Lumen Life and Accidental Death and Dismemberment (AD&D) Insurance Plan*

Summary Plan Description (SPD) For Active Employees

Effective January 1, 2021

* The Lumen brand was launched on September 14, 2020. As a result, CenturyLink, Inc. is referred to as Lumen Technologies, or simply Lumen. The legal name CenturyLink, Inc. is expected to be formally changed to Lumen Technologies, Inc. upon the completion of all applicable requirements.

Issued Jan. 1, 2021

LUMEN®

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INTRODUCTION

Lumen Technologies, Inc. (hereinafter “Lumen” or “Company”) is pleased to provide you with this Summary Plan Description (hereinafter “Benefit Summary” or “SPD”). This SPD presents an overview of the general plan provisions, rights and responsibilities under the Company’s Life and AD&D Insurance Plan (the “Life or AD&D Plan”). Collectively, this SPD might refer to these plans as “Life Insurance Plans”,” Life Insurance” or the “Plans”.

The effective date of this updated SPD is January 1, 2021. This SPD summarizes Life insurance and AD&D benefits for all active full-time employees. Otherwise, this SPD, together with other plan documents (such as the Summary of Material Modifications (SMMs) including materials you receive at Annual Enrollment) briefly describe your Benefits as well as rights and responsibilities under the Plan. This SPD supersedes and replaces, in its entirety, any other SPD describing its provisions that you currently may possess. This SPD is intended to accurately reflect the provisions of the Group Life and AD&D insurance policies that underwrite the Company’s Life and AD&D Insurance Plans.

Since this is only a summary of the policies, it does not cover all details found in the group policies. In the event of any discrepancy between this SPD and the official Plan Document, the group insurance policies shall govern.

The Life and AD&D Plans, as described in this SPD are a part of your total compensation from the Company. You are encouraged to review this information carefully, share it with your dependents and keep it for future reference.

January 1, 2021 is the date changes were most recently made to the coverages available under the Plans.

Questions regarding your Life and AD&D Plans’ insurance benefits should be directed to the following:

Lumen Health and Life Service Center at 866-935-5011

However, you may also contact the Plan Administrator, the Employee Benefits Committee directly at:

Lumen Employee Benefits Committee
214 East 24th Street
Vancouver, WA 98663

Reserved Rights

The Company reserves the right to amend, change or terminate the Plans and any of the Benefits provided under the Plans – with respect to all classes of Covered Person, retired or otherwise – without prior notice to or consultation with any Covered Person, subject only to applicable law and if applicable, collective bargaining agreements or other written applicable agreements.

The Plan Administrator has the right and discretion to determine all matters of fact or

interpretation relative to the administration of the benefit options — including questions of eligibility, interpretations of the Plans’ provisions and any other matter. The decisions of the Plan Administrator and any other person or group to whom such discretion has been delegated, including the Claims Administrators (the Insurers), shall be conclusive and binding on all persons. More information about the Plan Administrator and the Claims Administrator can be found in the Appendix of this SPD.

This plan is maintained with respect to the Company’s Employees pursuant to collective bargaining agreements, if applicable. A copy of the current collective bargaining agreements are available on the Company’s Intranet or by contacting your union directly.

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No Company Employee or Service Providers hired by the Company can be responsible for advising you on the tax effects of your participation in the Plan as described in this SPD. Because tax laws are constantly changing, you should consult a tax advisor if you have questions about how participation in any Company plans will affect your personal tax situation.

How to Use this Document

This SPD is provided to explain how the Plans work. It describes your Benefits and rights as well as your obligations under the Plans. It is important for you to understand that because this SPD is only a summary, it cannot cover all of the details of the Plans or how the rules will apply to every person in every situation. All of the specific rules governing the Plans are contained in the Plan Documents and underlying group insurance policies. You and your beneficiaries may examine the Plan Documents and insurance policies relating to the Plans during regular business hours or by appointment at a mutually convenient time in the office of the Plan Administrator. For additional information, refer to **Statement of ERISA Rights**.

Capitalized terms are defined in the "Glossary of Defined Terms" section and throughout this SPD. All uses of "we," "us," and "our" in this document, are references to the Claims Administrator or Company's. References to "you" and "your" are references to people who are Covered Persons as the term is defined in the "Glossary of Defined Terms".

You are encouraged to read and keep all SPDs and any attachments (summary of material modifications ("SMMs"), amendments, and addendums) for future reference.

What is an SPD?

This SPD is designed to provide you with a summary and general description, in non-technical language, of the Life and AD&D insurance benefits and coverages available under the Plans, without describing all the details set forth in all the Plan Documents. Other important details can be found in the Plan Documents. This SPD is not the Plan Document. The legal rights and obligations of any person having any interest in the Plans are determined solely by the provisions of the Plan Documents. If any of the terms of the Plan Documents are in conflict with the contents of the SPD, the Plan Documents and insurance policies will always govern. The Plan Documents and this SPD supersede any and all prior documents you may have been provided regarding your benefits under the Plans.

LIFE AND AD&D INSURANCE PLANS

The Life and AD&D Insurance Plans provide a wide range of coverage in the event of death or certain other serious physical losses.

- The **Basic Life Insurance Benefit** under the Life Plan pays benefits in the form of a lump sum payment to your beneficiary(ies) if you die while covered.
- The **Supplemental Life Insurance Benefit** allows you to buy additional coverage under the Life Plan for yourself and, if you want, coverage for your spouse or domestic partner (subject to statutory guidelines where you live) and eligible children. The Supplemental Life coverage pays benefits in the form of a lump sum payment to your beneficiary(ies) if you die while covered. Dependent Life coverage pays benefits in the form of a lump sum payment to you if your dependents die while covered.
- The **Basic Accidental Death and Dismemberment (AD&D) Benefit** under the AD&D Plan pays benefits if you die as a result of an accident or have another covered physical loss due to an accident.
- The **Supplemental Accidental Death and Dismemberment Benefit** under the AD&D Plan allows you to buy additional AD&D coverage for yourself, your spouse or domestic partner (subject to statutory guidelines where you live) or your dependent children.

For assistance in understanding terminology associated with the administration of your benefit plans, please refer to **GLOSSARY OF DEFINED TERMS**.

COMMON FEATURES OF THE PLANS

This section provides an overview and common features of the Company's Life and AD&D Plans. Specific and distinct features to each of the Life and AD&D Plans are listed below in separate sections.

Eligibility

You are eligible for Life and AD&D coverage described in this summary on the 31st day on which you are:

- A full-time employee working 30 or more hours per week; and
- You are employed by the Company or one of our affiliated/subsidiary companies.

You are **not** eligible for Life and AD&D insurance benefits described in this summary if you are:

- A temporary employee, incidental employee, part-time employee, seasonal employee or full-time member of the armed forces of any country (unless the state in which you reside or a predecessor company indicates otherwise), a leased employee, an independent contractor, or an individual who is not classified by the Company as an employee, or
- An individual who is carried on the payroll of another company including but not limited to, a temporary employment service, or whom the Company has classified and/or treated as a vendor or consultant.

Dependent Eligibility

You may also cover your eligible dependents when you enroll in the Plans. The Claims Administrator reserves the right to require supporting financial and/or legal documentation to confirm eligibility at any time. Your eligible dependents include:

- Your legal spouse.
- Your domestic partner is defined as a person of the same or opposite sex who:
- Shares your residence for the past 12 months (the residence requirement doesn't apply where there is an exception as permitted by the Plan Administrator, as required by applicable law);
- Is no less than 18 years of age;
- Is financially interdependent with you and has proven such interdependence by providing proof of joint ownership;
- Is not blood-related or any closer than would prohibit legal marriage; and
- Provides a Certificate of Domestic Partner Registration if you reside in a state that provides such registration OR has signed jointly with you, a notarized affidavit, if you reside in a state that does not provide Domestic Partner Registration.

Note: If you have previously submitted a Domestic Partner Affidavit that was validated and coverage provided accordingly, there is no need to submit a new Affidavit unless you have had a change in your Domestic Partner status.

- Your child(ren), up to the end of the month in which they attain age 26. Child(ren) include:
- Your natural child(ren)
- Your legally adopted child(ren) including child(ren) who are legally placed for adoption. In the case of a pending adoption, the effective date is the placement date in the home.
- Foster child(ren)
- Child(ren) of your spouse or your domestic partner (natural, legally-adopted or placed for adoption or foster child(ren)). **Note:** You are not required to enroll your spouse or your domestic partner in order to enroll your spouse or your domestic partner's child(ren).
- Child(ren) for whom you are the legal guardian or are the legal ward for grandchild(ren), nieces or nephews.
- You may cover any or all of your eligible dependents according to the rules of each Plan; **however**, no one may be a dependent of more than one employee under the Plans.
- An unmarried child who is determined by the Life Plan (Insurance Carrier) to be incapable of self-support and fully dependent on the participant (you) for support. **Note:** If a disabled child is removed from coverage, the child will not be eligible for reinstatement and therefore will no longer be eligible for coverage under the Plan, except when the

employee is rehired, then the child will be treated the same as the child of any rehired participant.

- Unmarried child(ren) who turn age 26 while covered under the Plan and continue to depend on you for support because of a physical handicap that occurred prior to the age of 26, or who are incapable of self-support due to mental disability, mental illness or developmental disability --- where the condition occurred prior to the age of 26; subject to administrative approval by the Life Plan (Insurance Carrier). Notes: Contact the Lumen Health and Life Service Center within 45 days prior to your child's 26th birthday for additional details and forms. For **NEW HIRES**, even if your unmarried child(ren) is age 26 or older but continues to depend on you for support because of a physical handicap may be covered if you enroll the dependent child(ren) within your *initial* eligibility period.

If Both You and Your Spouse/Domestic Partner Work for the Company

If both you and your spouse or domestic partner work for the Company and are eligible for Life and AD&D insurance coverage through the Company, you will each be covered for Basic Life and AD&D insurance and eligible for Employee Supplemental Life and AD&D insurance. You cannot be covered for Supplemental Life and AD&D insurance coverage as both an employee and a dependent. In addition, both parents cannot cover a dependent child, if both are employed by the Company. Co-employed spouses who wish to have Supplemental Life and AD&D Plan insurance coverage for their children must select which employee will hold the coverage for each child.

Your Beneficiary

Your beneficiary is the person you choose to receive survivor benefits in the event of your death. You may name any person(s), your estate, almost any organization or a trust as the beneficiary(ies) under your Life and AD&D Insurance Plans (the "Life Plan"). You may name one beneficiary or divide the benefit among multiple beneficiaries. If you name multiple beneficiaries, you must specify the percentage each beneficiary will receive. You also may name different beneficiary(ies) for each Plan.

It is important to specify your beneficiary(ies) designation clearly when you enroll. In the event that a beneficiary is named for one coverage but not the others, **the named beneficiary will apply to all coverages.**

If you enroll your spouse or domestic partner and your dependent child(ren) in any of the Supplemental Life and AD&D plans, you are automatically the beneficiary for their coverage. If you and your spouse, domestic partner and/or child(ren) die at the same time, the beneficiary is the person(s) that you designate on your Life Insurance Beneficiary form.

If no beneficiary is alive on the date of your death or you have not elected a beneficiary, the benefit will be paid as follows:

1. to your spouse or domestic partner, if living; or
2. if there is no surviving spouse or domestic partner, to your surviving child(ren) in equal shares; or
3. if there is no surviving spouse or domestic partner or child(ren), to your surviving parents in equal shares; or
4. if there is no surviving spouse or domestic partner, child(ren) or parents, to your surviving brothers and sisters in equal shares; or
5. if there is no surviving spouse or domestic partner, child(ren), parents, brothers or sisters, to your surviving grandparents in equal shares; or
6. if none of the above, to your estate.

Please confirm that you have designated beneficiaries for all of your Life Insurance Plans by going to lumen.com/healthandlife or calling the Lumen Health and Life Service Center **866-935-5011**. ***The Lumen Health and Life Service Center is the recordkeeper of beneficiary designations.*** If there is no beneficiary designation on file upon your death, any eligible amount will be payable according to the plan rules and may not be whom you intended to receive the benefit. In addition, naming a beneficiary and having all the information on file may expedite the claim processing.

Important Note About Naming Minor Children: If you name your minor child(ren) as beneficiary(ies), please be advised that the Plan will be unable to pay benefits to them until the earlier of:

1. The date your child(ren) reach the age of majority (usually age 18 or 21), depending on applicable state; or
2. The date a legal guardian of the minors' estate has been appointed by a court. This can be a costly process, and state laws may limit who may be named as guardian of an estate.

When Coverage Begins

You are automatically enrolled for your Basic Life and Basic AD&D within 31 days of becoming eligible and usually coincides with your 31st day of employment. Supplemental Life and Supplemental AD&D insurance coverage, if you enroll within 31 days of becoming eligible, normally coincides with your 31st day of employment. However, if you elect Supplemental Life coverage above the guaranteed issue, the amount of coverage above the guaranteed issue will not be effective until evidence of insurability (EOI) has been approved.

If you are a rehired retiree and eligible for active benefits, any retiree life insurance you had previous to becoming active will continue through the end of the month in which you were hired. Once rehired, your Basic Life, Basic AD&D, and Supplemental Life and AD&D insurance coverage will be effective the 1st of the month following your new date of hire. Any amount of Supplemental Life continued during your retirement will be reinstated as an active employee but will be adjusted for any age-related changes and any accelerated benefit payments. However, if you elect an increase in your Supplemental Life coverage above the guaranteed issue, the amount of coverage above the guaranteed issue will not be effective until evidence of insurability (EOI) has been approved. If you are a rehired retiree and not eligible for active Life and AD&D, please contact the Lumen Health and Life Service Center to learn the options available to you.

If you want to cover your eligible dependents in the plans available to them, you must enroll them in the plan(s); coverage is not automatic. Your dependents are eligible for coverage when you become eligible but their coverage will not begin until you apply for dependent coverage.

If your dependent is required to submit evidence of insurability (EOI), then coverage begins when EOI is approved.

Coverage or increases in coverage will be delayed to a later date under the following circumstances:

- If you are not actively at work on the day coverage is to begin or increase, coverage for you and your eligible dependent(s) will be delayed until you return to an actively at work status.
- If your dependent is confined at home under a Physician's Care, receiving or applying to receive disability benefits from any source, or hospitalized at the time coverage is to begin or increase, the insurance or change will take effect upon the qualified dependent's final medical release from all such confinement. Hospital confined does not apply to a newborn child.

How to Enroll Upon Initial Eligibility

You may enroll either online at lumen.com/healthandlife, or by calling 866-935-5011. At that time, you can make your beneficiary designations for all the Life and AD&D Plans. You must enroll within 31 days of becoming eligible. For rehired retirees, you must enroll within 31 days of your rehire date.

Adding Coverage for a New Dependent

You have up to 45 days after a dependent first becomes eligible to enroll them for dependent life insurance coverage (365 days to add a newborn, adoption or placement for adoption of a dependent child). Provided you enroll your dependent for coverage within this period, coverage coincides with the date the dependent first became eligible (unless dependent evidence of insurability is required). If dependent evidence of insurability (EOI) is required, coverage begins on the date EOI is approved. For a Qualifying Event, you will have 45 days from the date of that change to make a request.

Changing Your Coverage

Annual Enrollment

Each fall, you will have the opportunity to change your Supplemental Life and AD&D coverage. This is called the annual enrollment period. Any changes you make at that time will become effective the following Jan. 1st, subject to Evidence of Insurability (EOI) for the Supplemental Life.

Mid-year Changes to Enrollment

You may start, stop or change your Supplemental Life insurance coverage mid-year without a qualified status change, but will be subject to providing Evidence of Insurability (EOI). Evidence of Insurability is not applicable for reducing or terminating Supplemental Life insurance.

For your Supplemental Life and Supplemental AD&D, you must be actively at work on the date coverage is supposed to begin or increase; otherwise, the change will not go into effect until you return to actively at work status. In addition to having been Actively at Work on the date the Supplemental Life insurance benefit is to take effect, you must also have been Actively at Work for at least 20 hours during the seven (7) calendar days preceding that date.

Applicable to both Supplemental Life and Supplemental AD&D, for Qualifying Events, you must apply within 45 days following the qualifying event, (365 days to add a newborn or adopted child) or no change can be made before the next annual enrollment period. The effective date of the change coincides with the qualifying event. In the case of adoption or placement for adoption, the effective date is the date the adoption becomes final or the placement for adoption occurs.

For Dependent Supplemental Life, in addition to you being actively at work on the date coverage is supposed to begin or increase, on the date the Dependent Supplemental Life is scheduled to take effect, the Dependent must not be confined at home under a Physician's Care, receiving or applying to receive disability benefits from any source, or hospitalized.

To submit a change, please contact the Lumen Health and Life Service Center at 866-935-5011 .

Qualified Status Changes

The Company reserves the right to require supporting legal documentation to confirm the status change at any time. Qualified status changes include the following:

- **Marriage –**Your status has changed from single to married.
- **Domestic Partner Status –** Any event that causes the employee's domestic partner to satisfy or cease to satisfy the requirements for coverage.
- **Addition of dependent –** You gained a new dependent, i.e., birth, adoption or placement for adoption of a child or legal guardianship.
- **Divorce or Separation –** Your divorce is final, or you have a legal separation from your spouse.
- **Death of spouse or dependent**

Loss of dependent eligibility

- Your covered dependent (excluding spouse) loses eligibility or turns age 26.
- **Change of employment status –** You or your spouse or domestic partner change from working full-time to part-time or the reverse, or your spouse or domestic partner gains or loses employment. In case of a waiting period prior to the eligibility of your spouse's or domestic partner's benefit coverage, you can change your coverage when the waiting period expires. Change of employment status also includes if you were placed on layoff status or notified that you will be placed on layoff status.
- **Unpaid leave of absence –** You or your spouse or domestic partner takes an unpaid leave of absence.

Any other event the Plan Administrator determines what qualifies as a status change under law.

Generally, the affected person must lose or gain eligibility for Life Insurance coverage as a result of the status change, and the coverage change you elect must correspond to the gain or loss of eligibility.

What Coverage Costs

The Company's Basic Life and Basic AD&D are insured plans and the cost of coverage is based on premium charged by the insurance company, which is employer paid.

The Company's Supplemental Life Benefit Plan is an insured plan based on your age for Employee Supplemental Life (based on your spouse's or domestic partner's age for Dependent Supplemental Life) and the amount of coverage you elect at the time of enrollment. Dependent Supplemental Life insurance for your dependent children is a flat rate per thousand and covers all eligible dependent children. This plan is entirely paid by the employee.

The Company's Supplemental AD&D Benefit Plan is an insured Plan and the cost of coverage is based on premium charged by the insurance company for a single employee or an employee with dependents, which is entirely paid by the employee.

This means the cost of coverage is based on the premium charged by the insurance company for all of the above plans.

The Lumen Health and Life Service Center can provide you with information about the costs of your Supplemental Life and Supplemental AD&D coverage when you are enrolling or changing your coverage. Information is also available in the Company's Annual Enrollment Guide.

Income Taxes on the Value of Your Life Insurance

Company Paid Group Basic Term Life coverage up to $50,000 is a tax-free benefit to employees. Company Paid Basic Life insurance coverage greater than $50,000 is considered taxable income by the Internal Revenue Service (IRS) and the Company must report as income the "cost" of the excess life coverage on your W-2. This amount will be reported on your paycheck as "Imputed Income".

The "cost" included in your gross income is not the actual premium paid by the Company for the insurance coverage. Instead, it is an amount computed under a Uniform Premium Table published by the IRS.

Please contact the Lumen Health and Life Service Center should you have any questions or how to avoid imputed income, such as designating a charitable organization for your Basic Life Insurance beneficiary.

Leaves of Absence

You may be eligible to continue your life insurance coverage in accordance with Human Resources policies and procedures while you are on an approved Leave of Absence.

If applicable, you will be required to make a monthly contribution for your benefits coverage. The amount of the contribution is the same amount as for active employees. Contact the Lumen Health and Life Service Center for more detailed information.

If You Become Disabled

If you become disabled and begin receiving monthly benefits under the Company's Long Term Disability Insurance Plan (LTD) or Worker's Compensation, your Employer Paid Basic Life Insurance may continue up to 36 months from your date of short term disability. If you are eligible for retiree basic life insurance, at the end of the 36 months from your date of short term disability, you will transition from active basic life to retiree basic life insurance unless your bargaining agreement indicates otherwise. Please contact the Lumen Health and Life Service Center for more details. Additional provisions are applicable to certain employee populations that are considered a disabled retiree.

If you become totally disabled (as specifically defined by the Life Plan) prior to age 60, you may be eligible for Waiver of Premium for your Employee and Dependent Supplemental Life Insurance (if you have elected to purchase this coverage prior to your disability, continually insured for Supplemental Life insurance for 12 months prior to your disability, and this coverage was approved by the Life Insurance carrier). If you are approved by the insurance carrier for Waiver of Premium, your Employee and Dependent Supplemental Life (if covered) may continue without premium payment required.

You must apply for Waiver of Premium no later than 12 months after you cease to be actively at work. Proof of Claim is required no later than 12 months after you cease to be actively at work. The Plan may require periodic proof of the continuance of total disability (as specifically defined by the Life Plan) at reasonable intervals, but not more often than once per year after you have been continuously totally disabled for two years.

The waiver of premium ceases on the earliest of:

- The date you cease to be totally disabled (as specifically defined by the Life Plan).
- The date you fail to furnish any required proof that you continue to be totally disabled.
- The date you fail to submit to any required examinations.
- Any period you are not under the regular and continuing care of a Physician providing appropriate treatment by means of examination and testing in accordance with the disabling condition.
- The date you retire, unless you are eligible for Retiree Life Insurance.
- The date you attain age 70 (in some instances, attainment of age 80), unless you are eligible for Retiree Life Insurance.

If you are not approved for waiver of premium, Supplemental Life insurance coverage for you and any covered dependents may continue for a certain period of time, but for details about this coverage, contact the Lumen Health and Life Service Center. At the end of the period of which you may be allowed to continue coverage, you will be given the opportunity to convert the Supplemental Life insurance coverage to an individual policy at that time.

Basic Accidental Death & Dismemberment and Supplemental Accidental Death & Dismemberment coverage **terminates** when you begin receiving Long Term Disability benefits.

Life Insurance Benefits at Retirement

If you go from full-time active to retirement status, you may be eligible for Company paid Retiree Basic Life insurance contingent on your date of hire. Contact the Lumen Health and Life Service Center for additional information.

You may be eligible to continue your Supplemental Life insurance coverage following retirement. Please contact the Lumen Health and Life Service Center for further details. The Company reserves the right to change (e.g., decrease or terminate) Retiree Basic Life insurance benefits or to change (e.g., begin to charge or increase) required contributions at any time (including after retirement) for any reason, and may terminate the Life plan at any time (including after retirement). For more information, refer to **Plan Amendments** and the **Reserved Rights** sections of this SPD.

With respect to a Dual Retiree, in the event you are a retiree from a legacy company, for example, if you initially retired from Qwest as a represented employee, then were rehired and re-retired again under the same plan or from another company, please refer to *Your Retiree SPDs* or *Departing Employee Guide* for those legacy companies for further information.

How to File a Claim

A claim must be filed to receive benefits from any of the Company's Life and AD&D insurance plans.

Claims for Basic or Supplemental Life Insurance Benefits

When there has been the death of an insured person, notify the Lumen Health and Life Service Center by calling 866-935-5011.

For the purpose of this section, the Lumen Health and Life Service Center is the party designated by the Policyholder to maintain certain records needed to administer the insurance provided under the Life Plans. This notice should be given to the Lumen Health and Life Service Center as soon as is reasonably possible after the death. The Lumen Health and Life Service Center will notify MetLife and a claim form will be sent to the beneficiary or beneficiaries of record. The beneficiary or beneficiaries should complete the claim form and send it and Proof of the death to MetLife as instructed on the claim form. When MetLife receives the claim form and Proof, MetLife will review the claim and, if approved, they will pay benefits subject to the terms and provisions of the Life Plan. The benefit amount may be reduced by the amount of any due and unpaid contributions to premium outstanding at the time payment is made. It may be further reduced for any life amounts paid to You under the Accelerated Benefit Option as a result of a terminal illness.

Claims for Basic or Supplemental Accidental Death & Dismemberment (AD&D) Insurance Benefits

When there has been an accidental dismemberment claim or a death due to an accidental injury of an insured person, notify the Lumen Health and Life Service Center by calling 866-935-5011For the purpose of this section, the Lumen Health and Life Service Center is the party designated by the Policyholder to maintain certain records needed to administer the insurance provided under the AD&D Plans. This notice should be given to the Lumen Health and Life Service Center as soon as is reasonably possible after an accidental injury or death. The Lumen Health and Life Service Center will notify Zurich (AD&D insurance carrier) and a claim form will be sent to the beneficiary or beneficiaries of record. The beneficiary or beneficiaries should complete the claim form and send it along with Proof of the death or dismemberment to Zurich as instructed on the claim form. When Zurich (AD&D) receives the claim form and Proof, Zurich will review the claim and, if approved, they will pay benefits subject to the terms and provisions of the AD&D (Zurich) Plans. The benefit amount may be reduced by the amount of any due and unpaid contributions to premium outstanding at the time payment is made.

If a claim is denied, you or your beneficiary has certain rights of appeal, which are described in the “Important Information About the Plans” section.

Benefits Assignment

You may assign your Life Insurance rights and benefits under the Group Life Insurance Policy as a gift or as a viatical assignment. Such assignment must be provided to the life insurer on a written form satisfactory to them. This assignment provision is not applicable to AD&D insurance plans.

Release of Medical or Confidential Information

By accepting benefits from the Plans, you authorize the Plan Administrator or insurance carriers to examine any medical records needed to process evidence of insurability, if applicable, and/or claims or appeals.

Information will be kept confidential whenever possible. Under certain circumstances, this information may be disclosed to other parties with your or your beneficiary’s authorization or as required by state or federal law. Please keep in mind that it is very important for you to follow the Plans’ procedures, as summarized in this SPD, in order to obtain Plan Benefits and to help keep your personal confidential 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 or your beneficiary do not follow the Plan’s procedures for claiming a Benefit or resolving an issue involving Plan Benefits, there is no guarantee that 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 confidential information will remain private and protected.

When Coverage Ends

Your insurance will end on the earliest of:

1. the date the Group Policies ends; or
2. the date insurance ends for Your class; or
3. the date of the period for which the last premium has been paid for You; or
4. the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the Section If You Become Disabled; or
5. the date You retire and are not eligible for Retiree Life insurance.

For Your Dependents, their insurance will end on the earliest of:

1. for Dependent Life and AD&D insurance, the date all of the Life and AD&D insurance under the Group Policies ends; or
2. the date You die; or
3. the date the Group Policies ends; or
4. the date Your Employee Life and AD&D insurance under the Group Policies ends; or
5. the date insurance for Your Dependents ends under the Group Policies; or
6. the date insurance for Your Dependents ends for Your class; or
7. the date the person ceases to be a Dependent; or
8. the date Your employment ends. Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the Section If You Become Disabled; or
9. for Dependent Life and AD&D, the date You retire; or
10. the end of the period for which the last premium has been paid for the Dependent.

Converting to Individual Insurance

If for any reason your Basic Life coverage ends, you may request the Life Insurance carrier to convert your coverage to an individual policy. For You to convert, MetLife must receive a completed conversion application form from You **within 31 days** after the date Your Life Insurance ends or is reduced.

If for any reason your Employee or Dependent Supplemental Life ends, you have the option to continue that insurance under another group policy in accordance with the conditions and requirements applicable to **Portability**. For You or Your Dependent to port, MetLife must receive a completed request form within the Request period as described below:

If written notice of the option to port is given **within 15 days** before or after the date such insurance ends, the Request Period:

- begins on the date the insurance ends, and
- **expires 31 days** after the date.

If written notice of the option to port is **given more than 15 days after but within 91 days** of the date such insurance ends, the Request Period:

- begins on the date the insurance ends, and
- **expires 45 days** after the date of the notice.

If written notice of the option to port is not given **within 91 days** of the date such insurance ends, the Request Period:

- begins on the date the insurance ends, and
- **expires at the end of such 91-day period.**

The above duly applies for porting and is only applicable to Supplemental Life insurance coverage.

You may choose to Port due to the following events:

- You become retired from active service with the Employer; or
- Your employment ends, due to a reason other than retirement; or
- You cease to be in a class that is eligible for such insurance; or
- The Policy is amended to end the Portability Eligible Insurance or Portability Eligible Dependent Insurance, unless such insurance is replaced by similar insurance under another group insurance policy issued to the Company or its successor; or
- This Policy has ended, unless such insurance is replaced by similar insurance under another group policy issued to the Company or its successor.

You may choose to Port the reduced amount of insurance if Your Portability Eligible Insurance is reduced due to:

- Your age; or
- An amendment to the Plan which affects the amount of insurance for Your class.

Your former Dependent Spouse may choose to Port if their Portability Eligible Dependent Insurance on his or her own life ends because:

- You die; or
- Your marriage ends in divorce or annulment

Provided that former Dependent Spouse satisfies Dependent Eligibility.

Your former Dependent Spouse may also apply for Portability Eligible Dependent Insurance on Your Dependent Child if Your former Dependent Spouse ports insurance on his or her own life. If Your former Dependent Spouse ports that insurance on that Dependent Child, that Porting will have no effect on the insurance You may have on that Dependent Child.

Your former Dependent Child may request to port Portability Eligible Dependent insurance on his or her own life if that insurance ends because Your former Dependent Child no longer meets the definition of Child.

The individual converted life insurance policy will be issued in a policy format customarily issued by the insurance carrier at the time and rate for your class of risk and age. You must pay the full cost. The cost, terms and benefits of conversion policies differ substantially from those of the Company's Life Plans.

If You die within 31 days of the date Portability Eligible Life Insurance ends and an application to Port is not received by MetLife during such period, MetLife will determine whether Your life insurance qualifies for payment.

This determination will be made in accordance with MetLife's Life Insurance **Conversion** Option for You.

For Basic and Supplemental AD&D Insurance

Conversion Privilege

If the insurance of an Insured ceases for reasons other than termination of the Policy or non- payment of premium, the Insured is entitled to convert his or her Coverage to an Individual Accidental Death or Dismemberment (IAD) policy or to a Family AD&D (FAD) policy if the Insured selected a Plan covering his or her Dependents for the Supplemental AD&D. The new IAD or FAD policy will be on approved forms and will not include all the Benefits and Additional Benefits of the Group Accident Policy. The Insured must make a written application for the IAD or FAD policy within sixty (60) days of the cessation of insurance under the Group Accident Policy (Basic and Supplemental AD&D).

To request a Conversion Application Form, the Insured must call 1-800-834-1959 (Zurich). The Insured does not have to show proof of good health.

The issuance of the IAD or FAD policy is subject to the following conditions:

1. the Principal Sum for the IAD or FAD policy will be the lesser of the Insured's Principal Sum under the Group Accident Policy or $200,000;
2. the premium for the IAD or FAD policy will be the rate on file with the proper regulatory authority, if such filing is required;
3. any IAD or FAD policy issued will take effect on the termination date of the Insured's insurance under the Group Accident Policy; and
4. when an IAD or FAD policy becomes effective, the relationship between the Insured and Zurich will be governed by that policy, including all terms and conditions, benefits, and termination dates.

Plan Amendments

The Company reserves the right at any time, to terminate, modify or amend, in whole or in part, any or all of the provisions of the Plans.

Interpretation of the Plans

The Employee Benefits Committee, the Plan Administrator, has the discretion and authority to interpret, resolve ambiguities, control and manage the operation and administration of the Plans. The Plan Administrator has delegated to third party claims administrators, the insurance carrier(s) its discretionary authority to make all final determinations regarding claims for benefits under the Plans. This discretionary authority includes, but is not limited to, the determination of eligibility for benefits, based upon enrollment information provided by the Company, and the amount of any benefits due, and to construe, interpret and resolve ambiguities relative to the terms of the Plans.

Any decision made by the third-party claims administrators (the insurance carrier(s)) in the exercise of this delegated discretion and authority, including review of denials of benefit, is conclusive and binding on all parties. Any court reviewing determinations by the third-party claims administrators (the insurance carrier(s)) shall uphold such determination unless the claimant proves the determinations are arbitrary and capricious.

BASIC LIFE INSURANCE

Benefits from the Basic Life Plan will be in addition to any benefits payable by the other Company Life Insurance plans.

Amount of Coverage

Your Basic Life coverage equals 100% of your annual salary, as described below, rounded up to the next higher $1,000. The maximum benefit payable by the Basic Life Plan is $2,000,000. Any increase in your coverage due to an increase in pay will take effect only if you are actively at work on the date of the increase. If you are not actively employed on that date, your increased coverage will begin on the date you return to active work.

Madison River Bargained Employees applicable to those currently on LTD prior to 1/1/2010: Your Basic Life coverage equals $10,000.

To avoid imputed income, you may elect to be covered for a flat $50,000 of Basic Life insurance.

Annual Salary

The Basic Life Plan uses your annual eligible pay including your target incentive (short term incentive pay) if eligible for the Company's Incentive Plan as of your last day of employment before death to determine benefits for your beneficiaries. Annualized commissions are included, if a sales-related employee, as determined by the Company. Annual salary does not include bonuses, overtime, lump-sum merit awards, shift differentials or any other extra compensation.

Cost of Coverage

Except to the extent a collective bargaining agreement provides otherwise the cost of Basic Life coverage for eligible employees is currently paid by the Company.

For Participants Age 70 and Older

If you are actively at work at age 70, your Basic Life Insurance coverage amount will be reduced by 50% effective the first of the month following the age reduction except for those employees who have elected the flat $50,000 of Basic Life.

SUPPLEMENTAL LIFE INSURANCE

You may select Supplemental Life Insurance coverage for yourself, as well your spouse or domestic partner and/or your child(ren). ***You do not need to participate in the Employee Supplemental Life plan to cover your eligible dependents.*** Participation is optional. Benefits from this Plan will be in addition to any benefits payable by other Company Life insurance plan coverages.

Employee Coverage

The Supplemental Life Plan offers a choice of eight coverage options. You may choose coverage equal to one, two, three, four, five, six, seven, or eight times your annual base pay subject to Evidence of Insurability (EOI) provisions provided herein. Annual base pay for Supplemental Life **does not include** your target incentive (short term incentive pay), commissions, overtime, bonuses, lump-sum merit awards or shift differential.

Any increase in your coverage due to an increase in pay will take effect only if you are actively at work on the day the increase is to be effective except for Annual Enrollment when effective date is Jan. 1 if approved prior to Jan. 1. If you are not Actively at Work on that date, your increased coverage will begin on the date you return to active work subject to the EOI provision in the Supplemental Life insurance policy. In addition to having been Actively at Work on the date the insurance benefit is to take effect, you must also have been Actively at Work for at least 20 hours during the seven (7) calendar days preceding that date.

Family Coverage

You may also enroll your family for Supplemental Life Insurance. Family members you enroll in the supplemental coverage under the Life Plan will be covered as follows:

- The Life Plan offers a choice of seven supplemental coverage options for your **dependent spouse or domestic partner.** Your spouse or domestic partner may choose coverage equal to $5,000, $10,000, $25,000, $50,000, $75,000, $100,000 or $200,000 subject to Evidence of Insurability (EOI) provisions provided herein. Coverage for your dependent spouse or domestic partner cannot be more than the lesser of 100% of your total life insurance amount (combined Employee Basic and Supplemental Life) or $200,000.
  - **Examples:** (1) You have $100,000 of Employee Basic Life insurance + $200,000 of Employee Supplemental Life = $300,000 total; dependent spouse/domestic partner cannot have more than $200,000 of Dependent Spouse/ Domestic Partner Supplemental Life insurance; (2) You have $100,000 of Employee Basic Life but no Employee Supplemental Life = $100,000 total; dependent spouse/domestic partner cannot have more than $100,000 of Dependent Spouse/Domestic Partner Supplemental Life.
- The Life Plan offers a choice of four supplemental coverage options for your **dependent child**. You may choose coverage equal to $3,000, $5,000, $10,000 or $20,000. Evidence of Insurability (EOI) is not applicable. Coverage for your child(ren) cannot be more than the lesser of 100% of your total life insurance amount (combined Employee Basic and Supplemental Life) or $20,000.

If both you and your spouse or domestic partner works for the Company, you cannot have Supplemental Life coverage as both the employee and the spouse or domestic partner of an employee. In addition, your dependent child(ren) may be covered only once as your dependents or your spouse's or domestic partner's dependents.

Maximum Coverage

The maximum benefit payable for Employee Supplemental Life is $2,000,000.

Annual Salary

The Supplemental Life Plan uses your annual base pay only. Annual salary does not include target incentive pay (short term incentive pay), commissions, bonuses, overtime, lump-sum merit awards, shift differentials or any other extra compensation.

Cost of Coverage

The Supplemental Life coverage under the Life Plan is an insured benefit, which means that the cost of coverage is based on the premium charged by the insurance company. You pay the cost of coverage, which is determined as follows:

The cost of *your* coverage is based on your age and the amount of benefit you select.

The cost of *your spouse's or domestic partner's* coverage is based on your spouse's or domestic partner's age and the amount of the benefit you select for your spouse or domestic partner.

The cost of your *children's* coverage is a flat amount per thousand, no matter how many eligible dependent children you have.

Note: Your Supplemental Life insurance premium as an employee will increase (or decrease) if you experience a change in salary. This does not apply to supplemental coverage for your dependents. This increase is effective the pay period of your salary adjustment. In addition, your premium (as well as your spouse's or domestic partner's premium, if applicable) will increase in the pay period of your birthday if that birthday results in a change from one age bracket to another. There may be a substantial increase in premium from one age bracket to another; so be sure to review the costs for you or your dependent's current age as well as the age on your next birthday.

The Company intranet site or the Lumen Health and Life Service Center can provide you with a current schedule of costs for Supplemental Life Insurance.

Evidence of Insurability

You are not required to provide evidence of insurability when electing coverage as shown below, provided coverage is elected within 31 days of your initial eligibility:

- Coverage for yourself is up to two (2) times annual base pay
- Coverage for your spouse or domestic partner up to $50,000
- Coverage for your child(ren)

During each Annual Enrollment (generally held in November) following your initial eligibility, you may select up to one time greater than your current level of coverage without evidence of insurability, subject to the guaranteed issue of two times pay. For example, if you are currently enrolled for one (1) times your annual base pay, you may select two (2) times your annual base pay, without evidence of insurability during Annual Enrollment.

Evidence of insurability for Supplemental Life (Employee) must be completed under the following conditions:

- You are not enrolled currently and elect any amount;
- You are currently enrolled and increase your coverage more than one (1) times eligible pay (example – you are currently enrolled for one (1) times eligible pay and increase to three (3) times eligible pay); or
- You increase your coverage above two (2) times eligible pay
- If you are already enrolled and denied an increase in coverage, then coverage reverts back to the previous amount before the increase in coverage was requested.

- Your spouse or domestic partner must provide evidence of insurability for Supplemental Dependent Life under the following conditions:
- Your spouse or domestic partner is not enrolled currently and elects any amount unless you are a newly hired employee and enroll within your eligibility period;
- Your spouse or domestic partner increases current coverage more than one level (example – your spouse or domestic partner is currently enrolled for $5,000 and increases to $25,000); or
- Your spouse or domestic partner chooses coverage in excess of $50,000

If your spouse or domestic partner is denied coverage, coverage cannot be reinstated without providing evidence of insurability.

If your spouse or domestic partner is already enrolled and denied an increase in coverage, then coverage reverts back to the previous amount before the increase in coverage was requested.

You may complete the Evidence of Insurability (EOI) Form on the lumen.com/healthandlife website **within 14 days** of your selection. If you do not complete your EOI **within 14 days**, you will be mailed a paper Statement of Health (SOH) Form that must be completed.

For Participants Age 70 and Older

If you are actively at work at age 70, your Supplemental Life Insurance coverage amount will be reduced by 50%. Your reduction in employee coverage at age 70 may also affect your spouse's/domestic partner's coverage amount. Your spouse's/domestic partner's coverage cannot exceed the lesser of 100% of your total life insurance coverage amount (combined Employee Basic and Supplemental Life) or $200,000.

- **Example:** You are covered for $200,000 of Supplemental Life Insurance and are actively working at age 70. Your Supplemental Life Insurance will be reduced to $100,000 the 1st of the month following your 70th birthday. Your dependent spouse/ domestic partner is currently covered for $200,000. Due to your age reduction, your dependent spouse/domestic partner's supplemental dependent life insurance would reduce to $100,000.

How the Plan Pays Benefits

Basic and Supplemental Life and Basic and Supplemental AD&D insurance benefits are payable to your designated beneficiaries living at the time. Unless otherwise specified, if there is more than one surviving beneficiary, all surviving beneficiaries will share equally. If you do not select a beneficiary per plan, benefits for all plans will be paid to the beneficiary you designate.

Benefits paid by the Basic and Supplemental Life and Basic and Supplemental AD&D Insurance Plans are normally made in a lump sum but other methods of payment can be arranged with the carrier if requested. The request must be on a form approved by the insurance carriers.

Please see **COMMON FEATURES OF THE PLANS** section for further details relative to Beneficiary Designations.

Accelerated Benefit Option

If you have a qualifying medical condition (you are terminally ill, with a life expectancy of 24

months), you may be eligible to receive during your lifetime a portion of your Supplemental Life insurance paid to you as an accelerated benefit in the form of a single lump sum unless you or your legal representative selects another payment mode. The provisions for the accelerated benefit option are outlined below. Applications are available from the Lumen Health and Life Service Center.

- **Employee Basic and Supplemental Life –** You may receive an accelerated benefit equal to 90% of your total Basic and Supplemental Life coverage, up to a combined maximum of $500,000. The remaining amount of life insurance payable at death will be reduced by the amount of the accelerated benefit previously received. The accelerated benefit may be elected only once during your lifetime.
- **Spouse or Domestic Partner Supplemental Life –** The accelerated benefit is an amount up to 90% of your

spouse's or domestic partner's Supplemental Life coverage. The maximum amount of the accelerated benefit request is $180,000. The remaining amount of life insurance payable at death will be reduced by the amount of the accelerated benefit previously received. The accelerated benefit is paid to your spouse or domestic partner at your request. The accelerated benefit may be elected only once during your spouse's or domestic partner's lifetime.

The Accelerated Benefit Option is not applicable to Dependent Children.

Notice and Proof of Claim

A claim must be filed in order to receive benefits from the Basic and Supplemental Life Plan. Please notify the Lumen Health and Life Service Center by calling 866-935-5011. A Life Insurance Claim Packet will be mailed to Your Beneficiary on record. It is imperative that you confirm that the Beneficiary on record aligns with your request. A notice of claim should be filed with the Lumen Health and Life Service Center as soon as reasonably possible but no later than 30 days after the date of death. Additionally, proof of claim must then be provided no later than 120 days after the date of death. For additional details, please see How to File a Claim in the Common Features of the Plans.

Claims Appeal Procedure

Appealing the Initial Determination for Life Insurance

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. MetLife has multiple Claims offices. It is imperative you appeal to the address of the office which processed 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.

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 MetLife receives 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. The policy under which you filed a claim has a provision, which states, in part, that no lawsuit or legal action shall be brought to recover on the policy after the expiration of three years from the time proof of loss is required.

Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Additional Services Provided by MetLife

The following services are provided at no additional cost to individuals insured for Group Supplemental Life Insurance coverage as described herein.

THE FOLLOWING APPLIES TO RESIDENTS OF ALL STATES OTHER THAN TEXAS

Will Preparation Service

If You elect Group Supplemental Life Insurance coverage, a Will Preparation Service (the "Service") will be made available to You, through a MetLife affiliate (the "Affiliate"), while Your Group Supplemental Life

Insurance coverage is in effect. This Service will be made available at no cost to You. It enables You to have a will prepared for You and Your Spouse free of charge by attorneys designated by the Affiliate. If You have a will prepared by an attorney not designated by the Affiliate, You must pay for the attorney's services directly. Upon Proof of such payment, You will be reimbursed for the attorney's services in an amount equal to the lesser of the amount You paid for the attorney's services and the amount customarily reimbursed for such services by the Affiliate. This service is offered by Hyatt Legal Plans, Inc., a MetLife company in Cleveland, Ohio. In certain states, legal services benefits are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and Affiliates, Warwick, Rhode Island.

If you would like to speak with a representative from Hyatt Legal Plans, Inc. or get the name of a Plan Attorney that you can speak with about this service, please call Hyatt Legal Plans, Inc. at 800-821-6400.

Probate Service

If You become insured for Group Supplemental Life Insurance coverage and die while such Group Supplemental Life Insurance coverage is in effect, a probate benefit (the "Benefit") will be made available to Your estate, through a MetLife affiliate ("Affiliate").

The Benefit provides for certain probate services to be made available upon Your death, free of charge by attorneys designated by the Affiliate. If probate services are provided by an attorney not designated by the Affiliate, Your estate must pay for those attorney's services directly. Upon Proof of such payment, Your estate will be reimbursed for the attorney's services in an amount equal to the lesser of the amount Your estate paid for the attorney's services and the amount customarily reimbursed for such services by the Affiliate. This Benefit will be provided at no cost to You and will end on the date Your Group Supplemental Life Insurance coverage ends. Please call Hyatt Legal Plans, Inc. at 800-821-6400.

Grief Counseling and Funeral Assistance Services

Your MetLife Group Term Life Insurance coverage through the Company includes Grief Counseling Services, which is provided through LifeWorks US Inc. for you, your dependents and your beneficiaries at no extra cost. It is valuable, confidential support that can provide the comfort and guidance you need at the most difficult of times, such as death of a loved one, divorce, receiving a serious medical diagnosis, or losing a pet.

LifeWorks US Inc. is not an affiliate of MetLife and the services LifeWorks provides are separate and apart from the insurance. LifeWorks has a nationwide network of over 30,000 counselors. Counselors have master's or doctoral degrees and are licensed professionals.

Simply call the dedicated 24/7 toll-free number, 888-319-7819, to speak with a professional counselor experienced in helping people who have suffered a loss. You, your dependents, and your beneficiaries can have up to five (5) confidential counseling sessions per event. Sessions can either take place in-person, because meeting face-to-face may provide a personalized experience if you so desire, or by phone if you prefer. The choice is yours depending upon your preference.

If further assistance is desired, the counselor will help you access services that are appropriate to your situation, preferences, finances, and health insurance coverage.

You can also log on to https://metlifegc.lifeworks.com (username: metlifeassist; password: support) to contact a counselor or access helpful grief-related information and resources.

Funeral Assistance services are provided through Dignity Memorial for you, your dependents and your beneficiaries at no extra cost. Through private sessions, counselors can help you, your loved ones and your beneficiaries with customizing funeral arrangements. They can provide referrals and provide helpful information, like:

- Nearby Funeral Homes and Cemetery options
- Funeral cost estimates from local providers
- Other service providers, such as florists, caterers and hotels
- Back-up care for children or elderly

- Notifying the Social Security Administration, banks, and utilities
- Local Support Groups

Dignity Memorial is not an affiliate of MetLife and the services Dignity Memorial provides are separate and apart from the insurance. You may prepare your family for life's unexpected outcomes with Dignity Memorial by visiting www.finalwishesplanning.com or calling 866-853-0954.

BASIC ACCIDENTAL DEATH & DISMEMBERMENT

The Basic Accidental Death & Dismemberment (AD&D) plan pays benefits for death or other covered losses, which are the direct result of and occur within 365 days of the covered injury. Benefits are payable for losses that occur on or off the job. To qualify for payment, you must be covered by the Plan at the time of the accident. Benefits from this Plan are in addition to any life insurance benefits payable from a Life Plan.

Amount of Coverage

Your Basic AD&D coverage equals 100% of your annual salary, as described below, rounded up to the next higher $1,000. The maximum benefit payable by the Basic AD&D Plan is $2,000,000. The amount of your Basic AD&D is considered your Principal Sum. Any increase in your coverage due to an increase in pay will take effect only if you are actively at work on the date of the increase. If you are not actively employed on that date, your increased coverage will begin on the date you return to active work.

Annual Salary

The Basic AD&D Plan uses your annual eligible pay including your target incentive (short term incentive pay) if eligible for a the Company's Incentive Plan as of your last day of employment before death to determine benefits for your beneficiaries. Annualized commissions are included, if a sales-related employee, as determined by the Company. Annual salary does not include bonuses, overtime, lump-sum merit awards, shift differentials or any other extra compensation.

Cost of Coverage

Except to the extent a collective bargaining agreement provides otherwise, the cost of Basic AD&D coverage for eligible employees is currently paid by the Company.

SUPPLEMENTAL ACCIDENTAL DEATH & DISMEMBERMENT

You may select Supplemental Accidental Death & Dismemberment coverage for yourself, as well as, your family. Participation is optional. This Plan pays benefits for losses that occur within 365 days of the covered injury on or off the job. To qualify, you must have been covered by the Plan at the time of the accident.

Employee Coverage

The Supplemental AD&D Plan offers a choice of eight coverage options. You may choose coverage equal to one, two, three, four, five, six, seven, or eight times your eligible pay (base + target incentive + annualized commissions if a sales-related employee) rounded up to the next higher $1,000, up to a maximum of $2,000,000. The amount you choose will be considered your Principal Sum.

Annual Salary

The Supplemental AD&D Plan uses your annual eligible pay including your target incentive (short term incentive pay) if eligible for the Company's Incentive Plan as of your last day of employment before death to determine benefits for your beneficiaries. Annualized commissions are included, if a sales-related employee, as determined by the Compny. Annual salary does not include bonuses, overtime, lump-sum merit awards, shift differentials or any other extra compensation.

Spouse or Domestic Partner Coverage

If you enroll yourself, you may also cover your spouse/domestic partner. If you enroll your spouse or domestic partner, the spouse or domestic partner is automatically covered for 50% of the Employee Supplemental AD&D amount up to the maximum of $750,000.

Child(ren) Coverage

If you enroll yourself, you may also cover your child(ren). If you enroll your child(ren), the child or children are automatically covered for 25% of the Employee Supplemental AD&D amount. The maximum AD&D benefit per child is $100,000.

If both you and your spouse or domestic partner works for the Company, you cannot have coverage as both the employee and the spouse or domestic partner of an employee. In addition, your children may be covered only once, as your dependents or your spouse's or domestic partner's dependents.

Cost of Coverage

Except to the extent a collective bargaining agreement provides otherwise, you pay the full cost of coverage on a post-tax basis. The Company intranet site or the Lumen Health and Life Service Center can provide you with a current schedule of costs for Supplemental AD&D Insurance.

The following provisions are applicable to Basic and Supplemental AD&D

Payment Schedule

The Basic and Supplemental AD&D Insurance Plans will pay a percentage of the Principal Sum (the amount of the coverage) based on your covered loss.

Type of Loss	% of Principal Sum
Life	100%
Both hands, both feet or sight of both eyes	100%
One hand and one foot	100%
Speech and hearing	100%
Either hand or foot and sight of one eye	100%
Four limbs	150%
Three limbs	75%
Two limbs	66 2/3%
One limb	50%
Speech or hearing	50%
Thumb and index finger of same hand	25%

Loss means with regard to:

- Limbs (Foot or Hand) – actual severance through or above wrist or ankle joints.
- Sight, Speech or Hearing – total and permanent loss thereof
- Thumb and index finger – actual severance through or above the metacarpophalangeal joint of a thumb or index finger
- Limbs – (Limbs mean an Arm or Leg) permanent, complete and irreversible paralysis of such limbs

If you die accidentally, the benefit will be paid to your beneficiary. For any other covered loss, you will receive the benefit. If a covered individual sustains more than one loss due to a single accident, the plan will pay only one benefit, the largest, for the loss.

Safety Device Benefit:

If an insured suffers an injury resulting in a Covered Loss, which is payable under the Accidental Death Benefit, and the Injury which caused the Accidental death directly resulted from an Accident, Zurich will pay an additional benefit, which equals 10% of the Insured's Principal Sum up to a maximum of $25,000 for the Basic and Supplemental AD&D contingent on certain stipulations, which are duly noted in the applicable insurance policies.

Hazard Limitations:

In case of an air accident injury, benefits are payable only for a loss due to an accident while you are a passenger, (or pilot, operator or crew member of the Company owned or leased aircraft) riding in or on, boarding or getting off:

- any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:
  - medical certificate; and
  - pilot certificate with a proper rating to pilot such aircraft.
- any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

What Is Not Covered

The Basic and Supplemental AD&D Plans do not cover any loss caused or contributed to by any of the following:

- suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury;
- war or any act of war, whether declared or undeclared;
- involvement in any type of active military service;
- illness or disease; regardless of how contracted; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for accidental ingestion of contaminated foods;
- participation in the commission or attempted commission of any felony or assault;
- being intoxicated while operating a motor vehicle;
  - An insured will be conclusively presumed to be intoxicated if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the accident occurred, to be intoxicated, if operating a motor vehicle.
  - An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the insured's intoxication.
- being under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage;
- travel or flight in any aircraft except to the extent stated in the Hazard Limitations' section.

Notice and Proof of Loss

A separate claim must be filed to receive benefits from the Basic and Supplemental AD&D Plans. A notice of claim should be filed with the Lumen Health and Life Service Center as soon as reasonably possible but no later than 90 days after a covered loss begins.

If you are not able to send the proof of loss within the timeframe, it may be sent as soon as reasonably possible without affecting the claim. The additional time allowed cannot exceed one year unless you are legally incapacitated.

Claims Appeal Procedure

In accordance with the rules and regulations of the Employee Retirement Income Security Act, which governs this plan, you have the right to appeal Zurich's decision to deny the accidental death benefit. You have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor Regulations. Your appeal should provide in writing your reason for disagreeing with Zurich's decision, and should include supplemental documentation that will have a bearing on Zurich's decision. This appeal must be received by Zurich within 60 days of the date of the denial letter you receive from Zurich.

A decision on appeal will be made no later than 60 days after Zurich receives your written request for review of the initial determination. The review will take into account all new information, whether or not presented or available at the initial determination. If Zurich determines that special circumstances require an extension of time for a decision on appeal, the review period may be extended by an additional 60 days (120 days in total).

Zurich will notify you in writing if an additional 60-day extension is needed.

In accordance with Section 502(a) of ERISA, you have the right to bring a civil action following an adverse benefit determination, but you must complete this appeal procedure before filing suit. If Zurich does not receive your written appeal within 60 days of the date of the denial letter you receive, Zurich's claim determination will be final. The policy under which you filed a claim has a provision, which states, in part, that no lawsuit or legal action shall be brought to recover on the policy after the expiration of three years from the time proof of loss is required. If the law of the state where You live makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.

Please direct your appeal to:

Zurich American Insurance Company
P. O. Box 968041
Schaumburg, IL 60196-8041
Attn: ERISA Appeal Committee Specialties Division
A&H Special Risk Claims

Additional Services Provided through Zurich American Insurance Company

TRAVEL ASSISTANCE PLAN

You may contact Zurich regarding the Travel Assistance Plan by calling 800-263-0261 from the United States or Canada and collect from anywhere else in the world at +1-416-977-0277.

Website is www.zurichtravelassist.com. Reference Policy Number GTU 4279163 (Basic AD&D) or GTU 4279164 (Supplemental AD&D).

This Travel Assistance Plan will apply to the following Covered Persons when they are traveling **100 miles or more** from their Principal Residence (means legal domicile of the Covered Person): the Insured and his or her Spouse/Domestic Partner and/or Child(ren) if the Spouse/Domestic Partner and/or Child(ren) are with the Insured while he or she is covered under this Policy. The Spouse/Domestic Partner and/or Child(ren) will not be covered while making a trip without the Insured. The transportation and/or services provided under this Travel Assistance Plan must be pre-authorized by Zurich. For Pre-Authorization, please call 1-800-263-0261 from the United States or Canada and collect from anywhere else in the world at +1-416-977-0277. Under this Policy, the Travel Assistance Plan consists of the following:

TRAVEL ASSISTANCE BENEFITS AS FOLLOWS:

Medical Evacuation

If a Covered Person is Injured or Ill on a Covered Trip and is being treated in a hospital, medical facility, clinic or by a medical provider which, based upon Zurich's evaluation, cannot provide medical care in accordance with Western Medical Standards, Zurich will arrange for, and cover the cost for, the transport of the Covered Person to the nearest hospital or medical facility which can provide such care. Zurich must be contacted prior to the transport and Zurich must pre- authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending physician. For the limited purpose of determining Zurich's liability, Zurich has the sole right to determine the standard of care of a hospital or medical facility, clinic or medical provider.

Medical Repatriation

If a Covered Person is Injured or Ill on a Covered Trip and has sufficiently recovered to travel in a non-scheduled commercial air flight or a regularly scheduled air flight with special equipment and/or personnel with minimal risk to his or her health, Zurich will arrange for, and cover the cost for, the transport of the Covered Person to his or her Principal Residence, or to his or her residence in the country where he or she is currently assigned (at his or her option), in such transportation. Zurich must be contacted prior to the transport and Zurich must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending physician. For the limited purpose of determining Zurich's liability, Zurich has the sole right to determine the scheduling, the mode of transportation and the special equipment and/or personnel which are covered.

Non-Medical Repatriation

If a Covered Person is Injured or Ill on a Covered Trip and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, Zurich will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating, to his or her Principal Residence or to the country where he or she is currently assigned (at his or her option). Zurich must be contacted prior to the transport and Zurich must agree to the change in the travel date and/or upgrade for benefits to be payable. No change or upgrade will be made without the prior recommendation of the attending physician. The upgrade will be subject to Zurich's sole discretion.

Return of Remains

If a Covered Person dies while on a Covered Trip, Zurich will make arrangements and pay for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. Zurich must be contacted prior to the preparation and transportation of the body and Zurich must pre-authorize the services and transportation for benefits to be payable.

Visit to Hospital

If a Covered Person is scheduled to be hospitalized for more than seven (7) consecutive days while on a Covered Trip, Zurich will arrange for, and cover the cost of, a regularly scheduled round trip economy class air flight of the person chosen by the Covered Person to visit the Covered Person while he or she is hospitalized. We must pre-authorize the transportation for benefits to be payable.

Return of Child

If a Covered Person is traveling with a Child(ren), who is under twenty-six (26) years of age or a Child(ren) who prior to age twenty-six (26) became incapable of self-sustaining employment by reason of physical or disabling handicap and remains chiefly dependent upon the Covered Person for support and maintenance, while on a Covered Trip, and due to the Illness or Injury to the Covered Person, such Child(ren) is left unattended, Zurich will arrange for, and cover the cost of, the transport of the Child(ren) by a regularly scheduled economy class

air flight to the location chosen by the Covered Person, and for an attendant, if applicable. Zurich must pre-authorize the transportation of the Child(ren) and attendant, if applicable, for benefits to be payable.

Return of Companion

If a Covered Person is traveling with a companion while on a Covered Trip, and due to the Illness or Injury to the Covered Person the Covered Person cannot complete the Covered Trip as scheduled, Zurich will pay for the lesser of the change fee for the companion's return air flight or a one way economy class flight. Zurich must pre-authorize such costs for benefits to be payable.

TRAVEL ASSISTANCE EXCLUSIONS

Zurich will not provide the Travel Assistance Plan if the Coverage is excluded under Section VII

– General Exclusions of the Policy (except for an Illness), or if:

1. the Covered Trip was undertaken for the specific purpose of securing medical treatment;
2. the Injuries or Illness requiring medical services resulted from the Covered Person being under the influence of any controlled substance, unless such controlled substance was prescribed by a physician and was taken in accordance with the prescribed dosage;
3. with respect to a MEDICAL EVACUATION, the medical care which is being provided is consistent with Western Medical Standards. Zurich has sole discretion in making that determination;
4. with respect to MEDICAL EVACUATION, it is not medically necessary to transport the Covered Person to another hospital or medical facility. Zurich has the sole discretion in making that determination; based upon the medical condition of the Covered Person and/or the local conditions and circumstances, Zurich determines that MEDICAL EVACUATION or MEDICAL REPATRIATION is not appropriate. Zurich has sole discretion in making that determination;
5. any local, state, country or international law prohibits the provision of the transportation or services provided for under this plan. Zurich will be fully and completely excused from performance and discharged from any contractual obligation;
6. Zurich did not pre-authorize the transportation and/or services.

TRAVEL ASSISTANCE DEFINITIONS

For purposes of this **Travel Assistance Plan** only, the following definitions apply:

"Covered Trip" means when a **Covered Person** is traveling more than 100 miles from his or her **Principal Residence** and such travel is covered under the **Policy** and is not excluded under the TRAVEL ASSISTANCE EXCLUSIONS set forth above.

"Illness" or **"Ill"** means a sickness or disease which impairs normal functions of the body.

"Injured" "Injury" or **"Injuries"** means a bodily **Injury** or **Injuries** and is not limited to accidental bodily injuries.

"Principal Residence" means the legal domicile of the **Covered Person**.

"Western Medical Standards" means generally accepted medical standards comparable to those in the United States, Canada or Western Europe.

For the purpose of the **Travel Assistance Plan**, if there are any differences in the definition of a term between the **Travel Assistance Plan** and the Policy, the definition in the **Travel Assistance Plan** will govern.

TRAVEL ASSISTANCE - OTHER PROVISIONS

Right of Recovery

Zurich has the right to recover any benefits which Zurich has paid under this Travel Assistance Plan if the Policyholder or Covered Person recovers any money from a third party for the expenses incurred by

the Policyholder or Covered Person which were covered under this Travel Assistance Plan. Zurich will be reimbursed from such recovery and Zurich will have a lien against that recovery. Zurich has the right to recover any benefits from the Covered Person for transportation services and/or expenses, which were not covered under the Travel Assistance Plan.

Reservation of Rights

Zurich reserves the right to suspend, curtail or limit their coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit Zurich to provide services or in any country for which a travel warning has been issued by the Department of State of the United States of America.

Scope

Illness, as covered under this Travel Assistance Plan, is solely covered under this Travel Assistance Plan, and in no way supersedes or modifies the other Coverages provided under this Policy. To contact Zurich regarding this Travel Assistance Plan, the Covered Person must call 800-263-0261 from the U.S. or Canada; and collect from anywhere else in the world at +1-416-977-0277.

IMPORTANT INFORMATION ABOUT THE PLANS

The Life Insurance Plans are subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Statement of ERISA Rights

The Employee Retirement Income Security Act of 1974 (ERISA) affords you with certain legal protection under the plans the Company provides.

As a participant in the Life Insurance Plan component of the Company's Welfare Benefits Plan No. 513, certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator office and other specified locations, such as work sites, and union halls, all documents governing the plan including insurance contracts, collective bargaining agreements 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 collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for copies.
- Receive a summary of the Plan's annual financial reports. The plan administrator is required by law to furnish each participant with a copy of this annual summary report.

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

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 materials 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 your claim for benefits 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 plans' 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.

If you have any questions about the Plan(s), 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, Pension and Welfare Benefits 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 publication's hotline of the Employee Benefits Security Administration.

Plan Amendments

The Company reserves the right at any time, to terminate, modify or amend, in whole or in part, any or all of the provisions of the plans.

Interpretation of the Plan

The Plan Administrator has authority to control and manage the operation and administration of the plans. However, the plan administrator has delegated to the group sponsored Life and AD&D insurance carriers its entire discretionary authority to make all final determinations regarding claims for benefits under the benefit plan insured by these policies. This discretionary authority includes, but is not limited to, the determination of eligibility for benefits, based upon enrollment information provided by the policyholder, and the amount of any benefits due, and to construe the terms of these policies.

Any decision made by the group sponsored Life and AD&D insurance carriers 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 and AD&D insurance carriers' determinations shall uphold such determination unless the claimant proves the determinations are arbitrary and capricious.

Plan Name and Type

The names of the Plans in which this SPD summarizes the benefits is outlined below. These Plans are components of the Company's Group Welfare Benefits Plan 513, which is an umbrella Section 125 cafeteria plan. Components of this Plan summarized here include the following:

The Company's Life Insurance Plan which offers the following benefits and coverage:

- Basic Life
- Supplemental Life

The Company's Accidental Death and Dismemberment Plan which offers the following benefits and coverage:

- Basic Accidental Death and Dismemberment
- Supplemental Accidental Death and Dismemberment

Plan Financing and Administration

- Plan Year: Jan. 1 through Dec. 31.

- Plan Financing: The Plans are financed on a fully insured basis. The insurance premiums paid under the Plans may be funded through one or more of the following: employer general assets, employee contributions or, if applicable, a Voluntary Employee Beneficiary Association (VEBA) trust.

Administration Type: The Life and AD&D Plans are administered by third party claims administrator(s) – insurance carriers operating under group policies.

Plan Sponsor

Lumen
214 East 24th Street
Vancouver, WA 98663

Employer Identification Number: 72-0651161

Agent for Legal Service

Associate General Counsel
Lumen
931 14th Street, 9th Floor
Denver, CO 80202

Legal process may also be served on:

The Corporation Company (a.k.a. CT Corp)
1675 Broadway, Suite 1200
Denver, Colorado 80202

Limitation on Civil Actions

You cannot bring any legal proceeding or action against the Plan, the Plan Administrator, Claims Administrators or the Company unless you first complete all the steps in the claims and appeal process described in this 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 one (1) year of the date the Claims Administrator notified you of the final decision on your appeal. 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 Company's Employee Benefits Committee or any other fiduciary, or any third party service provider, after the expiration of three years from the time proof of loss is required.

Clerical Error

If a clerical error or other mistake occurs, however occurring, that error does not create a right to 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, and 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 Plans or our designees, including the Claims Administrator(s), in accordance with the terms of this 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 Benefits under the Plan, you authorize and direct any person or institution 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 Covered Persons, including Enrolled Dependents whether or not they have signed the enrollment form. The Plan agrees that such information and records will be considered confidential. We 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.

Circumstances That May Affect Your Plan Benefits

Under certain circumstances all or a portion of your Benefits under the Plans may be denied, reduced, suspended, terminated or otherwise affected. Many of these circumstances have been addressed elsewhere in this SPD. Such circumstances, in general, include but are not limited to:

- You are no longer in an eligible class of participants
- The Plan is amended, changed or terminated
- You attain the maximum benefit available under the Plans, such as may apply to certain Life and AD&D Benefits
- You misrepresent or falsify any information required under the Plans; you or your beneficiaries will not be permitted to benefit under the Plans from your own misrepresentation
- You have been overpaid a benefit and the Plans seek restitution
- Your coverage under the Plans is terminated for one of a variety of reasons, for example, failure to pay a supplemental benefit premium or to pay it on a timely basis

Your coverage is rescinded as permitted by law.

Consequences of Falsification or Misrepresentation

Coverage for you or your dependent(s) will be terminated if you or your dependent(s) falsify or intentionally omit medical history on the application for coverage, submit fraudulent, altered or duplicate billings for personal gain, allow another party not eligible for coverage to be covered under the Plan or obtain Plan Benefits, or allow improper use of your or your dependent's coverage. You and your Dependent(s) will not be permitted to benefit under the Plan from your own misrepresentation. If a person is found to have falsified any document in support of a claim for Benefits or coverage under the Plan, the Plan Administrator may, without anyone's consent, terminate coverage, possibly retroactively if permitted by law (called "recission"), and may seek reimbursement for Benefits that should not have been paid out. Additionally, the Claims Administrator may refuse to honor any claim under the Plan. You are also advised that suspected incidents of this nature are turned over to Corporate Security to investigate and to address the possible consequences of such actions. You may be periodically asked to submit proof of eligibility to verify claims. All participants are required to cooperate with requests to validate eligibility.

GLOSSARY OF DEFINED TERMS

To understand your Life and AD&D insurance coverage, you should be familiar with the following terms:

Actively at work – Any day you report for work and perform the usual duties of your job at your usual place of employment (or such other places as required by your employer).

Beneficiary – The person or persons you name to receive your Life Insurance and AD&D benefits if you die.

Converted life insurance policy – An individual policy that you may buy *without proof of good health* if your Life Insurance coverage ends.

Disabled dependent – A family member who is confined in the hospital. This also means a dependent that was confined to a hospital.

Domestic partner – A person of the same or opposite sex who shares your residence for the past 12 months (the residence requirement doesn't apply where there is an exception as permitted by the Plan Administrator as required by applicable law); is no less than 18 years of age; is financially interdependent with you and has proven such interdependence by providing proof of joint ownership; is not a blood related or any closer than would prohibit legal marriage; and provides a Certificate of Domestic Partner Registration if you reside in a state that provides such registration OR has signed jointly with you, a notarized affidavit if you reside in a state that does not provide Domestic Partner Registration. **Note:** If you have previously submitted a Domestic Partner Affidavit that was validated and coverage provided accordingly, there is no need to submit a new Affidavit unless you have had a change in your Domestic Partner status.

Initial enrollment – The first time you enroll in the Company's plans after you start work as an eligible employee.

Annual enrollment – Period at the end of each year, during which you make choices about your Supplemental Life and AD&D coverage for the coming year (usually held in November).

Plan – Plan pertains to Life and AD&D Plans.

Portability – Portability pertains to the Supplemental Life Plan whereby an employee or dependent which loses coverage for certain reasons may port their Supplemental Life coverage under another group policy. Two sets of rates apply: 1) without Evidence of Insurability and 2) with Evidence of Insurability. The choice of which to apply for is yours.

Principal Sum – The full coverage amount under the AD&D plans, payable for accidental death and certain other covered losses.

Qualified status change – Significant changes in your family that may allow you to change your coverage. Examples may include marriage, divorce, birth or adoption of a child, death of a spouse or domestic partner or child, or changes in your or your spouse's or domestic partner's employment.

APPENDIX

Life Insurance Company

Metropolitan Life Insurance Company “MetLife”
200 Park Avenue
New York, New York 10166

1-800-638-6420

Group Policy No. 148069

Accidental Death & Dismemberment “AD&D” Insurance Company

Zurich American Insurance Company
Post Office Box 9102
Plainview, NY 11803-9102

1-866-841-4771

Group Policy #4279163 (Basic AD&D)

Group Policy #4279164 (Supplemental AD&D)