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2013 APR -2 PM 1:29
CLERK U.S. DISTRICT COURT
CENTRAL DIST. OF CALIF.
RIVERSIDE

FILED

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA - EASTERN DIVISION

EVERETT MCMAHON,

Plaintiff,

vs.

METROPOLITAN LIFE INSURANCE
COMPANY; and, KAISER
PERMANENTE WELFARE BENEFIT
PLAN,

Defendants.

CV 13

Case No: **02351**

COMPLAINT FOR BENEFITS UNDER
AN EMPLOYEE WELFARE BENEFIT
PLAN

Plaintiff alleges as follows:

1. This Court's jurisdiction is invoked pursuant to 28 U.S.C. §§ 1331, 1337 and 29 U.S.C. § 1132(a), (e), (f), and (g), of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1101, *et seq.* (hereafter "ERISA") as it involves a claim by Plaintiff for Disability benefits under an employee benefit plan regulated and governed under ERISA. Jurisdiction is predicated under these code sections as well as 28 U.S.C. § 1331 as this action involves a federal question.

2. The events or omissions giving rise to Plaintiff's claim occurred in this

1 judicial district, thus venue is proper here pursuant to 28 U.S.C. § 1391(b)(2), and the
2 ends of justice so require.

3 3. The ERISA statute at 29 U.S.C. § 1133, in accordance with Regulations of
4 the Secretary of Labor, provides a mechanism for internal appeal of benefit denials.
5 Those avenues of appeal have been exhausted.

6 4. Plaintiff is informed and believes and thereon alleges that the KAISER
7 PERMANENTE WELFARE BENEFIT PLAN ("Plan") is an employee welfare benefit
8 plan established and maintained by Kaiser Permanente to provide its employees and
9 those of its subsidiaries and affiliates, including Plaintiff, EVERETT MCMAHON ("MR.
10 MCMAHON"), with income protection in the event of a disability and is the Plan
11 Administrator.

12 5. Plaintiff alleges upon information and belief that Defendant,
13 METROPOLITAN LIFE INSURANCE COMPANY ("METLIFE"), is, and at all relevant
14 times was, a corporation duly organized and existing under and by virtue of the laws of
15 the State of New York, authorized to transact and transacting the business of insurance
16 in this state, and, the insurer and Claims Administrator for the Plan.

17 6. Plaintiff further alleges that venue is proper in this district pursuant to 29
18 U.S.C. § 1132(e)(2) in that defendant METLIFE, which fully insured the policy and which
19 is ultimately liable if Plaintiff is found disabled, may be found in this district. Since on or
20 about November 2, 1901, METLIFE has been registered as a corporation with the state of
21 California, has extensive contacts within the state, employs California residents, conducts
22 ongoing business within the state and therefore, may be found within the state.

23 7. At all relevant times Plaintiff was a resident and citizen of the state of
24 California, an employee of Kaiser Permanente, its successors, affiliates and/or
25 subsidiaries, and a participant in the Plan.

26
27 ¹ 29 USC section 1132(e)(2) provides: "Where an action under this subchapter is brought in a district
28 court of the United States, it may be brought in the district where the plan is administered, where the
breach took place, or where a defendant resides or may be found, and process may be served in any
other district where a defendant resides or may be found."

8. Based upon information and belief, Plaintiff alleges that at all relevant times herein Plaintiff was covered under group disability policy number 95910-1-G that had been issued by Defendant METLIFE to Kaiser Permanente to insure its Plan, and the eligible participants and beneficiaries of the Plan, including Plaintiff. A copy of the Certificate of Insurance issued pursuant to the subject Policy is attached hereto as Exhibit "A".

9. Based upon information and belief, Plaintiff alleges that the subject Policy promised to pay Plaintiff monthly long term disability benefits for a specified period of time should he become disabled. Therefore, METLIFE both funds and decides whether claimants will receive benefits under the Plan and as such suffers from a structural conflict² which requires additional skepticism³.

10. Based upon information and belief, Plaintiff alleges that, according to the terms of the Plan, if Plaintiff became disabled, METLIFE promised to pay long term disability benefits to Plaintiff as follows:

Term	Provision
Elimination Period	180 days

² Where an administrator "both decides who gets benefits and pays for them, ... it has a direct financial incentive to deny claims," and therefore "labors under ... a conflict of interest." *Saffon v. Wells Fargo & Co. Long Term Disability Plan*, 511 F.3d 1206, 1211 (9th Cir. 2008). See also *Metropolitan Life Ins. Co. v. Glenn*, 128 S. Ct. 2343, 2349-50 (2008) (dual role where administrator both determines eligibility for benefits and funds benefits creates a conflict of interest). Pursuant to *Abatie*, "a reviewing court must always consider the inherent conflict that exists when a plan administrator both administers and funds it." *Saffon*, 511 F.3d at 1211 (quoting *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 967 (9th Cir. 2006) (emphasis added). "When reviewing a discretionary denial of benefits by a plan administrator who is subject to a conflict of interest, [the Court] must determine the extent to which the conflict influenced the administrator's decisions and discount to that extent the deference ... accorded the administrator's decision." *Id.* at 1212. As the Supreme Court recently explained, the "conflict of interest...should prove more important (perhaps of great importance) where circumstances suggest a higher likelihood that it affected the benefits decision, including, but not limited to cases where an insurance company administrator has a history of biased claims administration." *Glenn*, 128 S. Ct. at 2351.

³ We must judge the reasonableness of the plan administrator skeptically where, as here, the administrator has a conflict of interest. Even without the special skepticism we are to apply in cases of conflict of interest, deference to the plan administrator's judgment does not mean that the plan prevails. "Deference" is not a "talismanic word[] that can avoid the process of judgment." The conflict of interest requires additional skepticism because the plan acts as judge in its own cause. [*Salomaa v. Honda Long Term Disability Plan*, 642 F.3d 666 (9th Cir. 2011)]

Term	Provision				
Monthly Benefit	The lesser of: <ul style="list-style-type: none"> • 60% of Your Predisability Earnings; or • 70% of Your Predisability Earnings subject to the income which will reduce your disability benefits section; or the Maximum Monthly Benefit 				
Maximum Monthly Benefit	None				
Minimum Monthly Benefit	None				
Maximum Benefit Duration	<table> <tr> <th>Age on Date of Your Disability</th><th>Benefit Period</th></tr> <tr> <td>Less than 60</td><td>To age 65</td></tr> </table>	Age on Date of Your Disability	Benefit Period	Less than 60	To age 65
Age on Date of Your Disability	Benefit Period				
Less than 60	To age 65				
Disability "Own Occupation" Disability Definition	During the Elimination Period and the next 24 months, You are unable to perform with reasonable continuity the Substantial and Material Acts necessary to pursue Your Usual Occupation in the usual and customary way.				
"Any Occupation" Disability Definition	<p>After such period, You are not able to engage with reasonable continuity in any occupation in which You could reasonably be expected to perform satisfactorily in light of Your:</p> <ul style="list-style-type: none"> • age; • education; • training; • experience; • station in life; and • physical and mental capacity <p>that exists within any of the following locations:</p> <ul style="list-style-type: none"> • a reasonable distance or travel time from Your residence in light of the commuting practices of Your community; • a distance of travel time equivalent to the distance or travel time 				

Term	Provision
	<p>You traveled to work before becoming disabled; or</p> <ul style="list-style-type: none"> • the regional labor market, if You reside or resided prior to becoming disabled in a metropolitan area.

11. Prior to his disability under the terms of the Plan, on or about June 1, 2010, Plaintiff, who had been employed with Kaiser Permanente, its successors, affiliates and/or subsidiaries, since in or about 2002, was working as a psychology assistant. This occupation naturally required sustained concentration and attention to detail, along with working with the public to provide assistance and care.

12. However, Plaintiff became disabled under the terms of the Plan and subsequently submitted a claim to METLIFE for payment of disability benefits.

13. But, on or about January 9, 2012, METLIFE unreasonably, unlawfully, capriciously and arbitrarily denied his long term disability claim. And, on or about November 15, 2012, METLIFE unreasonably, unlawfully, capriciously and arbitrarily upheld its denial of the disability claim.

14. According to METLIFE's denial letters:

- **January 9, 2012:** "...your claim for Long Term Disability (LTD) benefits has been denied...In the event your appeal is denied in whole or in part, you will have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974."
- **November 15, 2012:** "...we are upholding the denial of Mr. McMahon's claim... Mr. McMahon has exhausted his administrative remedies under the plan, and no further appeals will be considered."

15. In so doing, METLIFE unreasonably, unlawfully, arbitrarily and capriciously failed to timely identify the medical personnel who reviewed Plaintiff's file;

failed to have Plaintiff independently examined⁴; relied strictly upon physical requirements of occupations labeled as “sedentary” instead of taking into consideration the non exertional requirements of Plaintiff’s own, or any, occupation; failed to complete a full and fair vocational assessment; failed to establish that Plaintiff could perform, with reasonable continuity, the substantial and material duties of his usual, or any, occupation; relied upon the opinions of physicians who did not examine Plaintiff, and were financially biased and/or not qualified to refute the findings of Plaintiff’s board certified physicians; and, misrepresented the terms of the Policy⁵.

16. Additionally, METLIFE knew or should have known that the documentation submitted to and/or obtained by METLIFE clearly substantiated his disability, including, but not limited to, the following:

Date	Document/Finding
05/19/2010	MEDICAL RECORD
	Diagnoses:

⁴ This in and of itself may be indicative of an attempt by an insurance company to avoid paying out on a legitimate claim. See *Salomaa v. Honda Long Term Disability Plan*, No. 08-55426, 2011 WL 768070 at *8 (9th Cir. Mar. 7, 2011) [*22] (“An insurance company may choose to avoid an independent medical examination because of the risk that the physicians it employs may conclude that the claimant is entitled to benefits. The skepticism we are required to apply because of the plan’s conflict of interests requires us to consider the possibility in this case.”)

Additionally, it is well established in case law that the opinions of psychiatrists and psychologists who have not examined the individual should be disregarded. The reasoning for this is that, “[u]nlike cardiologists or orthopedists, who can formulate medical opinions based upon objective findings derived from objective clinical tests, the psychiatrist typically treats his patient’s subjective symptoms.” *Sheehan v. Metropolitan Life Ins. Co.*, 368 F. Supp. 2d 228, 255 (S.D.N.Y. 2005). And, in *Smith v. Hartford Life & Accident Ins. Co.*, 2013 U.S. Dist. LEXIS 13868 (N.D. Cal. January 30, 2013), the court rejected an opinion from Dr. Rater and cited several rulings that have been critical of psychiatric reviews - *Sheehan v. Metro. Life Ins. Co.*, 368 F. Supp. 2d 228, 254-55 (S.D.N.Y. 2005); *Smith v. Bayer Corp. Long Term Disability Plan*, 275 Fed. Appx. 495, 508 (6th Cir. 2008); and *Winkler v. Metro. Life Ins. Co.*, 170 Fed. Appx. 167, 168-69 (2d Cir. 2006) (“MetLife’s exclusive reliance on second-hand opinions adds to the overall picture of its decision as less than fair. First-hand observation is especially important in the context of assessing psychiatric disabilities.”) (citing *Sheehan*).

⁵ In its denial letters METLIFE stated that “There is no indication that you were/are unable to perform your activities of daily living...”, and “information available to review did not support significant, global psychiatric functional limitations.” At the time that METLIFE wrote these letters it knew, or should have known, that the Plan did not require an inability “to perform your activities of daily living” or “significant global psychiatric functional limitations” in order to qualify for benefits.



	Stress-Primary Hyperlipidemia ⁶ Hypogonadism ⁷ , male Lab tests, abnormal Attention Deficit Disorder
11/02/2010	MEDICAL RECORD Diagnosis: Attention Deficit Hyperactivity Disorder Spoke with patient regarding recent lab; elevated CK, ALT. High probability all related to Androgel ⁸ therapy. Persistent elevation of cholesterol, but reluctant to add medications due to these abnormalities. Has been struggling since job termination with decreased concentration, more reclusive, decreased motivation.
03/28/2011	SUPERVISOR STATEMENT Frequency of interpersonal relationships necessary to perform the job: Continually (67-100% of the time) Can employee's job be modified? No.
11/11/2011	LABORATORY REPORT Creatine Kinase Total (CK ⁹) 403 (High)
11/25/2011	MEDICAL RECORD HTN: Not well controlled. Patient compliant with meds.
11/26/2011	ATTENDING PHYSICIAN STATEMENT Primary diagnosis: Major depressive disorder Secondary diagnosis: Generalized anxiety disorder

⁶ Hyperlipidemia is an increase in the amount of fat (such as cholesterol and triglycerides) in the blood. These increases can lead to heart disease and pancreatitis.

⁷ Male hypogonadism is defined as the failure of the testes to produce androgen, sperm, or both. Men with hypogonadism have low levels of testosterone (low T) and accompanying symptoms, which may include reduced muscle mass and strength, a reduction in bone density, changes in mood, and/or an increase in fat mass.

⁸ Androgel is a gel containing testosterone. Side effects include headache, high blood pressure, abnormal lab tests, and, in large prostate.

⁹ Creatine kinase (CK or CPK) is an enzyme (a type of protein) found in muscle and brain. Normally, very little CK is found circulating in the blood. Elevated levels indicate damage to either muscle or brain; possibly from a myocardial infarction (heart attack), muscle disease, or stroke.



	<p>Objective findings: depressed affect... Psychomotor retardation... Tearfulness... Hopelessness</p> <p>Medications: Lorazepam¹⁰; Metoprolol¹¹; Gemfibrozil¹²; Sertraline¹³; Tamsulosin¹⁴</p> <p>Patient is unable to engage in stress situations or engage interpersonal relations (marked limitations)</p> <p>Unable to work at this time.</p>
12/12/2011	<p>LETTER FROM DR. NAOMI RAPPORT</p> <p>Mr. McMahon has been followed for multiple medical conditions.</p> <p>He has been medically disabled from 5/27/2010-5/27/2011.</p>
01/09/2012	<p>LETTER FROM METLIFE TO MR. MCMAHON</p> <p>...the notes received from Dr. Rapport do indicate that you were having difficulty with concentration and focus as well and decreased motivation...</p>
01/13/2012	<p>BEHAVIORAL HEALTH INITIAL FUNCTIONAL ASSESSMENT FORM BY DR. FLEMING</p> <p>Difficult to control blood pressure; depressed mood * * *</p> <p>Based on your evaluation of the claimant's most recent clinical functional status, please give your assessment on this patient's current level of functional capabilities.</p>

¹⁰ Lorazepam is used to relieve anxiety. Side effects include drowsiness; dizziness; tiredness; weakness; diarrhea; nausea; blurred vision; persistent fine tremor or inability to sit still; and irregular heartbeat.

¹¹ Metoprolol is used alone or in combination with other medications to treat high blood pressure. Side effects include dizziness or lightheadedness, tiredness, depression, nausea, stomach pain, vomiting, heartburn, and, rapid, pounding, or irregular heartbeat.

¹² Gemfibrozil is in a class of lipid-regulating medications called fibrates. It works by reducing the production of triglycerides in the liver. Side effects include stomach pain; heartburn; muscle pain, tenderness or weakness; and blurred vision.

¹³ This medication, which is used to treat depression, as the following side effects: nausea; diarrhea; vomiting; drowsiness; dizziness; excessive tiredness; headache; nervousness; uncontrollable shaking of a part of the body; blurred vision; and seizures.

¹⁴ Tamsulosin is in a class of medications called alpha blockers. It works by relaxing the muscles in the prostate and bladder so that urine can flow easily. Side effects include: sleepiness; weakness; blurred vision; diarrhea; difficulty falling asleep or staying asleep.

1	Date functional abilities were last evaluated by you: 01/13/12
2	Have you reviewed the patient's job description? Yes
3	"Extreme inability to function in most areas due to continuous
4	impairment."
5	05/08/2012 CARDIOLOGY TESTING
6	IMPRESSION:
7	Severe concentric left ventricular hypertrophy ¹⁵
8	10/19/2012 LETTER FROM SAVE A LIFE WELLNESS CENTER
9	Mr. McMahon has been followed for multiple medical conditions.
10	He has been medically disabled from 5/27/2010 through 10/19/2012.

11 17. To date, even though Plaintiff has been disabled, METLIFE has not paid
 12 Plaintiff any disability benefits beyond the end of the Elimination Period. The arbitrary
 13 and capricious nature of METLIFE's denial decision is evidenced by, but not limited to,
 14 the following:

- 15 • METLIFE engaged in procedural violations of its statutory obligations
 16 under ERISA, including, but not limited to, failing to promptly identify the
 17 medical consultants who reviewed his file; failing to timely advise
 18 Plaintiff of what specific documentation it needed from him to perfect his
 19 claim; and, failing to provide a complete copy of all documents, records,
 20 and other information relevant to his claim despite a request by Plaintiff
 21 in violation of 29 C.F.R. Section 2560.530-1(h)(2)(iii);
- 22 • METLIFE ignored the obvious, combed the record and took selective
 23 evidence out of context as a pretext to deny Plaintiff's claim; and,

24
 25 ¹⁵ **Left ventricular hypertrophy** is enlargement (hypertrophy) of the muscle tissue that makes up the wall
 26 of your heart's main pumping chamber (left ventricle). Left ventricular hypertrophy develops in response
 27 to some factor, such as high blood pressure, that requires the left ventricle to work harder. As the
 28 workload increases, the walls of the chamber grow thicker, lose elasticity and eventually may fail to pump
 with as much force as that of a healthy heart. Left ventricular hypertrophy is more common in people who
 have uncontrolled high blood pressure or other heart problems. Symptoms include shortness of breath,
 chest pain, sensation of rapid fluttering or pounding heartbeats (palpitations), dizziness or fainting.

- METLIFE ignored the opinions of Plaintiff's board certified treating physicians and/or misrepresented the opinions of Plaintiff's treating physicians. Deference should be given to the treating physician's opinions as there are no **specific, legitimate** reasons for rejecting the treating physicians' opinions which are based on **substantial evidence** in the claim file. Further, METLIFE's highly conflicted **physician's** opinion does not serve as **substantial evidence**, as it is not **supported by evidence** in the claim file, was not issued by a physician with the same level of medical expertise as the board certified treating physicians, nor is it **consistent with the overall evidence** in the claim file.

18. For all the reasons set forth above, the decision to deny disability insurance benefits was arbitrary, capricious, wrongful, unreasonable, irrational, sorely contrary to the evidence, contrary to the terms of the Plan and contrary to law. Clearly, METLIFE abused its discretion in deciding to deny this claim as the evidence shows its denial decision was arbitrary and capricious. Further, METLIFE's denial decision and actions heighten the level of skepticism with which a court views a conflicted administrator's decision under *Abatie v. Alta Health & Life Insurance Co.*, 458 F.3d 955 (9th Cir. 2006) and *Metropolitan Life Insurance Co. v. Glenn*, 128 S. Ct. 2342 (2008).

19. Additionally, ERISA imposes higher-than-marketplace quality standards on insurers. It sets forth a special standard of care upon a plan administrator, namely, that the administrator "discharge [its] duties" in respect to discretionary claims processing "solely in the interests of the participants and beneficiaries" of the plan, § 1104(a)(1); it simultaneously underscores the particular importance of accurate claims processing by insisting that administrators "provide a 'full and fair review' of claim denials," *Firestone*, 489 U.S., at 113 (quoting § 1133(2)); and it supplements marketplace and regulatory controls with judicial review of individual claim denials, see § 1132(a)(1)(B).

1 20. As a direct and proximate result of METLIFE's failure to provide Plaintiff
2 with disability benefits, Plaintiff has been deprived of said disability benefits beginning
3 on or about the end of the Elimination Period to the present date.

4 21. As a further direct and proximate result of the denial of benefits, Plaintiff
5 has incurred attorney fees to pursue this action, and is entitled to have such fees paid
6 by defendants pursuant to 29 U.S.C. § 1132(g)(1), ERISA § 502(g)(1).

7 22. A controversy now exists between the parties as to whether Plaintiff is
8 disabled as defined in the Plan. Plaintiff seeks the declaration of this Court that he
9 meets the Plan definition of disability and consequently he is entitled to all benefits from
10 the Plan to which he might be entitled while receiving disability benefits including, but
11 not limited to, any medical, vision and dental benefits, life insurance and pension, with
12 reimbursement of all expenses and premiums paid for such benefits from the
13 termination of benefits to the present. In the alternative, Plaintiff seeks a remand for a
14 determination of Plaintiff's claim consistent with the terms of the Plan.

15 WHEREFORE, Plaintiff prays for relief against Defendants as follows:

16 1. An award of benefits in the amount not paid Plaintiff beginning on or about
17 the end of the Elimination Period, together with interest at the legal rate on each
18 monthly payment from the date it became due until the date it is paid; plus all other
19 benefits from the Plan to which he might be entitled while receiving disability benefits
20 including, but not limited to, any medical, vision and dental benefits, life insurance and
21 pension, with reimbursement of all expenses and premiums paid for such benefits or, in
22 the alternative, a remand for a determination of Plaintiff's claim consistent with the terms
23 of the Plan;

24 2. An order determining Plaintiff is entitled to future disability
25 payments/benefits so long as he remains disabled as defined in the Plan;

26 ///


27 ///

28 ///

3. For reasonable attorney fees incurred in this action; and,
4. For such other and further relief as the Court deems just and proper.

Dated: April 2, 2013

 DarrasLaw


FRANK N. DARRAS
LISSA A. MARTINEZ
SUSAN B. GRABARSKY
PHILLIP S. BATHER
Attorneys for Plaintiff
EVERETT MCMAHON

Courthouse News Service



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

CERTIFICATE OF INSURANCE

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

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

Policyholder: Kaiser Foundation Health Plan, Inc.
Group Policy Number: 95910-1-G
Type of Insurance: Disability Income Insurance; Long Term Benefits
MetLife Toll Free Number(s):
For Claim Information FOR DISABILITY INCOME CLAIMS: 1-800-638-2242

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

THIS CERTIFICATE ONLY DESCRIBES DISABILITY INSURANCE.

THE BENEFITS OF THE POLICY PROVIDING YOU COVERAGE ARE GOVERNED PRIMARILY BY THE LAWS OF A STATE OTHER THAN FLORIDA.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

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

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EXHIBIT A

GCERT2000

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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

1-800-638-2242

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
Web: <http://www.tdi.state.tx.us>

Email: ConsumerProtection@tdi.state.tx.us

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 información o para someter una queja:

Usted puede llamar al numero de teléfono gratis de MetLife para información o para someter una queja al

1-800-638-2242

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, 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
Web: <http://www.tdi.state.tx.us>

Email: ConsumerProtection@tdi.state.tx.us

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 propósito de información y no se convierte en parte o condición del documento adjunto.

NOTICE FOR RESIDENTS OF ARKANSAS

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

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

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

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EXHIBIT A

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

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

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

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

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EXHIBIT A

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

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

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NOTICE FOR RESIDENTS OF IDAHO

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

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

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 or www.DOI.Idaho.gov

Courthouse News Service

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EXHIBIT A

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

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

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

Courthouse News Service

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EXHIBIT A

NOTICE FOR MASSACHUSETTS RESIDENTS

CONTINUATION OF DISABILITY INCOME INSURANCE

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

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

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

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

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EXHIBIT A

NOTICE FOR RESIDENTS OF NORTH CAROLINA

Read your Certificate Carefully.

This Certificate Contains a Pre-existing Condition Limitation.

IMPORTANT CANCELLATION INFORMATION

Please Read The Provision Entitled

DATE YOUR INSURANCE ENDS

Found on Pages ~~4/6~~

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EXHIBIT A

NOTICE FOR RESIDENTS OF NORTH CAROLINA

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL:

- (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND
- (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES.

VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

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EXHIBIT A¹¹

NOTICE FOR RESIDENTS OF UTAH

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

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

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

The basic protections provided by the Association are:

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

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

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

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

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

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

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EXHIBIT A

NOTICE FOR RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

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

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

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1-877-310-6560 - toll-free
1-804-371-5691 - locally
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov - email

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EXHIBIT A

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

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

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

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

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EXHIBIT A

NOTICE FOR RESIDENTS OF ALL STATES

WORKERS' COMPENSATION

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

MANDATORY DISABILITY INCOME BENEFIT LAWS

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

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

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SCHEDULE OF BENEFITS

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

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

BENEFIT

BENEFIT AMOUNT AND HIGHLIGHTS

Disability Income Insurance For You: Long Term Benefits

Monthly Benefit The lesser of:

- 60% of Your Predisability Earnings; or
- 70% of Your Predisability Earnings subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section; or
- the Maximum Monthly Benefit

Maximum Monthly Benefit None

Minimum Monthly Benefit None

Elimination Period 180 Days

Maximum Benefit Period*

the period shown below:

Age on Date of Your Disability	Benefit Period
Less than 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

*The Maximum Benefit Period is subject to the LIMITED DISABILITY BENEFITS and DATE BENEFIT PAYMENTS END sections.

Rehabilitation Incentives Yes

Additional Benefits:

Single Sum Payment in the Event of Your Death Yes

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EXHIBIT A

DEFINITIONS

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

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

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

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

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

Benefit Eligible means Active Work on the Policyholder's regular work schedule for the eligible class of employees to which You belong. The work schedule must be at least 20 hours a week. For Northwest Region, employees must be scheduled to work, or have Benefit Average Hours (BAH) of at least 20 hours each week.

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

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

Contributory Insurance includes: Disability Income Insurance; Long Term Benefits.

Disability or Disabled The definition of "Disability or Disabled" is outlined on a separate page which can be found at the end of the Definitions section.

Domestic Partner means each of two people of the same or opposite sex, one of whom is an employee of the Policyholder, who represent themselves publicly as each other's domestic partner and have:

- registered as domestic partners or are members of a civil union with a government agency or office where such registration is available; or
- submitted a domestic partner affidavit to the Policyholder.

The domestic partner affidavit must be notarized, signed by both parties and establish that:

- each person is 18 years of age or older;
- neither person is married;
- neither person has had another domestic partner within 6 months prior to the date they enrolled for insurance for the Domestic Partner under the Group Policy;
- they have shared the same residence for at least 6 months prior to the date they enrolled for insurance for the Domestic Partner under the Group Policy;
- they are not related by blood in a manner that would bar their marriage in the jurisdiction in which they reside;
- they have an exclusive mutual commitment to share the responsibility for each other's welfare and financial obligations which commitment existed for at least 6 months prior to the date they enrolled for insurance for the Domestic Partner under the Group Policy, and such commitment is expected to last indefinitely; and

DEFINITIONS (continued)

The domestic partner affidavit must be notarized, signed by both parties, and establish that 2 or more of the following exist as evidence of joint responsibility for basic financial obligations:

- a joint mortgage or lease;
- designation of the Domestic Partner as beneficiary for life insurance or retirement benefits;
- joint wills or designation of the Domestic Partner as executor and/or primary beneficiary;
- designation of the Domestic Partner as durable power of attorney or health care proxy;
- ownership of a joint bank account, joint credit cards or other evidence of joint financial responsibility; or
- other evidence of economic interdependence.

For Texas residents **Domestic Partner** means the following:

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 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 affidavit attesting to the existence of an insurable interest in one another's lives must be completed and Signed by the Employee.

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

Physician means:

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

The term does not include:

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

DEFINITIONS (continued)

- siblings;
- grandparents; or
- grandchildren.

Policyholder's Retirement Plan means a plan which:

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

The term does not include:

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

Predisability Earnings means base salary or wages You were earning from the Policyholder as of Your last day of Your Elimination Period. We calculate this amount on a monthly basis.

The term includes:

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

The term does not include:

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

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

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and

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EXHIBIT A

DEFINITIONS (continued)

- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

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

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

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

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

Spouse means Your lawful spouse. The term also includes Your Domestic Partner.

We, Us and Our mean MetLife.

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

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

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EXHIBIT A

DEFINITIONS (continued)

Disability or Disabled means that as a result of Sickness or injury You are either Totally Disabled or Partially Disabled.

Totally Disabled or Total Disability means:

During the Elimination Period and the next 24 months, You are unable to perform with reasonable continuity the Substantial and Material Acts necessary to pursue Your Usual Occupation in the usual and customary way.

After such period, You are not able to engage with reasonable continuity in any occupation in which You could reasonably be expected to perform satisfactorily in light of Your:

- age;
- education;
- training;
- experience;
- station in life; and
- physical and mental capacity

that exists within any of the following locations:

- a reasonable distance or travel time from Your residence in light of the commuting practices of Your community;
- a distance of travel time equivalent to the distance or travel time You traveled to work before becoming disabled; or
- the regional labor market, if You reside or resided prior to becoming disabled in a metropolitan area.

Partially Disabled or Partial Disability means while actually working in an occupation, You are unable to earn 80% or more of Your Predisability Earnings.

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

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

- Your Predisability Earnings times
- the annual rate of increase in the Consumer Price Index for the prior calendar year.

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

For purposes of determining whether a Disability is the direct result of an injury, the Disability must have occurred within 90 days of the injury and not as a result of Sickness.

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

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EXHIBIT A

DEFINITIONS (continued)

Substantial and Material Acts means the important tasks, functions and operations generally required by employers from those engaged in Your Usual Occupation that cannot be reasonably omitted or modified. In determining what substantial and material acts are necessary to pursue Your Usual Occupation, We will first look at the specific duties required by Your job. If You are unable to perform one or more of these duties with reasonable continuity, We will then determine whether those duties are customarily required of other employees engaged in Your Usual Occupation. If any specific, material duties required of You by Your job differ from the material duties customarily required of other employees engaged in Your Usual Occupation, then We will not consider those duties in determining what substantial and material acts are necessary to pursue Your Usual Occupation.

Usual Occupation means any employment, business, trade or profession and the Substantial and Material Acts of the occupation You were regularly performing for the employer when the Disability began. Usual Occupation is not necessarily limited to the specific job that You performed for the employer.

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ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Benefit Eligible employees of the Policyholder who have a work schedule of 20 hours a week, but not temporary or seasonal employees, and who are not enrolled in any other long term disability plan provided by the Policyholder. In the Northwest Region, employees must be scheduled to work, or have Benefit Average Hours (BAH) of at least 20 hours each week.

For the purpose of this definition, employee includes:

Program Offices

- Exempt Salaried Employees
- Non-exempt Salaried Employees
- Executives

Hawaii Region

- Exempt Employees
- Non-union Non-exempt (NUNE) Employees

Ohio Region

- Non-exempt Salaried Employees
- Non-exempt Non-union Employees

Southern California Region

- Salaried / Salaried Patient Care Providers / Non-union Non-exempt Employees
- Non-union Employee Group

Northern California Region

- Exempt Salaried Employees
- Non-exempt Salaried Employees
- Physical Therapists
- Occupational Therapists
- Pharmacists
- SEIU Local 535, Mental Health Workers
- SEIU Local 250 Dieticians

Kaiser Permanente Information Technology

- Salaried Employees

Colorado Region

- Exempt and Non-Exempt Salaried Employees

Mid-Atlantic States Region

- Salaried Employees
- Non-union professionals

Georgia Region

- Exempt Salaried Employees
- Non-exempt Salaried Employees
- TSPMG Support Staff Employees
- UFCW Local 1996 (Professional, Clerical & Technical)

Northwest Region

- Managers
- Professionals
- Operating Engineers
- OFNHP Lab Professionals
- OFNHP Professionals
- Non-union Hourly Employees
- ILWU Local 28, Security

DATE YOU ARE ELIGIBLE FOR INSURANCE

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

You will be eligible for insurance on the later of:

1. January 1, 2010; and
2. the first day of the calendar month following the date You complete the Waiting Period that applies to such insurance.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

The Waiting Periods in effect under the Group Policy are as follows:

Insurance Benefit	Waiting Period
Disability Income Insurance: Long Term Benefits	90 days

ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing the required form. If You enroll for Contributory Insurance, You must also give the Policyholder Written permission to deduct premiums from Your pay for such insurance. You will be notified by the Policyholder how much You will be required to contribute.

The insurance listed below is part of a flexible benefits plan established by the Policyholder. Subject to the rules of the flexible benefits plan and the Group Policy, You may enroll for:

- Disability Income Insurance: Long Term Benefits;

only when You are first eligible or during an annual enrollment period. You should contact the Policyholder for more information regarding the flexible benefits plan.

DATE YOUR INSURANCE THAT IS PART OF THE FLEXIBLE BENEFITS PLAN TAKES EFFECT

Enrollment When First Eligible

If You complete the enrollment process within 31 days of becoming eligible for insurance, such insurance will take effect as follows:

- if You are **not required** to give evidence of Your insurability, such insurance will take effect on the date You become eligible for such insurance if You are Actively at Work on that date.
- if You are **required** to give evidence of Your insurability and We determine that You are insurable, the benefit will take effect on the date We state in Writing, provided You are Actively at Work on that date.

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

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

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ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

Enrollment During An Annual Enrollment Period

During any annual enrollment period as determined by the Policyholder, You may enroll for insurance for which You are eligible or choose a different option than the one for which You are currently enrolled. The insurance enrolled for or changes to Your insurance made during an annual enrollment period will take effect as follows:

- for any amount for which You are **not required** to give evidence of Your insurability, such insurance will take effect on the first day of the calendar year following the annual enrollment period, if You are Actively at Work on that date.
- for any amount for which You are **required** to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the date We state in Writing, if You are Actively at Work on that date.

If You are not Actively at Work on the date an amount of insurance would otherwise take effect, that amount of insurance will take effect on the day You resume Active Work.

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

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends; or
2. the date insurance ends for Your class; or
3. the end of the period for which the last premium has been paid for You; or
4. the date You cease to be in an eligible class. You will cease to be in an eligible class on the date You cease Active Work in an eligible class, if You are not disabled on that date; or
5. the date Your employment ends; or
6. the date You retire in accordance with the date Your employment ends.

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

Reinstatement of Disability Income Insurance

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

1. If Your insurance ends because:
 - You cease to be in an eligible class; or
 - Your employment ends; and

You become a member of an eligible class again within 6 months or longer if You are rehired in the same calendar year of the date Your insurance ended, You will not have to complete a new Waiting Period or provide evidence of Your insurability.

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

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

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

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

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

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

To prevent a loss of insurance because of a change in insurance carriers, the following rules will apply if this Disability Income Insurance replaces a plan of group disability income insurance provided to You by the Policyholder:

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

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

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

- **If You are Actively at Work on the day before the Replacement Date**, You will become insured for Disability Income Insurance under this certificate on the Replacement Date.
- **If You are not Actively at Work on such date because you are Disabled**, You will become insured for Disability Income Insurance under this certificate on the Replacement Date.

We will credit any time You accumulated toward the Elimination Period under the Prior Plan to the satisfaction of the Elimination Period required to be met under this certificate.

Any benefits paid for such Disability will be equal to those that would have been payable to You under the Prior Plan less any amount for which the prior carrier is liable.

Benefit payments for such Disability will end on the earliest of:

- the date that payments end under the subsection DATE BENEFIT PAYMENTS END in this certificate; or
- the date that payments would have ended under the provisions of the Prior Plan of Insurance.
- **If You are not Actively at Work on such date for any other reason**, You will become insured for Disability Income Insurance under this certificate on the date you return to Active Work.

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

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

Rules for Pre-existing Conditions

In determining whether a Disability is due to a Pre-existing Condition, We will credit You for any time You were insured under the Prior Plan. If Your Disability is due to a Pre-existing Condition as described in this certificate, but would not have been due to a pre-existing condition under the Prior Plan, We will pay a benefit equal to the lesser of:

- the benefit amount under this certificate; or
- the disability income insurance benefit that would have been payable to You under the Prior Plan.

If Your Disability would have been due to a pre-existing condition under the Prior Plan, it will be treated as having been caused by a Pre-existing Condition under this certificate.

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EXHIBIT A

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

Rules for Temporary Recovery from a Disability under the Prior Plan

We will waive the Elimination Period that would otherwise apply to a Disability under this certificate if You:

- received benefits for a disability that began under the Prior Plan ("Prior Plan's disability");
- returned to work as an active Full-Time employee prior to the Replacement Date;
- become Disabled, as defined in this certificate, after the Replacement Date and within 90 days of Your return to work due to a sickness or accidental injury that is the same as or related to the Prior Plan's disability;
- are no longer entitled to benefit payments for the Prior Plan's disability since You are no longer insured under such Plan; and
- would have been entitled to benefit payments with no further elimination period under the Prior Plan, had it remained in force.

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EXHIBIT A

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Policyholder for information regarding such legally mandated leave of absence laws.

AT YOUR OPTION: CONTINUATION OF YOUR DISABILITY INCOME INSURANCE DURING A LABOR DISPUTE

You may elect to continue Your Disability Income Insurance if You cease to be Actively at Work as the result of a labor dispute. Your Disability Income Insurance will continue for up to 6 months if the following conditions are met:

- at least 75% of the Employees eligible to continue their Disability Income Insurance elect to continue this insurance for such time period; and
- You pay the required premium for Your Disability Income Insurance.

If continued, Your Disability Income Insurance will end if:

- Premium payment is required and You fail to pay premiums for such insurance;
- the number of Employees who elect to continue such insurance falls below 75% of all employees eligible to continue this insurance for such time period; or
- You cease to be eligible to continue Your Disability Income Insurance under this section and You do not immediately resume Active Work in a class that is eligible for Disability Income Insurance.

AT THE POLICYHOLDER'S OPTION

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

Disability Income Insurance will continue until the earliest of

1. the date the Policyholder stops paying the required premium;
2. the date the leave ends; or
3. the last day of the month in which your leave of absence begins.

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

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

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EXHIBIT A

EVIDENCE OF INSURABILITY

We require evidence of insurability satisfactory to Us as follows:

1. if You make a late request for Disability Income Insurance: Long Term Benefits. A late request is one made after You were first eligible to enroll for Disability Income Insurance: Long Term Benefits and You did not enroll for such insurance during such period. However, if such request was made due to a Qualifying Event, it will not be considered to be a late request.

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

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

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EXHIBIT A

DISABILITY INCOME INSURANCE: LONG TERM BENEFITS

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

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

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

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

BENEFIT PAYMENT

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

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

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

RECOVERY FROM A DISABILITY

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

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

If You Return to Active Work Before Completing Your Elimination Period

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

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

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

If You Return to Active Work After Completing Your Elimination Period

If You return to Active Work after completing Your Elimination Period for a period of 6 months or less, and then become Disabled again due to the same or related Sickness or accidental injury, We will not require You to complete a new Elimination Period. For the purpose of determining Your benefits, We will consider such Disability to be a part of the original Disability and will use the same Predisability Earnings and apply the same terms, provisions and conditions that were used for the original Disability.

EXHIBIT A

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DISABILITY INCOME INSURANCE: LONG TERM BENEFITS (continued)

If You return to Active Work for a period of more than 6 months and then become Disabled again, You will have to complete a new Elimination Period.

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

REHABILITATION INCENTIVES

Rehabilitation Program Incentive

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

Work Incentive

While You are Disabled, We encourage You to work. If You work while You are Disabled and receiving Monthly Benefits, Your Monthly Benefit will be adjusted as follows:

- Your Monthly Benefit will be increased by Your Rehabilitation Program Incentive, if any; and
- reduced by Other Income as defined in the DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.

Your Monthly Benefit as adjusted above will not be reduced by the amount You earn from working, except to the extent that such adjusted Monthly Benefit plus the amount You earn from working and the income You receive from Other Income exceeds 100% of Your Predisability Earnings as calculated in the definition of Disability.

Limit on Work Incentive

After the first 24 months following your return to work, We will reduce Your Monthly Benefit by 50% of the amount You earn from working while Disabled.

Family Care Incentive

If You work or participate in a Rehabilitation Program while You are Disabled, We will reimburse You for up to \$250 for monthly expenses You incur for each family member to provide:

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

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

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

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

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EXHIBIT A

DISABILITY INCOME INSURANCE: LONG TERM BENEFITS (continued)

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

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EXHIBIT A

DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT

We will reduce Your Disability benefit by the amount of all Other Income that was actually paid to You for the same disability for which You are claiming benefits under this certificate. Other Income includes the following:

1. any disability benefits for You, Your Spouse or child(ren) under:
 - Federal Social Security Act;
 - Canadian Pension Plan;
 - Quebec Pension Plan;
 - Railroad Retirement Act; or
 - any similar plan or act;
2. temporary disability benefits under a workers' compensation law;
3. amounts under any other occupational disease law, Longshoremen's and Harbor Worker's Act, Maritime Doctrine of Maintenance, Wages and Cure or similar act;
4. any disability benefits under:
 - the Jones Act;
 - any state compulsory/statutory benefit law;
 - any government retirement system, including but not limited to the California State Teachers Retirement System (CalSTRS) and/or the California Public Employee Retirement System (CalPERS); or
 - the Policyholder's retirement plan;
5. any retirement benefits under:
 - Federal Social Security Act;
 - Canadian Pension Plan;
 - Quebec Pension Plan;
 - Railroad Retirement Act;
 - the Policyholder's retirement plan; or
 - any similar plan or act;
6. third party liability payments by judgment, settlement or otherwise (minus attorneys' fees);
7. sick pay;
8. amounts from compromise or settlement of any claim for any of the Other Income sources shown in this provision (minus attorneys' fees);
9. any salary continuation, personal time off, and annual leave pay; and/or
10. return to work earnings as set forth in the Work Incentive and Limit on Work Incentive sub-provisions, in the REHABILITATION INCENTIVES provision.

REDUCING YOUR DISABILITY BENEFIT BY AN ESTIMATED BENEFIT

If We have a reasonable, good faith belief that You are entitled to disability benefits under the following sources of Other Income, You must apply for such benefits:

- Federal Social Security Act (Primary and/or Family Benefits); and/or
- any state compulsory/statutory benefit law.

DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT (continued)

To apply for the Other Income benefits referenced above means to pursue such benefits with reasonable diligence until You receive the respective approval from the Social Security Administration and/or the appropriate state agency.

You must send Us Proof that You have applied for such benefits. If Your application for such benefits is approved, We will reduce Your Disability benefit by the amount actually paid to You from such source(s).

If You fail to:

- apply for any of the above referenced Other Income benefits; and
- pursue such benefits with reasonable diligence, and

if there is a reasonable means of estimating the amount of such benefits payable to You, We will reduce the amount of Your Disability benefit by the amount of such benefits We estimate that You, Your Spouse or child(ren) are eligible to receive because of Your Disability. We will start to do so with the first Disability benefit payment coincident with the date You were eligible to receive such benefits unless We have received:

- Proof that You have applied for and are pursuing such benefits with reasonable diligence;
- approval of Your claim for such benefits; or
- a notice of denial of such benefits.

When You do receive approval or notice of final denial of the above referenced Other Income benefits, You must notify Us immediately. We will adjust the amount of Your Disability benefit. You must promptly repay Us for any overpayment.

SINGLE SUM PAYMENT

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

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

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

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

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

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

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EXHIBIT A

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

We will not reduce Your Disability benefit by any Other Income that is not shown in Income Which Will Reduce Your Disability Benefit.

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EXHIBIT A

DISABILITY INCOME INSURANCE: DATE BENEFIT PAYMENTS END

Your Disability benefit payments will end on the earliest of:

- the end of the Maximum Benefit Period;
- the date benefits end as specified in the section entitled LIMITED DISABILITY BENEFITS;
- the date You are no longer Disabled;
- the date You die except for benefits paid under section entitled ADDITIONAL LONG TERM BENEFIT: SINGLE SUM PAYMENT IN THE EVENT OF YOUR DEATH;
- the date You fail to have a medical exam requested by Us as described in the Physical Exams subsection of the GENERAL PROVISIONS section;
- the date You fail to provide required Proof of continuing Disability.

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

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

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EXHIBIT A

DISABILITY INCOME INSURANCE

ADDITIONAL LONG TERM BENEFIT: SINGLE SUM PAYMENT IN THE EVENT OF YOUR DEATH

If You die while You are Disabled and You were entitled to receive Monthly Benefits under this certificate, Proof of Your death must be sent to Us. When We receive such Proof, We will pay the benefit described in this section.

BENEFIT AMOUNT

The benefit will be equal to 3 times the lesser of:

- the Monthly Benefit You receive for the calendar month immediately preceding Your death;
- the Monthly Benefit You were entitled to receive for the month You die, if You die during the first month that Disability benefits are payable.

We will reduce the benefit amount by any overpayment We are entitled to recover.

BENEFIT PAYMENT

Benefit payments will be made as described in the GENERAL PROVISIONS subsection entitled Disability Income Benefit Payments: Who We Will Pay.

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EXHIBIT A

DISABILITY INCOME INSURANCE: PRE-EXISTING CONDITIONS

Pre-existing Condition means You:

- received medical treatment, care, or services for a diagnosed condition; or
- took prescribed medication for a diagnosed condition;

in the 3 months immediately prior to the effective date of coverage under this certificate; and the Disability caused or substantially contributed to by the condition begins in the first 12 consecutive months after the effective date of coverage under this certificate.

You are not covered for a Disability caused or substantially contributed to by a Pre-existing Condition or medical or surgical treatment of a Pre-existing Condition.

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EXHIBIT A

DISABILITY INCOME INSURANCE: LIMITED DISABILITY BENEFITS

For Disability Due to Alcohol, Drug or Substance Abuse or Addiction

If You are Disabled due to alcohol, drug or substance abuse or addiction, We will limit Your Disability benefits to one period of Disability during your lifetime. During Your Disability, We require You to participate in an alcohol, drug or substance abuse or addiction recovery program recommended by a Physician.

We will end Disability benefit payments at the earliest of:

- the date You receive 24 months of Disability benefit payments;
- the date You cease or refuse to participate in the recovery program referred to above; or
- the date You complete such recovery program.

For Disability Due to Mental or Nervous Disorders or Diseases

If You are Disabled due to a Mental or Nervous Disorder or Disease, We will limit Your Disability benefits to a lifetime maximum equal to the lesser of:

- 24 months; or
- the Maximum Benefit Period.

This limitation will not apply to a Disability resulting from:

- schizophrenia;
- bipolar disorder;
- dementia; or
- organic brain disease.

Mental or Nervous Disorder or Disease means a medical condition which meets the diagnostic criteria set forth in the most recent edition of the Diagnostic And Statistical Manual Of Mental Disorders as of the date of Your Disability. A condition may be classified as a Mental or Nervous Disorder or Disease regardless of its cause.

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EXHIBIT A

DISABILITY INCOME INSURANCE: EXCLUSIONS

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

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

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EXHIBIT A

FILING A CLAIM

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

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

CLAIMS FOR INSURANCE BENEFITS

When a claimant files an initial claim for Disability Income Insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to Us within 90 days of the date of a loss.

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

Step 1

A claimant may give Us notice by calling Us at the toll free number shown in the Certificate Face Page within 20 days of the date of a loss.

Step 2

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

Step 3

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

If the claimant does not receive a claim form within 15 days after giving Us notice of claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

Step 4

The claimant must give Us Proof not later than 90 days after the date of the loss.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible but, in no event, other than for lack of legal capacity, may Proof be given later than one year after the date it is otherwise required.

Items to be Submitted for a Disability Income Insurance Claim

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

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

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EXHIBIT A

FILING A CLAIM (continued)

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

Regular Care of a Physician Requirement

In addition, You must be under the Regular Care of a Physician unless Regular Care:

1. will not improve the condition(s) causing Your Disability; or
2. will not prevent a worsening of the condition(s) causing Your Disability.

Regular care means:

1. You personally visit a Physician(s) as frequently as is medically required to effectively manage and treat the condition(s) causing Your Disability; and
2. You are receiving appropriate treatment and care which conforms with generally accepted medical standards for the condition(s) causing Your Disability.

Prior to the initial payment of benefits, provided You are receiving appropriate treatment and care which conforms with generally accepted medical standards for the condition(s) causing Your Disability, if the time period between Your visits to a Physician(s) is reasonable, You will be deemed to have satisfied the Regular Care of a Physician requirement, even if this results in a visit to a Physician(s) occurring after the end of the Elimination Period.

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

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EXHIBIT A

GENERAL PROVISIONS

Assignment

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

Disability Income Benefit Payments: Who We Will Pay

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

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

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

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

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

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

Entire Contract

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

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

Incontestability: Statements Made by You

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

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

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

Misstatement of Age

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

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EXHIBIT A

GENERAL PROVISIONS (continued)

Conformity with Law

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

Physical Exams

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

Autopsy

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

Overpayments for Disability Income Insurance

Recovery of Overpayments

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

An overpayment occurs if We determine that:

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

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

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

How We Recover Overpayments

We may recover the overpayment from You by:

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

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

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

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EXHIBIT A

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

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EXHIBIT A

SPECIAL SERVICES

Social Security Assistance Program

If your claim for Disability benefits under this plan is approved, MetLife provides you with assistance in applying for Social Security disability benefits. Before outlining the details of this assistance, you should understand why applying for Social Security disability benefits is important.

Why You Should Apply For Social Security Disability Benefits

Both you and your employer contribute payroll taxes to Social Security. A portion of those tax dollars are used to finance Social Security's program of disability protection. Since your tax dollars help fund this program, it is in your best interest to apply for any benefits to which you may be entitled. Your spouse and children may also be eligible to receive Social Security disability benefits due to your Disability. There are several reasons why it may be to your financial advantage to receive Social Security disability benefits. Some of them are:

1. Avoids Reduced Retirement Benefits

Should you become disabled and approved for Social Security disability benefits, Social Security will freeze your earnings record as of the date Social Security determines that your disability has begun. This means that the months/years that you are unable to work because of your disability will not be counted against you in figuring your average earnings for retirement and survivors benefit.

2. Medicare Protection

Once you have received 24 months of Social Security disability benefits, you will have Medicare protection for hospital expenses. You will also be eligible to apply for the medical insurance portion of Medicare.

3. Trial Work Period

Social Security provides a trial work period for the rehabilitation efforts of disabled workers who return to work while still disabled. Full benefit checks can continue for up to 9 months during the trial work period.

4. Cost-of-Living Increases Awarded by Social Security Will Not Reduce Your Disability Benefits

MetLife will not decrease your Disability benefit by the periodic cost-of-living increases awarded by Social Security. This is also true for any cost-of-living increases awarded by Social Security to your spouse and children.

This is called a Social Security "freeze." It means that only the Social Security benefit awarded to you and your dependents will be used by MetLife to reduce your Disability benefit; with the following exceptions:

- a) an error by Social Security in computing the initial amount;
- b) a change in dependent status; or
- c) your Employer submitting updated earnings records to Social Security for earnings received prior to your Disability.

Over a period of years, the net effect of these cost-of-living increases can be substantial.

How MetLife Assists You in the Social Security Approval Process

As soon as you are approved for Disability benefits, MetLife begins assisting you with the Social Security approval process.

1. Assistance Throughout the Application Process

MetLife has a dedicated team of Social Security Specialists. These Specialists, many of whom have worked for the Social Security Administration, are also located within our Claim Department. They

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EXHIBIT A

SPECIAL SERVICES

provide expert assistance up front, offer support while you are completing the Social Security forms, and help guide you through the application process.

2. Guidance Through Appeal Process by Social Security Specialists

Social Security disability benefits may be initially denied, but are often approved following an appeal. If your benefits are denied, our dedicated team of Social Security Specialists provides expert assistance on an appeal if your situation warrants continuing the appeal process. They guide you through each stage of the appeal process. These stages may include:

- a) Reconsideration by the Social Security Administration
- b) Hearing before an Administrative Law Judge
- c) Review by an Appeals Council established within the Social Security Administration in Washington, D.C.
- d) A civil suit in Federal Court

3. Social Security Attorneys

Depending on your individual needs, MetLife may provide a referral to an attorney who specializes in Social Security law. The Social Security approved attorney's fee is credited to the Long Term Disability overpayment, which results upon your receipt of the retroactive Social Security benefits. The attorney's fee, which is capped by Social Security law, will be deducted from the lump sum Social Security Disability benefits award and will not be used to further reduce your Long Term Disability benefit.

Early Intervention Program

The MetLife Early Intervention Program is offered to all covered employees, and your participation is voluntary*. The program helps identify early those employees who might benefit from vocational analyses and rehabilitation services before they are eligible for Long Term Disability benefits. Early rehabilitation efforts are more likely to reduce the length of your Long Term Disability and help you return to work sooner than expected.

If you cannot work, or can only work part-time due to a disability, your employer will notify MetLife. Our Clinical Specialists may be able to assist you by:

1. Reviewing and evaluating your disabling condition, even before a claim for Long Term Disability benefits is submitted (with your consent);
2. Designing individualized return to work plans that focus on your abilities, with the goal of return to work;
3. Identifying local community resources;
4. Coordinating services with other benefit providers, including: medical carrier, short term disability carrier,* workers' compensation carrier, and state disability plans;
5. Monitoring return to work plans in progress and modifying them as recommended by the attending physician (with your consent).

Our assistance is offered at no cost to either you or your employer.

* If you also have MetLife Short Term Disability coverage or Salary Continuance Plan Management, these services are provided automatically. Notification by your employer is not necessary.

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EXHIBIT A

SPECIAL SERVICES

Return To Work Program

Goal of Rehabilitation

The goal of MetLife is to focus on employees' abilities, instead of disabilities. This "abilities" philosophy is the foundation of our Return to Work Program. By focusing on what employees can do versus what they can't, we can assist you in returning to work sooner than expected.

Incentives For Returning To Work

Your Disability plan is designed to provide clear advantages and financial incentives for returning to work either full-time or part-time, while still receiving a Disability benefit. In addition to financial incentives, there may be personal benefits resulting from returning to work. Many employees experience higher self-esteem and the personal satisfaction of being self-sufficient and productive once again. If it is determined that you are capable, but you do not participate in the Return to Work Program, your Disability benefits may cease.

Return-to-Work Services

As a covered employee you are automatically eligible to participate in our Return-to-Work Program. The program aims to identify the necessary training and therapy that can help you return to work. In many cases, this means helping you return to your former occupation, although rehabilitation can also lead to a new occupation which is better suited to your condition and makes the most of your abilities. There is no additional cost to you for the services we provide, and they are tailored to meet your individual needs. These services include, but are not limited to, the following:

- 1. Vocational Analyses**

Assessment and counseling to help determine how your skills and abilities can be applied to a new or a modified job with your employer.

- 2. Labor Market Surveys**

Studies to find jobs available in your locale that would utilize your abilities and skills. Also identify one's earning potential for a specific occupation.

- 3. Retraining Programs**

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

- 4. Job Modifications/Accommodations**

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

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

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

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

Return-to-Work Program Staff

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

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EXHIBIT A

SPECIAL SERVICES

Rehabilitation Vendor Specialists

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

1. attending physician's evaluation and recommendations;
2. your individual vocational needs; and
3. vendor's credentials, specialty, reputation and experience.

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

Courthouse News Service

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EXHIBIT A

THE FOLLOWING IS ADDITIONAL INFORMATION.

Courthouse News Service

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EXHIBIT A

ERISA INFORMATION

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

Kaiser Foundation Health Plan, Inc.
One Kaiser Plaza, Suite 2028
Oakland, CA 94612
510-271-6377

EMPLOYER IDENTIFICATION NUMBER: 94-1340523

PLAN NUMBER	COVERAGE	PLAN NAME
550	All Coverages	Kaiser Permanente Welfare Benefit Plan

TYPE OF ADMINISTRATION

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

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

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan administrator at the above address. For disputes 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 DATE YOUR INSURANCE ENDS subsection of Your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in Your MetLife certificate.

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EXHIBIT A

CONTRIBUTIONS

You must make a contribution to the cost of Disability Income Insurance: Long Term Benefits.

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

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 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

Disability 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

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

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

Initial Determination

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

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

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

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EXHIBIT A

Appealing the Initial Determination

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

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

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

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

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

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

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.

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EXHIBIT A

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.

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EXHIBIT A

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 Kaiser Foundation Health Plan, Inc. 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 Kaiser Foundation Health Plan, Inc. shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.

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EXHIBIT A

**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA**

NOTICE OF ASSIGNMENT TO UNITED STATES MAGISTRATE JUDGE FOR DISCOVERY

This case has been assigned to District Judge Dean D. Pregerson and the assigned discovery Magistrate Judge is Jacqueline Chooljian.

The case number on all documents filed with the Court should read as follows:

CV13- 2351 DDP (JCx)

Pursuant to General Order 05-07 of the United States District Court for the Central District of California, the Magistrate Judge has been designated to hear discovery related motions.

All discovery related motions should be noticed on the calendar of the Magistrate Judge

NOTICE TO COUNSEL

A copy of this notice must be served with the summons and complaint on all defendants (if a removal action is filed, a copy of this notice must be served on all plaintiffs).

Subsequent documents must be filed at the following location:

☒ **Western Division**
312 N. Spring St., Rm. G-8
Los Angeles, CA 90012

☐ **Southern Division**
411 West Fourth St., Rm. 1-053
Santa Ana, CA 92701-4516

☐ **Eastern Division**
3470 Twelfth St., Rm. 134
Riverside, CA 92501

Failure to file at the proper location will result in your documents being returned to you.

Frank N. Darras #128904 (909) 390-3770
 Lissa A. Martinez #206994
 Susan B. Grabarsky #203004
 Phillip S. Bather #273236
 DARRASLAW
 3257 East Guasti Road, Suite 300, Ontario, CA 91761
 Attorneys for Plaintiff

**UNITED STATES DISTRICT COURT
 CENTRAL DISTRICT OF CALIFORNIA**

EVERETT MCMAHON,

CASE NUMBER

PLAINTIFF(S)

13 - 02351

v.

METROPOLITAN LIFE INSURANCE COMPANY; and,
 KAISER PERMANENTE WELFARE BENEFIT PLAN,

SUMMONS

DEFENDANT(S).

TO: DEFENDANT(S):

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it), you must serve on the plaintiff an answer to the attached ☒ complaint ☐ amended complaint ☐ counterclaim ☐ cross-claim or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff's attorney, DARRASLAW, whose address is 3257 East Guasti Road, Suite 300, Ontario, California 91761 (909) 390-3770. If you fail to do so, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

TERRY NAFISI
 Clerk, U.S. District Court

Dated: APR - 2 2013

By: [Signature]
 Deputy Clerk

(Seal of the Court)

[Use 60 days if the defendant is the United States or a United States agency, or is an officer or employee of the United States. Allowed 60 days by Rule 12(a)(3)].

**UNITED STATES DISTRICT COURT, CENTRAL DISTRICT OF CALIFORNIA
CIVIL COVER SHEET**

I (a) PLAINTIFFS (Check box if you are representing yourself ☐)

EVERETT MCMAHON,

DEFENDANTS

METROPOLITAN LIFE INSURANCE COMPANY; and, KAISER
PERMANENTE WELFARE BENEFIT PLAN,

(b) Attorneys (Firm Name, Address and Telephone Number, If you are representing yourself, provide same.)

DarrasLaw (909) 390-3770
3257 E. Guasti Road, Suite 300, Ontario, CA 91761

Attorneys (If Known)

II. BASIS OF JURISDICTION (Place an X in one box only.)

- ☐ 1 U.S. Government Plaintiff ☒ 3 Federal Question (U.S. Government Not a Party)
- ☐ 2 U.S. Government Defendant ☐ 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES - For Diversity Cases Only
(Place an X in one box for plaintiff and one for defendant.)

- | | | | |
|---|--|---|---|
| Citizen of This State | PTF <input type="checkbox"/> 1 DEF <input checked="" type="checkbox"/> 1 | Incorporated or Principal Place of Business in this State | PTF <input type="checkbox"/> 4 DEF <input type="checkbox"/> 4 |
| Citizen of Another State | <input type="checkbox"/> 2 <input type="checkbox"/> 2 | Incorporated and Principal Place of Business in Another State | <input type="checkbox"/> 5 <input type="checkbox"/> 5 |
| Citizen or Subject of a Foreign Country | <input type="checkbox"/> 3 <input type="checkbox"/> 3 | Foreign Nation | <input type="checkbox"/> 6 <input type="checkbox"/> 6 |

IV. ORIGIN (Place an X in one box only.)

- ☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from another district (specify): ☐ 6 Multi-District Litigation ☐ 7 Appeal to District Judge from Magistrate Judge

V. REQUESTED IN COMPLAINT: JURY DEMAND: ☐ Yes ☒ No (Check 'Yes' only if demanded in complaint.)

CLASS ACTION under F.R.C.P. 23: ☐ Yes ☒ No

MONEY DEMANDED IN COMPLAINT: \$

VI. CAUSE OF ACTION (Cite the U.S. Civil Statute under which you are filing and write a brief statement of cause. Do not cite jurisdictional statutes unless diversity.)

28 U.S.C. §§1331, 1337 & 29 U.S.C. §1132(a),(e),(f) & (g) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1101, et seq.

VII. NATURE OF SUIT (Place an X in one box only.)

OTHER STATUTES	CONTRACT	TORTS	TORTS	PRISONER PETITIONS	LABOR
<input type="checkbox"/> 400 State Reapportionment <input type="checkbox"/> 410 Antitrust <input type="checkbox"/> 430 Banks and Banking <input type="checkbox"/> 450 Commerce/ICC Rates/etc. <input type="checkbox"/> 460 Deportation <input type="checkbox"/> 470 Racketeer Influenced and Corrupt Organizations <input type="checkbox"/> 480 Consumer Credit <input type="checkbox"/> 490 Cable/Sat TV <input type="checkbox"/> 810 Selective Service <input type="checkbox"/> 850 Securities/Commodities/Exchange <input type="checkbox"/> 875 Customer Challenge 12 USC 3410 <input type="checkbox"/> 890 Other Statutory Actions <input type="checkbox"/> 891 Agricultural Act <input type="checkbox"/> 892 Economic Stabilization Act <input type="checkbox"/> 893 Environmental Matters <input type="checkbox"/> 894 Energy Allocation Act <input type="checkbox"/> 895 Freedom of Info. Act <input type="checkbox"/> 900 Appeal of Fee Determination Under Equal Access to Justice <input type="checkbox"/> 950 Constitutionality of State Statutes	<input type="checkbox"/> 110 Insurance <input type="checkbox"/> 120 Marine <input type="checkbox"/> 130 Miller Act <input type="checkbox"/> 140 Negotiable Instrument <input type="checkbox"/> 150 Recovery of Overpayment & Enforcement of Judgment <input type="checkbox"/> 151 Medicare Act <input type="checkbox"/> 152 Recovery of Defaulted Student Loan (Excl. Veterans) <input type="checkbox"/> 153 Recovery of Overpayment of Veteran's Benefits <input type="checkbox"/> 160 Stockholders' Suits <input type="checkbox"/> 190 Other Contract <input type="checkbox"/> 195 Contract Product Liability <input type="checkbox"/> 196 Franchise <input type="checkbox"/> 210 Land Condemnation <input type="checkbox"/> 220 Foreclosure <input type="checkbox"/> 230 Rent Lease & Ejectment <input type="checkbox"/> 240 Torts to Land <input type="checkbox"/> 245 Tort Product Liability <input type="checkbox"/> 290 All Other Real Property	<input type="checkbox"/> 310 Airplane <input type="checkbox"/> 315 Airplane Product Liability <input type="checkbox"/> 320 Assault, Libel & Slander <input type="checkbox"/> 330 Fed. Employers' Liability <input type="checkbox"/> 340 Marine <input type="checkbox"/> 345 Marine Product Liability <input type="checkbox"/> 350 Motor Vehicle <input type="checkbox"/> 355 Motor Vehicle Product Liability <input type="checkbox"/> 360 Other Personal Injury <input type="checkbox"/> 362 Personal Injury-Med Malpractice <input type="checkbox"/> 365 Personal Injury-Product Liability <input type="checkbox"/> 368 Asbestos Personal Injury Product Liability <input type="checkbox"/> 462 Naturalization Application <input type="checkbox"/> 463 Habeas Corpus-Alien Detainee <input type="checkbox"/> 465 Other Immigration Actions	<input type="checkbox"/> 370 Other Fraud <input type="checkbox"/> 371 Truth in Lending <input type="checkbox"/> 380 Other Personal Property Damage <input type="checkbox"/> 385 Property Damage Product Liability <input type="checkbox"/> 422 Appeal 28 USC 158 <input type="checkbox"/> 423 Withdrawal 28 USC 157 <input type="checkbox"/> 441 Voting <input type="checkbox"/> 442 Employment <input type="checkbox"/> 443 Housing/Accommodations <input type="checkbox"/> 444 Welfare <input type="checkbox"/> 445 American with Disabilities - Employment <input type="checkbox"/> 446 American with Disabilities - Other <input type="checkbox"/> 440 Other Civil Rights	<input type="checkbox"/> 510 Motions to Vacate Sentence Habeas Corpus <input type="checkbox"/> 530 General <input type="checkbox"/> 535 Death Penalty <input type="checkbox"/> 540 Mandamus/Other <input type="checkbox"/> 550 Civil Rights <input type="checkbox"/> 555 Prison Condition <input type="checkbox"/> 610 Agriculture <input type="checkbox"/> 620 Other Food & Drug <input type="checkbox"/> 625 Drug Related Seizure of Property 21 USC 881 <input type="checkbox"/> 630 Liquor Laws <input type="checkbox"/> 640 R.R. & Truck <input type="checkbox"/> 650 Airline Regs <input type="checkbox"/> 660 Occupational Safety/Health <input type="checkbox"/> 690 Other	<input type="checkbox"/> 710 Fair Labor Standards Act <input type="checkbox"/> 720 Labor/Mgmt. Relations <input type="checkbox"/> 730 Labor/Mgmt. Reporting & Disclosure Act <input type="checkbox"/> 740 Railway Labor Act <input type="checkbox"/> 790 Other Labor Litigation <input checked="" type="checkbox"/> 791 Empl. Ret. Inc. Security Act <input type="checkbox"/> 820 Copyrights <input type="checkbox"/> 830 Patent <input type="checkbox"/> 840 Trademark <input type="checkbox"/> 861 HIA (1395ff) <input type="checkbox"/> 862 Black Lung (923) <input type="checkbox"/> 863 DIWC/DIWW (405(g)) <input type="checkbox"/> 864 SSID Title XVI <input type="checkbox"/> 865 RS1 (405(g)) <input type="checkbox"/> 870 Taxes (U.S. Plaintiff or Defendant) <input type="checkbox"/> 871 IRS-Third Party 26 USC 7609

CV 13 - 02351

FOR OFFICE USE ONLY: Case Number:

AFTER COMPLETING THE FRONT SIDE OF FORM CV-71, COMPLETE THE INFORMATION REQUESTED BELOW.

**UNITED STATES DISTRICT COURT, CENTRAL DISTRICT OF CALIFORNIA
CIVIL COVER SHEET**

VIII(a). IDENTICAL CASES: Has this action been previously filed in this court and dismissed, remanded or closed? ☒ No ☐ Yes

If yes, list case number(s): _____

VIII(b). RELATED CASES: Have any cases been previously filed in this court that are related to the present case? ☒ No ☐ Yes

If yes, list case number(s): _____

Civil cases are deemed related if a previously filed case and the present case:

- (Check all boxes that apply) ☐ A. Arise from the same or closely related transactions, happenings, or events; or
☐ B. Call for determination of the same or substantially related or similar questions of law and fact; or
☐ C. For other reasons would entail substantial duplication of labor if heard by different judges; or
☐ D. Involve the same patent, trademark or copyright, and one of the factors identified above in a, b or c also is present.

IX. VENUE: (When completing the following information, use an additional sheet if necessary.)

(a) List the County in this District; California County outside of this District; State if other than California; or Foreign Country, in which **EACH** named plaintiff resides.
☐ Check here if the **government**, its **agencies** or **employees** is a named plaintiff. If this box is checked, go to item (b).

County in this District:*	California County outside of this District; State, if other than California; or Foreign Country
	Illinois

(b) List the County in this District; California County outside of this District; State if other than California; or Foreign Country, in which **EACH** named defendant resides.
☐ Check here if the **government**, its **agencies** or **employees** is a named defendant. If this box is checked, go to item (c).

County in this District:*	California County outside of this District; State, if other than California; or Foreign Country
	Metropolitan Life Insurance Company - New York Kaiser Permanente Welfare Benefit Plan - Alameda County

(c) List the County in this District; California County outside of this District; State if other than California; or Foreign Country, in which **EACH** claim arose.
Note: In land condemnation cases, use the location of the tract of land involved.

County in this District:*	California County outside of this District; State, if other than California; or Foreign Country
Los Angeles	

* Los Angeles, Orange, San Bernardino, Riverside, Ventura, Santa Barbara, or San Luis Obispo Counties

Note: In land condemnation cases, use the location of the tract of land involved

X. SIGNATURE OF ATTORNEY (OR PRO PER):

Date April 2, 2013

LUISA A. MARTINEZ

Notice to Counsel/Parties: The CV-71 (05-68) Civil Cover Sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law. This form, approved by the Judicial Conference of the United States in September 1974, is required pursuant to Local Rule 3-1 is not filed but is used by the Clerk of the Court for the purpose of statistics, venue and initiating the civil docket sheet. (For more detailed instructions, see separate instructions sheet.)

Key to Statistical codes relating to Social Security Cases:

Nature of Suit Code	Abbreviation	Substantive Statement of Cause of Action
861	HIA	All claims for health insurance benefits (Medicare) under Title 18, Part A, of the Social Security Act, as amended. Also, include claims by hospitals, skilled nursing facilities, etc., for certification as providers of services under the program. (42 U.S.C. 1935FF(b))
862	BL	All claims for "Black Lung" benefits under Title 4, Part B, of the Federal Coal Mine Health and Safety Act of 1969. (30 U.S.C. 923)
863	DIWC	All claims filed by insured workers for disability insurance benefits under Title 2 of the Social Security Act, as amended; plus all claims filed for child's insurance benefits based on disability. (42 U.S.C. 405(g))
863	DIWW	All claims filed for widows or widowers insurance benefits based on disability under Title 2 of the Social Security Act, as amended. (42 U.S.C. 405(g))
864	SSID	All claims for supplemental security income payments based upon disability filed under Title 16 of the Social Security Act, as amended.
865	RSI	All claims for retirement (old age) and survivors benefits under Title 2 of the Social Security Act, as amended. (42 U.S.C. (g))