CenturyLink Disability Plan
Long-Term Disability (LTD) Plan

Summary Plan Description
For CenturyLink U.S. Employees

Supplement to Your Standard Insurance Company Certificate of Coverage and Summary Plan Description

CenturyLink, Inc.

Effective January 1, 2020

CenturyLink®

Issued June 06, 2020

Table of Contents

Introduction

CenturyLink, Inc. (hereinafter the “Company”) is pleased to provide you with this Supplement to your Certificate of Coverage and Summary Plan Description, and related Summaries of Material Modification, if any (collectively, the “SPD”). This Supplement presents an overview of the administration of your

Long-Term Disability (LTD) benefits under the CenturyLink Disability Plan (the “Disability Plan”). The Plan was established by the Company to provide Short and Long-Term Disability coverage and this document supplements the information about the insured Long-Term Disability Plan benefits that are available.

Reservation of Company Rights

The Company reserves the right to amend or terminate the Plan, and all or any of the benefits available under the Plan, including participant contribution obligations, if any, with respect to all participant classes, retired or otherwise without prior notice to or consultation with any participant, subject to applicable laws and collective bargaining agreements. In the event of any discrepancy between this Supplement, the SPD and the official Plan document, the Plan document shall govern.

How to Use this Document

We encourage you to read this Supplement. With respect to the LTD benefits you may be eligible for, you will need to read this Supplement in connection with the SPD and Certificate of Coverage prepared by The Standard Insurance Company, the Plan’s third-party administrator. Many sections of this Supplement are related to the LTD SPD located on HRConnect.

This Supplement and the SPD must be read together to fully understand your rights and benefits under the Plan.

This is an Important Document

This Supplement and the SPD are provided to explain how the Plan works. Together, they describe your benefits and rights as well as your obligations under the Plan. It is important for you to understand that because this is only a summary; it cannot cover all of the details of the Plan or how the rules will apply to every person in every situation. All of the specific rules governing the Plan are contained in the Plan document. You, your dependents and beneficiaries, and your lawyer (or other legal representative) may examine the Plan document and other documents relating to the Plan during regular business hours, or by appointment at a mutually convenient time in the office of the Plan Administrator.

We encourage you to read the Supplement and the SPD, in their entirety. Many sections of the SPD are related to other sections of the document. You may not have all of the information you need by reading just one section. You should keep this Supplement and the SPD in a safe place so you can refer to each, as needed, from time to time. If you should have questions after reading these documents, please contact the Claims Administrator or the Plan Administrator.

Whose Benefits are Explained in this SPD?

In general, the Plan provides Long-Term Disability coverage to Non-Represented and Represented employees who are determined to be “disabled” (as defined by the Plan) and eligible for LTD benefits.

General Plan Information

The SPD provides general Plan information including, but not limited to, the following:

- Eligibility
- When Coverage Begins
- When Coverage Ends
- Questions, Complaints, How to File a Claim and an Appeal
- The Plan's Right to Recover Overpaid Benefits
- Coordination of Benefits
- Your ERISA Rights
- Glossary of Defined Terms

To Contact the Plan

Throughout this Supplement you will find statements that encourage you to contact the Claims Administrator (the insurer, The Standard) for the Plan. Whenever you have a question or concern regarding LTD benefits or a claim, please call the Standard first:

- If it is to initiate an LTD claim telephonically and it has not been completed (assigned to an analyst), call 855-290-9480.
- If the claim is complete and has been assigned to an analyst, or you have general questions regarding LTD, call 800-368-1135.

Inform the Plan of Changes

You must notify the Plan of a change in your address or telephone number as well as notifying the Plan of other changes to your name and/or marital status. To do this, you must contact the CenturyLink Service Center as soon as possible at ***866-935-5011***.

A Word About Your Privacy

In determining benefits and eligibility, the Plan will use confidential or personal health information. Please keep in mind it is very important for you to follow the Plan's procedures, as summarized in the SPD, in order to obtain Plan benefits and to help keep your personal health information private and protected. For example, contacting someone at the Company other than the claims administrator or Plan Administrator (or their duly authorized delegates), in order to try to get a benefit claim issue resolved, is not following the Plan's procedures. If you do not follow the Plan's procedures for claiming a benefit or resolving an issue involving Plan benefits, there is no guarantee the Plan benefits for which you may be eligible will be paid to you on a timely basis, or paid at all, and there can be no guarantee that your personal health information will remain private and protected.

Plan Determinations are Not Health Care Advice

Please keep in mind the sole purpose of the Plan is to provide for the payment of disability benefits and may provide you with eligibility to other Company-sponsored benefits (such as health or life insurance benefits); not to guide or direct the course of treatment of any employee or eligible dependent. A determination by the Claims Administrator that a particular course of treatment is not helpful in determining your eligibility for LTD benefits, does not mean the recommended course of treatments, services or procedures should not be provided to the individual or that they should not be provided in the setting or facility proposed.

Only you and your healthcare provider can decide what is the right health care decision for you. *Decisions by the Plan Administrator or Claims Administrator are solely decisions with respect to Plan LTD benefits and do not constitute health care recommendations or advice.*

Conversion Rights When Coverage Ends

There are no individual conversion rights to this insurance benefit.

Loss of Eligibility due to Falsification; Reimbursement Required

Coverage for a participant may be terminated based on enrollment or eligibility information received which was falsely provided.

Note: If a participant's coverage for LTD benefits is terminated, the termination of coverage may relate back to the effective date of benefits based on the circumstances. The Plan will seek to be made whole by the participant for amounts improperly paid on behalf of the participant (and any dependents) for LTD benefits paid. Your loss of LTD benefits may impact your eligibility for other Company-sponsored benefits, such as health, life insurance or disability pension benefits.

General Administrative Information

Plan Name:	**CenturyLink Disability Plan**, a group disability plan
Plan Sponsor:	CenturyLink, Inc. 931 14th Street, 9th Floor Denver CO 80202
Telephone:	(866) 935-5011
Employer Identification Number:	72-0651161
Plan Number:	513

Agent for Service of Legal Process:

Process in legal actions with respect to the provisions of the Plan should be directed to:
Plan Administrator:

c/o Associate General Counsel-Litigation
214 East 24th Street
Vancouver, WA 98663

or to the Plan Sponsor's agent for service of legal process:

The Corporation Company (CT Corp)
931 14th Street, 9th Floor
Denver, Colorado 80202

Interpretation of the Plan and Claims Fiduciary

The LTD Claims Administrator is the claims fiduciary, for purposes of the federal law known as "ERISA" which governs disability plans such as this. The LTD Claims Administrator has been delegated the sole and exclusive discretion to:

- Interpret benefits covered under the Plan
- Interpret the other terms, conditions, limitations and exclusions under the Plan
- Making factual determinations, finding and determining all facts related to benefits
- Decide all disputes and questions related to benefits

The LTD Claims Administrator may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of this benefit.

Plan Fiduciary

The named fiduciary of the Plan is the CenturyLink Employee Benefits Committee. The Company has designated the Claims Administrator (the insurer, The Standard) as a claims fiduciary for purposes of all claims arising under this benefit.

Type of Administration of the Plan

The Company provides certain administrative services in connection with the Plan and uses the services of third-party administrators for benefits available under the Plan. The LTD benefit is fully insured by The Standard.

Funding

The LTD benefits under the Plan are currently fully insured and paid by The Standard.

Circumstances That May Affect Your Plan Benefits

Under certain circumstances all or a portion of your benefits under the Plan may be denied, reduced, suspended, terminated or otherwise affected. Many of these circumstances have been specifically addressed in the SPD. Such circumstances, in general, include:

- You are no longer in an eligible class of participants
- The Plan is changed, amended or terminated or the contract with The Standard amended or terminated
- You attain the maximum benefit available under the Plan
- You misrepresent or falsify any information required under the Plan; you will not be permitted to benefit under the Plan from your own misrepresentation
- You have been overpaid a benefit and the Plan seeks recovery of the overpayment
- If you are entitled to receive benefits from the Plan for injuries caused by a third-party, the Plan has the right to obtain restitution, or by other equitable means, to a repayment of the LTD benefits paid under the Plan from any part of payments received from such party, your insurance carrier or by any other party, including an individual or corporate entity
- Your coverage under the Plan is terminated for one of a variety of reasons, for example, failure to submit required documentation timely or, if applicable, to pay a premium

Time Limitation on Civil Actions

You cannot bring any legal proceeding or action against the Plan, the Plan Administrator, Claims Administrator or the Company unless you first complete all the steps in the claims and appeals procedure – the reviews process described in the SPD.

After completing that process, you can bring any legal proceedings or action against the Plan or us or the claims administrator within 12 months or 1 year of the date the claims administrator notified you of the final decision on your appeal, unless otherwise specified in an applicable insurance policy. No person has the right to file a civil action, proceeding or lawsuit against the Plan or any person acting with respect to the Plan, including, but not limited to, the Company, any participating company, the CenturyLink Employee Benefits Committee or any other fiduciary, or any third party service provider, after the last day of the 12th month following the later of (a) the 60th day after receipt by the claimant of written notification of the Adverse Benefit Determination or (b) the date on which the Adverse Benefit Determination on appeal was issued with respect to such Plan benefit claim.

Clerical Error

If a clerical error or other mistake occurs, however occurring, that error does not create a right to LTD benefits. Clerical errors include, but are not limited to, providing misinformation on eligibility or benefit coverages or entitlements or relating to information transmittal and/or communications, perfunctory or ministerial in nature, involving claims processing, recordkeeping. Although every effort is and will be made to administer the Plan in a fully accurate manner, any inadvertent error, misstatement or omission will be disregarded and the actual Plan provisions will be controlling. A clerical error will not void coverage to which a Participant is entitled under the terms of the Plan, nor will it continue coverage that should have ended under the terms of the Plan. When an error is found, it will be corrected or adjusted appropriately as soon as practicable. Interest shall not be payable with respect to a benefit corrected or adjusted. It is your responsibility to confirm the accuracy of statements made by the Plan or our designees, including the claims administrator(s), in accordance with the terms of the SPD and other Plan documents.

Records and Information and Your Obligation to Furnish Information

At times, the Plan or the Claims Administrator may need information from you. You agree to furnish the Plan and/or the Claims Administrator with all information and proofs that are reasonably required regarding any matters pertaining to the Plan. If you do not provide this information when requested, it may delay or result in the denial of your claim.

By accepting LTD benefits under the Plan, you authorize and direct any person that has provided services to you, to furnish the Plan or the claims administrator with all information or copies of records relating to the services provided to you. The Plan or the claims administrator has the right to request this information at any reasonable time. This applies to all Participants.

The Plan agrees that such information and records will be considered confidential. The Company and the Claims Administrator have the right to release any and all records which are necessary to implement and administer the terms of the Plans, for appropriate medical review or quality assessment, or as we are required by law or regulation.

Interpretation of the Plan

The Plan Administrator has authority to control and manage the operation and administration of the Plan. However, the Plan Administrator has delegated to the Claims Administrator, The Standard, its discretionary authority to make all final determinations regarding claims and appeals for benefits

under the Plan. This discretionary authority includes, but is not limited to, the determination of eligibility for benefits, based upon enrollment information, and the amount of any benefits due, and to construe the terms of the policy insuring the benefits for the Plan.

Any decision made by the group sponsored life insurance carrier in the exercise of this authority, including review of denials of benefit, is conclusive and binding on all parties. Any court reviewing the group sponsored life insurance carrier's determinations shall uphold such determination unless the claimant proves the determinations are arbitrary and capricious.

STANDARD INSURANCE COMPANY

A Stock Life Insurance Company
900 SW Fifth Avenue
Portland, Oregon 97204-1282
(503) 321-7000

CERTIFICATE AND SUMMARY PLAN DESCRIPTION

GROUP LONG TERM DISABILITY INSURANCE

Policyholder:	CenturyLink
Policy Number:	643388-H
Effective Date:	January 1, 2019

The Group Policy has been issued to the Policyholder. We certify that you will be insured as provided by the terms of your Employer's coverage under the Group Policy. If the terms of this Certificate and Summary Plan Description differ from the terms of your Employer's coverage under the Group Policy, the latter will govern. If your coverage is changed by an amendment to the Group Policy, we will provide the Employer with a revised Certificate and Summary Plan Description or other notice to be given to you. In the event of a premium increase, the Policyholder will be given 180 days prior notice.

Possession of this Certificate and Summary Plan Description does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this Certificate and Summary Plan Description.

"You" and "your" mean the Member. "We", "us" and "our" mean Standard Insurance Company. Other defined terms appear with the initial letters capitalized. Section headings, and references to them, appear in boldface type.

Chairman, President and CEO

Table of Contents

Index of Defined Terms

COVERAGE FEATURES

This section contains many of the features of your long term disability (LTD) insurance. Other provisions, including exclusions, limitations, and Deductible Income, appear in other sections. Please refer to the text of each section for full details. The Table of Contents and the Index of Defined Terms help locate sections and definitions.

GENERAL POLICY INFORMATION

Group Policy Number:	643388-H
Policyholder:	CenturyLink
Employer(s):	CenturyLink and Affiliated or Subsidiary Companies
Group Policy Effective Date:	January 1, 2019
Policy Issued in:	Louisiana

Member means a citizen or resident of the United States (including US Territories) or Canada and one of the following:

1. A regular full-time employee of the Employer who is Actively At Work at least 30 hours a week; or
2. A regular full-time Qwest Represented employee of the Employer who was hired, rehired or transferred on or after January 1, 2018 and who is Actively At Work at least 30 hours a week; or
3. A regular full-time employee of the Employer who is Actively At Work at least 30 hours a week outside of the United States; or
4. A regular Qwest Represented Full-time Employee, Part-time Employee, or Term Employee, of the Employer who was hired prior to January 1, 2018 and who is Actively At Work for at least 21 hours a week.

For purposes of the Member definition, Actively At Work will include regularly scheduled days off, holidays, or vacation days, so long as the person is capable of Active Work on those days.

Member does not include a temporary employee, a full-time member of the armed forces of any country (unless your Employer indicates otherwise), a leased employee as defined in 414n of the Internal Revenue Code, an independent contractor, an occasional or incidental employee or a non-employee consultant.

Class Definition:

Class 1:	CenturyLink Non-Represented Members and Qwest Represented Retail/Outside Sales Representatives, CenturyLink Represented Members as defined in their collective bargaining agreement
Class 2:	Qwest Represented Employees hired prior to January 1, 2018
Class 3:	Qwest Represented Employees who are hired, rehired or transferred on or after January 1, 2018

SCHEDULE OF INSURANCE

Eligibility Waiting Period:	You are eligible on the latter of (A) the Group Policy Effective Date, and (B) one of the following: Basic LTD: The first day following 365 days as a Member Supplemental LTD: The January 1 following 365 days as a Member

Eligibility Waiting Period means the period you must be a Member before you become eligible for insurance.

NOTE for All Classes: If you are a Member under the Group Policy, but have not yet become eligible for insurance, your Eligibility Waiting Period will continue to accrue as if you are Actively at Work while:

a) You are not Actively at Work due to an Employer approved Leave of Absence; or

b) You are not Actively at Work due to an on-the-job injury or illness.

NOTE: If you cease to be a Member due to a reduction in workforce, and if you become a Member again within 12 months from the date of your termination, your Eligibility Waiting Period will apply as follows:

1. If you were rehired and had not previously met your initial Eligibility Waiting Period, your Eligibility Waiting Period will be reduced by any continuous period as a Member of the Employer immediately prior to the date you became a Member.
2. Your Preexisting Condition exclusion period as shown in the **Disabilities Excluded From Coverage** section will be reduced by the prior continuous period as a Member of the Employer immediately prior to becoming a member under the Group Policy.
3. Evidence of Insurability will not apply to your Supplemental LTD Benefit if you apply within 30 days after you become eligible.
4. The amount of your Basic LTD or Supplemental LTD Benefit will be the same amount of insurance that you had in effect on the date of your termination due to a reduction in workforce contingent on your earnings being the same.

Annual Enrollment Period:

Evidence of Insurability (medical evidence) will not be required if you apply for Supplemental LTD Insurance during your Employer's Annual Enrollment Period immediately following the date you become eligible. If you apply during this time period, your Supplemental LTD Insurance will become effective on the January 1 next following the Annual Enrollment Period during which you apply.

If you do not elect to become insured under Supplemental LTD insurance during your first annual enrollment after you become eligible, and later apply, Evidence of Insurability requirements will apply.

Annual Enrollment Period means the period designated each year by your Employer when you may change insurance elections and is subject to the **Active Work Provisions**.

Please see item A.2.b and item C. of the **When Insurance Becomes Effective** section for more information on Evidence of Insurability requirements.

NOTE: If you cease to be a Member due to a reduction in workforce, and if you become a Member again within 12 months from the date of your termination, the amount of your Basic LTD or Supplemental LTD Benefit will be the same amount of insurance that you had in effect on the date

of your termination due to a reduction in workforce contingent on your earnings being the same. See **When Your Insurance Becomes Effective** section.

Own Occupation Period:	The first 24 months for which LTD Benefits are paid.
Any Occupation Period:	From the end of the Own Occupation Period to the end of the Maximum Benefit Period.

LTD Benefit:

You may be insured under either Basic LTD or Supplemental LTD, but not both. You will be insured under Basic LTD unless you are insured under Supplemental LTD. If you cease paying for premiums for Supplemental LTD, you will automatically be insured under Basic LTD.

LTD Benefits are paid on a monthly basis.

Basic LTD:	50% of the first $24,000 of your monthly Predisability Earnings, reduced by Deductible Income.
Supplemental LTD:	65% of the first $38,462 of your monthly Predisability Earnings, reduced by Deductible Income.
Monthly Maximum:	
Basic LTD:	$12,000 before reduction by Deductible Income.
Supplemental LTD:	$25,000 before reduction by Deductible Income.
Minimum:	$100 or 10% of your LTD Benefit before reduction by Deductible Income, whichever is greater.
Benefit Waiting Period:	**Class 1 and 3**: The longer of: a) 182 days/26 Weeks b) Through the date for which STD or Supplemental Worker's Comp Payment (SWCP) benefits are paid to you under your Employer's Disability Plan; or c) the date STD Benefits are exhausted **Class 2:** In no case will LTD Benefits be paid to you while you are eligible to receive Short Term Disability benefits under your Employer's Short Term Disability Plan. As applicable, your Benefit Waiting Period is as follows: a) 270 days/39 weeks; or b) 12 months in any consecutive 18 month period regardless of the number or length of the claims, but not to exceed the STD Maximum Benefit Period of 9 months for any one claim; or c) the date STD Benefits are exhausted Note: If you temporarily recover from your Disability and then become Disabled again from a different cause or causes, your STD Benefits may be extended for a maximum of 12 months within any 18 month period.

Maximum Benefit Period: Determined by your age when Disability begins, as follows:

Age	Maximum Benefit Period
61 or younger	To age 65, or to SSNRA, or 3 years 6 months, whichever is longest.
62	To SSNRA, or 3 years 6 months, whichever is longer.
63	To SSNRA, or 3 years, whichever is longer.
64	To SSNRA, or 2 years 6 months, whichever is longer.
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69 or older	1 year

Social Security Normal Retirement Age (SSNRA) means your normal retirement age under the Federal Social Security Act, as amended.

It's important to understand your normal retirement age. Here's a list of possible years you were born followed by your normal retirement age according to the Social Security Administration.

1937 or earlier	65 years
1938	65 years and 2 months
1939	65 years and 4 months
1940	65 years and 6 months
1941	65 years and 8 months
1942	65 years and 10 months
1943 through 1954	66 years
1955	66 years and 2 months
1956	66 years and 4 months
1957	66 years and 6 months
1958	66 years and 8 months
1959	66 years and 10 months
1960 or later	67 years

PREMIUM CONTRIBUTIONS

Insurance is:

Basic LTD:	Noncontributory
Supplemental LTD:	Contributory: You and Your Employer share the cost of coverage. Employer contribution level determines the taxability of the benefit amount.

ERISA SUMMARY PLAN DESCRIPTION INFORMATION

Name of Plan:	Long Term Disability Insurance
Name, Address of Plan Sponsor:	CenturyLink 931 14th Street, 9th Floor Denver, CO 80202
Plan Sponsor Tax ID Number:	72-0651161
Plan Number:	513
Type of Plan:	Group Insurance Plan
Type of Administration:	Contract Administration
Name, Address, Phone Number of Plan Administrator:	Plan Sponsor (800) 729-7526
Name, Address of Registered Agent for Service of Legal Process:	Plan Administrator
If Legal Process Involves Claims For Benefits Under The Group Policy, Additional Notification of Legal Process Must Be Sent To:	Standard Insurance Company 1100 SW 6th Ave Portland OR 97204-1093
Sources of Contributions:	Employer/Member
Funding Medium:	Standard Insurance Company - Fully Insured
Plan Fiscal Year End:	December 31

INSURING CLAUSE

If you become Disabled while insured under the Group Policy, we will pay LTD Benefits according to the terms of the Group Policy after we receive Proof Of Loss satisfactory to us.

LT.IC.OT.1

BECOMING INSURED

To become insured you must be a Member, complete your Eligibility Waiting Period, and meet the requirements in **Active Work Provisions** and **When Your Insurance Becomes Effective**.

You are a Member if you are a citizen or resident of the United States (including US Territories) or Canada and one of the following:

1. A regular full-time employee of the Employer who is Actively At Work at least 30 hours a week; or
2. A regular full-time Qwest Represented employee of the Employer who was hired, rehired or transferred on or after January 1, 2018 and who is Actively At Work at least 30 hours a week; or
3. A regular full-time employee of the Employer who is Actively At Work at least 30 hours a week outside of the United States; or
4. A regular Qwest Represented Full-time Employee, Part-time Employee, or Term Employee, of the Employer who was hired prior to January 1, 2018 and who is Actively At Work for at least 21 hours a week.

For purposes of the Member definition, Actively At Work will include regularly scheduled days off, holidays, or vacation days, so long as the person is capable of Active Work on those days.

Member does not include a temporary employee, a full-time member of the armed forces of any country (unless your Employer indicates otherwise), a leased employee as defined in 414n of the Internal Revenue Code, an independent contractor, an occasional or incidental employee or a non-employee consultant.

(VAR MBR DEF) LT.BI.OT.1X

WHEN YOUR INSURANCE BECOMES EFFECTIVE

A. When Insurance Becomes Effective

Subject to the **Active Work Provisions**, your insurance becomes effective as follows:

1. Insurance Subject To Evidence Of Insurability

   Insurance subject to Evidence Of Insurability becomes effective on the January 1 next following the Annual Enrollment Period during which you apply or the date we approve your Evidence Of Insurability, whichever is later.

2. Insurance Not Subject To Evidence of Insurability

   The **Coverage Features** states whether insurance is Contributory or Noncontributory.

   a. Noncontributory Insurance (Basic)

      Noncontributory insurance not subject to Evidence Of Insurability becomes effective on the date you become eligible, unless you become insured for Contributory insurance.

b. Contributory Insurance (Supplemental)

You must apply in writing for Contributory insurance and agree to pay premiums. You may only apply during your Employer's Annual Enrollment Period.

Contributory insurance not subject to Evidence Of Insurability becomes effective on the January 1 next following the Annual Enrollment Period during which you apply.

Late application: Evidence Of Insurability is required if you apply after the first Annual Enrollment Period in which you are eligible to apply for Contributory Insurance and will become effective as shown above in item A.1.

B. Takeover Provisions

If you were insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Group Policy, your Eligibility Waiting Period is waived on the effective date of your Employer's coverage under the Group Policy.

C. Evidence Of Insurability Requirement

Evidence Of Insurability satisfactory to us is required:

a. For late application for Contributory insurance.

b. For reinstatements if required.

Providing Evidence Of Insurability means you must:

1. Complete and sign our medical history statement electronically or on paper;
2. Sign our form authorizing us to obtain information about your health;
3. Undergo a physical examination, if required by us, which may include blood testing; and
4. Provide any additional information about your insurability that we may reasonably require.

(VAR EOI) LT.EF.OT.1X

ACTIVE WORK PROVISIONS

A. Active Work Requirement

You must be capable of Active Work on the day before the scheduled effective date of your insurance or your insurance will not become effective as scheduled. If you are incapable of Active Work because of Physical Disease, Injury, Pregnancy or Mental Disorder on the day before the scheduled effective date of your insurance, your insurance will not become effective until the day you complete one full day of Active Work as an eligible Member.

Active Work and Actively At Work mean performing with reasonable continuity the Material Duties of your Own Occupation at your Employer's usual place of business.

B. Changes In Insurance

This Active Work requirement also applies to any increase in your insurance, other than an increase in your Predisability Earnings.

LT.AW.OT.1X

CONTINUITY OF COVERAGE

If your Disability is subject to the Preexisting Condition Exclusion, LTD Benefits will be payable if:

1. You were insured under the Prior Plan on the day before the effective date of your Employer's coverage under the Group Policy;

2. You became insured under the Group Policy when your insurance under the Prior Plan ceased;
3. You were continuously insured under the Group Policy from the effective date of your insurance under the Group Policy through the date you became Disabled from the Preexisting Condition; and
4. Benefits would have been payable under the terms of the Prior Plan if it had remained in force, taking into account the preexisting condition exclusion, if any, of the Prior Plan.

For such a Disability, the amount of your LTD Benefit will be the lesser of:

a. The monthly benefit that would have been payable under the terms of the Prior Plan if it had remained in force; or
b. The LTD Benefit payable under the terms of the Group Policy, but without application of the Preexisting Condition Exclusion.

Your LTD Benefits for such a Disability will end on the earlier of the following dates:

a. The date benefits would have ended under the terms of the Prior Plan if it had remained in force; or
b. The date LTD Benefits end under the terms of the Group Policy.

(PX) LT.CC.OT.1

WHEN YOUR INSURANCE ENDS

Your insurance ends automatically on the earliest of:

1. The date the last period ends for which a premium contribution was made for your insurance, if any.
2. The date the Group Policy terminates.
3. The latter of the date your employment terminates or the last day in which premium contributions were made.
4. The date you cease to be a Member. However, your insurance will be continued during the following periods when you are absent from Active Work, unless it ends under any of the above.
   a. During a leave of absence if continuation of your insurance under the Group Policy is required by a state-mandated family or medical leave act or law.
   b. During a military leave of absence providing a) you apply in writing to continue your insurance and b) premium payments continue to be made.
   c. During any other temporary leave of absence approved by your Employer in advance and in writing but not beyond the last day of the calendar month following the calendar month in which the leave of absence begins, or the leave period shown in your collective bargaining agreement. A period of Disability is not a leave of absence.
   d. During the Benefit Waiting Period.

LT.EN.OT.1X

WAIVER OF PREMIUM

We will waive payment of premium for your insurance while LTD Benefits are payable.

LT.WP.OT.1

REINSTATEMENT OF INSURANCE

If your insurance ends, you may become insured again as a new Member. However, the following will apply:

1. If you cease to be a Member because of a covered Disability, your insurance will end; however, if you become a Member again immediately after LTD Benefits end, the Eligibility Waiting Period will be waived (subject to your Employer's rehire provision for Reduction In Force employees) and, with respect to the condition(s) for which LTD Benefits were payable, the Preexisting Condition Exclusion will be applied as if your insurance had remained in effect during that period of Disability.
2. If your insurance ends because you fail to make a required premium contribution, you must provide Evidence Of Insurability to become insured again.
3. If your insurance ends because you are on a federal or state-mandated family or medical leave of absence, and you become a Member again immediately following the period allowed, your insurance will be reinstated pursuant to the federal or state-mandated family or medical leave act or law.
4. The Preexisting Conditions Exclusion will be applied as if insurance had remained in effect in the following instances:
   a. If you become insured again within 12 months.
   b. If required by federal or state-mandated family or medical leave act or law and you become insured again immediately following the period allowed under the family or medical leave act or law.
5. In no event will insurance be retroactive.

LT.RE.OT.1

DEFINITION OF DISABILITY

You are Disabled if you meet the following definitions during the periods they apply:

A. Own Occupation Definition Of Disability.

B. Any Occupation Definition Of Disability.

A. Own Occupation Definition Of Disability

During the Benefit Waiting Period and the Own Occupation Period you are required to be Disabled only from your Own Occupation.

You are Disabled from your Own Occupation if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder:

1. You are unable to perform with reasonable continuity the Material Duties of your Own Occupation; and
2. You suffer a loss of at least 20% in your Indexed Predisability Earnings when working in your Own Occupation.

Note: You are not Disabled merely because your right to perform your Own Occupation is restricted, including a restriction or loss of license.

During the Own Occupation Period you may work in another occupation while you meet the Own Occupation Definition Of Disability. However, you will no longer be Disabled when your Work Earnings from another occupation exceed 80% of your Indexed Predisability Earnings. Your Work Earnings may be Deductible Income. See **Return To Work Provisions** and **Deductible Income**.

Own Occupation means any employment, business, trade, profession, calling or vocation that involves Material Duties of the same general character as the occupation you are regularly performing for your Employer when Disability begins. In determining your Own Occupation, we are not limited to looking at the way you perform your job for your Employer, but we may also look at the way the occupation is generally performed in the national economy. If your Own Occupation involves the rendering of professional services and you are required to have a professional or occupational license in order to work, your Own Occupation is as broad as the scope of your license.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by Employers from those engaged in a particular occupation that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

B. Any Occupation Definition Of Disability

During the Any Occupation Period you are required to be Disabled from all occupations.

You are Disabled from all occupations if, as a result of Physical Disease, Injury, Pregnancy or Mental Disorder, you are unable to perform with reasonable continuity the Material Duties of Any Occupation.

Any Occupation means any occupation or employment which you are able to perform, whether due to education, training, or experience, which is available at one or more locations in the national economy and in which you can be expected to earn at least 80% of your Predisability Earnings within twelve months following your return to work, regardless of whether you are working in that or any other occupation.

Material Duties means the essential tasks, functions and operations, and the skills, abilities, knowledge, training and experience, generally required by Employers from those engaged in a particular occupation that cannot be reasonably modified or omitted. In no event will we consider working an average of more than 40 hours per week to be a Material Duty.

Your Any Occupation Period and Own Occupation Period are shown in the **Coverage Features**.

(OWN_ANY_WITH 40) LT.DD.LA.1

RETURN TO WORK PROVISIONS

A. Return To Work Responsibility

During the Own Occupation Period no LTD Benefits will be paid for any period when you are able to work in your Own Occupation and able to earn at least 20% of your Indexed Predisability Earnings, but you elect not to work.

During the Any Occupation Period no LTD Benefits will be paid for any period when you are able to work in Any Occupation and able to earn at least 20% of your Indexed Predisability Earnings, but you elect not to work.

B. Return To Work Incentive

You may serve your Benefit Waiting Period while working if you meet the Own Occupation Definition Of Disability.

You are eligible for the Return To Work Incentive on the first day you work after the Benefit Waiting Period if LTD Benefits are payable on that date. The Return To Work Incentive changes 12 months after that date, as follows:

1. During the first 12 months, your Work Earnings will be Deductible Income as determined in a., b. and c:

   a. Determine the amount of your LTD Benefit as if there were no Deductible Income, and add your Work Earnings to that amount.

   b. Determine 100% of your Indexed Predisability Earnings.

   c. If a. is greater than b., the difference will be Deductible Income.

2. After those first 12 months, 50% of your Work Earnings will be Deductible Income.

C. Work Earnings Definition

Work Earnings means your gross monthly earnings from work you perform while Disabled, plus the earnings you could receive if you worked as much as you are able to, considering your Disability, in work that is reasonably available:

a. In your Own Occupation during the Own Occupation Period; and

b. In Any Occupation during the Any Occupation Period.

Work Earnings includes earnings from your Employer, any other Employer, or self-employment, and any sick pay, vacation pay, annual or personal leave pay or other salary continuation earned or accrued while working.

Earnings from work you perform will be included in Work Earnings when you have the right to receive them. If you are paid in a lump sum or on a basis other than monthly, we will prorate your Work Earnings over the period of time to which they apply. If no period of time is stated, we will use a reasonable one.

In determining your Work Earnings we:

1. Will use the financial accounting method you use for income tax purposes, if you use that method on a consistent basis.

2. Will not be limited to the taxable income you report to the Internal Revenue Service.

3. May ignore expenses under section 179 of the IRC as a deduction from your gross earnings.

4. May ignore depreciation as a deduction from your gross earnings.

5. May adjust the financial information you give us in order to clearly reflect your Work Earnings.

If we determine that your earnings vary substantially from month to month, we may determine your Work Earnings by averaging your earnings over the most recent three-month period. During the Own Occupation Period you will no longer be Disabled when your average Work Earnings over the last three months exceed 80% of your Indexed Predisability Earnings. During the Any Occupation Period you will no longer be Disabled when your average Work Earnings over the last three months exceed 80% of your Predisability Earnings.

D. Family Care Expenses Adjustment

If you must pay Family Care Expenses in order to work, we will reduce the amount of the Work Earnings used in determining your Deductible Income, subject to the following:

1. Your Work Earnings will be reduced by the first $350 per Family Member of the monthly Family Care Expenses you pay, but not to exceed a total of $500 for all Family Members.

2. The Work Earnings and the Family Care Expenses must be for the same period.

3. You must give us satisfactory proof of the Family Care Expenses you pay.

4. The Work Earnings reduction by Family Care Expenses will end 12 months after it begins.

Family Care Expenses means the amount you pay to a licensed care provider for the care of your Family which is necessary in order for you to work.

Family Member means:

1. Your Child; or

2. Your spouse, parent, grandparent, sibling, or other close family member residing in your home who is:

   a. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

   b. Chiefly dependent upon you for support and maintenance.

Child means:

1. Your child residing in your home (including your stepchild and an adopted child), from live birth through age 15; or

2. Your child, age 16 or older, residing in your home (including your stepchild and an adopted child) who is:

   a. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

   b. Chiefly dependent upon you for support and maintenance.

(FAMILY CR) LT.RW.LA.1X

REASONABLE ACCOMMODATION EXPENSE BENEFIT

If you return to work in any occupation for any Employer, not including self-employment, as a result of a reasonable accommodation made by such Employer, we will pay that Employer a Reasonable Accommodation Expense Benefit of up to $25,000, but not to exceed the expenses incurred.

The Reasonable Accommodation Expense Benefit is payable only if the reasonable accommodation is approved by us in writing prior to its implementation.

LT.RA.OT.1

REHABILITATION PLAN PROVISION

While you are Disabled you may qualify to participate in a Rehabilitation Plan. Rehabilitation Plan means a written plan, program or course of vocational training or education that is intended to prepare you to return to work.

To participate in a Rehabilitation Plan you must apply on our forms or in a letter to us. The terms, conditions and objectives of the plan must be accepted by you and approved by us in advance. We have the sole discretion to approve your Rehabilitation Plan.

While you are participating in an approved Rehabilitation Plan, your LTD Benefit will be increased by the lesser of $1,000 or 10% of your LTD Benefit before reduction by Deductible Income. Your LTD Benefit may exceed the Maximum LTD Benefit as shown in the **Coverage Features** as a result of this increase.

An approved Rehabilitation Plan may include our payment of some or all of the expenses you incur in connection with the plan, including:

a. Training and education expenses.

b. Family care expenses.

c. Job-related expenses.

d. Job search expenses.

LT.RH.OT.1X

TEMPORARY RECOVERY

You may temporarily recover from your Disability and then become Disabled again from the same cause or causes without having to serve a new Benefit Waiting Period. Temporary Recovery means you cease to be Disabled for no longer than the applicable Allowable Period. See **Definition Of Disability**.

A. Allowable Periods

1. During the Benefit Waiting Period: a total of 182 days of recovery.
2. During the Maximum Benefit Period: 180 days for each period of recovery.

B. Effect Of Temporary Recovery

If your Temporary Recovery does not exceed the Allowable Periods, the following will apply.

1. The Predisability Earnings used to determine your LTD Benefit will not change.
2. The period of Temporary Recovery will not count toward your Benefit Waiting Period, your Maximum Benefit Period or your Own Occupation Period.
3. No LTD Benefits will be payable for the period of Temporary Recovery.
4. No LTD Benefits will be payable after benefits become payable to you under any other disability insurance plan under which you become insured during your period of Temporary Recovery.
5. Except as stated above, the provisions of the Group Policy will be applied as if there had been no interruption of your Disability.

LT.TR.OT.1

WHEN LTD BENEFITS END

Your LTD Benefits end automatically on the earliest of:

1. The date you are no longer Disabled.
2. The date your Maximum Benefit Period ends.
3. The date you die.
4. The date benefits become payable under any other group LTD plan under which you become insured through employment during a period of Temporary Recovery.
5. The date you fail to provide proof of continued Disability and entitlement to LTD Benefits.

LT.BE.OT.1

PREDISABILITY EARNINGS

Your Predisability Earnings will be based on your earnings in effect on your last full day of Active Work as reported to us by your Employer; however, this does not mean your W-2 earnings. Any subsequent

change in your earnings after that last full day of Active Work will not affect your Predisability Earnings.

For Legacy Qwest Bargaining Retail/Outside Sales Representatives: Predisability Earnings means an amount equal to the Average Hourly Rate, as defined in the leveraged compensation plan, on your last full day of Active Work.

All other Members: Predisability Earnings means your monthly rate of earnings as reported to us by your Employer, including but not limited to the following:

1. Contributions you make through a salary reduction agreement with your Employer to:
   a. An Internal Revenue Code (IRC) Section 401(k), 403(b), 408(k), 408(p), or 457 deferred compensation arrangement; or
   b. An executive nonqualified deferred compensation arrangement.
2. Commissions (if applicable).
3. Target incentive pay (if applicable).
4. Overtime pay, (as provided in the leveraged compensation plan only).
5. Amounts contributed to your fringe benefits according to a salary reduction agreement under n IRC Section 125 plan.

Predisability Earnings does not include:

1. Bonuses, except as defined under target incentive pay above.
2. Overtime pay, except as otherwise provided in the leveraged compensation plan.
3. Shift differential pay
4. Stock options or stock bonuses.
5. Imputed income and rebates.
6. Your Employer's contributions on your behalf to any deferred compensation arrangement or pension plan.
7. Any other extra compensation.

If you are paid on an annual contract basis, your monthly rate of earnings is one-twelfth (1/12th) of your annual contract salary.

If you are paid hourly, your monthly rate of earnings is based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per month, but not more than 173 hours. If you do not have regular work hours, your monthly rate of earnings is based on the average number of hours you worked per month during the preceding 12 calendar months (or during your period of employment if less than 12 months), but not more than 173 hours.

(REG WITH COM_NO STOCK) LT.PD.OT.1X

DEDUCTIBLE INCOME

Subject to **Exceptions To Deductible Income**, Deductible Income means:

1. Sick pay, annual or personal leave pay, severance pay, vacation pay, personal paid days, or any other salary continuation (including donated amounts) paid to you by your Employer, if it exceeds the amount found in a., b., and c.
   a. Determine the amount of your LTD Benefit as if there were no Deductible Income, and add your sick pay or other salary continuation to that amount.

b. Determine 100% of your Indexed Predisability Earnings.

c. If a. is greater than b., the difference will be Deductible Income.

2. Your Work Earnings, as described in the **Return To Work Provisions**.

3. Any amount you receive or are eligible to receive because of your disability, including amounts for partial or total disability, whether permanent, temporary, or vocational, under any of the following:

   a. A workers' compensation law;

   b. The Jones Act;

   c. Maritime Doctrine of Maintenance, Wages, or Cure;

   d. Longshoremen's and Harbor Worker's Act; or

   e. Any similar act or law.

4. Any amount you receive or are eligible to receive because of your disability or retirement under:

   a. The Federal Social Security Act;

   b. The Canada Pension Plan;

   c. The Quebec Pension Plan;

   d. The Railroad Retirement Act; or

   e. Any similar plan or act.

   Primary offset only: Primary benefits (the benefit awarded to you) are Deductible Income, but dependents benefits are not.

5. Any amount you receive or are eligible to receive because of your disability under any state disability income benefit law or similar law.

6. Any amount you receive or are eligible to receive because of your disability under another group insurance coverage.

7. Any disability or retirement benefits you receive or are eligible to receive under your Employer's retirement plan, including a plan arranged or maintained by a union for the benefits of its members.

8. Any disability benefits received or eligible to receive as a rotational employee under the Bellcore pension plan.

9. Any disability or retirement benefits you receive or are eligible to receive under your Employer's retirement plan including any lump sum payments.

10. Any earnings or compensation included in Predisability Earnings which you receive or are eligible to receive while LTD Benefits are payable.

11. Any amount you receive or are eligible to receive under any unemployment compensation law or similar act or law.

12. Any amount you receive or are eligible to receive from or on behalf of a third party because of your disability, whether by judgement, settlement or other method. If you notify us before filing suit or settling your claim against such third party, the amount used as Deductible Income will be reduced by a pro rata share of your costs of recovery, including reasonable attorney fees.

13. Any amount you receive by compromise, settlement, or other method as a result of a claim for any of the above, whether disputed or undisputed.

(NO OTHR OFFST_PRIV_WITH 3RD) LT.DI.OT.1X

EXCEPTIONS TO DEDUCTIBLE INCOME

Deductible Income does not include:

1. Any cost of living increase in any Deductible Income other than Work Earnings, if the increase becomes effective while you are Disabled and while you are eligible for the Deductible Income.
2. Reimbursement for hospital, medical, or surgical expense.
3. Reasonable attorneys fees incurred in connection with a claim for Deductible Income.
4. Benefits from any individual disability insurance policy.
5. Early retirement benefits under the Federal Social Security Act which are not actually received.
6. Group credit or mortgage disability insurance benefits.
7. Accelerated death benefits paid under a life insurance policy.
8. Any Benefits you receive as a result of military service with the United States.
9. Benefits from the following:
   a. Profit sharing plan.
   b. Thrift or savings plan.
   c. Deferred compensation plan.
   d. Plan under IRC Section 401(k), 408(k), 408(p), or 457.
   e. Individual Retirement Account (IRA).
   f. Tax Sheltered Annuity (TSA) under IRC Section 403(b).
   g. Stock ownership plan.
   h. Keogh (HR-10) plan.

(PRIV_NO OTHR OFFST) LT.ED.OT.1X

RULES FOR DEDUCTIBLE INCOME

A. Monthly Equivalents

Each month we will determine your LTD Benefit using the Deductible Income for the same monthly period, even if you actually receive the Deductible Income in another month.

If you are paid Deductible Income in a lump sum or by a method other than monthly, we will determine your LTD Benefit using a prorated amount. We will use the period of time to which the Deductible Income applies. If no period of time is stated, we will use a reasonable one.

B. Your Duty To Pursue Deductible Income

You must pursue Deductible Income for which you may be eligible. We may ask for written documentation of your pursuit of Deductible Income. You must provide it within 60 days after we mail you our request. Otherwise, we may reduce your LTD Benefits by the amount we estimate you would be eligible to receive upon proper pursuit of the Deductible Income.

C. Pending Deductible Income

We will not deduct pending Deductible Income until it becomes payable. You must notify us of the amount of the Deductible Income when it is approved. You must repay us for the resulting overpayment of your claim.

D. Overpayment Of Claim

We will notify you of the amount of any overpayment of your claim under any group disability insurance policy issued by us. You must immediately repay us. You will not receive any LTD Benefits until we have been repaid in full. In the meantime, any LTD Benefits paid, including the Minimum LTD Benefit, will be applied to reduce the amount of the overpayment. We may charge you interest at the legal rate for any overpayment which is not repaid within 30 days after we first mail you notice of the amount of the overpayment.

LT.RU.OT.1

SUBROGATION

If LTD Benefits are paid or payable to you under the Group Policy as the result of any act or omission of a third party, we will be subrogated to all rights of recovery you may have in respect to such act or omission, to the extent that LTD Benefits were paid. You must execute and deliver to us such instruments and papers as may be required and do whatever else is needed to secure such rights. You must avoid doing anything that would prejudice our rights of subrogation.

If you notify us before filing suit or settling your claim against such third party, the amount to which we are subrogated will be reduced by a pro rata share of your costs of recovery, including reasonable attorney fees. If suit or action is filed, we may record a notice of payments of LTD Benefits, and such notice shall constitute a lien on any judgement recovered.

If you or your legal representative fail to bring suit or action promptly against such third party, we may institute such suit or action in our name or in your name. We are entitled to retain from any judgement recovered the amount of LTD Benefits paid or to be paid to you or on your behalf, together with our costs of recovery, including attorney fees. The remainder of such recovery, if any, shall be paid to you or as the court may direct.

LT.SG.LA.1

BENEFITS AFTER INSURANCE ENDS OR IS CHANGED

During each period of continuous Disability, we will pay LTD Benefits according to the terms of the Group Policy in effect on the date you become Disabled. Your right to receive LTD Benefits will not be affected by:

1. Any amendment to the Group Policy that is effective after you become Disabled.
2. Termination of the Group Policy after you become Disabled.

LT.BA.OT.1

EFFECT OF NEW DISABILITY

If a period of Disability is extended by a new cause while LTD Benefits are payable, LTD Benefits will continue while you remain Disabled. However, 1 and 2 apply.

1. LTD Benefits will not continue beyond the end of the original Maximum Benefit Period.
2. The **Disabilities Excluded From Coverage, Disabilities Subject To Limited Pay Periods,** and **Limitations** sections will apply to the new cause of Disability.

LT.ND.OT.1

DISABILITIES EXCLUDED FROM COVERAGE

A. War

You are not covered for a Disability caused or contributed to by War or any act of War. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

B. Intentionally Self-Inflicted Injury

You are not covered for a Disability caused or contributed to by an intentionally self-inflicted Injury, while sane or insane.

C. Preexisting Condition

A separate Preexisting Condition exclusion applies to Basic LTD and Supplemental LTD. However, if you change your Plan selection from Basic LTD to Supplemental LTD and benefits are not payable under Supplemental LTD because of the Preexisting Condition exclusion, your claim will be administered as if you had not changed your Plan selection.

1. Definition

   A separate Preexisting Condition exclusion applies to Basic LTD and Supplemental LTD.

   Preexisting Condition means a mental or physical condition whether or not diagnosed or misdiagnosed:

   a. For which you have done or for which a reasonably prudent person would have done any of the following:

      i. Consulted a physician or other licensed medical professional;

      ii. Received medical treatment, services or advice;

      iii. Undergone diagnostic procedures, including self-administered procedures;

      iv. Taken prescribed drugs or medications;

   b. Which, as a result of any medical examination, including routine examination, was discovered or suspected;

   With respect to Basic LTD, at any time during the 365-day period just before the date your insurance becomes effective under the Group Policy.

   With respect to Supplemental LTD, at any time during the 365-day period just before your insurance becomes effective under Supplemental LTD.

2. Exclusion

   With respect to Basic LTD, you are not covered for a Disability caused or contributed to by a Preexisting Condition or medical or surgical treatment of a Preexisting Condition unless, on the date you become Disabled, you:

   a. Have been continuously insured under the Group Policy for 12 months and have been Actively At Work for at least one full day after that 12 months; or

   b. Have been continuously insured under the Group Policy for a 12-month Treatment Free Period without having done any of the following in connection with the Preexisting Condition:

      i. Consulted a physician or other licensed medical professional;

      ii. Received medical treatment, services or advice;

iii. Undergone diagnostic procedures, including self-administered procedures;

iv. Taken prescribed drugs or medications.

With respect to Supplemental LTD, you are not covered for a Disability caused or contributed to by a Preexisting Condition or medical or surgical treatment of a Preexisting Condition unless, on the date you become Disabled, you:

a. Have been continuously insured under Supplemental LTD for 12 months and have been Actively At Work for at least one full day after that 12 months; or

b. Have been continuously insured under Supplemental LTD for a 12-month Treatment Free Period without having done any of the following in connection with the Preexisting Condition:

i. Consulted a physician or other licensed medical professional;

ii. Received medical treatment, services or advice;

iii. Undergone diagnostic procedures, including self-administered procedures;

iv. Taken prescribed drugs or medications.

D. Loss Of License Or Certification

You are not covered for a Disability caused or contributed to by the loss of your professional license, occupational license or certification.

E. Violent Or Criminal Conduct

You are not covered for a Disability caused or contributed to by your committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at the scene of a violent disorder or riot while performing your official duties.

(WITH PRUDNT_TFP) LT.XD.OT.1

DISABILITIES SUBJECT TO LIMITED PAY PERIODS

A. Mental Disorders, Substance Abuse and Other Limited Conditions

Payment of LTD Benefits is limited to 12 months during your entire lifetime for a Disability caused or contributed to by any one or more of the following, or medical or surgical treatment of one or more of the following:

1. Mental Disorders;

2. Substance Abuse; or

3. Other Limited Conditions.

However, if you are confined in a Hospital solely because of a Mental Disorder at the end of the 12 months, this limitation will not apply while you are continuously confined.

Mental Disorder means any mental, emotional, behavioral, psychological, personality, cognitive, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome, regardless of cause (including any biological or biochemical disorder or imbalance of the brain) or the presence of physical symptoms. Mental Disorder includes, but is not limited to, bipolar affective disorder, organic brain syndrome, schizophrenia, psychotic illness, manic depressive illness, depression and depressive disorders, anxiety and anxiety disorders.

Substance Abuse means use of alcohol, alcoholism, use of any drug, including hallucinogens, or drug addiction.

Other Limited Conditions means chronic fatigue conditions (such as chronic fatigue syndrome, chronic fatigue immunodeficiency syndrome, post viral syndrome, limbic encephalopathy, Epstein-Barr virus infection, herpes virus type 6 infection, or myalgic encephalomyelitis), any allergy or sensitivity to chemicals or the environment (such as environmental allergies, sick building syndrome, multiple chemical sensitivity syndrome or chronic toxic encephalopathy), chronic pain conditions (such as fibromyalgia, reflex sympathetic dystrophy or myofascial pain), carpal tunnel or repetitive motion syndrome, temporomandibular joint disorder, or craniomandibular joint disorder.

However, Other Limited Conditions does not include neoplastic diseases, neurologic diseases, endocrine diseases, hematologic diseases, asthma, allergy-induced reactive lung disease, tumors, malignancies, or vascular malformations, demyelinating diseases, or lupus.

Hospital means a legally operated hospital providing full-time medical care and treatment under the direction of a full-time staff of licensed physicians. Rest homes, nursing homes, convalescent homes, homes for the aged, and facilities primarily affording custodial, educational, or rehabilitative care are not Hospitals.

B. Rules For Disabilities Subject To Limited Pay Periods

1. If you are Disabled as a result of a Mental Disorder or any Physical Disease or Injury for which payment of LTD Benefits is subject to a limited pay period, and at the same time are Disabled as a result of a Physical Disease, Injury, or Pregnancy that is not subject to such limitation, LTD Benefits will be payable first for conditions that are subject to the limitation.

2. No LTD Benefits will be payable after the end of the limited pay period, unless on that date you continue to be Disabled as a result of a Physical Disease, Injury, or Pregnancy for which payment of LTD Benefits is not limited.

LT.LP.OT.1

LIMITATIONS

A. Care Of A Physician

You must be under the ongoing care of a Physician in the appropriate specialty as determined by us during the Benefit Waiting Period. No LTD Benefits will be paid for any period of Disability when you are not under the ongoing care of a Physician in the appropriate specialty as determined by us.

B. Return To Work Responsibility

During the Own Occupation Period no LTD Benefits will be paid for any period of Disability when you are able to work in your Own Occupation and able to earn at least 20% of your Indexed Predisability Earnings, but you elect not to work.

During the Any Occupation Period, no LTD Benefits will be paid for any period of Disability when you are able to work in Any Occupation and able to earn at least 20% of your Indexed Predisability Earnings, but elect not to work.

C. Rehabilitation Program

No LTD Benefits will be paid for any period of Disability when you are not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by us unless your Disability prevents you from participating.

D. Foreign Residency

Payment of LTD Benefits is limited to 12 months for each period of continuous Disability while you reside outside of the United States, a U.S Territory or Canada.

E. Imprisonment

No LTD Benefits will be paid for any period of Disability when you are confined for any reason in a penal or correctional institution.

LT.LM.OT.1

CLAIMS

A. Filing A Claim

Claims should be filed on our forms. If we do not provide our forms within 15 days after they are requested, you may submit your claim in a letter to us. The letter should include the date disability began, and the cause and nature of the disability.

B. Time Limits On Filing Proof Of Loss

You must give us Proof Of Loss within 90 days after the end of the Benefit Waiting Period. If you cannot do so, you must give it to us as soon as reasonably possible, but not later than one year after that 90-day period. If Proof Of Loss is filed outside these time limits, your claim will be denied. These limits will not apply while you lack legal capacity.

C. Proof Of Loss

Proof Of Loss means written proof that you are Disabled and entitled to LTD Benefits. Proof Of Loss must be provided at your expense.

For claims of Disability due to conditions other than Mental Disorders, we may require proof of physical impairment that results from anatomical or physiological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

D. Documentation

Completed claims statements, a signed authorization for us to obtain information, and any other items we may reasonably require in support of a claim must be submitted at your expense. If the required documentation is not provided within 45 days after we mail our request, your claim may be denied.

E. Investigation Of Claim

We may investigate your claim at any time.

At our expense, we may have you examined at reasonable intervals by specialists of our choice. We may deny or suspend LTD Benefits if you fail to attend an examination or cooperate with the examiner.

F. Time Of Payment

We will pay LTD Benefits within 30 days after you satisfy Proof Of Loss.

LTD Benefits will be paid to you at the end of each month you qualify for them. LTD Benefits remaining unpaid at your death will be paid to your estate.

We will evaluate your claim promptly after you file it. Within 45 days after we receive your claim we will send you: (a) a written decision on your claim; or (b) a notice that we are extending the period to decide your claim for 30 days. Before the end of this extension period we will send you: (a) a written decision on your claim; or (b) a notice that we are extending the period to decide your claim for an additional 30 days. If an extension is due to your failure to provide information necessary to decide the claim, the extended time period for deciding your claim will not begin until you provide the information or otherwise respond.

If we extend the period to decide your claim, we will notify you of the following: (a) the reasons for the extension; (b) when we expect to decide your claim; (c) an explanation of the standards on which entitlement to benefits is based; (d) the unresolved issues preventing a decision; and (e) any additional information we need to resolve those issues.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.

b. Reference to the parts of the Group Policy on which our decision is based.

c. A copy of any internal rule or guideline relied upon in making our decision, or a statement that no such rule exists.

d. A description of any additional information needed to support your claim.

e. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.

f. Information concerning your right to a review of our decision.

g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA if your claim is denied on review.

H. Review Procedure

If all or part of a claim is denied, you may request a review. You must request a review in writing within 180 days after receiving notice of the denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your request for review. There will be no charge for such copies. You may request the names of medical or vocational experts who provided advice to us about your claim.

The person conducting the review will be someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based on a medical judgement, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original medical judgement and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request. Within 45 days after we receive your request for review we will send you: (a) a written decision on review; or (b) a notice that we are extending the review period for 45 days. If the extension is due to your failure to provide information necessary to decide the claim on review, the extended time period for review of your claim will not begin until you provide the information or otherwise respond.

If we extend the review period, we will notify you of the following: (a) the reasons for the extension; (b) when we expect to decide your claim on review; and (c) any additional information we need to decide your claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may conclude our review of your claim based on the information we have received.

Before we issue a decision on review, we will provide you, free of charge, with any new evidence or rationale considered, relied upon, or generated by us in connection with the claim, and we would provide such new evidence or rationale sufficiently in advance of the decision deadline date to give you a reasonable opportunity to respond prior to that date.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.

b. Reference to the parts of the Group Policy on which our decision is based.

c. A copy of any internal rule or guideline relied upon in making our decision, or a statement that no such rules or guidelines exist.

d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.

e. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA. This information will also include a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

The Group Policy does not provide voluntary alternative dispute resolution options. However, you may contact your local U.S. Department of Labor Office and your State insurance regulatory agency for assistance.

I. Assignment

The rights and benefits under the Group Policy are not assignable.

(REV PRIV WRDG) LT.CL.LA.2X

ALLOCATION OF AUTHORITY

Except for those functions which the Group Policy specifically reserves to the Policyholder or Employer, we have full and exclusive authority to control and manage the Group Policy, to administer claims, and to interpret the Group Policy and resolve all questions arising in the administration, interpretation, and application of the Group Policy.

Our authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;
2. The right to establish and enforce rules and procedures for the administration of the Group Policy and any claim under it;
3. The right to determine:
   a. Eligibility for insurance;
   b. Entitlement to benefits;
   c. The amount of benefits payable; and
   d. The sufficiency and the amount of information we may reasonably require to determine a., b., or c., above.

Subject to the review procedures of the Group Policy, any decision we make in the exercise of our authority is conclusive. However, this provision will not restrict any right you may have to file a lawsuit or contact the Louisiana Insurance Commissioner if your claim for benefits is denied.

LT.AL.LA.1

TIME LIMITS ON LEGAL ACTIONS

No action at law or in equity may be brought until 60 days after you have given us Proof Of Loss. No such action may be brought more than three years after the earlier of:

1. The date we receive Proof Of Loss; and
2. The time within which Proof Of Loss is required to be given.

LT.TL.OT.1

INCONTESTABILITY PROVISIONS

A. Incontestability Of Insurance

Any statement made to obtain insurance or to increase insurance is a representation and not a warranty.

No misrepresentation will be used to reduce or deny a claim or contest the validity of insurance unless:

1. The insurance would not have been approved if we had known the truth; and
2. We have given you or any other person claiming benefits a copy of the signed written instrument which contains the misrepresentation.

After insurance has been in effect for two years during the lifetime of the insured, we will not use a misrepresentation to reduce or deny the claim, unless it was a fraudulent misrepresentation.

B. Incontestability Of The Group Policy

Any statement made by the Policyholder or Employer to obtain the Group Policy is a representation and not a warranty.

No misrepresentation by the Policyholder or your Employer will be used to deny a claim or to deny the validity of the Group Policy unless:

1. The Group Policy would not have been issued if we had known the truth; and
2. We have given the Policyholder or Employer a copy of a written instrument signed by the Policyholder or Employer which contains the misrepresentation.

The validity of the Group Policy will not be contested after it has been in force for two years, except for nonpayment of premiums or fraudulent misrepresentations.

LT.IN.OT.1

CLERICAL ERROR, AGENCY, AND MISSTATEMENT

A. Clerical Error

Clerical error by the Policyholder, your Employer, or their respective employees or representatives will not:

1. Cause a person to become insured.
2. Invalidate insurance under the Group Policy otherwise validly in force.
3. Continue insurance under the Group Policy otherwise validly terminated.

B. Agency

The Policyholder and your Employer act on their own behalf as your agent, and not as our agent. The Policyholder and your Employer have no authority to alter, expand or extend our liability or to waive, modify or compromise any defense or right we may have under the Group Policy.

C. Misstatement Of Age

If a person's age has been misstated, we will make an equitable adjustment of premiums, benefits, or both. The adjustment will be based on:

1. The amount of insurance based on the correct age; and

2. The difference between the premiums paid and the premiums which would have been paid if the age had been correctly stated.

LT.CE.OT.1

TERMINATION OR AMENDMENT OF THE GROUP POLICY

The Group Policy may be terminated by us or the Policyholder according to its terms. It will terminate automatically for nonpayment of premium. The Policyholder may terminate the Group Policy in whole, and may terminate insurance for any class or group of Members, at any time by giving us written notice.

Benefits under the Group Policy are limited to its terms, including any valid amendment. No change or amendment will be valid unless it is approved in writing by one of our executive officers and given to the Policyholder for attachment to the Group Policy. If the terms of the certificate differ from the Group Policy, the terms stated in the Group Policy will govern. The Policyholder, your Employer, and their respective employees or representatives have no right or authority to change or amend the Group Policy or to waive any of its terms or provisions without our signed written approval.

We may change the Group Policy in whole or in part when any change or clarification in law or governmental regulation affects our obligations under the Group Policy, or with the Policyholder's consent.

Any such change or amendment of the Group Policy may apply to current or future Members or to any separate classes or groups of Members.

LT.TA.OT.1

DEFINITIONS

Benefit Waiting Period means the period you must be continuously Disabled before LTD Benefits become payable. No LTD Benefits are payable for the Benefit Waiting Period. See **Coverage Features**.

Contributory means insurance is elective and Members pay all or part of the premium for insurance.

CPI-W means the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. If the CPI-W is discontinued or changed, we may use a comparable index. Where required, we will obtain prior state approval of the new index.

Employer means an Employer (including approved affiliates and subsidiaries) for which coverage under the Group Policy is approved in writing by us.

Group Policy means the group LTD insurance policy issued by us to the Policyholder and identified by the Group Policy Number.

Indexed Predisability Earnings means your Predisability Earnings adjusted by the rate of increase in the CPI-W. During your first year of Disability, your Indexed Predisability Earnings are the same as your Predisability Earnings. Thereafter, your Indexed Predisability Earnings are determined on each anniversary of your Disability by increasing the previous year's Indexed Predisability Earnings by the rate of increase in the CPI-W for the prior calendar year. The maximum adjustment in any year is 10%. Your Indexed Predisability Earnings will not decrease, even if the CPI-W decreases.

Injury means an injury to the body.

L.L.C. Owner-Employee means an individual who owns an equity interest in an Employer and is actively employed in the conduct of the Employer's business.

LTD Benefit means the monthly benefit payable to you under the terms of the Group Policy.

Maximum Benefit Period means the longest period for which LTD Benefits are payable for any one period of continuous Disability, whether from one or more causes. It begins at the end of the Benefit

Waiting Period. No LTD Benefits are payable after the end of the Maximum Benefit Period, even if you are still Disabled. See **Coverage Features**.

Noncontributory means (a) insurance is nonelective and the Policyholder or Employer pay the entire premium for insurance; or (b) the Policyholder or Employer require all eligible Members to have insurance and to pay all or part of the premium for insurance.

Physical Disease means a physical disease entity or process that produces structural or functional changes in the body as diagnosed by a Physician.

Physician means a licensed M.D. or D.O., acting within the scope of the license. Physician does not include you or your spouse, or the brother, sister, parent, or child of either you or your spouse.

Pregnancy means your pregnancy, childbirth, or related medical conditions, including complications of pregnancy.

Prior Plan means

a. your Employer's group long term disability insurance plan in effect on the day before the effective date of your Employer's participation under the Group Policy and which is replaced by coverage under the Group Policy; or

b. your Employer's group long term disability insurance policy that you were insured under on the day before your insurance under the Group Policy became effective.

Supplemental Workers' Compensation Payment benefit (SWCP) means your wage replacement for approved on-the-job accidents.

LT.DF.OT.1X

ERISA INFORMATION AND NOTICE OF RIGHTS

The following information and notice of rights and protections is furnished by the Plan Administrator as required by the Employee Retirement Income Security Act of 1974 (ERISA).

A. General Plan Information

The General Plan Information required by ERISA is shown in the **Coverage Features**.

B. Statement Of Your Rights Under ERISA

1. Right To Examine Plan Documents

You have the right to examine all Plan documents, including any insurance contracts or collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. These documents may be examined free of charge at the Plan Administrator's office.

2. Right To Obtain Copies Of Plan Documents

You have the right to obtain copies of all Plan documents, including any insurance contracts or collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies.

3. Right To Receive A Copy Of Annual Report

The Plan Administrator must give you a copy of the Plan's summary annual financial report, if the Plan was required to file an annual report. There will be no charge for the report.

4. Right To Review Of Denied Claims

   If your claim for a Plan benefit is denied or ignored, in whole or in part, you have the right: a) to know why this was done; b) to obtain copies of documents relating to the decision, without charge; and c) to have your claim reviewed and reconsidered, all within certain time schedules.

C. Obligations Of Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries'' of the Plan, have a duty to do so prudently and in the interest of all Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

D. Enforcing ERISA Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request Plan documents or the latest annual report from the Plan 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 Plan 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. 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.

E. Additional Procedures For Claims Based on Disability Determinations Filed on or after April 1, 2018

If we deny any part of your claim for a benefit that relies on a disability determination, you will receive a written notice of denial containing a copy of any internal rule or guideline relied upon in making the decision, or a statement that no such rules or guidelines exist. The notice of denial will also include information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.

If all or part of a claim is denied, you may request a review. Before we issue a decision on review for a benefit that relies on a disability decision, we will provide you, free of charge, with any new evidence or rationale considered, relied upon, or generated by us in connection with the claim, and we will provide such new evidence or rationale sufficiently in advance of the decision deadline date to give you a reasonable opportunity to respond prior to that date.

If our review results in a denial of any part of your claim for a benefit that relies on a disability decision, your written notice of denial will contain a copy of any internal rule or guideline relied upon in making the decision, or a statement that no such rules or guidelines exist. The notice of denial will also include information concerning your right to bring a civil action for benefits under section 502(a) of ERISA and a description of any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

F. Plan And ERISA Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security

Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 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.

(NON-DENT_WITHOUT T/A REFS) ERISA.3

LA/LTDC2000