ADDENDUM TO THE ERISA INFORMATION SECTION PROVIDED WITH YOUR CERTIFICATE OF INSURANCE

1. The section **QUALIFIED DOMESTIC RELATIONS ORDERS/QUALIFIED MEDICAL CHILD SUPPORT ORDERS** is removed.

2. In the section **CLAIMS INFORMATION, Claims Involving Disability Determinations in connection with Life Insurance** the last paragraph under **Initial Determination** is replaced with the following:

   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.

3. In the section **CLAIMS INFORMATION, Claims Involving Disability Determinations in connection with Life Insurance** the last paragraph under **Appealing the Initial Determination.** is replaced with the following:

   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, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

4. The following sentence from the section **STATEMENT OF ERISA RIGHTS**, under **Enforce Your Rights** is removed:

   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.

Department of Labor (DOL) Rule ERISA Regulation Update

Background

In late 2016, The Department of Labor (DOL) published a Final Rule amending the disability claim procedure regulations under the Employee Retirement Income Security Act of 1974 (ERISA). These regulations were effective 1.18.17 and initially applied to all claims for disability benefits filed on or after 1.1.18.

On 10.6.17, the DOL issued a Request for Information (RFI) seeking comments and data from the public concerning the potential impact of the Final Rule and proposing to delay its applicability to 4.1.18. Comments on the proposed delay were due on 10.27.17. Comments and data concerning the potential impact of the Final Rule were due on 12.11.17.

On 11.29.17, the DOL delayed the applicability of the Final Rule to 4.1.18 to enable the DOL to consider the comments and data provided. On 1.5.18, the DOL announced that the Final Rule will become applicable on 4.1.18 unchanged.

MetLife Compliance

MetLife is in compliance with the DOL requirements on all ERISA governed claims for disability benefits filed on or after 4.1.18. We have updated our claims processes and communications to ensure compliance.

To ensure compliance post implementation, MetLife claims operations will be expanded with management oversight and monitoring, focused quality reviews, control reporting and continuous access to subject matter experts.

Questions

If you have any questions relating to MetLife's compliance with the Final Rule please contact your MetLife Sales or Service Representative.

Department of Labor (DOL) Rule ERISA Regulation Update - Requirements

1. Improvement to Basic Disclosure Requirements

Notices of adverse benefit determinations must contain the following elements:

(1) An explanation as to why the plan did not agree with the views of the claimant's own treating physicians and vocational professionals (if any),

(2) An explanation as to why the plan did not follow the opinions, obtained in connection with the claim, of the plan's medical or vocational experts, regardless of whether those views were relied upon in making the benefit decision,

(3) An explanation as to why the plan did not agree with the claimant's SSDI decision, if presented by the claimant in support of the claim, and

(4) The specific rules, guidelines or similar criteria of the plan relied upon in making the benefit decision or a statement that such rules or guidelines do not exist.

Reference: 29 CFR §§ 2560.503-1(g)(1)(vii)(A) and (j)(6)(i) and 29 CFR § 2560.503-1(g)(1)(vii)(C).

MetLife Actions

MetLife was in compliance with #1, 2, and 3 listed above before the Final Rule was promulgated. We have include this information within our adverse benefit determination communications for several years.

Effective 4.1.18, for #4 above MetLife denial and termination letters have been updated to include any customer specific variance that was used in making the decision. If there was no guideline used in making the decision, an option to include a statement to that effect has been added to the letters.

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2. Right to Review and Respond to New Information before Final Decision

The claimant must be provided with, and permitted to respond to, any new evidence generated by the plan in the course of making a decision on appeal, before an adverse decision is rendered. If an adverse decision on appeal is based on a new rationale, the claimant must be given an opportunity to respond prior the rendering of the decision.

Reference: 29 CFR § 2560.503-1(h)(4).

MetLife Actions

Effective 4.1.18, MetLife's Appeal Specialist provide the claimant with the opportunity to review and respond to new information received during the appeal process.

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3. Avoiding Conflicts of Interest

Claims and appeals must be adjudicated in a manner designed to ensure the independence of the decision maker.

Reference: 29 CFR § 2560.503-1(b)(7).

MetLife Actions

No action is necessary by MetLife. MetLife is in compliance with this requirement. We currently process appeal decisions utilizing resources not associated with the initial adverse benefit determination.

In addition, MetLife does not hire, compensate, terminate, promote or take other similar action based on the likelihood that the individual will support the denial of benefits.

4. Deemed Exhaustion of Claims and Appeal Processes

If the claims administrator does not strictly follow the requirements of the claims procedure regulations, the claimant is deemed to have exhausted administrative remedies and the claim or appeal will be deemed denied on review, permitting litigation by the claimant to proceed. De minimis* violations are excepted.

*From the rule: "de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant".

Reference: 29 CFR § 2560.503-1(l)(2).

MetLife Actions

MetLife has developed a process to be in compliance with the below requirement:

"The claimant may request a written explanation of the violation from the plan, and the plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the plan to be deemed exhausted".

5. Certain Coverage Rescissions Are Adverse Benefit Determinations Subject to the Claims Procedure Regulations

A rescission of coverage must be treated as an adverse benefit determination, unless it is attributable to a failure to timely pay required contributions of premiums.

Reference: 29 CFR § 2560.503-1(m)(4).

MetLife Actions

Generally, MetLife does not make rescissions of coverage under group policies independent of a claim for benefits. When an adverse benefit determination is made on the grounds that the participant is not covered, we comply fully with all ERISA requirements.

MetLife is fully compliant for Individual Disability Insurance rescissions not accompanied by an actual claim and covered under ERISA.

6. Culturally and Linguistically Appropriate Notices

If any notice is sent to an address in a county where, according to the US Census Bureau, 10% or more of the population is literate only in the same non-English language, the plan must:

(1) Provide in the English version of the notice a prominently displayed statement in the non-English language indicating how to access the language services provided by the plan;
(2) Provide, upon request, notices in the non-English language; and
(3) Provide oral services in the non-English language, including assistance with filing claims and appeals in the non-English language.

Reference: 29 CFR § 2560.503-1(o).

MetLife Actions

Effective 4.1.18, MetLife has updated communications on all ERISA governed claims of claimants residing in the applicable counties. We will communicate in English as well as the following non-English languages utilizing our current translation and interpretation services:

- Chinese
- Navajo
- Spanish
- Tagalog

These four non-English languages were required based on US Census data, whereby 10% or more of the population in a particular county is literate only in the same non-English language.

7. Notice of Contractual Limitations Period

Notices of adverse benefit determinations on appeal must provide the calendar date by which the claimant has a right to file suit, if the plan has a contractual limitations period.

Reference: 29 CFR § 2560.503-1(j)(4)(ii).

MetLife Actions

Effective 4.1.18, MetLife appeal uphold notifications provide the actual calendar date by which the claimant has a right to file suit.

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