



Metropolitan Life Insurance Company  
New York, New York

**CERTIFICATE OF INSURANCE**

**FACE PAGE**

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

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

Policyholder:	Powell Industries, Inc.
Group Policy Number:	148269-BTA
MetLife Toll Free Number(s):	
For Claim Information	1-800-638-6420
For General Information	1-800-638-5433
Type of Insurance	Business Travel Accidental Death and Dismemberment Insurance
Effective Date of Insurance:	January 1, 2013

**THIS CERTIFICATE DESCRIBES BUSINESS TRAVEL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE. THE INSURANCE DESCRIBED DOES NOT PROVIDE BENEFITS FOR LOSS CAUSED BY SICKNESS.**

If You sustain an accidental bodily injury in a Covered Accident which is the Direct and Sole Cause of a Covered Loss described in the SCHEDULE OF BENEFITS, Proof of the accidental bodily injury and Covered Loss must be sent to Us. When We receive the Proof, We will review the claim. If We approve the claim We will pay the insurance for which You were insured on the date and time of the Covered Accident within 60 days of Our receipt of such Proof. This insurance is subject to all the terms and exclusions set forth in this certificate.

If an injury would otherwise be considered an accidental bodily injury, We will not deny benefits for the accidental bodily injury solely because You sustain it as a result of an action taken in an effort to save life or avoid injury.

## NOTICE FOR TEXAS RESIDENTS

### For Texas Residents:

#### IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll free telephone number for information or to make a complaint at

1-800-638-5433

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

**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

1-800-638-5433

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

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas  
P.O. Box 149104  
Austin, TX 78714-9104  
Fax # (512) 475-1771

**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.

## **NOTICE FOR RESIDENTS OF ARKANSAS**

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

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

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, Arkansas 72201  
1-800-852-5494

## NOTICE FOR RESIDENTS OF IDAHO

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

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

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

## NOTICE FOR RESIDENTS OF UTAH

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

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

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

The basic protections provided by the Association are:

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

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

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 IA, Chapter 28.

**Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.**

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at [www.utlifega.org](http://www.utlifega.org) or contact:

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

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

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

## **FOR RESIDENTS OF VIRGINIA**

### **IMPORTANT INFORMATION REGARDING YOUR INSURANCE**

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

MetLife  
P.O. Box 789  
Johnstown, Pennsylvania 15904  
Attn: Corporate Customer Relations Department

To phone in a claim related question, you may call Claims Customer Service at:  
1-800-638-5433

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

Life and Health Division  
Bureau of Insurance  
P.O. Box 1157  
Richmond, VA 23218  
1-877-310-6560 – national toll free  
1-804-371-9691 – locally

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

## CIVIL UNION NOTICE FOR RESIDENTS OF VERMONT

Vermont law provides that the following definitions apply to Your certificate:

- Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," "wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family" and any other such terms include the relationship created by a Civil Union established according to Vermont law.
- Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage" and any other such terms include the inception or dissolution of a Civil Union established according to Vermont law.
- Terms that mean or refer to family relationships arising from a marriage, such as "family," "immediate family," "dependent," "children," "next of kin," "relative," "beneficiary," "survivor" and any other such terms include family relationships created by a Civil Union established according to Vermont law.
- "Dependent" includes a spouse, a party to a Civil Union established according to Vermont law, and a child or children (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.
- "Child" includes a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.
- "Civil Union" means a civil union established pursuant to Act 91 of the 2000 Vermont Legislative Session, entitled "Act Relating to Civil Unions".

All references in this notice to Civil Unions are limited to Civil Unions in which the parties are residents of Vermont.

If dependent insurance for a spouse and/or child is not provided under Your certificate, such insurance is not added by virtue of this notice.

For purposes of dependent insurance, any person who meets the definition of "dependent" as set forth in this notice is required to meet all other applicable requirements in order to qualify for such insurance.

This notice does not limit any definitions or terms included in Your certificate. It broadens definitions and terms only to the extent required by Vermont law.

### **DISCLOSURE:**

Vermont law grants parties to a Civil Union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to life and health insurance that are available to married persons under federal law may not be available to parties to a Civil Union. For example, a federal law, the Employee Retirement Income Security Act of 1974 known as "ERISA", controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a Civil Union in an ERISA employee benefit plan. However, governmental employers (not federal government) are required to provide life and health benefits to the dependents of a party to a Civil Union if the public employer provides such benefits to dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of insurance premiums. As a result, parties to a Civil Union and their families may or may not have access to certain benefits under this notice and the certificate to which it is attached that derive from federal law. You are advised to seek expert advice to determine Your rights under this notice and the certificate to which it is attached.

**NOTICE FOR RESIDENTS OF WISCONSIN**

**KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS**

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

**MetLife**

**Attn: Corporate Consumer Relations Department**

**P.O. Box 789**

**Johnstown, Pennsylvania 15904**

**1-800-638-5433**

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

**Office of the Commissioner of Insurance**

**Complaints Department**

**P.O. Box 7873**

**Madison, WI 53707-7873**

**1-800-236-8517 outside of Madison or 608-266-0103 in Madison.**



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## ELIGIBILITY PROVISIONS

### TABLE OF COVERED PERSONS

Covered Class	Covered Accidents
Class 1 - All active U.S. employees of the Policyholder*	<ul style="list-style-type: none"><li>• 24-Hour Business Travel</li></ul>

\* Exposure to the Elements and Presumption of Death provisions apply to the Covered Class(es) designated by an asterisk.

#### For You

You will be covered for the risks and for the time periods described in the Covered Accident(s) applicable to the Class of Covered Persons to which You belong.

You will not be included as a member of more than one Covered Class at the same time. If You could be included in more than one Covered Class at the time of a Covered Accident, We will consider You to be a member of the Covered Class that provides the greatest benefit.

## SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You will only be insured for benefits for which You are insured at the time of the Covered Accident.

### Business Travel Accidental Death and Dismemberment Insurance

For Class 1:

#### BENEFIT

#### BENEFIT AMOUNTS AND HIGHLIGHTS

#### How We Will Pay Benefits

Unless the Beneficiary requests payment by check, when the Certificate states that We will pay benefits in "one sum", We may pay the full benefit amount:

- by check;
- by establishing an account that earns interest and provides the Beneficiary with immediate access to the full benefit amount; or
- by any other method that provides the Beneficiary with immediate access to the full benefit amount.

Other modes of payment may be available upon request. For details, call Our toll free number shown on the Certificate Face Page.

Full Amount.....	An amount equal to 3 times Your Base Annual Earnings rounded to the highest \$1,000 to a maximum of \$1,000,000
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#### Table of Covered Losses and Benefits Payable

All amounts listed are stated as percentages of the Full Amount

#### Covered Loss

Loss of life.....	100%
Loss of a hand permanently severed at or above the wrist but below the elbow.....	50%
Loss of a foot permanently severed at or above the ankle but below the knee.....	50%
Loss of an arm permanently severed at or above the elbow.....	50%
Loss of a leg permanently severed at or above the knee.....	50%
Loss of Sight in one eye.....	50%

**Loss of Sight** means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.

Loss of the Thumb and Index Finger of Same Hand.....	25%
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## SCHEDULE OF BENEFITS (Continued)

**Loss of Thumb and Index Finger of Same Hand** means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.

Loss of Speech **and** Loss of Hearing..... 100%

Loss of Speech **or** Loss of Hearing..... 50%

**Loss of Speech** means a loss of speech continuing for 6 consecutive months after which a Physician must determine the loss to be entire and irrecoverable.

**Loss of Hearing** means a loss of hearing continuing for 6 consecutive months after which a Physician must determine the loss to be entire and irrecoverable.

Paralysis of both arms and both legs..... 100%

Paralysis of both legs..... 50%

Paralysis of the arm and leg on either side of the body..... 50%

Paralysis of one arm or leg..... 25%

**Paralysis** means the complete loss of use of a limb, without severance. A Physician must determine the loss of use to be permanent and irreversible.

You will not be included as a member of more than one Covered Class at the same time. If You could be included in more than one Covered Class at the time of a Covered Accident, We will consider You to be a member of the Covered Class that provides the greatest benefit.

If You sustain an accidental injury due to any one Covered Accident which is the Direct and Sole Cause of more than one Covered Loss, the amount We will pay will not exceed the Full Amount.

We will pay benefits only once for any one Covered Loss resulting from the same accident.

### Aggregate Maximum

We will not pay more than \$5,000,000 for all Covered Losses and injuries sustained by all insured persons under the Group Policy as a result of any one Covered Accident or series or combination of Covered Accidents directly arising out of one or more associated events. Events are associated if they have a common cause or are a chain of events forming part of a larger or broader event even if the individual events themselves are separate in time and place. If the total amount claimed by all insured persons is greater than this amount, then the amount We will pay to each insured person will be reduced in the same proportion, so that the total amount does not exceed the maximum amount stated in this paragraph.

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

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

**Airworthiness Certificate** means:

- the standard airworthiness certificate issued by the Federal Aviation Agency or successor agency of the United States; or
- the equivalent issued by the governmental authority having jurisdiction over civil aviation in the country of registry.

**Base Annual Earnings** mean Your gross salary or wages as reported to Us by the Policyholder.

**The term does not include** overtime, bonuses or commissions.

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

**Chartered Aircraft** means an aircraft that is hired by the Policyholder for a period of time which is less than 10 days.

**Common Carrier** means a government-regulated entity that is in the business of transporting fare-paying passengers.

**The term does not include:**

- chartered or other privately-arranged transportation;
- taxis; or
- limousines.

**Covered Accident** means an accident (i.e. an unexpected, unintentional or unforeseeable event or occurrence which happens suddenly and violently and occurs while coverage under this policy is in effect) which is listed as a Covered Accident in the Table of Covered Persons in the ELIGIBILITY PROVISIONS of this certificate.

**Direct and Sole Cause** means that the Covered Loss occurs within 12 months of the date of an accidental injury sustained in a Covered Accident and is the direct result of that accidental injury independent of other causes.

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

**Hazardous Activity** means an activity that exposes a Covered Person to dangerous conditions and significantly increases risk of death or bodily injury.

## DEFINITIONS (Continued)

**Leased or Controlled Aircraft** means an aircraft which;

- has been leased, rented or borrowed by the Policyholder for at least 10 consecutive days;
- subject to the terms of the lease agreement, can be used at the Policyholder's discretion; and
- cannot be altered or sold by the Policyholder without the consent of the owner or lessor.

**Owned Aircraft** means an aircraft to which the Policyholder holds legal or equitable title.

**Physician** means:

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

**The term does not include:**

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

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

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

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, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

**Spouse** means Your lawful spouse.

**Terrorist Act** means a politically or socially-motivated act of violence carried out by an individual or group of persons who may or may not be operating on behalf of a sovereign state with the intent to change political or social policy. A Terrorist Act does not include any act of violence carried out by a branch of the armed forces of a sovereign state.

**We, Us and Our** mean MetLife.

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

**You and Your** means a Covered Class member who is insured under the Group Policy for the insurance described in this certificate.

**GCERT-BTA04**

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## GENERAL EXCLUSIONS

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

1. physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
2. suicide or attempted suicide;
3. intentionally self-inflicted injury;
4. infection, other than infection occurring in an external accidental wound or from accidental food poisoning;
5. participation in Hazardous Activities such as: scuba diving; bungee jumping; skydiving; hang gliding; ballooning; drag racing; driving a car fitted for competitive racing; aerial hunting; aerial skiing; or travel in an aircraft for the purpose of parachuting or otherwise exiting an aircraft while the aircraft is in flight except for the purpose of self-preservation:
6. service in the armed forces of any country or international authority, except the United States National Guard;
7. any nuclear reaction or release of nuclear energy. This includes the radioactive, toxic, explosive or other hazardous or contaminating properties of radioactive matter;
8. the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical or biological agent;
9. any incident related to travel in an aircraft:
  - a) as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
  - b) and parachuting or otherwise exiting from such aircraft while the aircraft is in flight except for the purpose of self-preservation;
  - c) that does not have a valid Certificate of Airworthiness;
  - d) that is not flown by a pilot with a valid license to operate that aircraft;
  - e) which is Owned, Leased, Controlled or Chartered by the Policyholder;
  - f) or device used:
    - for testing or experimental purposes;
    - by or for any military authority;
    - for travel or designed for travel beyond the earth's atmosphere;
    - for crop dusting, spraying, or seeding;
    - for fire fighting;
    - for sky diving;
    - for hang gliding;
    - for pipeline or power line inspection;
    - for sky writing;
    - for aerial photography or exploration;
    - for racing, endurance tests, stunt or acrobatic flying; or
    - for any use which requires a special permit from the Federal Aviation Administration.
10. war, whether declared or undeclared; or act of war, insurrection, rebellion, riot or Terrorist Act.

## **GENERAL EXCLUSIONS (Continued)**

### **Exclusion for Intoxication**

We will not pay benefits for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

**Intoxicated** means that the injured party's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

### **Exclusion for Commission of a Felony**

We will not pay benefits on behalf of a Covered Person for any loss caused or contributed to by the injured party committing or attempting to commit a felony.

### **Exclusion for Drugs; Alcohol; Poison; Gas; or Fumes**

We will not pay benefits on behalf of a Covered Person for any loss caused by or contributed to by that person's voluntary intake or use by any means of:

- any drug, medication or sedative, unless it is:
  - a) taken or used as prescribed by a Physician, or
  - b) an "over the counter" drug, medication or sedative taken as directed;
- alcohol in combination with any drug, medication, or sedative; or
- poison, gas, or fumes.



## **COVERED ACCIDENT: 24-HOUR BUSINESS TRAVEL**

We will pay the benefit amount(s) stated in the Schedule of Benefits if, while Traveling on Business for the Policyholder, an accidental bodily injury resulting in a Covered Loss is sustained as described on the face page of this certificate.

**Traveling on Business** means, for the purposes of this Covered Accident, that You are on a business trip requested, authorized or consented to by the Policyholder, for the purpose of furthering the business of the Policyholder and at the expense of the Policyholder.

Traveling on Business starts when You leave from Your residence, regular place of employment or other location (whichever occurs last), for the purpose of traveling to the destination of the business trip. The business trip ends when You return to or arrive at Your residence or Your regular place of employment (whichever occurs first).

Traveling on Business does not include:

1. travel between Your residence and regular place of employment;
2. regular driving assignments for truck drivers, delivery persons, chauffeurs and other commercial drivers employed by the Policyholder;
3. leaves of absence;
4. vacations; or
5. Personal Deviations.

**Personal Deviation** means any travel or activity:

- not reasonably related to the business of the Policyholder; or
- not incidental to the business trip;

and not at the expense of the Policyholder.

We will deem that Your regular place of employment has changed and that Traveling on Business has ended if:

- You are expected to remain in the location to which You have Traveled on Business for more than 30 days; or
- the Policyholder deems a new location to be Your regular place of employment.

## **EXPOSURE TO THE ELEMENTS AND PRESUMPTION OF DEATH**

### **EXPOSURE TO THE ELEMENTS**

If You sustain an accidental bodily injury in a Covered Accident, We will not deny a claim because the injury was not the Direct and Sole Cause of the Covered Loss if:

- the Covered Loss results from unavoidable exposure to the elements; and
- the exposure is a direct result of a Covered Accident independent of other causes.

### **PRESUMPTION OF DEATH**

For purposes of any benefits paid under this certificate, We will presume that the Covered Loss sustained by You for such loss is loss of life if:

- an aircraft or other vehicle in which You were Traveling on Business for which coverage is provided under a Covered Accident disappears, sinks, or is wrecked; and
- Your body is not found within one year of:
  - the date the aircraft or other vehicle was scheduled to have arrived at its destination, if traveling in an aircraft or other vehicle operated by a Common Carrier; or
  - the date You are reported missing to the authorities, if traveling in any other aircraft or vehicle.

## **FILING A CLAIM**

### **CLAIMS FOR INSURANCE BENEFITS**

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

#### **Step 1**

Contact the Policyholder. The Policyholder will either have claim forms or provide information as to how to obtain a claim form. Otherwise, notice may be given by calling Us at the toll free number shown in the Certificate Face Page within 20 days of the date of a loss.

#### **Step 2**

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

#### **Step 3**

When the claimant receives the claim form the claimant should fill it out as instructed and return it with the required Proof described in the claim form. If the claimant does not receive a claim form within 15 days after giving Us notice of claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

#### **Step 4**

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

The Policyholder will be required to verify Your insurance under the Group Policy. When We receive the Proof, claim and verification, We will review the claim and if We approve it, We will pay benefits subject to the terms and provisions of this certificate and the Group Policy.

If it is not reasonably possible to provide notice of claim or Proof 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 later than one year after the date of the loss except in the case of legal incapacity.

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

## **GENERAL PROVISIONS**

### **Assignment**

Your insurance rights and benefits are not assignable prior to a loss.

### **Autopsy**

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

### **Who We Will Pay**

For Loss of Your life, We will pay benefits to Your Beneficiary.

For any other Loss sustained by You, We will pay benefits to You.

We will pay benefits in one sum. Other modes of payment may be available upon request. For details call Our toll free number shown on the Face Page.

You may designate a Beneficiary using a form satisfactory to Us. You may change Your Beneficiary at any time. To do so, You must send a Signed and dated Written request to the Policyholder using a form satisfactory to Us. Your Written request to change the Beneficiary must be sent to the Policyholder during Your lifetime within 30 days of the date You Sign such request.

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.

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

If a Beneficiary or payee is a minor or incompetent to receive payment, We will pay that person's guardian.

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

- Your Spouse;
- Your child(ren);
- Your parent(s); or
- Your sibling(s).

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

### **Conformity with Law**

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

### **Entire Contract**

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

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

## **GENERAL PROVISIONS (Continued)**

### **Incontestability: Statements Made by You**

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

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

We will not use Your statements to contest insurance after it has been in force for 2 years during Your life.

### **Physical Exams**

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

### **Recovery of Overpayments**

We have the right to recover any amount that We determine to be an overpayment. An overpayment occurs if We determine that the total amount paid by Us on Your claim is more than the total of the benefits due to You under this certificate.

If such overpayment occurs, You have an obligation to reimburse Us.

**THE PRECEDING PAGE IS THE END OF THE CERTIFICATE.  
THE FOLLOWING IS ADDITIONAL INFORMATION.**

## **NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR**

Powell Industries, Inc.  
8550 Mosley Road  
Houston, TX 77075

**EMPLOYER IDENTIFICATION NUMBER:** 74-1245849

<b>PLAN NUMBER</b>	<b>COVERAGE</b>	<b>PLAN NAME</b>
501	Business Travel Accident	Powell Industries, Inc. Employee Benefit Plan

## **TYPE OF ADMINISTRATION**

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

## **AGENT FOR SERVICE OF LEGAL PROCESS**

For disputes arising under the Plan, service of legal process may be made upon the Plan administrator at the above address. For disputes arising under those portions of the Plan insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

## **ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS**

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan. It also includes a detailed description of the insurance provided by MetLife under the Plan.

## **PLAN TERMINATION OR CHANGES**

The group policy sets forth those situations in which the Employer and/or MetLife have the rights to end the policy.

The Employer reserves the right to change or terminate the plan at any time. Therefore, there is no guarantee that you will be eligible for the insurance described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

## **CONTRIBUTIONS**

No employee contribution is required for Business Travel Accident Insurance as this is fully Employer paid coverage.

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

## **PLAN YEAR**

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

## **Qualified Domestic Relations Orders/Qualified Medical Child Support Orders**

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

## **CLAIMS INFORMATION**

### **Procedures for Presenting Claims for Business Travel Accident Benefits**

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who will also be ready to answer questions about the insurance benefits and to assist you or, if applicable, the claimant in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

### **Routine Questions**

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

### **CLAIM SUBMISSION**

In submitting claims for Business Travel Accident benefits ("Benefits"), the claimant must complete the appropriate claim form and submit the required proof as described in the certificate.

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

### **Initial Determination**

After MetLife receives your claim for Benefits, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date we received your claim, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

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. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

### **Appealing the Initial Determination**

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your beneficiary deem appropriate. Upon your written request, MetLife will provide you free of charge with copies of relevant documents, records and other information.

MetLife will re evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received your request for review, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send 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.



## **Discretionary Authority of Plan Administrator and Other Plan Fiduciaries**

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

### **STATEMENT OF ERISA RIGHTS**

The following statement is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

#### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan administrator's office and at other specified locations, all Plan documents, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

#### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

#### **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

### **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory of the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

### **FUTURE OF THE PLAN**

It is hoped that the Plan will be continued indefinitely, but Powell Industries, Inc. reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of Powell Industries, Inc. shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.