Exclusions:

No benefits are payable for any loss for a Covered Person caused by the Covered Person's Sickness, or the diagnosis or treatment of such Sickness, except for the Covered Person's use of: any drug, medication or sedative that is taken or used as prescribed by a Physician; or an "over the counter" drug, medication or sedative taken as directed. We will not pay benefits for any loss for a Covered Person caused or contributed to by: the Covered Person's voluntary use, by any means, of poison, gas, or fumes; the Covered Person's suicide or attempted suicide (while sane or insane); the Covered Person's intentionally self-inflicted Injury; war, whether declared or undeclared; or act of war; the Covered Person's active participation in an insurrection, rebellion, riot, or terrorist act; the Covered Person's infection, other than infection occurring in an external wound resulting from an Injury that results proximately from an Accident; food poisoning; the Covered Person's operation, while intoxicated, of a motor vehicle involved in the incident. For purposes of this exclusion: intoxicated means that the Insured's blood alcohol level met or exceeded .08%; and motor vehicle means any vehicle that is powered by a motor, including, but not limited to: an automobile; a boat; a motorcycle; a truck; an all terrain vehicle; or a snow mobile; dental or plastic Surgery for cosmetic purposes, except when such Surgery is performed to: treat an Injury that results proximately from an Accident; correct a disorder of normal bodily function or structure that was caused by an Injury that results proximately from an Accident for which coverage is not otherwise excluded under this Certificate; or reconstruct a part of the body which was disfigured or removed as a result of an Injury that results proximately from an Accident for which coverage is not otherwise excluded under this Certificate; the Covered Person's mental illness, or the diagnosis or treatment of such mental illness, except for the Covered Person's use of: any drug, medication or sedative that is taken or used as prescribed by a Physician; or an "over the counter" drug, medication or sedative taken as directed; or activities required by the Covered Person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority.

In addition, We will not pay benefits for: a Covered Person while incarcerated in any type of penal or detention facility; or any of the following outside of the United States, Canada or Mexico: medical treatment; Hospital admission or Confinement; or inpatient stay in a Rehabilitation Facility.

Effective Date for Accident Insurance:

Insurance will take effect on the last day of the pay period for which Your corresponding payroll deduction is taken, provided You were Actively at Work on that day. 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 following Your payroll deduction.

Date Insurance Ends for Accident Insurance:

Your insurance will end on the earliest of: the date the Group Policyends; the date You die; 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 for any reason other than Your retirement; or the date You cease to be a Member.

A Dependent's insurance will end on the earliest of: the date Your insurance under the Certificate ends; the date Dependent Insurance ends under the Group Policy for all members or for Your class; the date the person ceases to be a Dependent; the date the Dependent is no longer eligible as described in the Eligible Classes for Dependent Insurance provision; or the end of the period for which the last full premium has been paid for the Dependent. Termination of a Covered Person's insurance will be without prejudice to an existing claim.

Brought to you by:

Employees Club of California
311 South Spring Street, Suite 1300
Los Angeles, CA 90013
(800) 464-0452
www.EmployeesClub.com

This plan is available in CA only.
Group policy number: 0165584

METLIFE'S ACCIDENT INSURANCE IS A LIMITED BENEFIT GROUP INSURANCE POLICY. The policy is not intended to be a substitute for medical coverage and certain states may require the insured to have medical coverage to enroll for the coverage. The policy or its provisions may vary or be unavailable in some states. There are benefit reductions that begin at age 65, if applicable. Like most group accident and health insurance policies, policies offered by MetLife may include waiting periods and contain certain exclusions, limitations and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP12-AX or contact your plan administrator

Benefits are underwritten by Metropo litan Life Insurance Company, New York, NY. Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

Underwritten by:

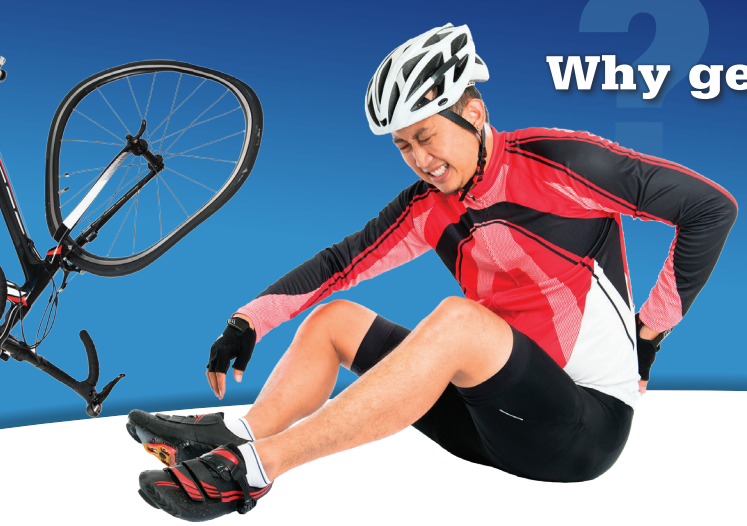
MetLife

Metropolitan Life Insurance Company
200 Park Avenue | New York, NY 10166 | www.metlife.com
L0322021037[exp0224][CA]

Accident Insurance

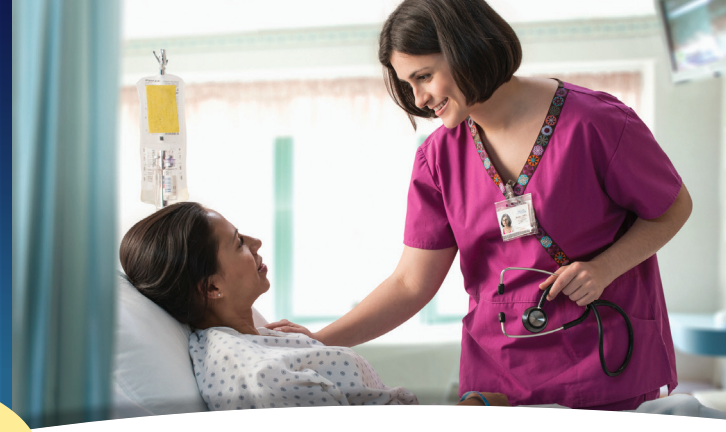
Accidents can happen anytime and when you least expect them. Make sure you are prepared with accident insurance.

EMPLOYEES CLUB OF CALIFORNIA
www.EmployeesClub.com



Why get Accident Insurance?

Accidents can happen anywhere and to anyone. They can lead to trips to the emergency room and the doctor's office, which could amount to bills and expenses not covered by your medical and disability insurance. Help alleviate the added cost that may result from an accident with accident insurance.



Guaranteed coverage without a medical exam[1]

How does Accident Insurance work?

Accident insurance pays out a lump sum if you incur an injury as a result of an accident.[2] With MetLife, you'll have the choice of two comprehensive plans which provides payments in addition to any other insurance payments you may receive.

Complete the attached Enrollment form. Then, Complete/ Sign the Payroll Deduction Card. Return both items together via mail to the Employees Club of California, at the address shown.

MetLife Rates:

	Standard monthly	Premier monthly
Member Only	$19.90	$29.90
Member + Spouse	$29.90	$44.90
Member + Children	$32.90	$48.90
Member + Spouse/ Children	$44.90	$66.90

Rates are subject to change.

What can Accident Insurance from the Club offer me?

Accident insurance may complement both medical and disability insurance if a covered incident causes you to have expenses that your health insurance doesn't cover — or causes you to lose income due to being out of work. As a member of Los Angeles City Employees Association, you can take advantage of the benefits this important protection offers:

We've got you covered

- With over 150 covered events and services, such as fractures,[3] dislocations,[3] 2nd and 3rd degree burns, and medical treatments or tests resulting from an accident.

It's your money

- Payments are **made directly** to you. You decide how to spend them. Pay for medical expenses not covered by your medical plan, like copays or deductibles, or for non-medical needs like household bills, childcare, or home modifications.

You won't be denied coverage

- You and your eligible family members are guaranteed[1] coverage, as long as you are actively at work. No medical exam and no hassle.

Don't worry about missing a payment

- Premiums will be automatically deducted from your paycheck making this coverage more convenient for you.

Get Accident Insurance Today!

Simply complete and sign this form and the payroll deduction authorization. Then mail this postage-paid brochure back to the Club. Or, call the Employees Club of California at (800) 464-0452, and a Club Counselor will take your information over the phone.

Who is eligible to apply?

All Actively at Work Members can apply for coverage as long as you are under age 65 on the date coverage starts. If you are older when coverage is scheduled to start, you will not be covered.

A Dependent will not be eligible while the Dependent: is serving in the armed forces, or any auxiliary units of the armed forces, of any country; or lives outside of the United States, Canada or Mexico for more than 12 consecutive months.

A Dependent (Spouse or Domestic Partner) must be under age 65 on the date Dependent coverage starts. If the Dependent is age 65 or older when coverage is scheduled to start, the Dependent will not be covered.

Questions?

Club Counselors are ready to answer your questions about Accident Insurance. Call today.

(800) 464-0452

Employees Club of California
311 S. Spring St. Ste 1300
Los Angeles, CA 90013
(800) 464-0452
www.EmployeesClub.com

[1] Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.

[2] Covered services/treatments must be the result of a covered accident as defined in the group policy/certificate. See your Disclosure Statement or Outline of Coverage/Disclosure Document for more details.

[3] Chip fractures are paid at 25% of Fracture Benefit and partial dislocations are paid at 25% of Dislocation Benefit.

Accident Insurance
Plan Benefits

Here are just some of the covered events/services. For a full list please refer to your certificate or visit www.EmployeesClub.com/AccidentPolicy

Hospital Benefits

	COVERAGE TIER STANDARD	PREMIER
Hospital Admission Benefit		
Non-ICU Hospital Admission	$1,100	$1,500
Intensive CareUnit Admission	$2,100	$2,700
Hospital Confinement Benefit		
Non-ICU Hospital Admission (per day, up to 365 days per Covered Person/Accident)	$275	$370
Intensive CareUnit Admission (per day, up to 31 days per Covered Person/Accident)	$700	$950
Inpatient Rehabilitation Benefit (per day, up to 30 days per covered Person/Accident, not to exceed 30 days per calendar year)	$160	$200

Ambulance Benefit Schedule

Ground Ambulance	$225	$300
Air Ambulance	$1,600	$2,000

Burns Benefit Schedule
(for 3rd Degree)

Less than 10%	$1,375	$1,800
At least 10% but less than 25%	$4,000	$5,200
At least 25% but less than 35%	$9,000	$12,000
35% or more	$13,000	$17,000

Paralysis Benefit
(for Member/Spouse),(see Cert for child)

Two limbs (paraplegia or hemiplegia)	$7,000	$9,300
Four limbs (quadriplegia)	$14,000	$19,000

Surgical Benefit

	COVERAGE TIER STANDARD	PREMIER
Torn, Ruptured or Severed Tendon/ Ligament/Rotator Cuff	$700	$950
Ruptured Disc with Surgical Repair Benefit	$700	$950
Torn Cartilage in Knee with surgical repair	$700	$950
Torn Cartilage in Knee with exploratory Surgery without repair	$330	$400
Cranial Surgery	$1,375	$1,800
Hernia repair	$575	$1,000
Thoracis cavity or abdominal pelvic cavity Surgery	$1,375	$1,800

Fracture Benefit
(Closed Reduction)

Hip, Thigh (femur)	$3,000	$4,000
Leg (tibia and/or fibula)	$1,500	$2,000
Finger, Toe	$140	$185
Ankle	$750	$1,000
Foot (except Toes)	$750	$1,000
Shoulder Blade (scapula), Collarbone (clavicle, Sternum)	$750	$1,000
Upper Arm between Elbow and Shoulder (humerus)	$750	$1,000
Upper Jaw, Mandible (except alveolar process)	$750	$1,000
Lower Jaw, Maxilla (except alveolar process)	$750	$1,000
Coccyx	$300	$400
Face or Nose (except mandible or maxilla)	$750	$1,000
Vertebral Processes	$450	$600

Fracture Benefit
(Open Reduction)

	COVERAGE TIER STANDARD	PREMIER
Hip, Thigh (femur)	$6,000	$8,000
Leg (tibia and/or fibula)	$3,000	$4,000
Finger, Toe	$700	$950
Ankle	$1,500	$2,000
Foot (except Toes)	$1,500	$2,000
Shoulder Blade (scapula), Collarbone (clavicle, Sternum)	$1,500	$2,000
Upper Arm between Elbow and Shoulder (humerus)	$1,500	$1,500
Upper Jaw, Mandible (except alveolar process)	$1,500	$2,000
Lower Jaw, Maxilla (except alveolar process)	$1,500	$2,000
Coccyx	$600	$800
Face or Nose (except mandible or maxilla)	$1,500	$2,000
Vertebral Processes	$3,000	$4,000

Other Benefits

Emergency Room Benefit	$150	$200
Lodging Benefit (per day, up to 31 days per calendar year)	$150	$200
Laceration Benefit Repaired with Stitches (less than 2 inches)	$150	$200
Physical Therapy Benefit (per treatment)	$40	$50
Prosthetic Devise Benefit	$825	$1,100
Transportation Benefit	$650	$800

Employees Club of California
(800) 464-0452 • www.EmployeesClub.com

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Coverage Effective Date (MM/DD/YYYY)
Los Angeles City Employees Association Inc (LACEA)	**165584**	

YOUR ENROLLMENT INFORMATION (To be Completed by the Member)

Name (First, Middle, Last)	Social Security #	☐ Male ☐ Female
Address (Street, City, State, Zip Code)	Date of Birth (MM/DD/YYYY)	

☐ New Enrollment ☐ Change in Enrollment	Are you a member of the Association? ☐ Yes ☐ No	Date of Hire (MM/DD/YYYY)

Work Phone #	Cell Phone #	Email Address

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below. If I am enrolling for Accident Insurance: I declare that all individuals to be insured have comprehensive medical coverage in force that provides benefits for medical treatment, including hospital, surgical and medical expenses. I have received and read a copy of the Outline of Coverage or other disclosure document for the Accident Insurance.

Accident Insurance

First select your option

- ☐ Standard Plan
- ☐ Premier Plan

Then select your level of coverage

- ☐ Member Only
- ☐ Member + Spouse/Domestic Partner[1]
- ☐ Member + Child(ren)
- ☐ Member + Spouse/Domestic Partner[1] + Child(ren)

Dependent Information

If you are applying for coverage for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below:

Name of your Spouse/Domestic Partner (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female
Name of your Child (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female
Name of your Child (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female
Name of your Child (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female
Name of your Child (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

[1] Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner if you and your Domestic Partner have either a substantial interest in the other engendered by love and affection; or a lawful and substantial economic interest in the continued life, health or bodily safety of each other, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the other person. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to such relationship.

GEF02-1
ADM
(The form number above applies to residents of all states except as follows: Form number **GEF02-1 ADM** *applies to residents of Oregon;*
GEF09-1 *applies to residents of Louisiana and Montana;*
GEF02-1
ADM *applies to residents of New Mexico, North Dakota and Utah)*

After completion, **sign and date the form where indicated.** Make a copy for your records and return to
Employees Club of California, 311 S. Spring Street Suite 1300, Los Angeles, CA 90013

MetLife

Metropolitan Life Insurance Company, New York, NY 10166

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

California: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GEF09-1a
(The form number above applies to residents of all states except as follows: Form number **GEF09-1 FW** *applies to residents of Oregon;*
GEF09-1 *applies to residents of Louisiana and Montana;*
GEF09-1
FW *applies to residents of New Mexico, North Dakota and Utah)*

DECLARATIONS AND SIGNATURE(S)

Your Accident certificate provides limited benefits. Read your certificate carefully.

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Member	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1a
(The form number above applies to residents of all states except as follows: Form number **GEF09-1 DEC** *applies to residents of Oregon;*
GEF09-1 *applies to residents of Louisiana and Montana;*
GEF09-1
DEC *applies to residents of New Mexico, North Dakota and Utah)*

FOR LOS ANGELES CITY AND DWP EMPLOYEES

PAYROLL DEDUCTION AUTHORIZATION

By signing the Payroll Authorization Form, I authorize a monthly payroll or pension deduction of $7.50 ($4.00 for retirees), in addition to any other authorized deductions, for access to full Club benefits. This authorization will remain in effect until I revoke it in writing.

Last Name | First Name | Middle Initial | Social Security Number ___ - ___ - ____

◯ City Dept # | ◯ City Employee # (5 - 6 Digits) | ◯ DWP Employee #

Please select one:

- ◯ City Active
- ◯ City Retired
- ◯ DWP Active
- ◯ DWP Retired
- ◯ Fire/ Police Pension (Officers Only)

To: **Controller–City of Los Angeles, or Fire and Police Pension, or City Employees Retirement System, or Paymaster–Department of Water and Power**

I hereby authorize the deduction from my salary or pension of amounts sufficient to cover premiums/membership fees for any of my group benefits provided by the Employees Club of California. In the event that any premiums should change due to age, an increase in salary or benefits, or a general rate increase for the entire Association, I authorize you to make such changes upon notification from the Employees Club of California. This deduction will remain in force until canceled by me in writing.

Employees Club of California
311 S. Spring St. STE 1300
Los Angeles, CA 90013
(800) 464-0452
info@employeesclub.com
www.EmployeesClub.com

SIGN HERE X

Los Angeles City / DWP Employee | Date

FOR OFFICE USE ONLY

Code | Deduction

FOR EMPLOYEES OF THE STATE OF CALIFORNIA

PAYROLL DEDUCTION AUTHORIZATION

By signing the Payroll Deduction Authorization, I authorize a monthly deduction of $7.50 from my payroll, plus any other authorized deductions, for full Club benefits access. This remains in effect until I revoke it in writing.

Last Name	First Name	Middle Initial	Social Security Number
			– –

Organization Name

Los Angeles City Employees Association, Inc. (LACEA)

Ded./ Org. Code: 089-067

To: **California State Controller**

I hereby authorize the State Controller to deduct from my salary and wages the amount specified now or in the future for membership dues and any benefit program for which I have applied, which is sponsored by the above-named organization. This authorization will remain in effect until canceled by me or by the above-named organization. I certify that I am a member of the above-named organization and understand that termination of membership will cancel all deductions made under this authorization.

SIGN HERE X

California State Employee Date

Employees Club of California
311 S. Spring St. STE 1300
Los Angeles, CA 90013
(800) 464-0452
info@employeesclub.com
www.EmployeesClub.com

FOR OFFICE USE ONLY

Code	Deduction

CLUB MEMBERSHIP FOR NEW POLICYHOLDERS

Employees Club of California

Enjoy the cheapest tickets in California and save up to 55% off movie theater tickets, theme parks, attractions, sporting events, musical shows, and more exclusively for Club members. With over 75,000 discounts, your Club membership is your passport to everyday savings on shopping, dining, services, travel and more across the United States and Canada.

☑ Club Membership:

Club membership fees will be automatically deducted.

As a new policyholder, you will automatically be enrolled as a member of the Employees Club of California, a membership program of the Los Angeles City Employees Association. Membership is required to participate in group-rated insurance programs. Membership is limited to active or retired municipal employees in the state of California. As a member of the Employees Club of California, you will have access to many Club-exclusive benefits and programs including the convenience of automatic payroll deduction.