger means actual severance 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 hearing means the entire and irrecoverable loss which has lasted continuously for 12 consecutive months following the injury.

Quadriplegia means total paralysis of both upper and lower limbs.

Paraplegia means total paralysis of both lower limbs.

Hemiplegia means total paralysis of upper and lower limbs on one side of the body.

Paralysis means loss of use, without severance, of a limb. Paralysis must be determined by competent medical authority to be permanent, complete and irreversible.

D. Exclusions

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

1. physical or mental illness, diagnosis of or treatment for the illness; or
2. an infection, unless it is caused by an external wound that can be seen and which was sustained in an accident; or
3. suicide or attempted suicide; or
4. injuring oneself on purpose; or
5. the use of any drug or medicine; or
6. a war, or a warlike action in time of peace, including terrorist acts; or
7. committing or trying to commit a felony or an assault; or
8. any poison or gas, voluntarily taken, administered or absorbed; or
9. service in the armed forces of any country or international authority, except the United States National Guard; or
10. operating, learning to operate, or serving as a member of a crew of an aircraft; or while in any aircraft operated by or under any military authority (other than the Military Airlift Command); or while in any aircraft being used for a test or experimental purposes; or while in any aircraft used or designed for use beyond the Earth's atmosphere; or while in any aircraft for the purpose of descent from such aircraft while in flight (except for self preservation); or
11. driving a vehicle while intoxicated as defined by the laws of the jurisdiction in which the vehicle was being operated.

E. Payment of Benefits

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

Accidental Death or Dismemberment Benefits will be paid:

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

3. to you for the loss of life of a Dependent, if you survive the Dependent; the benefits will be paid to your estate if:
 - a. that Dependent dies at the same time your death occurs; or
 - b. that Dependent dies within 24 hours of your death;in any other instance the benefits will be paid to that Dependent's estate; and
4. to you for any other Covered Loss sustained by a Dependent, if you survive that Dependent; otherwise the benefits will be paid to that Dependent.

Training Benefit for a Dependent Spouse will be paid to your Dependent Spouse.

Education Benefit for Dependent Children will be paid to each Dependent child.

Child Care Center Benefit will be paid to any person or persons who have incurred Child Care Center Benefits on account of the Dependent child.

The Child Care Center Benefit will be payable on a quarterly basis, with the first quarter beginning on the first day of the month following the date of your death, and with the first benefit being payable at the end of the first quarter.

F. Optional Types of Payment

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

Form G.23000-4L

BENEFICIARY

A. Your Beneficiary

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

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

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

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

B. More Than One Beneficiary

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

C. Death of a Beneficiary

A person's rights as a Beneficiary end if:

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

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

D. No Beneficiary at Your Death

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

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

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

Form G.23000-G

CLAIM PROCEDURE FOR ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

A. When Notice of Claim Must be Given

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

B. Claim Forms

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

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

C. When Proof of Claim Must Be Given

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

D. Late Notice or Proof

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

E. Time Limits on Starting Lawsuits

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

No lawsuit may be started more than 3 years after the time proof must be given.

F. Medical Examinations

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

G. Autopsy

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

Form G.23000-H4

WHEN BENEFITS END

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

The end of any type of benefits on account of a Covered Person will not affect a claim which is incurred on the date of the loss.

PORTABILITY

For purposes of this subsection, the term "Portability Eligible Insurance for you" refers to Accidental Death or Dismemberment Benefits.

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

- your coverage ends; or
- you cease to be in a class that is eligible for such insurance.

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

A request for portability may be made, if on the date of the request, the following requirements are met:

- the Group Policy is in effect;
- We have not received notice from the Employer of its intent to end the Group Policy;
- The person making the request resides in a jurisdiction that permits portability.

Request Period

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

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

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

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

Amount of the New Certificate

The maximum amount of Accidental Death or Dismemberment Benefits which may be continued is the lesser of:

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

Premiums for the New Certificate.

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

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

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

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

In any case, the benefits will end on:

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

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

With respect to all Personal Benefits and all Dependent Benefits, the period determined in accordance with the Employer's general practice for an Employee in your job class. Employees on unpaid leave of absence will be permitted to continue coverage amounts while on leave as long as premiums are paid to MetLife.

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

Form G.23000-L

NOTICES

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

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

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

Form G.23000-E

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

