YOUR EMPLOYEE BENEFIT PLAN

The Johns Hopkins University

Full-Time Bargaining Unit Employees

Basic Life Benefits
Supplemental Life Benefits
Dependent Life Benefits

Certificate Date: September 1, 2015
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 The Johns Hopkins University by Metropolitan Life Insurance Company.

The Johns Hopkins University
CERTIFICATE RIDER

Group Policy No.: 106567-G
Policyholder: The Johns Hopkins University
Effective Date: September 1, 2015

The certificate is changed as shown below:

The definition of Domestic Partner is added as follows:

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

- have registered as each other’s domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same 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 employee.

For Texas residents:

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

- have registered as each other’s domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:

  1. 18 years of age or older;
  2. unmarried;
  3. the sole domestic partner of the other 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 employee.

This rider is to be attached to and made a part of the Certificate

Steven A. Kandarian  
Chairman, President and Chief Executive Officer
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.

Steven A. Kandarian
Chairman of the Board, President and Chief Executive Officer

Employer: The Johns Hopkins University
Group Policy No.: 106567-G

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

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

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

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

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

Form G.23000-Cert.-1
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:

1-800-638-6420

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

1-800-252-3439

You may write the Texas Department of Insurance:

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

Web: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

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

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

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

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

1-800-638-6420

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

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

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

Sitio Web: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov

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

ADJUNTE UNA ESTE AVISO A SU CERTIFICADO: Este aviso es solamente para propósitos de informativos y no se convierte en parte o en condición 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:

1-800-438-6388

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 STREET
LITTLE ROCK, ARKANSAS 72201-1904
(501) 371-2640 or (800) 852-5494
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
200 PARK AVENUE
NEW YORK, NY 10166
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.
Idaho 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. 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:

IDAHO DEPARTMENT OF INSURANCE
CONSUMER AFFAIRS
700 WEST STATE STREET, 3RD FLOOR
PO BOX 83720
BOISE, IDAHO 83720-0043
1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or www.DOI.Idaho.gov
NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company
1-800-438-6388

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

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

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

Complaint can be filed electronically at www.in.gov/idoi
NOTICE FOR RESIDENTS OF MINNESOTA

RIGHT TO CONTINUE LIFE BENEFITS (On Your Own Account) AND LIFE BENEFITS (On Account of Dependents)

A. When the RIGHT TO CONTINUE LIFE BENEFITS (On Your Own Account) AND LIFE BENEFITS (On Account of Dependents) is available.

The right to continue these Benefits will be available to you when these Benefits would otherwise end because Active Work ends due to:

1. the voluntary or involuntary termination of your employment; or
2. your being Laid Off; or
3. your ceasing to be in an eligible class;

except that this right will not be available:

a. if these Benefits end because This Plan ends; or
b. if your Dependents were not covered for LIFE BENEFITS (On Account of Dependents) for at least 60 days.

"Laid Off" means that there is a reduction in hours to the point where you are no longer eligible for these Benefits under This Plan.

B. What Must Be Done to Continue LIFE BENEFITS (On Your Own Account) and LIFE BENEFITS (On Account of Dependents).

In order to continue these Benefits, you must:

1. make a request to the Employer to continue these Benefits; and
2. make any payment which is required for the cost of the continued Benefits.

For the first 18 months of continuation the amount of the premium you will be required to pay will not exceed the amount of premium required to be paid for active employees for such insurance (the amount that will be required includes any premium amounts previously paid by the employer as well as the employee). All premium payments must be made directly to us. You will be provided with payment instructions.

The request and the first payment must be made within 60 days after the later of:

a. the date on which you received notice of the right to continue these Benefits; and
b. the date on which these Benefits would otherwise have ended.

The notice will be sent to you by the Employer by first class certified mail to your last known address.

If the conditions set forth in this Section B are complied with, these Benefits will continue to be in effect until the earliest of the dates set forth in Section C.

If you continue insurance under this section, any reductions in insurance or increases in premiums that would have applied if you were Actively at Work will apply to the continued insurance.

At the end of 18 months you may choose to continue the insurance under this section. If you choose to continue the insurance, we reserve the right to change premiums at that time, and may change premiums from time to time thereafter. All premium payments must be made directly to us. We will provide a schedule of the new premiums and payment instructions.
C. When LIFE BENEFITS (On Your Own Account) AND LIFE BENEFITS (On Account of Dependents) Ends.

If continued, these Benefits will end on the earliest of:

1. the date This Plan ends; or

2. the date you become covered as an employee for similar types of benefits under any other group plan or program; or

3. if you do not make a payment which is required by the for the cost of these Benefits, the last day of the period for which a required payment was made; or

4. in the case of a Dependent, the date that person ceases to be a Dependent, as defined.

D. When the Right to Obtain a Personal Policy Is Available

When a continuation under this section ends (except if it is ending because you have become covered as an employee under this plan), the right to obtain a personal policy from us will be available if the (LIFE BENEFITS (On Your Own Account) or the LIFE BENEFITS (On Account of Dependents) end as set forth in items (1), (2), (3), or (4) of Section C, above.

The conditions under which a personal policy may be obtained are set forth in RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE and RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON THE LIFE OF A DEPENDENT. The personal policy will be on a form issued by us which provides the same or substantially similar benefits as those provided by these Benefits. Any limitation dealing with the right to apply during the Application Period or the amount of the policy will not apply in the event item (1) of Section C above occurs.
IMPORTANT NOTICE

NOTICE FOR RESIDENTS OF MONTANA

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

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

The Definition Of Dependent Is Modified For The Coverages Listed Below:

For Texas Residents (Life Benefits):

The term also includes Your grandchildren. The age limit for children and grandchildren will not be less than 25, regardless of the child’s or grandchild’s student status or full-time employment status. A child will be considered your adopted child during the period you are a party to a suit in which you are seeking the adoption of the child. In addition, grandchildren must be able to be claimed by you as a dependent for Federal Income Tax purposes at the time you applied for Insurance.
For Texas Residents:

IMPORTANT NOTICES

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

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

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

Due to the laws of the state of Texas, the requirements that a Texas resident must meet to show a terminal illness in order to qualify for Accelerated Benefits are:

1. your life span is drastically limited;
2. you are expected to die within 24 months; and
3. you are not expected to recover.

These must be certified by a Doctor and accepted by us.
Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

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

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

The basic protections provided by the Association are:

- **Life Insurance**
  - $500,000 in death benefits
  - $200,000 in cash surrender or withdrawal values

- **Health Insurance**
  - $500,000 in hospital, medical and surgical insurance benefits
  - $500,000 in long-term care insurance benefits
  - $500,000 in disability income insurance benefits
  - $500,000 in other types of health insurance benefits

- **Annuities**
  - $250,000 in withdrawal and cash values

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

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 31A, Chapter 28.

**Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance.** When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.
To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.  Utah Insurance Department
60 East South Temple, Suite 500            3110 State Office Building
Salt Lake City UT 84111                     Salt Lake City UT 84114-6901
(801) 320-9955                               (801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.
NOTICE FOR RESIDENTS OF THE STATE OF VERMONT

Vermont law provides that the following apply to your certificate:

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

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

Wherever the term "step-child" appears in this certificate it shall be read to include the children of your Domestic Partner.
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
200 Park Avenue
New York, New York 10166
Attn: Corporate Consumer Relations Department

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

1-800-275-4638

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

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Henrico, VA 23218

1-877-310-6560 - toll-free
1-804-371-9944 - fax
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov – email
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
200 Park Avenue
New York, NY 10166
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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CERTIFICATE RIDER

Group Policy No.: 106567-G

Employer: The Johns Hopkins University

Effective Date: September 1, 2015

The certificate is changed as follows:

The SCHEDULE OF BENEFITS section of the certificate is revised to add the following:

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:

1. by check;
2. by establishing an account that earns interest and provides the Beneficiary with immediate access to the full benefit amount; or
3. 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.

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

Steven A. Kandarian
Chairman of the Board, President and Chief Executive Officer

GCR11-13

gp
SCHEDULE OF BENEFITS
(Also see SCHEDULE SUPPLEMENT)

The following Benefits are provided subject to the provisions below.

The amount of Life Benefits that We will pay will be decreased by the amount of any contributions due and unpaid to Us for that insurance.

**BENEFITS (EMPLOYEE ONLY)**

<table>
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<th>Amount</th>
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</thead>
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<tr>
<td><strong>Basic Life Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Basic Life</td>
<td>An amount equal to 1 times your basic annual earnings, as determined by your Employer, rounded to the next lower $1,000</td>
</tr>
<tr>
<td>Maximum Basic Life Benefit</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Accelerated Benefit Option</td>
<td>Up to 50% of your Basic Life amount not to exceed $250,000</td>
</tr>
<tr>
<td><strong>Supplemental Life Benefits</strong></td>
<td></td>
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<tr>
<td>For Active Employees who elect:</td>
<td></td>
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<tr>
<td>Option 1* (Non-Contributory)</td>
<td>An amount equal to 1 times your basic annual earnings, as determined by your Employer (See NOTE)</td>
</tr>
<tr>
<td>Option 2* (Contributory)</td>
<td>An amount equal to 2 times your basic annual earnings, as determined by your Employer (See NOTE)</td>
</tr>
<tr>
<td>Maximum Supplemental Life Benefit</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Maximum Benefit for Basic Life and Supplemental Life Benefits Combined</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Non-Medical Issue Amount</td>
<td>$500,000</td>
</tr>
<tr>
<td>Accelerated Benefit Option</td>
<td>Up to 50% of your Supplemental Life amount not to exceed $250,000</td>
</tr>
</tbody>
</table>

*You are automatically enrolled in Option 1. However, if you elect Option 2, the total amount of your Supplemental Life Benefits will be equal to 2 times your basic annual earnings.

**NOTE:** Your Basic Life and Supplemental Life combined benefit amount will be rounded to the next lower $1,000.

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

The following Estate Resolution Services are provided at no additional cost to individuals insured for Supplemental Life Benefits as described below. If You are eligible to receive these Estate Resolution Services and you or your spouse (for the Will Preparation Service) or you or your spouse or a Beneficiary (for the Probate Service) would like to speak with a representative from Hyatt Legal Plans or get the name of a Plan Attorney that you can speak with about these Services, please call (800) 821-6400.

THE FOLLOWING APPLIES TO RESIDENTS OF ALL STATES OTHER THAN TEXAS

Will Preparation Service

If you elect Supplemental Life Benefits, a will preparation service (the “Service”) will be made available to you, through a MetLife affiliate (the “Affiliate”), while your Supplemental Life Benefits is in effect. This Service will be made available at no cost to you. It enables you to have a will prepared for you and your spouse free of charge by attorneys designated by the Affiliate. If you have a will prepared by an attorney not designated by the Affiliate, you must pay for the attorney’s services directly. Upon proof of such payment, you will be reimbursed for the attorney’s services in an amount equal to the lesser of the amount you paid for the attorney’s services and the amount customarily reimbursed for such services by the Affiliate.

Probate Service

If you become insured for Group Supplemental Life Benefits coverage and you or your spouse die while such Group Supplemental Life Benefits coverage is in effect, a probate benefit (the “Benefit”) will be made available to your estate in the event of your death or to your spouse’s estate in the event of your spouse’s death. Such benefit will be made available through a MetLife affiliate ("Affiliate").

The Benefit provides for certain probate services to be made available, free of charge by attorneys designated by the Affiliate. If probate services are provided by an attorney not designated by the Affiliate, the estate of the deceased must pay for those attorney’s services directly. Upon Proof of such payment, the estate of the deceased will be reimbursed for the attorney’s services in an amount equal to the lesser of the amount such estate paid for the attorney’s services and the amount customarily reimbursed for such services by the Affiliate.

This Benefit will be provided at no cost to you and will end on the date your Group Supplemental Life Benefits coverage ends.

THE FOLLOWING APPLIES TO RESIDENTS OF TEXAS ONLY

Will Preparation Service

If you elect Supplemental Life Benefits, a will preparation service (the “Service”) will be made available to you through a MetLife affiliate (the “Affiliate”), as agreed to by the Employer and MetLife, while your Supplemental Life Benefits is in effect under this Policy.

Will Preparation Service means a service covering the preparation of wills and codicils for you and your spouse. The creation of any testamentary trust is covered. The Will Preparation Service does not include tax planning.

This Service will be made available at no cost to you. It enables you to have a will prepared for you and your spouse free of charge by attorneys designated by the Affiliate. If you have a will prepared by an attorney not designated by the Affiliate, you must pay for the attorney’s services directly. Upon proof of such payment, you will be reimbursed for the attorney’s services in an amount equal to the lesser of the amount you paid for the attorney’s services and the amount customarily reimbursed for such services by the Affiliate.
Probate Service

If you become insured for Supplemental Life Benefits coverage and you or your spouse die while such Supplemental Life Benefits is in effect, a probate benefit (the “Benefit”) will be made available to your estate in the event of your death or to your spouse’s estate in the event of your spouse’s death. Such benefit will be made available through a MetLife affiliate (“Affiliate”).

The Benefit includes attorney representation and payment of legal fees for the executor or administrator of the deceased including representation for the preparation of all documents and all of the court proceedings needed to transfer probate assets from the estate of the deceased to applicable heirs; and the completion of correspondence necessary to transfer non-probate assets such as proceeds from insurance policies, joint bank accounts, stock accounts or a house; and associated tax filings.

The Benefit provides for such services to be made available, free of charge by attorneys designated by the Affiliate. If probate services are provided by an attorney not designated by the Affiliate, the estate of the deceased must pay for those attorney’s services directly. Upon proof of such payment, the estate of the deceased will be reimbursed for the attorney’s services in an amount equal to the lesser of the amount your estate paid for the attorney’s services and the amount customarily reimbursed for such services by the Affiliate.

This Benefit will be provided at no cost to you and will end on the date your Supplemental Life Benefits ends.

BENEFITS (DEPENDENTS ONLY)  AMOUNT

Dependent Life Benefits

| For your Spouse | $4,000 |
| For each of your children | $2,000 |

INCREASES AND DECREASES IN AMOUNTS OF BASIC AND SUPPLEMENTAL LIFE BENEFITS

Your earnings on the date you become covered under This Plan will determine your benefits on that date. Any increase or decrease in your benefits will take place on the date of change in your earnings provided you are Actively at Work on that date. If you are not Actively at Work on the date of change in your earnings, the change in your benefits will take place when you return to Active Work.

WHEN YOU RETIRE

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

Form G.23000-B
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

The benefits with respect to the Life Benefits (On Your Own Account) under This Plan may be assigned as a gift. Any such assignment will transfer all right, title, interest and incidents of ownership, both present and future, in such benefits, including, but not limited to, the following:

1. The right to make any contributions required to keep the benefits in force under This Plan.
2. The privilege of obtaining an individual policy of life insurance.
3. The right to change the Beneficiary.

No assignment will be binding on us nor on the Employer unless the following conditions are met:

1. The assignment is in a form which is acceptable to us and to the Employer.
2. The assignment is accepted, in writing, by us and by the Employer.
3. The assignment is filed at our Home Office.

We assume no obligation as to the validity or the sufficiency of any assignment; neither does the Employer.

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 notice or a proof must be given to us.

Form G.23000-B1
DEFINITIONS OF CERTAIN TERMS USED HEREIN

"Actively at Work" or "Active Work" means that you 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.

For residents of Texas, the Dependent definition with respect to child is modified as explained in the Notice pages of this certificate - please consult the Notice.

"Dependent" means your lawful Spouse (including your Domestic Partner) or your unmarried natural child except for:

1. a person who is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or

2. a person who is covered under This Plan as an Employee; or

3. a child who is 14 days of age and under; or

4. a child who is 26 years of age or older.

If a Dependent child is a Covered Person on the day before that child has reached the applicable age limit, that child will continue to be a Dependent after the age limit as long as:

a. that child is and remains unable to work in self-sustaining employment because of:
   i. physical handicap; or
   ii. mental incapacity; and

b. that child is and remains chiefly dependent upon you for support; and

c. that child is and remains a Dependent, as defined, except for the age limit; and

d. you give us proof, when we ask for it, that the child is and remains so unable to work and dependent upon you since the age limit. We will not ask for proof more than once a year. The proof must be satisfactory to us.

Subject to the same conditions which apply to a natural child, child also includes:

a. a child who is legally adopted; and

b. a stepchild (wherever the term "stepchild" appears in this certificate it shall be read to include the children of your Domestic Partner); and

b. a child for whom benefits must be provided by court order, that we have been notified of (as set forth in a divorce decree); and
d. a child for whom you are the legally appointed guardian who resides with and is supported by you.

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.

Domestic Partner - For the Domestic Partner Definition, please refer to the Domestic Partner Definition Rider in the front of this certificate.

"Employee" means a full-time bargaining unit person who is employed and paid for services by the Employer on a full-time basis as determined by the Employer. "Full-Time" means an Employee is regularly schedule to work at least 30 or more hours per week for the Employer.

"Hospitalized" means that you have received:

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

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

"Qualifying Events" means a change in your family, employment or group coverage status which would affect your Benefits under This Plan due to one or more of the following:

1. marriage;
2. birth, adoption or placement for adoption of a dependent child;
3. divorce, legal separation or annulment;
4. death of a dependent;
5. your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage; or
6. a change in your or your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes you or your dependent to gain or lose eligibility for group coverage.

"Spouse" means your lawful spouse. Wherever the term "Spouse" appears in this certificate it shall, unless otherwise specified, be read to include your Domestic Partner.
"This Plan" means the Group Policy which is issued by us to provide Personal Benefits and Dependent Benefits.

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

"Work Requirements" means that you have:

1. worked as an Employee at least 20 hours during the last 7 consecutive calendar days; and

2. worked at either your usual place of business or away from your usual place of business at your Employer's convenience.

"You" and "your" mean the Employee who is a Covered Person for Personal Benefits. 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 September 1, 2015, that is your Personal Benefits Eligibility Date.

If you become an Employee after September 1, 2015, 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

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

APPLICABLE TO NON-CONTRIBUTORY BENEFITS
(Basic Life Benefits and Supplemental Life Benefits – Option 1)

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

APPLICABLE TO CONTRIBUTORY BENEFITS
(Supplemental Life Benefits – Option 2)

A. Making a Request for Benefits

1. Your Employer has established a flexible 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 flexible benefits plan. In order to become covered for Personal Benefits under This Plan, you must make a written request to the Employer on the flexible benefits enrollment form furnished by the Employer.

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

a. when you are first eligible for Personal Benefits; or

b. when you have a Qualifying Event and want to make a change in your coverage for Personal Benefits to be more consistent with your new family status; or

c. 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 thirty-one day period following your Personal Benefits Eligibility Date; or

c. within thirty-one days of a Qualifying Event.

If you are already covered for Personal Benefits, requests for changes in Personal Benefits may only be made:

a. during the annual enrollment period, as designated by the Employer and reported to you; or

b. within thirty-one 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 covered for Personal Benefits within thirty-one days of your Personal Benefits Eligibility Date, your Personal Benefits will become effective on your Personal Benefits Eligibility Date, subject to the Work Requirements.
However if you request to be covered for Life Benefits and the requested amount of Life Benefits is more than the Non-Medical Issue Amount as shown in the SCHEDULE OF BENEFITS, then you must give us evidence of your good health. If you do not give us evidence of your good health, or if such evidence of good health is not accepted by us as satisfactory, the amount of Life Benefits will be limited to the Non-Medical Issue Amount.

3. If you make a request to be covered for Personal Benefits or a request for change(s) in Personal Benefits within thirty-one days of a Qualifying Event, your Personal Benefits or the change(s) in Personal Benefits will become effective on the first day of the month following the date of your request, subject to the Work Requirements, and provided that the change in coverage is consistent with your new family status.

However if you request to be covered for Life Benefits and the requested amount of Life Benefits is more than the Non-Medical Issue Amount as shown in the SCHEDULE OF BENEFITS, then you must give us evidence of your good health. If you do not give us evidence of your good health, or if such evidence of good health is not accepted by us as satisfactory, the amount of Life Benefits will be limited to the Non-Medical Issue Amount.

4. If you are not insured for Personal Benefits and make a request to be insured for Personal Benefits during an annual enrollment period, but more than 31 days after your Personal Benefits Eligibility Date evidence of your good health must be given to us.

5. If you make a request, during an annual enrollment period, to increase your Supplemental Life Benefits, you must give us evidence of your good health.

If you do not give us evidence of your good health, or if such evidence of good health is not accepted by us as satisfactory, the increase will not take effect and the amount of your Supplemental Life Benefits will be the amount of Supplemental Life Benefits for which you were covered prior to your request for an increase.

6. If you make a request, during a Qualifying Event, to increase your Supplemental Life Benefits, you must give us evidence of your good health.

If you do not give us evidence of your good health, or if such evidence of good health is not accepted by us as satisfactory, the increase will not take effect and the amount of your Supplemental Life Benefits will be the amount of Supplemental Life Benefits for which you were covered prior to your request for an increase.

7. If you make a request, during an annual enrollment period, to decrease your Supplemental Life Benefits to an option of the Plan providing a lower level of benefits, the decreased amount of Supplemental Life Benefits will become effective on the first day of the calendar month following the annual enrollment period.

B. Evidence of Good Health

The evidence of good health is to be given at your expense. Your Personal Benefits will become effective on the first day of the month following the date such evidence of good health is accepted by us as satisfactory, subject to the Work Requirement.

C. 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.
D. 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.

E. Work Requirements

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

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 make a written request to the Employer on the flexible benefits enrollment form furnished by the Employer.

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

a. during the thirty-one day period following your Dependent Benefits Eligibility Date; and

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; and

c. within thirty-one 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 thirty-one 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 thirty-one days of your Dependent Benefits Eligibility Date, your Dependent Benefits will become effective, subject to the Additional Requirements, and on the latest of:

a. your Dependent Benefits Eligibility Date; or

b. the effective date of your Personal Benefits; or

c. for Dependent Life Benefits the date the information on the enrollment form related to such Dependent is accepted by us as satisfactory.

3. If you make a request to be insured for Dependent Benefits or a request for change(s) in Dependent Benefits within thirty-one days of a Qualifying Event, your Dependent Benefits or the change(s) in the Dependent Benefits will become effective on the latest of:

a. the date of the Qualifying Event;
b. the effective date of your Personal Benefits; or

c. the date of your request;

subject to the Additional Requirements, and provided that the change in coverage is consistent with your new family status.

4. If you are not insured for Dependent Benefits and make a request to be insured for Dependent Benefits, during an annual enrollment period, the Dependent Benefits will become effective on the latest of:

a. your Dependent Benefits Eligibility Date; or

b. the effective date of your Personal Benefits; or

c. the date of your request.

B. Additional Requirements

If, on the date you would have become insured under This Plan for Life Benefits (On Account of Dependents), a Dependent:

1. has been Hospitalized in the last three months prior to the date you make a request for Dependent Benefits under This Plan;

2. is then Hospitalized; or

3. is not then able to perform Normal Activities;

then evidence of the good health of each such Dependent must be given to us.

C. 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.

D. 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
LIFE BENEFITS
(On Your Own Account)

A. Coverage

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

B. Optional Types of Payment

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

C. Suicide Provision (Applicable to Supplemental Life Benefits)

Supplemental Life Benefits will not be paid to the Beneficiary if you commit suicide, while sane or insane, within 2 years from the effective date of this certificate. Instead we will pay the Beneficiary an amount equal to any contributions paid, without interest.

If you commit suicide, while sane or insane, more than 2 years after the effective date of this certificate, but within 2 years from the effective date of any increase in the amount of your Supplemental Life Benefits, such increased amount will not be paid to the Beneficiary. Instead we will pay the Beneficiary:

1. an amount equal to all contributions paid for the increased amount, without interest; plus

2. an amount equal to the amount of Supplemental Life Benefits that was in effect on the day before the effective date of such increased amount.

Form G.23000-1
ACCELERATED BENEFITS
(On Your Own Account)

A. Definitions

"Meet the Requirements" means:

1. your life span is drastically limited; and

2. you are expected to die within 12 months; and

3. you are not expected to recover.

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

B. Coverage

We will pay Accelerated Benefits to you if:

1. you apply for Accelerated Benefits while your Life Benefits are in effect; and

2. you Meet the Requirements while you are covered for Life Benefits; and

3. you or your legal representative requests payment of Accelerated Benefits while your Life Benefits are in effect.

Accelerated Benefits are payable only once.

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

C. Proof

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

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

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

D. Amount

The amount of Accelerated Benefits payable is:

1. up to 50% of your Life Benefits as shown in the SCHEDULE OF BENEFITS; and

2. determined as of the date we accept certification that you Meet the Requirements; and
3. no more than $250,000 for Basic Life Benefits and $250,000 for Supplemental Life Benefits.

If your Life Benefits are scheduled to reduce within six months of such certification date, we will, for the purpose of determining the amount of Accelerated Benefits, deem the amount of your Life Benefits to have already been reduced on such certification date.

After payment of the Accelerated Benefits, the amount of your Life Benefits will be:

1. the amount of Life Benefits actually in effect on the certification date; less

2. the amount of Accelerated Benefits requested.

When the scheduled reduction date occurs, the amount of your Life Benefits will be reduced. The amount of such reduction will be determined by applying the percentage in accordance with the provisions of This Plan to the amount of your Life Benefits actually in effect on the certification date.

After such scheduled reduction, the amount of your Life Benefits will be the amount of your Life Benefits actually in effect on the certification date:

REDUCED BY

the amount of such scheduled reduction; and

MINUS

the amount of Accelerated Benefits requested.

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

You may be entitled to apply for a personal policy of Life Insurance up to the amount of such scheduled reduction under RIGHT TO OBTAIN A PERSONAL POLICY OF LIFE INSURANCE ON YOUR OWN LIFE.

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

E. Exclusions

Accelerated Benefits will not be payable if:

1. you have assigned your Life Benefits (see Assignment provision under SCHEDULE SUPPLEMENT); or

2. the amount of your Life Benefits is less than $10,000; or

3. you are required by a government agency to request payment of Accelerated Benefits in order to apply for, obtain or keep a government benefit or entitlement.
RIGHT TO OBTAIN A PERSONAL POLICY
OF LIFE INSURANCE ON YOUR OWN LIFE

A. Application

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

1. the date your Life Benefits end because your employment ends or because you are no longer in a class which remains eligible for Life Benefits; or

2. the date your Life Benefits end because This Plan ends, but only if your Life Benefits under This Plan have been in effect for at least 5 years; or

3. the date This Plan is changed to end the Life Benefits for your class, but only if your Life Benefits under This Plan have been in effect for at least 5 years.

If you are not given notice, in writing, of the Right To Obtain A Personal Policy Of Life Insurance On Your Own Life at least 15 days before the end of the Application Period, you will have additional time in which to apply. You will then have 15 days from the date you are given the notice in which to apply; but in no event may you apply later than the 60th day after the last day of the Application Period.

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

Proof that you are insurable is not required by us.

B. Conditions

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

1. it will be on one of the forms then usually issued by us, except term insurance; and

2. it will not take effect until after the Application Period ends; and

3. the premium for the policy will be based on:
   a. the class of risk to which you belong; and
   b. your age on the effective date of the policy; and
   c. the form and amount of the policy; and

4. if item A(1) applies to you, the amount of the policy will not be more than the amount of your Life Benefits on the date the Life Benefits end; and

5. if item A(2) or item A(3) applies to you, the amount of the policy will not be more than the lesser of:
   a. the amount of your Life Benefits on the date the Life Benefits end, less any amount of life insurance for which you may be eligible under any group policy which takes effect within 31 days after your Life Benefits end; and
   b. $10,000.
C. If You Die During the Application Period

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

Form G.23000-1A
LIFE BENEFITS
(On Account of Dependents)

A. Coverage

If a Dependent dies while Life Benefits are in effect for that Dependent, we will pay the amount of Life Benefits that is in effect for that Dependent on the date of that Dependent's death.

B. Payment of Benefits

The benefits will be paid to you if you survive the Dependent. The benefits will be paid to your estate if:

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

In any other instance the benefits will be paid to the Dependent's estate; or we may instead pay all or part of the benefits to one or more of the following persons who are related to that Dependent and who survive that Dependent:

   a. Spouse or Domestic Partner;
   b. children;
   c. parents;
   d. brother and sister.

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

C. Optional Types of Payment

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

D. Suicide

LIFE BENEFITS (On Account of Dependents) will not be paid if a Dependent commits suicide, while sane or insane, within 2 years from the effective date of this certificate. Instead we will pay an amount equal to any contributions paid, without interest, as set forth in Section B, Payment of Benefits.

If a Dependent commits suicide, while sane or insane, more than 2 years after the effective date of this certificate, but within 2 years from the effective date of any increase in the amount of LIFE BENEFITS (On Account of Dependents), such increased amount will not be paid. Instead we will pay:

   a. an amount equal to all contributions paid for the increased amount, without interest, plus
   b. an amount equal to the amount of LIFE BENEFITS (On Account of Dependents) that was in effect on the day before the effective date of such increased amount,

as set forth in Section B, Payment of Benefits.

Form G.23000-7C
A. **Application**

We will issue a personal policy of life insurance without disability or accidental death benefits to a Dependent if that Dependent applies for it in writing during the Application Period. The Application Period is the 31 day period after the date the Life Benefits on that Dependent end because:

1. your employment ends or you are no longer in a class which remains eligible for Dependent Life Benefits; or

2. This Plan ends, but only if the Life Benefits on that Dependent had been in effect under This Plan for at least 5 years; or

3. This Plan is changed to end the Dependent Life Benefits for your class, but only if the Life Benefits on that Dependent had been in effect under This Plan for at least 5 years; or

4. you die; or

5. the Dependent no longer qualifies as a Dependent as defined in DEFINITIONS OF CERTAIN TERMS USED HEREIN.

If the Dependent is not given notice, in writing, of the Right To Obtain A Personal Policy Of Life Insurance On The Life Of A Dependent at least 15 days before the end of the Application Period, that Dependent will have additional time in which to apply. The Dependent will then have 15 days from the date the Dependent is given the notice in which to apply; but in no event may the Dependent apply later than the 60th day after the last day of the Application Period.

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

Proof that the Dependent is insurable is not required by us.

B. **Conditions**

The personal policy will be issued to the Dependent subject to these conditions:

1. it will be on one of the forms then usually issued by us, except term insurance; and

2. it will not take effect until after the Application Period ends; and

3. the premium for the policy will be based on:
   a. the class of risk to which the Dependent belongs; and
   b. the Dependent's age on the effective date of the policy; and
   c. the form and the amount of the policy; and
4. if item A(2) or A(3) applies to the Dependent, the amount of the policy will not be more than the lesser of:
   
a. the amount of Life Benefits on that Dependent on the date the Life Benefits end, less any amount of life insurance on the life of that Dependent for which you or the Dependent may be eligible under any group policy which takes effect within 31 days after the Life Benefits on that Dependent end; and

   b. $10,000; and

5. if an item in paragraph A, other than item A(2) or A(3), applies to the Dependent, the amount of the policy will not be more than the amount of Life Benefits on that Dependent on the date the Life Benefits end.

C. If the Dependent Dies During the Application Period

If the Dependent dies during the Application Period, we will pay a death benefit. The payment of the death benefit will be in the same manner as if the Life Benefits on that Dependent had been in effect on the date of that Dependent's death. The amount of the death benefit will be the highest amount of life insurance, pursuant to item B(4) or B(5) for which a personal policy could have been issued. This death benefit will be paid even if the Dependent did not apply for a personal policy.

Form G.23000-7A
A. Your Beneficiary

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

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

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

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

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

B. More Than One Beneficiary

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

C. Death of a Beneficiary

A person's rights as a Beneficiary end if:

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

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

D. No Beneficiary at Your Death

If there is no Beneficiary at your death for any amount of benefits payable because of your death, that amount will be paid to one or more of the following persons who are related to you and who survive you:

1. Spouse or Domestic Partner;
2. child;
3. parent;
4. brother and sister.

However, we may instead pay all or part of that amount to your estate.

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

A. All of your benefits will end on the last day of the calendar month in which your employment ends. Your employment ends when you cease Active Work as an Employee. However, for the purpose of benefits, the Employer may deem your employment to continue for certain absences. See CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE.

B. If This Plan ends in whole or in part, your benefits which are affected will end.

C. Your Dependent Life Benefits will end on the earliest of:
   1. the date that the Dependent ceases to be your Dependent; or
   2. the end of the calendar year that the Dependent child reaches the limiting age; or
   3. the date you retire, as determined by the Employer; or
   4. 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 before those benefits ended.

Form G.23000-F
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.

However, in the event the leave qualifies under the Family and Medical Leave Act of 1993 (FMLA) or a similar state law, the period cannot be longer than the leave required by the law. If a leave qualifies under more than one such law, the period cannot be longer than the longest leave permitted under any of the laws.

Form G.23000-L
This certificate is of value to you. It should be kept in a safe place. Your Beneficiary should know where the certificate is kept.

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

**Our Home Office is located at 200 Park Avenue, New York, New York 10166.**

Form G.23000-E
THE PRECEDING PAGE IS THE END OF THE CERTIFICATE.
THE FOLLOWING IS ADDITIONAL INFORMATION.
ERISA INFORMATION

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE JOHNS HOPKINS UNIVERSITY TERM LIFE 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.

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

The Johns Hopkins University
633n Wyman Park Bldg. 3400 North Charles Street
Baltimore, MA 21218-2695

EMPLOYER IDENTIFICATION NUMBER: 52-0595110

PLAN NUMBER COVERAGE PLAN NAME
502 All Coverages The Johns Hopkins University Group Welfare Plan

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife"). MetLife is liable for all life 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 seeking payment of benefits, service of legal process may be made upon MetLife by serving MetLife's designated agent to accept service of process.

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 Employer and/or MetLife have the rights to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the 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 WHEN BENEFITS END 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 Supplemental Life Benefits, you are required to make contributions to premiums.

Premium rates are set by MetLife.

PLAN YEAR

The Plan’s fiscal records are kept on a Plan year basis beginning each January 1st and ending on the following December 31st.

QUALIFIED DOMESTIC RELATIONS ORDERS/QUALIFIED MEDICAL CHILD SUPPORT ORDERS

You and your beneficiaries can obtain, without charge, from the Plan Administrator a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and Qualified Medical Child Support Orders (QMCSO).

CLAIMS INFORMATION

Procedures for Presenting Claims for Life Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who will also be ready to answer questions about the insurance benefits and to assist 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.

Life Benefits Claims

Routine Questions

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

Claim Submission

In submitting claims for life 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 descriptions. 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 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.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a 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 the Plan will be continued indefinitely, but The Johns Hopkins University 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 Directors of The Johns Hopkins University shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.

**Supplementary ERISA Information For Legal Services**

The ERISA information set forth above which pertains to Group Supplemental Life Benefits also applies to Legal Services – Will Preparation Benefit and Estate Resolution Benefit, except as noted below:

**Coverage**

Legal Services – Will Preparation Benefit and Estate Resolution Benefit

**Type of Administration**

Legal Services – Will Preparation Benefit and Estate Resolution Benefit is administered by Hyatt Legal Plans, Inc.

**Agent for Service of Legal Process**

For disputes arising under those portions of the Plan administered by Hyatt Legal Plans, Inc., service of legal process may be made upon Hyatt Legal Plans, Inc.
Eligibility For Will Preparation Benefit and Estate Resolution Benefit - Description or Summary of Benefits

Your MetLife Group Supplemental Life Benefits certificate describes the eligibility requirements for the Legal Services - Will Preparation Benefit and Estate Resolution Benefit under the Plan. It also includes a summary description of the benefit. For more detailed information, you may contact the provider, Hyatt Legal Plans, Inc. by phone at 1-800-821-6400.

Plan Termination or Changes

The Will Preparation Benefit and Estate Resolution Benefit is being provided by Hyatt Legal Plans, Inc. through an agreement between MetLife and Hyatt Legal Plans, Inc. and may be terminated at any time.

Contributions

No contribution is required for Legal Services – Will Preparation Benefit and Estate Resolution Benefit.

Claims Information

Claims information for Legal Services – Will Preparation Benefit and Estate Resolution Benefit may be obtained by contacting the provider, Hyatt Legal Plans, Inc. by phone at 1-800-821-6400.
For information about the Will Preparation Service and Estate Resolution Service, you may contact the provider, Hyatt Legal Plans, Inc. by phone.

Phone: 1-800-821-6400