MetLife®

**METROPOLITAN LIFE INSURANCE COMPANY**
**200 PARK AVENUE, NEW YORK, NEW YORK 10166-0188**

## CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents 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.**

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

| | |
|---|---|
| Group Policyholder: | AH Belo Corporation |
| Group Policy Number: | 0145427 |
| Employee Name: | John Doe |
| Employee Policy ID: | 012345678 |
| Effective Date of Insurance: | January 1, 1999 |
| MetLife Toll Free Number(s): | 1-800-GET-MET8 |
| MetLife Email Address | cii@metlife.com |

We have issued this Certificate to You in consideration of the payment of the Contribution.

**Notice to Buyer: This is a critical illness insurance Certificate. Subject to the provisions of this Certificate, including limitations, exclusions and submission of Proof of a Covered Condition, this Certificate provides a limited benefit in the event You are Diagnosed with certain specified diseases, or have certain surgical procedures performed. Benefits provided are a supplement, and not a substitute for, Medical Coverage. You must have Medical Coverage in place in order to enroll for this insurance.**

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

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICES(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

## NOTICE FOR RESIDENTS OF TEXAS

**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-GET-MET8

You may also write to MetLife at:

MetLife
500 Schoolhouse Road
Johnstown, PA 15904

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 informacion o para someter una queja:

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

1-800-GET-MET8

Usted tambien puede escribir a MetLife

MetLife
500 Schoolhouse Road
Johnstown, PA 15904

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

1-800-252-3439

Puede escribir al Departmento 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 proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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## SCHEDULE OF INSURANCE

This schedule shows the benefits that You have selected under the Group Policy. You and Your Dependents will only be insured for benefits:

- for which You and Your Dependents become and remain eligible; and
- which are in effect under the Group Policy and this Certificate.

## CATEGORY BENEFIT AMOUNT

| | |
|---|---|
| For You | **$10,000** |

## TOTAL BENEFIT AMOUNT

| | |
|---|---|
| For You | **$30,000** |

## BENEFITS FOR COVERED CONDITIONS

| Covered Condition | |
|---|---|
| Bone Marrow Transplant | 100% of the Category Benefit Amount |
| Heart Attack | 100% of the Category Benefit Amount |
| Heart Transplant | 100% of the Category Benefit Amount |
| Kidney Failure | 100% of the Category Benefit Amount |
| Major Organ Transplant | 100% of the Category Benefit Amount |
| Stroke | 100% of the Category Benefit Amount |
| Full Benefit Cancer | 100% of the Category Benefit Amount |
| Partial Benefit Cancer | 25% of the Category Benefit Amount |
| Coronary Artery Bypass Graft | 25% of the Category Benefit Amount |

**Waiting Period**: 90 days for Partial Benefit Cancer and Full Benefit Cancer
30 days for all other Covered Conditions

**IMPORTANT NOTE:** This Certificate contains certain Proof requirements, exclusions, limitations and other provisions that may reduce benefits or prevent a Covered Person from receiving any benefits under this Certificate. PLEASE READ YOUR ENTIRE CERTIFICATE CAREFULLY.

## DEFINITIONS

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

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

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

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

**Benefit Increase** means a simultaneous increase in both the Category Benefit Amount and the Total Benefit Amount.

**Benefit Suspension Period** means the 180 day period following the date a Covered Condition, for which this Certificate pays a benefit, Occurs with respect to a Covered Person.

**Bone Marrow Transplant** means the irreversible failure of a Covered Person's bone marrow for which a Physician has determined that the replacement of such Covered Person's bone marrow with bone marrow from the Covered Person, or another human donor is medically necessary.

**Category Benefit Amount** means the maximum aggregate amount, as shown in the Schedule, that We will pay for all Covered Conditions combined in any category of Covered Conditions, per Covered Person, per lifetime, as provided under this Certificate. There are three categories of Covered Conditions and they are shown on page 16 of this Certificate in the Critical Illness Benefits provision. There is only one Category Benefit Amount in effect at any time for each Covered Person.

**Certificate** means this Certificate including any riders attached to it.

**Clinical Diagnosis** means a Diagnosis of Partial Benefit Cancer or Full Benefit Cancer based on the study of symptoms and diagnostic test results. We will accept a Clinical Diagnosis of Partial Benefit Cancer or Full Benefit Cancer only if the following conditions are met:

- under generally accepted medical standards, a pathological Diagnosis cannot be made because it would be medically inappropriate or life-threatening;
- medical diagnostic testing supports the Diagnosis; and
- a Physician is treating the Covered Person for Partial Benefit Cancer or Full Benefit Cancer.

**Contribution** means the amount You must pay towards the total premium charged by Us for insurance under this Certificate.

## DEFINITIONS

**Coronary Artery Bypass Graft** means the undergoing of open heart Surgery performed by a Physician to bypass a narrowing or blockage of one or more coronary arteries using venous or arterial grafts. The procedure must be deemed medically necessary by a Physician and be supported by pre-operative angiographic evidence. Coronary Artery Bypass Graft does not include:

- angioplasty (percutaneous transluminal coronary angioplasty);
- laser relief;
- stent insertion;
- coronary angiography; or
- any other intra-catheter technique.

**Covered Condition** means the following, as they are defined in this Certificate:

- Bone Marrow Transplant;
- Heart Attack;
- Heart Transplant;
- Kidney Failure;
- Major Organ Transplant;
- Stroke;
- Full Benefit Cancer;
- Partial Benefit Cancer; or
- Coronary Artery Bypass Graft.

**Covered Person** means You and, if insured under the Group Policy for the insurance described in this Certificate, Your Dependents.

**Dependent** means Your Spouse and/or Dependent Child.

**Dependent Child** means the following:

Your biological, adopted, or stepchild who is under age 25; and

Your grandchild who is under age 25, unmarried and who was able to be claimed by You as a dependent for Federal Income Tax purposes at the time You enrolled such grandchild.

The term does not include an unborn or stillborn child, or any person who is insured under the Group Policy as an employee.

A person cannot be insured as a Dependent Child of more than one employee under the Group Policy. Your adopted child will not be a Dependent Child prior to the date the child is placed in Your home for adoption.

**Dependent Insurance** means insurance under this Certificate for Your Dependents.

**Diagnosis** means the establishment of a Covered Condition by a Physician through the use of clinical and/or laboratory findings.

**Diagnose** means the act of making a Diagnosis.

**Enrollment Form** means the Written form provided by Us that You use to enroll for insurance under the Group Policy, including any amendments thereto.

## DEFINITIONS (continued)

**First Occurs** or First Occurrence means, with respect to each Covered Condition, the first time after a Covered Person initially becomes insured under the Group Policy that such Covered Condition Occurs.

**Full Benefit Cancer** means the presence of one or more malignant tumors characterized by the uncontrollable and abnormal growth and spread of malignant cells with invasion of normal tissue provided that a Physician has determined that:

- Surgery, radiotherapy, or chemotherapy is medically necessary;
- there is metastasis; or
- the patient has terminal cancer, is expected to die within 24 months or less from the date of Diagnosis and will not benefit from, or has exhausted, curative therapy.

**Full-Time** means Active Work on the Group Policyholder's regular work schedule for the class of employees to which You belong. The work schedule must be at least 20 hours per week.

**Group Policy** means the policy of insurance issued by Us to the Group Policyholder under which this Certificate is issued.

**Group Policyholder** means the employer named on the first page of this Certificate.

**Heart Attack** (myocardial infarction) means the death of a portion of the heart muscle as a result of obstruction of one or more coronary arteries due to atherosclerosis, spasm, thrombus or emboli.

**Heart Transplant** means the irreversible failure of a Covered Person's heart for which a Physician has determined that the complete replacement of such organ with an entire heart from a human donor is medically necessary, and either such Covered Person has been placed on the Transplant List or such transplant procedure has been performed.

**Hospital** means a short-term, acute care, general facility, which:

- is primarily engaged in providing, by or under the continuous supervision of Physicians, to inpatients, diagnostic services and therapeutic services for Diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

## DEFINITIONS (continued)

**Hospitalized** means:

- admission for inpatient care in a Hospital;
- receipt of care in a hospice facility, an intermediate care facility or a long-term care facility; or
- receipt of the following treatment, wherever performed:

    - chemotherapy;
    - radiation therapy; or
    - dialysis.

**Kidney Failure** means the total, end stage, irreversible failure of both kidneys to function, provided that a Physician has determined that such failure requires either:

- immediate and regular kidney dialysis (no less often than weekly) that is expected by such Physician to continue for at least 6 months; or
- a kidney transplant.

**Major Organ Transplant** means:

- the irreversible failure of a Covered Person's lung, pancreas, entire kidney or any combination thereof, for which a Physician has determined that the complete replacement of such organ with an entire organ from a human donor is medically necessary, and either such Covered Person has been placed on the Transplant List or such transplant procedure has been performed; or
- the irreversible failure of a Covered Person's liver for which a Physician has determined that the complete or partial replacement of the liver with a liver or liver tissue from a human donor is medically necessary by a Physician and either such Covered Person has been placed on the Transplant List or such procedure has been performed.

**Maximum Benefit Amount** means the maximum amount of benefits for which an individual in an eligible class can apply under the Group Policy.

**Medicaid** means any state medical assistance program under Title XIX of the Social Security Act as it is now and as it may be amended.

**Medical Coverage** means coverage under Medicare or an insurance policy, health maintenance organization contract, or employer's plan of self-insurance providing benefits for hospital, surgical and medical expenses or treatment. Medical Coverage does not include Medicaid.

## DEFINITIONS (continued)

**Occurs** or **Occurrence** means:

- with respect to Heart Attack, Kidney Failure, Stroke, Full Benefit Cancer, or Partial Benefit Cancer that the Covered Person:

    1. experiences such Covered Condition; and
    2. is Diagnosed with such Covered Condition.

- with respect to Coronary Artery Bypass Graft, that the Covered Person undergoes a Coronary Artery Bypass Graft.

- with respect to Heart Transplant or Major Organ Transplant, that the Covered Person:

    1. is placed on the Transplant List; or
    2. undergoes such Heart Transplant or Major Organ Transplant.

- with respect to Bone Marrow Transplant, that a Physician has determined that the replacement of the Covered Person's bone marrow with bone marrow from the Covered Person or another human donor is medically necessary to treat the irreversible failure of the Covered Person's bone marrow.

**Partial Benefit Cancer** means one of the following conditions that meets the TNM Staging classification and other qualifications specified below:

- carcinoma in situ classified as TisN0M0, provided that Surgery, radiotherapy or chemotherapy has been determined to be medically necessary by a Physician;
- malignant tumors classified as T1N0M0 or greater which are treated by endoscopic procedures alone;
- malignant melanomas classified as T1N0M0, for which a pathology report shows maximum thickness less than or equal to 0.75 millimeters using the Breslow method of determining tumor thickness; and
- tumors of the prostate classified as T1bN0M0, or T1cN0M0, provided that they are treated with a radical prostatectomy or external beam radiotherapy.

**Physician** means an individual who has received a degree of doctor of medicine (M.D.), or doctor of osteopathy (D.O.), and is acting within the scope of a valid license issued in the United States to Diagnose a Covered Condition or to perform the services required for a Covered Condition for which a claim is made. A Physician is not:

- You;
- Your Spouse or anyone to whom You are related by blood or marriage;
- anyone with whom You are residing;
- Your adopted or step-child;
- anyone with whom You share a business interest; or
- Your employee.

**Practitioner of the Healing Arts** means any person who holds a valid license in the United States to engage in the diagnosis or treatment of disease or any ailment of the human body.

## DEFINITIONS (continued)

**Proof** means Written evidence satisfactory to Us that a claimant has satisfied the conditions and requirements for a benefit described in this Certificate. Proof must include all of the information required under the terms of this Certificate and be timely submitted as described in this Certificate. When a claim is made for a benefit described in this Certificate, Proof must establish:

- the nature and extent of the Covered Condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Except as provided in the Examinations and Autopsy provisions of this Certificate, Proof must be provided at the claimant's expense.

**Signed** means any symbol or method executed or adopted by a person with the present intention to authenticate a record. The signature may be transmitted by paper or electronic media, provided it is consistent with applicable law.

**Spouse** means Your lawful spouse. The term does not include any person who is insured under the Group Policy as an employee.

**Stroke** means a cerebrovascular accident or incident producing measurable, functional and permanent neurological impairment (not including transient ischemic attacks (TIA), or prolonged reversible ischemic attacks) caused by any of the following which result in an infarction of brain tissue:

- hemorrhage;
- thrombus; or
- embolus from an extracranial source.

**Surgery** means a procedure performed by a Physician involving the cutting of the Covered Person's skin or tissue that in and of itself is intended to be curative or palliative. Surgery does not include endoscopic procedures.

**TNM Staging** means the classification standards for cancer developed by the American Joint Committee on Cancer.

**Total Benefit Amount** means the maximum aggregate amount, as specified in the Schedule of Insurance, that We will pay for any and all Covered Conditions combined, per Covered Person, per lifetime, as provided under this Certificate.

**Transplant List** means the Organ Procurement and Transplantation Network (OPTN) list.

**United States** means the United States of America, its territories and its possessions.

**We, Us and Our** mean Metropolitan Life Insurance Company.

**Write, Written or Writing** means a record that may be transmitted by paper or electronic media, and that is consistent with applicable law.

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

## ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

### Eligible Classes

**CLASS 1**

All full-time and part-time employees working at least 20 hours a week, but not temporary or seasonal employees.

### Date You Are Eligible For Insurance

You may only become eligible for the insurance available for Your eligible class.

If You are in an eligible class on the date insurance becomes available for the class, You will be eligible for insurance on that date. If You enter an eligible class after the date insurance is made available to the members of that class, You will be eligible for insurance on the date You enter the eligible class.

### Enrollment Process

If You are eligible for insurance, You may submit an Enrollment Form for insurance. Your insurance will not take effect unless You complete an Enrollment Form and We approve You for insurance. You must also give Written permission to deduct Contributions from Your pay for such insurance. We will not approve You for insurance if Your Enrollment Form does not indicate that You are covered for Medical Coverage.

### Date Your Insurance Takes Effect

Insurance under this Certificate will take effect for You on the date We approve You for insurance, if on that date You are Actively at Work in an eligible class. If You are not Actively at Work in an eligible class on that date, Your coverage will take effect on the date You return to Active Work in an eligible class.

### Benefit Increases

If You are insured under this Certificate at the time a Benefit Increase is offered for Your eligible class, You will be eligible for the Benefit Increase if You have not already attained the Maximum Benefit Amount. Your Benefit Increase will not take effect unless You complete an Enrollment Form and We approve You for the Benefit Increase. You must also give Written permission to deduct Contributions from Your pay for such Benefit Increase.

The Benefit Increase will take effect for You on the date We approve You for such Benefit Increase, if on that date You are Actively at Work in a class that is eligible for the Benefit Increase. If You are not Actively at Work in a class that is eligible for the Benefit Increase on that date, Your Benefit Increase will take effect on the date You return to Active Work in a class that is eligible for the Benefit Increase.

## ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE

### Eligible Classes For Dependent Insurance

All Class 1 employees of the Group Policyholder as specified in the section titled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU are eligible for Dependent Insurance.

### Date You Are Eligible For Dependent Insurance

If You are in an eligible class for Dependent Insurance on the date Your insurance takes effect, You will be eligible for Dependent Insurance on the later of the following:

- the date Your insurance takes effect;
- the date an individual becomes Your first Dependent.

If You enter an eligible class for Dependent Insurance after the date Your insurance takes effect, You will be eligible for Dependent Insurance on the later of the following:

- the date You enter a class eligible for Dependent Insurance; and
- the date an individual becomes Your first Dependent.

### Enrollment Process

If You are eligible for Dependent Insurance, You may submit an Enrollment Form for such insurance. Except as provided in the Newborn Children provision below, Dependent Insurance will not take effect unless You complete an Enrollment Form and, with respect to each Dependent, We approve that Dependent for Dependent Insurance. You must also give Written permission to deduct Contributions from Your pay for Dependent Insurance. We will not approve a Dependent for insurance if Your Enrollment Form does not indicate that the Dependent is covered for Medical Coverage.

### Date Dependent Insurance Takes Effect

Except as provided in the Newborn Children provision below, once You are eligible for and have applied for Dependent Insurance, it will take effect on the date We approve each Dependent for Insurance if on that date the Dependent meets the following requirement:

The Dependent is not:

- confined at home under a Physician’s care;
- receiving or applying to receive disability benefits from any source; or
- Hospitalized.

If the Dependent does not meet this requirement on such date, insurance for the Dependent will take effect on the date they are no longer:

- confined;
- receiving or applying to receive disability benefits from any source; or
- Hospitalized.

Once Dependent Insurance is in effect for at least one Dependent Child, any additional child who becomes Your Dependent Child will be insured from the date the child becomes Your Dependent Child. You do not need to enroll such additional Dependent Children for them to become insured for Dependent Insurance.

## Newborn Children

A Dependent Child born to You while insurance is in effect under this Certificate will be covered for 31 days from the moment of such Dependent Child's birth. Unless You already have Dependent Insurance in effect for other Dependent Children, to continue coverage beyond the first 31 days You must enroll the child and give Written permission to deduct Contributions from Your pay for Dependent Insurance.

## Benefit Increases

Dependents who are insured under this Certificate at the time a Benefit Increase that is applicable to Dependents is offered for Your eligible class, will be eligible for the Benefit Increase. Such Benefit Increase will not take effect unless You complete an Enrollment Form with respect to such Dependents and We approve such Dependents for the Benefit Increase. You must also give Written permission to deduct Contributions from Your pay for the Benefit Increase.

The Benefit Increase will take effect for each Dependent on the date We approve each Dependent for such Benefit Increase, if on that date the Dependent meets the following requirement:

The Dependent is not:

- confined at home under a Physician’s care;
- receiving or applying to receive disability benefits from any source; or
- Hospitalized.

If the Dependent does not meet this requirement on such date, the Benefit Increase for the Dependent will take effect on the date such Dependent is no longer:

- confined;
- receiving or applying to receive disability benefits from any source; or
- Hospitalized.

## CRITICAL ILLNESS BENEFITS

Covered Conditions are grouped into three categories, as shown in the table below. If a Covered Condition First Occurs for a Covered Person, while such Covered Person is insured under this Certificate, Proof of the Covered Condition must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the benefit described below for such Covered Condition, provided, however, that:

a) We will never pay more with respect to any Covered Person than the Category Benefit Amount shown in the Schedule of Insurance for all of the Covered Conditions listed in any one category; and
b) We will never pay more with respect to any Covered Person than the Total Benefit Amount shown in the Schedule of Insurance.

| Category 1 | Category 2 | Category 3 |
|---|---|---|
| Full Benefit Cancer<br>Partial Benefit Cancer<br>Bone Marrow Transplant | Heart Attack<br>Stroke<br>Coronary Artery Bypass Graft<br>Heart Transplant | Kidney Failure<br>Major Organ Transplant |

IMPORTANT NOTE: Receipt of benefits under this Certificate may affect eligibility for Medicaid or other governmental benefits and entitlements.

**100% of the Category Benefit Amount** is payable for one of the following Covered Conditions that First Occurs for a Covered Person while such Covered Person is insured under this Certificate:

1. Bone Marrow Transplant;
2. Heart Attack;
3. Heart Transplant
4. Kidney Failure;
5. Major Organ Transplant;
6. Stroke; or
7. Full Benefit Cancer.

**25% of the Category Benefit Amount** is payable for Partial Benefit Cancer that First Occurs for a Covered Person while such Covered Person is insured under this Certificate. Only one benefit for Partial Benefit Cancer is payable per Covered Person, per lifetime.

**25% of the Category Benefit Amount** is payable for a Coronary Artery Bypass Graft that First Occurs for a Covered Person while such Covered Person is insured under this Certificate. Only one benefit for Coronary Artery Bypass Graft is payable per Covered Person, per lifetime.

**Additional Covered Conditions**: We will not pay a benefit for any Covered Condition that First Occurs for a Covered Person during a Benefit Suspension Period if such Covered Condition is in a different category of Covered Conditions from the Covered Condition that started the Benefit Suspension Period. A Benefit Suspension Period will not apply to a Covered Condition that is within the same category of Covered Conditions as the Covered Condition that started the Benefit Suspension Period.

If a Covered Condition First Occurs for a Covered Person during a Benefit Suspension Period, and solely as a result of such Benefit Suspension Period, no benefit is paid for such Covered Condition, We will treat the next Occurrence (if any) of such Covered Condition after the Benefit Suspension Period ends, as the First Occurrence of such Covered Condition.

**Additional Covered Conditions (continued):** For each Covered Person, benefits payable under the Group Policy for all Covered Conditions within any one category of Covered Conditions, as shown in the table on page 16, will not exceed the Category Benefit Amount that applies to that Covered Person. We will reduce what We pay for a claim so that the amount that We pay, when combined with amounts for all claims We have previously paid for the same Covered Person in the same category of Covered Conditions, does not exceed the Category Benefit Amount that was in effect for that Covered Person on the date of the most recent Covered Condition.

We will reduce what We pay for a claim so that the amount We pay, when combined with amounts for all claims We have previously paid for the same Covered Person, does not exceed the Total Benefit Amount that was in effect for that Covered Person on the date of the most recent Covered Condition.

## EXCLUSIONS THAT APPLY TO SPECIFIC COVERED CONDITIONS

**Bone Marrow Transplant**
We will not pay benefits for a Bone Marrow Transplant involving bone marrow received from non-human donors.

**Heart Transplant**
We will not pay benefits for a Heart Transplant:

- performed outside the United States, unless the Covered Person was placed on the Transplant List prior to the Heart Transplant being performed;
- involving a heart received from non-human donors;
- involving implantation of mechanical devices or mechanical organs; or
- involving stem cell generated transplants.

**Major Organ Transplant**
We will not pay benefits for a Major Organ Transplant:

- performed outside the United States;
- involving organs received from non-human donors;
- involving implantation of mechanical devices or mechanical organs;
- involving stem cell generated transplants ;
- involving islet cell transplants; or
- involving a heart being transplanted in combination with any other organ.

**Stroke**
We will not pay benefits for a Diagnosis of Stroke for:

- cerebral symptoms due to migraine;
- cerebral injury resulting from trauma or hypoxia; or
- vascular disease affecting the eye or optic nerve or vestibular functions.

**Full Benefit Cancer**
We will not pay benefits for a Diagnosis of Full Benefit Cancer for:

- any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;
- any papillary tumor of the bladder classified as Ta under TNM Staging;
- any tumor of the prostate classified as T1N0M0 under TNM Staging;
- any papillary tumor of the thyroid that is classified as T1N0M0 or less under TNM Staging and is one centimeter or less in diameter unless there is metastasis;
- any tumor in the presence of human immuno-deficiency virus;
- any non-melanoma skin cancer unless there is metastasis;
- any malignant tumor classified as less than T1N0M0 under TNM Staging; or
- any condition that is Partial Benefit Cancer.

**Partial Benefit Cancer**
We will not pay benefits for a Diagnosis of Partial Benefit Cancer for:

- any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;
- any papillary tumor of the bladder classified as Ta under TNM Staging;
- any tumor of the prostate classified as T1aN0M0 under TNM Staging;
- any papillary tumor of the thyroid that is classified as T1N0M0 or less under TNM Staging and is one centimeter or less in diameter;
- any tumor in the presence of human immuno-deficiency virus;
- any non-melanoma skin cancer; or
- any melanoma in situ classified as TisN0M0 under TNM Staging.

**Coronary Artery Bypass Graft**
We will not pay benefits for Coronary Artery Bypass Graft:

- performed outside the United States; or
- that does not involve median sternotomy (a surgical incision in which the sternum, also known as the breastbone, is divided down the middle from top to bottom).

## ADDITIONAL PROOF REQUIREMENTS FOR EACH COVERED CONDITION

**Bone Marrow Transplant**
Proof of Bone Marrow Transplant requires submission of medical records evidencing that the Bone Marrow Transplant was deemed medically necessary by a Physician.

The Covered Condition for Bone Marrow Transplant will be deemed to Occur on the date the Physician deems the Bone Marrow Transplant to be medically necessary.

**Heart Transplant**
Proof of Heart Transplant requires submission of medical records evidencing that the Heart Transplant was deemed medically necessary by a Physician and that either:

- the Covered Person has been placed on the Transplant List; or
- the Heart Transplant had been performed.

The Covered Condition for Heart Transplant will be deemed to Occur on the earlier of:
- the date the Covered Person is placed on the Transplant List; or
- the date the Heart Transplant is performed.

**Heart Attack**
Diagnosis of Heart Attack must be made in Writing by a Physician and supported by medical records showing an elevation of enzymes, troponins or other biochemical cardiac markers, and two of the three following criteria associated with the Heart Attack for which a claim is being made:

1. typical chest pain characteristic of an acute myocardial infarction, requiring the Covered Person to be Hospitalized as an inpatient;
2. electrocardiograph (EKG) changes on one or a series of electrocardiograms taken at the time the Covered Person experiences the Heart Attack for which a claim is being made, which changes are indicative of an acute myocardial infarction, but, if the Covered Person had any prior electrocardiogram(s), the electrocardiogram(s) presented as Proof of Heart Attack must show changes from the Covered Person's last electrocardiogram, and such changes must be indicative of an acute myocardial infarction; or
3. confirmatory imaging studies such as thallium scans, or echocardiograms indicative of an acute myocardial infarction, but, if the Covered Person had any prior imaging studies, the imaging studies presented as Proof of Heart Attack must show changes from the Covered Person's last imaging studies, which changes must be indicative of a myocardial infarction.

The Covered Condition for Heart Attack will be deemed to Occur on the date the Diagnosis of Heart Attack is made.

**Kidney Failure**
Diagnosis of Kidney Failure must be made in Writing by a Physician and must be supported by medical records. The Covered Condition for Kidney Failure will be deemed to Occur on the date the Diagnosis of Kidney Failure is made.

## Additional Proof Requirements for Each Covered Condition (continued)

**Major Organ Transplant**
Proof of Major Organ Transplant requires submission of medical records evidencing that the Major Organ Transplant was deemed medically necessary by a Physician and that either:

- the Covered Person has been placed on the Transplant List; or
- the Major Organ Transplant has been performed.

The Covered Condition for Major Organ Transplant will be deemed to Occur on the earlier of:
- the date the Covered Person is placed on the Transplant List; or
- the date that the Major Organ Transplant is performed.

**Stroke**
Diagnosis of Stroke must be made in Writing and be based upon medical records indicating objective evidence of significant neurological impairment that is functional, measurable and permanent as demonstrated by magnetic resonance imaging, computerized tomography or other reliable imaging techniques. Such neurological impairment must be confirmed in Writing no earlier than 30 days after the cerebrovascular accident or incident by a Physician and be based upon objective evidence of significant neurological, motor or sensory impairment, which impairment must be present on the date that such Written confirmation is made. The Covered Condition for Stroke will be deemed to Occur on the date the Diagnosis of Stroke is made.

**Full Benefit Cancer**
Unless We accept a Clinical Diagnosis as provided in this Certificate, Diagnosis of Full Benefit Cancer must be based upon microscopic (histologic) examination of fixed tissues or preparations of blood or bone marrow. Such examination must be documented in a Written pathology report by a Physician. The Covered Condition for Full Benefit Cancer will be deemed to Occur upon the date that the Diagnosis of Full Benefit Cancer is made.

**Partial Benefit Cancer**
Unless We accept a Clinical Diagnosis as provided in this Certificate, Diagnosis of Partial Benefit Cancer must be based upon microscopic (histologic) examination of fixed tissue or preparations of blood or bone marrow. Such examination must be documented in a Written pathology report by a Physician. The Covered Condition for Partial Benefit Cancer will be deemed to Occur upon the date the Diagnosis of Partial Benefit Cancer is made.

**Coronary Artery Bypass Graft**
Proof of Coronary Artery Bypass Graft requires submission of medical records evidencing that the Coronary Artery Bypass Graft:

- was determined to be medically necessary by a Physician;
- was supported by pre-operative angiographic evidence; and
- has been performed.

The Covered Condition for Coronary Artery Bypass Graft will be deemed to Occur on the date that the Coronary Artery Bypass Graft is performed.

## LIMITATIONS

### Waiting Period

On the date Your insurance under this Certificate becomes effective, a waiting period starts with respect to such insurance. If You experience a Covered Condition during such waiting period, Your insurance will end on the date You experience the Covered Condition. The benefit We pay for a Covered Condition experienced by You during such waiting period will be limited to 10% of the amount that would be payable in the absence of this Waiting Period provision. We will also return any amount of premium paid to Us for insurance under this Certificate attributable to any period of time after the date of the Covered Condition.

On the date Your Spouse insurance under this Certificate becomes effective, a waiting period starts with respect to such insurance. If Your Spouse experiences a Covered Condition during such waiting period, insurance for Your Spouse under this Certificate will end on the date Your Spouse experiences the Covered Condition. The benefit We pay for a Covered Condition experienced by Your Spouse during such waiting period will be limited to 10% of the amount that would be payable in the absence of this Waiting Period provision. We will also return any amount of premium paid to Us with respect to Your Spouse for insurance under this Certificate attributable to any period of time after the date of the Covered Condition.

On the date a Benefit Increase becomes effective, a waiting period starts with respect to the Benefit Increase. If a Covered Person experiences a Covered Condition during the waiting period, the amount of the Benefit Increase payable to such Covered Condition will be limited to 10% of the amount of such Benefit Increase that would be payable in the absence of this Waiting Period provision, and such Benefit Increase will end with respect to such Covered Person.

The length of the waiting period is shown in the Schedule of Insurance.

## PREEXISTING CONDITION EXCLUSION

**Preexisting Condition** means a sickness or injury for which, in the 12 months before a Covered Person becomes insured under this Certificate, or before any Benefit Increase with respect to such Covered Person medical advice, treatment or care was sought by such Covered Person, or, recommended by, prescribed by or received from a Physician or other Practitioner of the Healing Arts.

We will not pay benefits for a Covered Condition that is caused by or results from a Preexisting Condition if the Covered Condition Occurs during the first 12 months that a Covered Person is insured under this Certificate.

With respect to a Benefit Increase, We will not pay benefits for such Benefit Increase for a Covered Condition that is caused by or results from a Preexisting Condition if the Covered Condition Occurs during the first 12 months after such increase in the Total Benefit Amount.

## OTHER EXCLUSIONS

### Exclusion for Intoxication

We will not pay benefits for any Covered Condition that is caused by, contributed to by, or results from a Covered Person's involvement in an incident, where such Covered Person is intoxicated at the time of the incident and is the operator of a vehicle involved in the incident.

**Intoxicated** means that the Covered Person's alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident happened.

### General Exclusions

We will not pay benefits for any Covered Conditions caused by, contributed to by, or resulting from a Covered Person:

- participating in a felony, riot or insurrection;
- intentionally causing a self-inflicted injury;
- committing or attempting to commit suicide while sane or insane;
- voluntarily taking or using any drug, medication or sedative unless it is:
    - taken or used as prescribed by a Physician, or
    - an “over the counter” drug, medication or sedative taken according to package directions;
- engaging in any illegal occupation; or
- serving in the armed forces or any auxiliary unit of the armed forces of any country.

We will not pay benefits for Covered Conditions arising from war or any act of war, even if war is not declared.

We will not pay benefits for any Covered Condition for which Diagnosis is made outside the United States, unless the Diagnosis is confirmed in the United States, in which case the Covered Condition will be deemed to Occur on the date the Diagnosis is made outside the United States.

We will not pay benefits for any Covered Condition that does not First Occur for a Covered Person while such Covered Person is insured under this Certificate.

## WHEN INSURANCE ENDS

### Date Your Insurance Ends

Your insurance will end on the earliest of:

- the date the Group Policy ends;
- the date You die;
- the date insurance ends for Your class;
- the date the Total Benefit Amount has been paid for You;
- the end of the period for which the last full premium has been paid for You;
- the date You cease to be in an eligible class; or
- the date Your employment ends for any reason.

### Date Dependent Insurance Ends

A Dependent's insurance will end on the earliest of:

- the date Your insurance under this Certificate ends;
- the date Dependent Insurance ends under the Group Policy for all employees or for Your class;
- the date the person ceases to be a Dependent;
- the date the Total Benefit Amount has been paid for that Dependent;
- the date You cease to be in a class that is eligible for Dependent Insurance; or
- the end of the period for which the last full premium has been paid for the Dependent.

In certain cases insurance may be continued as stated in the section titled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT. Please see that section for details.

## CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

### For Mentally Or Physically Handicapped Children

Insurance for a Dependent Child may be continued past the age limit if that child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Dependent Child attains the age limit and at reasonable intervals after such date, but not more often than annually after the two year period following such Dependent Child's attainment of the limiting age.

Except as stated in the Date Dependent Insurance Ends subsection of the section titled WHEN INSURANCE ENDS, insurance will continue while such Dependent Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap; and
- continues to qualify as a Dependent Child, except for the age limit.

### For Family And Medical Leave

Certain leaves of absence may qualify under the Family and Medical Leave Act of 1993 (FMLA) or similar state laws for continuation of insurance. Please contact the Group Policyholder for information regarding the FMLA or any similar state law.

### At Your Option: Continuation With Premium Payment

Insurance provided under this Certificate may be continued with premium payment in certain situations, as described in this provision. This is referred to in this provision as “Continued Insurance”. Evidence of insurability will not be required to obtain Continued Insurance. If You obtain Continued Insurance under this provision, You may also continue Dependent Insurance. For purposes of this provision, Insurance in effect under the Group Policy for which the Group Policyholder remits premium is referred to in this provision as “Group Billed Insurance”.

You may obtain Continued Insurance for You and for Your Dependents by making a request in Writing during the Request Period specified below if Your Group Billed Insurance ends because:

- Your employment ends; or
- You cease to be in a class that is eligible for Group Billed Insurance.

However, You cannot obtain Continued Insurance if Group Billed Insurance:

- ends for all employees;
- ends for the class of employees that You are in;
- ends for the class of employees that You were last in before Your Group Billed Insurance ends;
- ends because You failed to pay a required Contribution; or
- ends on a date preceding which You have not been continuously insured for at least 90 days under the Group Policy.

### Request Period

To obtain Continued Insurance, We must receive Your completed Written request on a form approved by Us within the Request Period which begins on the date Your Group Billed Insurance ends, and ends 31 days later. If You do not request Continued Insurance within the Request Period, You cannot obtain Continued Insurance.

## Premiums for Continued Insurance

The premium that You must pay for Continued Insurance may include the amount, if any, that You contributed for Your Group Billed Insurance before it ended, plus any amount the Employer paid. Premium rates for Continued Insurance will be the same as premium rates charged for Group Billed Insurance. Premium rate increases or decreases that apply to Group Billed Insurance will apply to Continued Insurance as well. When You make a request to obtain Continued Insurance, You must pay the first premium during the Request Period. All premium payments must be made directly to Us. When We approve Your request for Continued Insurance, We will also provide a schedule of premiums and payment instructions.

## End of Continued Insurance

Continued Insurance will end on the earliest of the following dates:

- the date Group Billed insurance ends for all employees;
- the date Group Billed insurance ends for the class of employees that You are in;
- the date Group Billed insurance ends for the class of employees You were last in before obtaining Continued Insurance;
- the date You die;
- the date the Total Benefit Amount has been paid for You;
- if You do not pay a premium that is required for Continued Insurance, the last day of the period for which a required premium payment was made;
- with respect to Dependent Insurance, the date Continued Insurance for You ends for any reason;
- with respect to Dependent Insurance, the date Dependent Insurance ends under the Group Policy for all employees;
- with respect to Dependent Insurance, the date Dependent Insurance ends under the Group Policy for the class of employees that You are in;
- with respect to Dependent Insurance, the date Dependent Insurance ends for the class of employees that You were last in before obtaining Continued Insurance;
- with respect to Dependent Insurance, the date the Dependent no longer meets the definition of a Dependent; or
- with respect to a Dependent's insurance, the date the Total Benefit Amount has been paid for that Dependent.

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 that time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at that 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 titled WHEN INSURANCE ENDS.

If Your insurance ends, Your Dependent Insurance will also end in accordance with the DATE DEPENDENT INSURANCE ENDS provision of the section titled WHEN INSURANCE ENDS.

## CLAIMS

### Filing A Claim

To file a claim for benefits under this Certificate, You must give Us notice of the claim and submit Proof of the claim to Us as described in this provision.

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

**Step 1**

You must give Us notice by Writing to Us or calling Us at the toll free number shown on the face page of this Certificate within 30 days of the date of the Covered Condition.

**Step 2**

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

**Step 3**

When You receive the claim form You should fill it out as instructed and return it with the required Proof described in this Certificate and the claim form. If You do not receive a claim form within 15 days after giving Us notice of claim, You may send Us Proof using any form sufficient to provide Us with the required Proof.

**Step 4**

You must give Us Proof not later than 90 days after the date of the Covered Condition. 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 in the absence of the legal capacity of the claimant, later than 12 months from the date the Covered Condition Occurred.

### Payment Of Benefits

When We receive the claim form and Proof We will review the claim and, if We approve it, We will pay benefits no later than 60 days after the date We receive the claim form and Proof, subject to the terms and provisions of this Certificate and the Group Policy.

All benefits paid under this Certificate while You are living will be paid to You, unless You have assigned this insurance. But, if You are not legally competent to claim or receive benefits under this Certificate, We may pay up to $10,000 to anyone related to You by blood or marriage who We believe is entitled to it. If We make such a payment in good faith, We will not be liable to anyone for the amount We pay. Any remaining benefits will be paid to Your legal representative.

If You designated a beneficiary, upon Your death We will pay to Your beneficiary any amount that is or becomes due. You may change Your beneficiary at any time. To do so, You must send a Signed and dated, Written request to the Group Policyholder using a form satisfactory to Us. Your Written request to change the beneficiary must be sent to the Group Policyholder no later than 90 days after the date You Sign such request.

Unless otherwise requested, We may at Our option pay benefits in one sum or by placing the amount in an account that earns interest. The person to whom We pay the benefits will have immediate access to all or any part of the account. We will pay interest on the benefits from the date they become payable until all funds in the account have been withdrawn.

## Payment Of Benefits (continued)

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

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

If there is no beneficiary designated or no surviving beneficiary at Your death, We may determine the beneficiary to be one or more of the following who survive You, in the order listed below:

1. Your Spouse;
2. Your child(ren);
3. Your parents(s); or
4. Your sibling(s).

Instead of making payment in the order above, We may pay Your estate. Any payment made in good faith will discharge Our liability to the extent of such payment.

## Authorizations

We may require that You provide authorization for Us to obtain medical information and any other information pertinent to Your claim.

## Examinations

At Our expense, as often as is reasonably necessary, We may require You to have an independent examination by a Physician of Our choice.

At Our expense, as often as is reasonably necessary, We may have Our representatives conduct telephone or in-person interviews with You regarding Your claim.

## Autopsy

At Our expense, We have the right to make a reasonable request for an autopsy and/or exhumation where permitted by law. Any such request will set forth the reasons We are requesting the autopsy or exhumation.

## 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 three years after the date such Proof is required to be filed.

## GENERAL PROVISIONS

### Changes in Standards

This Certificate refers to classification standards for disease that have been developed by independent third parties. If those independent third parties change the classification standards, or if new standards are developed that become generally accepted in the medical community in the United States, We will interpret this Certificate in a manner that recognizes such changed or new standards when We determine it is appropriate to do so.

### Entire Contract

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

- the Group Policy and its Exhibits, which include the Certificate(s);
- Your Enrollment Form;
- the Group Policyholder's application; and
- 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 a statement to void insurance, reduce benefits or defend a claim unless the following requirements are met:

- the statement is in an Enrollment Form that is in Writing;
- You have Signed the Enrollment Form; and
- a copy of the Enrollment Form has been given to You or Your beneficiary.

We will not use Your statements which relate to insurability to contest this insurance after it has been in force for 2 years, unless the statement is fraudulent. In addition, We will not use such statements to contest a Benefit Increase after the Benefit Increase has been in force for 2 years, unless such statement is fraudulent.

### Misstatements

If Your or Your Dependent's 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 Contributions.

### Assignment

The benefits under the Group Policy are not assignable prior to a claim for benefits, except to a Physician or other health care provider who provides health care provider health care services to You, or except as required by law or permitted by Us.

### 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.

### Standard of Time

All coverage becomes effective and terminates at 12:01 A.M. Eastern Standard Time, or at 12:01 A.M. Eastern Daylight Time if Daylight Saving Time is then being observed.

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

# CERTIFICATE RIDER

## Group Policy No.: 0145427

## Policyholder: AH Belo Corporation

## Effective date: January 1, 1999

Your Certificate is changed as follows:

1. The Texas Department of Insurance website and email contact information in the Important Notice (page 2) are updated as follows:

   Web: http://www.tdi.texas.gov
   E-mail: ConsumerProtection@tdi.texas.gov.

2. The definition of Dependent Child in the Definitions section will include a child for whom You must provide medical support under an order: issued under Texas Statutes, Chapter 154, Family Code; or enforceable by a court in the State of Texas, subject to all of the conditions in the Dependent Child definition.

3. The last paragraph of the definition of Dependent Child in the Definitions section shall be deleted and replaced by the following:

   A Dependent Child cannot be insured as a Dependent Child of more than one employee under the Group Policy. A child will be considered to be Your adopted child if You are a party to a suit in which You seek to adopt the child.

4. Step 4 of the Filing a Claim provision that appears in the Claims section is deleted and replaced with the following:

   **Step 4**

   You must give Us Proof not later than 90 days after the date of the Covered Condition. 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 in the absence of the legal capacity of the claimant, later than 15 months from the date the Covered Condition Occurred.

## GENERAL PROVISIONS (continued)

5. The first paragraph of the Payment of Benefits provision that appears in the Claims provision is deleted and replaced with the following:

**PAYMENT OF BENEFITS**

When We receive the claim form and Proof We will review the claim and provide notification in Writing of Our approval or denial of the claim no later than the 15th business day after the date We receive documentation in support of the claim. If We approve the claim, We will pay benefits no later than 60 days after the date We receive the claim form and Proof, subject to the terms and provisions of this Certificate and the Group Policy. If We deny the claim, Our notice will state the reason(s) for the denial. If We cannot approve or deny the claim within 15 business days after We receive documentation in support of the claim, We will provide notification within 15 business days, stating that We need additional time to review the claim and the reason(s) why. We will notify You or the claimant of Our decision to approve or deny the claim within 45 days after the date that We provide notification that We need additional time to review the claim.

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

# INSTRUCTIONS FOR COMPLETING BENEFICIARY DESIGNATION

Please read instructions before completing this form. Do not erase or attempt to make corrections. Please use a new form.

1. If you wish to name a Primary Beneficiary(ies), please complete page 2. Fill in the certificate holder's Name of Employer, Group Policy Number (found on your Certificate) and Social Security Number at the top of the form. If the insured has had a name change, please indicate in the section provided. Complete section A. Initial and date at the bottom of the page.

   **Primary Beneficiary:** Your primary beneficiary should be the individual(s) or organization that you wish to receive the insurance proceeds. You may have the proceeds divided among several primary beneficiaries. To do this, you must indicate what percentage of the proceeds you would like them to receive. Your total shares must equal 100%.

2. If you wish to name a Contingent Beneficiary(ies), please complete page 2. Fill in the certificate holder's Name of Employer, Group Policy Number (found on your Certificate) and Social Security Number at the top of the form. If the insured has had a name change, please indicate in the section provided. Complete section B. Initial and date at the bottom of the page.

   You may find the following definitions helpful in completing your Beneficiary Designation form.

   **Contingent Beneficiary:** Your contingent beneficiary should be the individual(s) or organization that you wish to receive the insurance proceeds if your primary beneficiary(ies) (see definition above) predecease(s) the insured. You may have the proceeds divided among several contingent beneficiaries. To do this, you must indicate what percentage of the proceeds you would like them to receive. Your total shares must equal 100%.

3. If you wish to name a Trust as beneficiary, please complete one of the two Trust Designations on page 3 **instead** of the Primary and Contingent Beneficiary sections. If the trust is an inter vivos trust, check only the first Trust Designation box, and complete the Trust designation section. You should enter (1) the name and address of the Trustee; (2) the Title of the Trust; and (3) the date of its execution. **NOTE: AN INTER VIVOS TRUST MUST BE A LEGALLY DRAWN AND EXECUTED DOCUMENT.**

   If you wish to designate a Testamentary Trust, check only the second Trust Designation box on page 3. **NOTE: A TESTAMENTARY TRUST MUST BE ESTABLISHED UNDER A VALID LAST WILL AND TESTAMENT OF THE INSURED OR OWNER (IF ASSIGNED).**

   You may find the following definitions helpful in completing your Beneficiary Designation form:

   **Trust Designation:** If you plan to have the insurance proceeds distributed to a Trust, you should complete this section with the appropriate information. The Trustee of the Trust will be responsible for the application for and disposition of the insurance proceeds in accordance with the terms of the trust. **This section should only be used if you have established an intervivos trust or directed the establishment of a trust under your Last Will and Testament. If you complete this section, do NOT complete the Primary or Contingent Beneficiary sections.**

   **Inter vivos Trust:** A trust established during the life of the trustor (the person who creates the trust) for the benefit of the trustor or other living persons.

4. The owner of the coverage should sign and date the form in the spaces provided on page 3.
   Retain a copy for your records.

5. Submit your completed form to:
   **MetLife Critical Illness Insurance Service Center, Metropolitan Life Insurance Company, P.O Box 6120, Scranton, PA 18505-9972**

**If you wish to name more beneficiaries than this form provides for, secure (create) an additional copy.** Complete your list of beneficiaries on that additional copied form. Attach the additional form to the first, indicating clearly on each form the number of additional forms attached. For example, if three forms are used, number the forms as follows: 1 of 3, 2 of 3 and 3 of 3.

You may change or revoke your beneficiary designation at any time by completing a new Beneficiary Designation form.

**PLEASE NOTE**

If death occurs as a result of a covered illness and a minor (a person not of legal age) is the beneficiary, it may be necessary to have a guardian appointed before any death benefit can be paid. If death occurs as a result of a covered illness and your estate is the beneficiary, the representative of the estate may need to finalize formal court procedures before any death benefit can be paid. In either case, the procedures may result in expenses for the beneficiary and/or a delay in the payment of the insurance proceeds. Please take this into consideration when naming your beneficiary.

# MetLife Critical Illness Insurance Change / Designation of Beneficiary By Certificate Owner

**Please Print or Type Information.**

MetLife®
Critical Illness Insurance
Metropolitan Life Insurance Company
P.O. Box 6120
Scranton, PA 18505-9972
Toll Free Phone: 1 800 GET-MET 8
Fax Number: 1-866-268-2621

Name of Employer _____

Group Policy Number _____ Insured's Social Security Number _____

Has your name changed? If so, check reason: ☐ Marriage ☐ Divorce ☐ Correction ☐ Naturalization ☐ Court Order

**Insured's Name:** _____
(Prefix) (First) (Middle) (Last) (Suffix)

**In accordance with the conditions of the Group Policy listed above, I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies) (if any).**

**A.** I name the following **Revocable Primary Beneficiary(ies)** to receive any amount payable under the policy in the event of my death:

| Individual's Name Prefix | First | Middle | Last | Suffix | Share % (Leave blank for equal distribution) |
|---|---|---|---|---|---|
| | | | | | |

| Date of Birth (mm/dd/yy) | SSN/EIN | Gender ☐ Male ☐ Female | Relationship to Insured |
|---|---|---|---|
| | | | |

| | Street | City | State | Zip Code |
|---|---|---|---|---|
| Primary Residence | | | | |
| Business Mailing | | | | |
| Other | | | | |

| Home Phone | Business Phone & Ext. |
|---|---|
| | |

| Individual's Name Prefix | First | Middle | Last | Suffix | Share % (Leave blank for equal distribution) |
|---|---|---|---|---|---|
| | | | | | |

| Date of Birth (mm/dd/yy) | SSN/EIN | Gender ☐ Male ☐ Female | Relationship to Insured |
|---|---|---|---|
| | | | |

| | Street | City | State | Zip Code |
|---|---|---|---|---|
| Primary Residence | | | | |
| Business Mailing | | | | |
| Other | | | | |

| Home Phone | Business Phone & Ext. |
|---|---|
| | |

**B.** If all the Beneficiaries named above shall predecease me, I name the following **Revocable Contingent Beneficiary(ies)** to receive any amount payable under the policy in the event of my death:

| Individual's Name Prefix | First | Middle | Last | Suffix | Share % (Leave blank for equal distribution) |
|---|---|---|---|---|---|
| | | | | | |

| Date of Birth (mm/dd/yy) | SSN/EIN | Gender ☐ Male ☐ Female | Relationship to Insured |
|---|---|---|---|
| | | | |

| | Street | City | State | Zip Code |
|---|---|---|---|---|
| Primary Residence | | | | |
| Business Mailing | | | | |
| Other | | | | |

| Home Phone | Business Phone & Ext. |
|---|---|
| | |

| Individual's Name Prefix | First | Middle | Last | Suffix | Share % (Leave blank for equal distribution) |
|---|---|---|---|---|---|
| | | | | | |

| Date of Birth (mm/dd/yy) | SSN/EIN | Gender ☐ Male ☐ Female | Relationship to Insured |
|---|---|---|---|
| | | | |

| | Street | City | State | Zip Code |
|---|---|---|---|---|
| Primary Residence | | | | |
| Business Mailing | | | | |
| Other | | | | |

| Home Phone | Business Phone & Ext. |
|---|---|
| | |

**If you wish to designate more than 2 Revocable Primary Beneficiaries or Contingent Beneficiaries, contact MetLife Critical Illness Insurance Service Center at 1 800 GET-MET 8 (1-800-438-6388) Monday through Friday, 8 a.m. to 11 p.m. EST, or your agent for a form which can accommodate that request.**

**Initial form here and Sign on last page** _____ (mm/dd/yy)
Certificate Owner's Initials Date

**TRUST DESIGNATION:**

☐ **Intervivos Trust Designation** (applies only if a trust has been created in an executed trust agreement e.g., John Doe, Trustee of the Jane Smith Family Trust dated January 1, 2000)

Name of Trustee(s) _____

Address _____ City _____ State _____ Zip Code _____

and successor(s) in trust, as Trustee(s) under _____
("Title of Agreement")

Dated mm/dd/yy executed by me and said Trustee(s).

MetLife shall not be responsible for the application or disposition of the proceeds by said Trustee(s), and the receipt of the proceeds by said Trustee(s) shall be full discharge of the liability of MetLife under the Group Policy.

If this form is executed by the insured, it is understood and agreed, however, that if MetLife receives proof satisfactory to it that the aforesaid trust has been revoked or is not in effect at the insured's death, the beneficiary shall be the insured's Estate, and payment to the estate's legal representative based on such proof shall be full discharge of liability of MetLife under the Group Policy or certificate.

If this form is executed by the current owner (who is not the insured), it is understood and agreed, however, that if MetLife receives proof satisfactory to it that the aforesaid trust has been revoked or is not in effect at the insured's death, the beneficiary shall be the current owner, if living at the insured's death, or the current owner's estate if the current owner is not living at the insured's death, and payment to the estate's legal representative based on such proof shall be full discharge of liability of MetLife under the Group Policy or certificate.

☐ **Testamentary Trust Designation** (applies only if a trust has been set forth in your Will)
The trust(ee) under any last Will and Testament of mine as shall be admitted to probate.

If for any reason whatsoever, no Trust(ee) under any such last Will and Testament shall be duly appointed, I hereby designate **My Estate** as beneficiary and any payment made in good faith to the legal representative of my estate shall be full discharge of the liability of MetLife under the Group Policy.

**I reserve the right to change the designated beneficiary(ies) at any time without (his/her/their) consent.**

I agree that any decision MetLife makes in determining unnamed contingent beneficiaries based upon written evidence acceptable to MetLife, will be final.

If multiple Beneficiaries or Contingent Beneficiaries are named above, payment will be made in equal shares or all to the survivor, unless otherwise specified. The share of any Beneficiary or Contingent Beneficiary who shall predecease me will be divided among the surviving beneficiaries in proportion to their interest, with all to the survivor. If there is no survivor, then payment shall be made to my estate.

Any payment by MetLife in good faith pursuant to the foregoing designation shall fully discharge MetLife of its liability under the policy.

I understand that this change shall be binding on MetLife only after it has been recorded and filed in the MetLife Home Office or Customer Service Center. Once recorded, the change will be effective as of the date signed below.

By signing below, I certify that I have read the information on all pages of this form and that I am in agreement with it.

MetLife means the Metropolitan Life Insurance Company or any of its affiliates.

| Witness | Signature of Certificate Owner | Date |
|---|---|---|
| | | mm/dd/yy |

| Print Name | Print Name (Prefix First Middle Last Suffix) |
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