Group Health and Welfare Plan for Retirees of Eversource

Summary Plan Description
Plan Document

EVERSOURCE

Contents

Plan Overview

What is this document?

Eversource Energy Service Company (the "Plan Sponsor" or "Eversource Energy") sponsors this Group Health and Welfare Plan for Retirees of Eversource (the "Plan"). The Plan offers benefits to eligible Retirees of the Plan Sponsor or a Participating Company (as defined below). This overview document — together with the Retiree Life Insurance certificates attached as Appendix A — provides a summary of these benefits and constitutes both the Plan document and the Summary Plan Description (SPD), as required under the Employee Retirement Income Security Act of 1974 (ERISA). This Plan is intended to be exempt from the Affordable Care Act as a separate "Retiree-only" Plan pursuant to ERISA Section 732(a), IRC Section 9831(a)(2), and The Health Insurance Portability and Accountability Act of 1996 (HIPAA). This document, effective January 1, 2017, amends and restates all prior Plans and summary plan descriptions and any of its predecessor Plans or summary plan descriptions.

Benefits under the Plan include the following, which are further described in this document:

- A health reimbursement arrangement (an "HRA") created for the purpose of reimbursing eligible Retirees and Eligible Dependents for certain medical expenses and health insurance premiums, which are not otherwise reimbursed,
- Access to a health care exchange, and
- Retiree Life Insurance.

The HRA is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended (the "Code"), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45.

The HRA also is intended to meet certain requirements of existing federal tax laws, under which the benefits (for example, reimbursements) Participants receive under the HRA generally are not taxable. However, neither the Plan Sponsor nor a Participating Company can guarantee the tax treatment to any given Participant, as individual circumstances may produce different results. If there is any doubt, Participants should consult their own tax advisor.

Any subsequent material changes to this document will be provided to Participants in a Summary of Material Modification (an "SMM") or will be reflected in a restated Plan. Other updates may be communicated in a special notice or through updates to this Plan. Participants are advised to keep copies of all Plan communications with this Plan and to maintain current contact information with the Plan Administrator.

Additional copies of this document can be requested by calling Eversource's HRConnect telephone number for Retirees at 888-232-6236.

Terms and Definitions

Capitalized terms can be found throughout this document. Most terms are defined within the text or in this section as follows:

401(h) Account: A 401(h) Account is an account established under the Pension Benefit pursuant to which the Plan Sponsor or a Participating Company contribute amounts that can be used to reimburse Eligible Medical Expenses.

401(k) Plan: The Eversource 401(k) Plan, as amended.

Basic Retiree Life Insurance: The term "Basic Retiree Life Insurance" refers to basic life insurance offered under the Plan.

Benefit Credit: The amount credited to a Participant's HRA Account for the provision of benefits under the HRA (see also "HRA Contribution").

Child(ren): The term "Child(ren)" is defined in the *Eligibility for HRA Contributions* section.

Claims Submission Agent: The party who receives and processes reimbursement requests from Participants for

payment from their HRA Account or with respect to Retire Life Insurance benefits on behalf of the Plan Administrator.

Code: The Internal Revenue Code of 1986, as amended.

Combined HRA: The term "Combined HRA" is defined in Chapter 3.

Continuous Service: Generally, the time from the first day of employment until termination of employment as long as such time included no breaks in service.

Credited Service: Generally, the time from the first day of employment until termination of employment excluding any breaks in service. Years of Credited Service are counted in completed months. Excluded from Credited Service are: (i) unauthorized absences except military leaves under the Uniformed Services Employment and Reemployment Rights Act or leaves under the Family and Medical Leave Act; (ii) authorized absences from which Participant does not return by the authorized end of the leave; (iii) layoffs with right of recall, but only after 12 months; and (iv) periods for which the Participant is treated as an independent contractor and not as an Employee.

Eligible Dependents: The term "Eligible Dependents" is defined in the *Eligibility for HRA Contributions* section.

Eligible Medical Expenses: The term "Eligible Medical Expenses" is defined in the *Enrollment in the HRA* section.

Employee: An individual who is on the W-2 payroll of a Participating Company and who is regularly scheduled to work at least 20 hours per week.

Eversource: Eversource Energy, the parent of the Plan Sponsor.

HIPAA: The Health Insurance Portability and Accountability Act of 1996.

HRA Account: The notional bookkeeping account for each Participant in the HRA to which HRA Contributions are credited and reimbursements of Eligible Medical Expenses are debited.

HRA Contribution: An HRA Contribution refers to the amount that is deposited into a Participant's HRA account on a schedule determined by the Plan Administrator (also referred to as Benefit Credits).

Involuntarily Terminated: An Employee is involuntarily terminated from employment with a Participating Company when the Plan Administrator determines that a Participating Company terminated the Employee's employment for reasons other than "cause," where "cause" means the Employee's conviction of a felony, commission of an act of fraud, embezzlement, or theft in connection with his or her duties, or his or her gross misconduct, or gross negligence in connection with his or her duties and his or her acts or omissions causing intentional, wrongful damage to a Participating Company's property.

K-Vantage: An age and service- based contribution that a Participating Company makes to the 401(k) Plan account of a K-Vantage Employee.

K-Vantage Employee: An Employee who participates in the 401k Plan and is eligible for a K-Vantage contribution under the terms of such plan.

Legacy NSTAR Retiree: An Employee or former Employee of a Participating Company who is eligible to receive benefits from the NSTAR Pension Plan component of the Pension Plan.

Legacy NU Retiree: An Employee or former Employee of a Participating Company who is eligible to receive benefits from the NUSCO Retirement Plan component of the Pension Plan.

Limited-Purpose HRA: An HRA that only permits reimbursements for medical premiums and reimbursements for eligible dental and vision expenses.

Optional Retiree Life Insurance: The term "Optional Retiree Life Insurance" refers to optional or supplemental life insurance that eligible Retirees may purchase under the terms of the Plan.

Participant: An individual receiving benefits under the Plan.

Participating Company: A company designated by the Plan Sponsor's Board of Directors to participate in the Plan and whose Board of Directors has accepted such designation. (See "Participating Companies" in the *Other Plan Information* section.)

Pension Plan: The Eversource Pension Plan, as amended from time to time. The Pension Plan includes

benefits offered under two components: the NSTAR Pension Plan and the NUSCO Retirement Plan.

Plan: The Group Health and Welfare Benefit Plan for Retirees of Eversource.

Plan Administrator: The Plan Administrator has the exclusive right to interpret this Plan and SPD and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and SPD, or in any other communications issued in connection with the Plan and SPD. The Plan Administrator may delegate any or all of its duties to third parties and may appoint accountants, actuaries, legal counsel, advisers or any other persons that it deems necessary or desirable in connection with the administration of the Plan.

Plan Sponsor: Eversource Energy Service Company.

Plan Year: A Plan year is a calendar year beginning January 1 and ending December 31.

QMSCO: A "QMSCO" refers to a Qualified Medical Child Support Order as described in the *Eligibility for HRA Contributions* section.

Qualifying Status Change Event: The term "Qualifying Status Change Event" is defined in the *Eligibility for HRA Contributions* section.

Retiree: An Employee who retires from employment with a Participating Company on a Retirement Date.

Retiree Life Insurance: Retiree Life Insurance includes Basic Retiree Life Insurance and Optional Retiree Life Insurance.

Retirement Date: The first day of the month following an Employee's termination of employment if he or she has met the Eligibility requirements described in the *Eligibility for HRA Contributions* section.

Spouse: The term "Spouse" is defined in the *Eligibility for HRA Contributions* section.

Third Party Administrator: The party who performs other administrative services on behalf of the Plan Administrator.

VEBA Trust(s): A post-retirement medical expense account that qualifies as a tax-exempt trust under Section 501(c)(9) of the Code and is used by the Plan Sponsor to pay for any eligible expenses and to which eligible Retirees may contribute amounts necessary to pay the premiums for Optional Retiree Life Insurance.

Termination, Modification or Amendment to the Plan

The Plan Sponsor reserves the right to modify or amend this Plan and SPD at any time without the consent of any Participant. Such modification or amendment shall be effective as of the date of approval, or at such other date as the Plan Sponsor shall determine.

The Plan Sponsor also reserves the right to terminate the Plan or any underlying benefits at any time. No vested rights of any nature are provided under the Plan. In the event of a Plan termination, any remaining contributions to the VEBA Trusts and the 401(h) Account, after satisfaction of expenses, will be used to provide permissible benefits and no part shall be returned to the Plan Sponsor or a Participating Company.

Role of the Plan Administrator Discretion

The administration of the Plan is under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the discretion to determine all matters relating to eligibility, coverage and benefits (including the adjustment of HRA benefit credits made available to Participants or any subset of Participants based on circumstances determined through the Plan Administrator's sole discretion). The Plan Administrator will also have the discretion to determine all matters relating to interpretation and operation of the Plan. Any determination by the Plan Administrator, or any authorized delegate, shall be final and binding, in the absence of clear and convincing evidence that the Plan Administrator or delegate acted arbitrarily or capriciously. The Plan Administrator may designate in writing other persons or entities to carry out duties under the Plan including insurance companies and other third party providers. However, with regard to the insured benefits, the insurer of each benefit will have the final discretionary authority with regard to the benefits it is providing.

Plan Funding

VEBA Trust

Either the Plan Sponsor or a Participating Company will contribute certain amounts to fund the benefits provided to eligible Retirees under the HRA or to provide Retiree Life Insurance. Such contributions will be invested in one or more VEBA Trusts and the 401(h) Account. The VEBA Trust serves only as a funding mechanism. Reimbursements under the HRA will be paid out of the VEBA Trust or the 401(h) Account. The Plan also provides access to a health care exchange for Eligible Retirees and Eligible Dependents; however, any medical coverage that a Participant purchases through such health care exchange is an individual policy of the Participant and is governed by the terms of the applicable policy and administered by the issuing insurance provider. As discussed in more detail below, the HRA can be used to defray the cost of such premiums and Eligible Medical Expenses.

The Third Party Administrator will maintain an HRA Account that credits any HRA Contributions accrued by a Participant and debits any Eligible Medical Expenses that are paid to such Participant. Please keep in mind that the HRA Account is notional, which means that it is not funded nor does it bear interest or accrue earnings of any kind. The Plan Sponsor and the Participating Companies may contribute to the VEBA Trusts or the 401(h) Account as the Plan Sponsor deems necessary to reimburse Participants for Eligible Medical Expenses—to the extent of the applicable Participant's HRA Account balance and to pay for premiums of Retiree Life Insurance. Eligible Retirees may also make contributions to the VEBA Trusts for the purchase of Optional Life Insurance (as described in the *Retiree Life Insurance* section). The Retiree Life Insurance benefits are considered fully insured and are provided under insurance policies. This means that the insurance company is responsible for paying claims and for the financial risk of paying claims under the Plan.

The Treasurer of the Plan Sponsor is responsible for oversight of the investments to the VEBA Trusts and the 401(h) Account, with the advice and consent of the Investment Trusts Committee. No part of the principal or income of the VEBA Trusts shall be used for, or diverted to purposes other than for, the exclusive benefit of Retirees and their beneficiaries, and to pay expenses of the Plan and the VEBA Trusts. Expenses of the Plan are paid out of the VEBA Trusts unless the Plan Sponsor pays such expenses. The Treasurer may also cause the Plan Sponsor to pay expenses that are payable by the VEBA Trusts and cause the VEBA Trusts to reimburse the Plan Sponsor for such expenses to the extent permitted by law. In the case of an insured benefit, the insurance company is the named fiduciary of the Plan. In the case of the HRA, Willis Towers Watson is the named fiduciary according to ERISA Section 402(a). The duties and obligations of the VEBA Trust and the named fiduciaries of the Plan are further described in the *Other Plan Information* section.

Contributions to the Retiree HRA Accounts

At the start of each Plan Year, the Plan Administrator may credit HRA Contributions to HRA Accounts of Eligible Retirees and their Eligible Dependents in accordance with enrollment and eligibility requirements described further in this document. This section describes the annual HRA Contributions that the Plan Sponsor intends to make to Participants' HRA Accounts. However, although the Plan Sponsor anticipates making these contributions in future years, the Plan Sponsor continues to reserve the right to change, amend or terminate these HRA Contributions, or any feature of the Plan, at any time in the future.

Benefit Credits are only available to (i) Medicare eligible Participants who enroll in a medical coverage through OneExchange; and (ii) non-Medicare eligible Participants who enroll in medical coverage (through OneExchange or through a public marketplace exchange) and provide evidence of enrollment. Benefit Credits to the HRA and access to any unused funds in the HRA will cease at the time a Participant fails to purchase medical coverage as required for participation in the HRA. Retirees who are less than age 55 are not

eligible for Benefit Credits. However, Retirees who are under age 55 may be eligible to participate in the Eversource Med-Vantage Plan, which is a plan separate from (and may be in addition to) this Plan. Pease contact Eversource's HR Connect Line for Retirees at 888-232-6236 in order to receive additional information about the Eversource Med-Vantage Plan. Upon the first day of the month in which an eligible Retiree reaches age 55, he or she and his or her Eligible Dependents who opt to participate in the HRA and purchase coverage through OneExchange or through a public marketplace exchange will begin to receive Benefit Credits.

Participants who are otherwise eligible to participate in the Plan who do not opt to participate in the HRA nor purchase medical coverage through OneExchange by the first day of the month in which they turn age 65, will no longer be eligible to enroll in the HRA at any time in the future. Refer to the *Eligibility for HRA Contributions* and the *Enrollment in the HRA* sections for more information.

- **Grandfathered Retirees**
  For purposes of determining the Benefit Credits provided to a "grandfathered" Retiree, a "Grandfathered Retiree" is defined as a Participant in the Plan (including an eligible Retiree or Eligible Dependent) on December 31, 2016 (prior to this amendment and restatement) who was not required to pay monthly premiums for medical coverage under the Plan. The annual notional contribution to HRA Accounts for Grandfathered Retirees is generally as follows:

  Participants under age 65
  - $6,500 for each Retiree,
  - $6,500 for each Dependent Spouse, and
  - $6,500 for all other non-Spouse Dependents.

  The maximum family contribution for Participants under age 65 is $19,500. These Benefit Credits for those under the age of 65 will cease on the first day of the month that a Participant turns age 65. A Grandfathered Retiree receives Benefit Credit regardless of the Participant's Medicare eligibility status.

  Participants age 65 or older
  - $3,600 for each Participant beginning in 2017. This amount is expected to increase by 3.5 percent each year beginning in 2018.

- **Non-Grandfathered Retirees**
  For purposes of determining the Benefit Credits provided to a "Non-Grandfathered Retiree," a "Non-Grandfathered Retiree" is defined as a Participant (including an eligible Retiree or Eligible Dependent) in the Plan, on or after December 31, 2016, who are not Grandfathered Retirees. The annual notional contributions to HRA Accounts for Non-Grandfathered Retirees are generally as follows:

  Participants under age 65
  - $6,500 for each Retiree,
  - $6,500 for each Dependent Spouse, and
  - $6,500 for all other non-Spouse Dependents.

  The maximum family contribution is $19,500. These Benefit Credits for those under the age of 65 will cease on the first day of the month that a Participant turns age 65. A Non-Grandfathered Retiree receives a Benefit Credit regardless of the Participant's Medicare eligibility status.

  Participants age 65 or older
  - $2,500 for each Participant.

Proration for Partial Years

Benefit Credits will be prorated if the Participant is enrolled in coverage for less than the full 12 months of a Plan Year and will be prorated to reflect the change of contributions upon turning age 65. Such proration will be calculated by OneExchange based on whole months of participation.

Eligibility for HRA Contributions

Retirees and their Eligible Dependents are eligible for HRA Contributions if they (i) purchase medical coverage through OneExchange or, if under the age of 65, purchase medical coverage through a public marketplace exchange, (ii) meet the Eligibility requirements described in this chapter, and (iii) opt to participate in the HRA.

Participants under the age of 65 may elect to opt in or out of participation in the HRA — at their discretion — but must enroll in Medicare and supplemental medical coverage through OneExchange no later than the first day of the month in which they turn age 65 to maintain eligibility for HRA Benefit Credits beyond the age of 65. If a Retiree or Eligible Dependent fails to enroll by the 1st of the month in which he or she attains age 65, or if a Participant enrolled in the HRA by such time later elects to opt out of the HRA after attaining age 65, such individual will not be eligible to participate in the HRA at any later time and will forfeit the balance of the HRA Account pursuant to the terms of this Plan. However, such individual may still be eligible for Retiree Life Insurance under the Plan. See the *Eligibility for HRA Contributions* and the *Enrollment in the HRA* sections for more information.

Retiree Eligibility

Retirees and the Surviving Dependents of deceased Retirees who are eligible to participate in the Plan as of December 31, 2016, shall continue to be eligible for benefits as described in this document as of January 1, 2017, subject to the provisions of the Plan.

Retirees with a Retirement Date on or after January 1, 2017, who have met any of the eligibility requirements below are eligible to opt to participate in the HRA provided the Retiree purchases coverage through OneExchange or, if under the age of 65, through a public marketplace exchange.

- Terminates employment with a Participating Company after reaching age 55 with 10 or more total years of Credited Service, or
- Terminates employment with a Participating Company at any age with 20 or more total years of Continuous Service, or
- Under special circumstances, as defined by the Plan Administrator, a non-bargaining unit Employee who terminates employment with a Participating Company after having reached age 50 but before reaching age 55, provided (i) the sum of his or her age and Credited Service are 65 or more years on such date, and (ii) the Employee is treated by the Plan Administrator as having been Involuntarily Terminated.

Employees Represented by Local 369

Retirees who were represented by Local 369 of the Utility Workers Union of America while employed by a Participating Company and who terminate employment with such Participating Company on or after January 1, 2017, must meet any of the following additional requirements below to be eligible for benefits under the HRA — provided the Retiree purchases coverage through OneExchange, or if he or she is under the age of 65, through a public marketplace exchange. Part-time employees are not eligible to participate in the HRA upon Retirement.

1. Age 55 or older with at least 20 years of Continuous Service
2. Age 62 or older with at least 10 years of Continuous Service
3. Age plus Continuous Service equals 85 or more
4. Age 45 or older with 20 or more years of Continuous service and who resigns for cause or is discharged for reasons that are not the fault of the Employee
5. Was represented under Locals 333, 338, 339 of the Utility Workers Union of America on December 31, 2000, and consolidated into Local 369 on January 1, 2001, and has age Plus Continuous Service years totaling 75 or more years ("Rule of 75")

6. Eligible and approved for "Disability Retirement" as a Legacy NSTAR Retiree

Employees Represented by Local 12004

Retirees who were represented by Local 12004 of the United Steelworkers while employed by a Participating Company and who terminate employment with such Participating Company January 1, 2017, or after, must meet any of the following additional requirements below to be eligible for benefits under the HRA — provided he or she purchases coverage through OneExchange or, if under age 65, through a public marketplace exchange.

1. Age 55 or older with at least 20 years of Continuous Service
2. Age 62 or older with at least 10 years of Continuous Service
3. Age plus Continuous Service equals 85 or more
4. Age 45 or older with 20 or more years of Continuous service and who resigns for cause or is discharged for reasons that are not the fault of the Employee

Spouse and Dependent Eligibility

The Plan Sponsor will provide contributions to an HRA for a Retiree's Eligible Dependent(s) based on the following definitions:

- **Spouse:** A Retiree's legal Spouse
- **Child:** A Retiree's and/or his or her Spouse's natural child, adopted child, or child for whom he or she has entered into a formal order of adoption, or child for whom the Retiree or Spouse has been appointed legal guardian.
- **Eligible Dependent:** The Spouse of a Retiree, or Child of a Retiree, who:
  - Is under age 26, or
  - Is over age 25, unmarried, was participating in the Plan immediately prior to turning age 26, and for whom the Retiree has provided satisfactory evidence to the Plan Administrator of the Child's total physical or mental handicap/disability.

Participation in the HRA is available to each eligible Retiree or Eligible Dependent individually, and family members are not required to enroll together. However, Benefit Credits for a Retiree and his or her Eligible Dependents who enroll will be combined into one HRA Account and available to the enrolled family members (a "Combined HRA"). Details about participation in the HRA are provided in the *Enrollment in the HRA* section.

Surviving Dependents upon Death of a Retiree

Participating Eligible Dependents of a Retiree, who are enrolled in the HRA on his or her date of death, are eligible for continuation of Benefit Credits to the HRA and to survivorship rights of funds currently in the HRA at the time of the Retiree's death, as long as the Eligible Dependents continue to purchase coverage with the assistance of OneExchange (or, for Participants who are under the age of 65, other coverage purchased on a public marketplace exchange). Surviving dependents of Retirees of the Commonwealth Energy System who died prior to January 1, 2016, are not eligible for participation in the HRA.

Proof of Eligibility

Proof of eligibility is required to enroll a new Dependent at the time of retirement or later upon a Qualifying Status Change Event. The following documentation will be required by the Plan Administrator:

- **Spouse:** Marriage certificate
- **Child:** Birth certificate, adoption certificate, or proof of legal guardianship or disabled status (for dependent children age 26 or older)

Failure to provide such proof may result in a delay in benefits provided under the HRA. In addition, the HRA will allow reimbursement of Eligible Medical Expenses for a Child of the Participant's in accordance with a Qualified Medical Child Support Order ("QMSCO"). The Plan Administrator will make a determination as to whether the order is a QMSCO in accordance with the Plan's QMSCO procedures. The Plan Administrator will notify both the Participant and the affected Child once a determination has been made. Participants may request a copy of the Plan's QMSCO procedures, free of charge, by contacting the Plan Administrator at the address listed in the *Other Plan Information* section.

Qualifying Status Change Events

Generally, changes to Plan elections cannot be made outside of the annual open enrollment period. However, for certain life events—referred to as Qualifying Status Change Events — certain election changes are allowed. In addition, a Participant can opt out of participation in the HRA at any time, although the Participant will then be ineligible for coverage under the HRA until a future open enrollment period or other Qualifying Status Change Event. But as noted above, a Retiree or Eligible Dependent who chooses to opt out of the HRA after attainment of age 65 will be ineligible to participate in the HRA at any later time. Participants should contact the Plan Administrator within 30 days of a Qualifying Status Change Event and will be required to present necessary documentation as requested by the Plan Administrator to effect a change to a benefit election to participate in the HRA. Unless proper and timely documentation is made, the Participant may experience a gap in coverage or other delay in the processing of his or her request. Any changes to medical coverage purchased through OneExchange or through the public marketplace exchange is governed by the terms of the applicable individual policy purchased from the applicable insurance carrier. The insurance carrier administers their policy and Participants should contact their carrier for assistance with respect to any changes to their policy.

- **Qualifying Status Change Event Notification Requirements**
  - **Death of a Participant:** In the event of a Participant's death, notice of the death should be made by providing a copy of the death certificate to the Plan Administrator within 30 days of the date of death. Surviving Dependents in a Combined HRA will continue to have access to the HRA credits in accordance with the rules described earlier in this section.
  - **Marriage**: Within 30 days of legal marriage, a Retiree must present a valid copy of the marriage certificate and any information required by the Plan Administrator, including the name, Social Security number, and other identifying information, necessary to validate the Spousal record. Once documentation is received and accepted by the Plan Administrator, the Spouse will be eligible to enroll in coverage through OneExchange (or, for Participants the under age of 65, other coverage through a public marketplace exchange) and will be eligible to begin receiving Benefit Credits to the Combined HRA with the Retiree.
  - **Divorce**: Within 30 days of a divorce, a Retiree must present a valid copy of the divorce agreement. Upon receipt of the agreement, the Plan Administrator will notify OneExchange of the loss of eligibility for HRA participation of the ex-Spouse. Any unused funds remaining in the HRA will be available to the Retiree and any other remaining Eligible Dependents in the Combined HRA. The ex-Spouse will be offered continuation of HRA coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA).
  - **Birth/Adoption of a New Child:** Within 30 days of the birth, adoption, or granting of legal guardianship of a newly eligible Child, a Retiree must present a copy of the child's birth certificate, adoption certificate or certificate of legal guardianship and any information required by the Plan Administrator, including the name, Social Security number and other identifying information, necessary to validate the Eligible Dependent record. Once documentation is received and accepted by the Plan Administrator, the Child will be made eligible to purchase coverage through OneExchange (or other coverage purchased on a public exchange) and will be eligible to begin receiving Benefit Credits to the Combined HRA with the Retiree, if applicable.

Enrollment in the HRA

Purpose

The purpose of the HRA is to reimburse Participants for Eligible Medical Expenses (as defined below) which are not otherwise reimbursed by any other Plan or program. Reimbursements for Eligible Medical Expenses paid by the Plan generally are excludable from the Participant's taxable income.

Participation in the HRA

An Eligible Retiree or Eligible Dependent, as defined in the *Eligibility for HRA Contributions* section, actually becomes a Participant in the HRA and begins receiving Benefit Credits under the HRA on the later of the January 1, 2017 (the Effective Date of the Plan), or the Retiree's Retirement Date, provided he or she has satisfied all of the following requirements:

- The Retiree has reached at least age 55, and
- If over the age of 65, the Participant has become eligible for Medicare and enrolled in coverage through OneExchange;
- If under the age of 65, he or she has obtained an individual health insurance policy through OneExchange or public marketplace exchange;
- He or she has completed any enrollment forms or procedures including opting into the HRA as required by the Plan Administrator

If a non-Medicare eligible individual is also eligible for the Federal Advance Premium Tax Credit (APTC), he or she must elect to receive Benefit Credits under the Plan or the APTC for the applicable time period. For any applicable time period, a non-Medicare eligible individual cannot receive both the APTC and Benefit Credits under this Plan.

If the Retiree and his or her Eligible Dependent(s) become eligible for Benefit Credits, the HRA Contributions will be credited to a Combined HRA Account established for all eligible Participants in that family.

Benefit Credits will be credited to HRA Accounts by the Plan Administrator at the start of each Plan Year and will be reduced from time to time by the amount of any Eligible Medical Expenses reimbursed to a Participant under the Plan. Benefit Credits will be prorated to reflect the number of months of participation and age of the Participants. At any time, a Participant may receive reimbursements for Eligible Medical Expenses up to the notional balance of his or her HRA Account or the Combined HRA, as applicable. The reimbursements will be paid from the VEBA Trusts or the 401(h) Account. Note that the law does not permit Participants to make any contributions to their HRA Accounts.

As explained earlier, an HRA Account is merely a bookkeeping account on the Plan Administrator's records; it is not funded and does not bear interest or accrue earnings of any kind.

Opting in and out of HRA Participation

Participants under the age of 65 may elect to opt in or out of participation in the HRA at their discretion, but must enroll in Medicare and supplemental medical coverage through OneExchange by no later than the first of the month in which they turn age 65 to maintain eligibility for HRA Benefit Credits beyond the age of 65. This rule will be applied individually based on each Participant's 65th birthday, so that Retirees and Eligible Dependents will each retain eligibility for participation in the HRA and Benefit Credits, without regard to the status of other family members.

Participants may not obtain reimbursement of any Eligible Medical Expenses (as defined below) incurred after the date eligibility ceases. A Participant has 180 days after his or her eligibility ceases to request

reimbursement of Eligible Medical Expenses incurred before eligibility ceased. After such 180-day period expires, the former Participant forfeits the balance in his or her HRA Account.

Unused Funds at the end of the Plan Year-HRA Rollover

Any unused portion of the maximum dollar amount at the end of the coverage period is carried forward to increase the maximum reimbursement amount in subsequent coverage periods. The Plan Administrator has the discretion to allow Participants to roll over Benefit Credits remaining in an HRA Account at the end of a Plan Year (after the expiration of the claims run-out period). Participants in the Plan are permitted to roll over funds from one Plan Year to the next Plan Year, to pay for Eligible Medical Expenses incurred during subsequent Plan Years, provided the Participant continues to purchase medical coverage through OneExchange (or if a Participant is under the age of 65, other coverage through a public marketplace exchange) and remains an Eligible Retiree or Eligible Dependent.

Eligible Expenses

An Eligible Medical Expense is an expense incurred by a Retiree or any Eligible Dependent for medical care, as defined in Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease). Some common examples of Eligible Medical Expenses include:

- Premiums for medical, prescription drug, dental and vision coverage purchased through OneExchange or a public marketplace exchange, as applicable.
- Medications (in reasonable quantities);
  - Medication is considered an Eligible Medical Expense only if the medication is insulin or is otherwise prescribed by a doctor (without regard to whether the medication is available without a prescription).
  - This Plan only reimburses expenses for covered Part D prescription drugs to the extent that catastrophic coverage reimbursement applies as explained in the *Other Plan Information* section. If catastrophic coverage reimbursement does not apply, then no reimbursement for covered Part D prescription drugs will be made.
- Dental expenses;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Birth control pills;
- Chiropractor treatments;
- Hearing aids; and
- Wheelchairs.

Some examples of common items that are not Eligible Medical Expenses include:

- Baby-sitting and child care;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy;
- Custodial care;
- Health club or fitness program dues; and
- Cosmetics, toiletries, toothpaste, etc.

For more information about what items may or may not be Eligible Medical Expenses, Participants should consult IRS Publication 502, "Medical and Dental Expenses," under the headings "What Medical Expenses Are Includible" and "What Expenses Are Not Includible." (Participants are cautioned to be careful in relying on this Publication, however, as it is specifically designed to address those medical expenses that are deductible on Form 1040, Schedule A—not what is reimbursable under an HRA Account.) Participants who need more information regarding whether an expense is an Eligible Medical Expense under the Plan should contact the Claims Submission Agent for the HRA. The Third Party Administrator (and its delegates) determine solely what is an Eligible Medical Expense but such determination will be made in accordance with the Third Party Administrator's understanding of the IRS guidance found in Publication 502.

Only Eligible Medical Expenses incurred while a Participant is in the HRA may be reimbursed from the Participant's HRA Account. (Note that, even if an

Eligible Dependent is not enrolled as a Participant in the Plan, a Participant may receive reimbursements from the HRA with respect to Eligible Medical Expenses incurred by or on behalf of such Participant's Eligible Dependents.) Eligible Medical Expenses are "incurred" when the medical care is provided, not when the expenses are billed, charged, or paid. Health insurance premiums are incurred for the coverage period to which they apply. An expense that has been paid but not incurred (for example, pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may not be reimbursed from an HRA Account:

- Expenses incurred for qualified long-term care services;
- Expenses incurred for covered Part D prescription drugs;
- Expenses incurred prior to the date that an individual became a Participant in the HRA;
- Expenses incurred after the date that a Participant ceases to be a Participant in the HRA;
- Expenses that have been reimbursed by another plan or expenses for which the Participant will seek reimbursement from another health plan; and
- Any other expenses specifically identified as excluded in Section 9 of the Other Plan Information Section of Chapter 11.

Reimbursement of Expenses from the HRA

A Participant must complete the Claims Submission Agent's reimbursement form with the applicable information required by the form and mail or fax the form (with the supporting documentation) to the Claims Submission Agent at the address provided in the *Other Plan Information* section. The Participant can obtain a reimbursement form from the Claims Submission Agent identified in the *Other Plan Information* Section. A claim is deemed filed when it is received by the Claims Submission Agent. (Participants should not mail their forms to the Plan Sponsor or Plan Administrator, as this may result in a delay in processing.)

If the claim for reimbursement is approved, the Participant will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by the Claims Submission Agent.

Interaction of the HRA with other Spending Accounts

Only medical care expenses that have not been (or will not be) reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). If a Participant is also participating in a health care flexible spending account (FSA), the expenses covered both by this Plan and the health care FSA must be submitted first to the health care FSA.

- **An Individual may not have general-purpose HRA coverage and contribute to an HSA, but may have Limited-Purpose HRA coverage and contribute to an HSA.** In order to be eligible to contribute to a health savings account (an "HSA"), an individual must have coverage under a high-deductible health plan (HDHP) and must not have any non-HDHP coverage except for "permitted insurance," "permitted coverage," or "preventive care." A general purpose HRA that pays or reimburses all Eligible Medical Expenses of a Retiree or Eligible Dependent without application of a deductible is impermissible non-HDHP coverage and prevents eligibility for HSA contributions. An individual who is covered by a general-purpose HRA will be ineligible for HSA contributions for the individual's entire period of coverage under the HRA even after the individual has completely exhausted his or her HRA Account balance. In addition, an individual will not be eligible for HSA contributions if his or her Eligible Medical Expenses can be paid or reimbursed under an HRA in which the individual's Spouse is enrolled in through the Spouse's employer.

  Although general-purpose HRA coverage will prevent an individual from being eligible for HSA contributions, a limited purpose HRA will not prevent eligibility for such contributions. A limited purpose HRA is an HRA that pays or reimburses only eligible dental and vision expenses and premiums for permitted insurance, or preventive care without regard to the HDHP deductible (for example, an HRA that reimburses vision and dental

expenses, permissible premiums for medical coverage and preventive care expenses on a first-dollar basis). Accordingly, if a Participant makes or receives contributions to an HSA, the Participant must immediately notify the Third Party Administrator of the HRA of the HSA contributions and request in writing that the HRA be a limited purpose HRA. A Retiree or Eligible Dependent is responsible for determining his or her eligibility for HSA contributions and the HRA available under this Plan will only be treated as a limited purpose HRA after the Participant provides a written request to the Third Party Administrator to treat his or her HRA as a limited purpose HRA and requests no reimbursements of Eligible Medical Expenses that would otherwise cause his or her HRA to be a general purpose HRA.

Interaction of an HRA and FSA

If a Participant also participates in a health care FSA, this Plan must be the payer of last resort. Thus, if a Participant participates in both an HRA and a health care FSA and both this Plan and the health care FSA cover the same expenses, the Participant must look first to the health FSA for reimbursement before any reimbursements will be made under the HRA.

Catastrophic Coverage Reimbursement for Medicare Part D Expenses

Catastrophic coverage reimbursement is provided as a separate benefit under this Plan. Only Participants with an HRA Account are eligible for catastrophic coverage reimbursements. Such catastrophic coverage reimbursements begin after any Medicare-eligible Participant has reached the "catastrophic coverage level," as defined by Medicare for the applicable Plan Year.

Catastrophic coverage reimbursements can be obtained by contacting OneExchange and requesting a claim form. The Participant will be required to submit documentation acceptable to the Claims Submission Agent for the expense to qualify for reimbursement.

Once a Participant reaches the "catastrophic coverage level" for an applicable year, all eligible claims for qualifying prescription drug expenses will be eligible for reimbursement without any dollar limits. Claims must be incurred during the applicable Plan Year and submitted within the time frame set forth in this Plan and SPD for other qualifying HRA Account claims. All other HRA Account provisions set forth in this Plan and SPD continue to apply.

Survivorship Rights for HRA Benefit Credits

If an eligible Participant dies — and he or she has an HRA Account that is a single account and not shared with any other Participant, his or her HRA Account is immediately forfeited upon death. However, claims for reimbursement of Eligible Medical Expenses incurred by the deceased Participant prior to the date of death can be submitted by the Participant's legal representatives for up to 180 days following the date of death.

If the eligible Retiree whose HRA Account is a Combined HRA with one or more participating Eligible Dependents, the Combined HRA shall continue to be available to the surviving Eligible Dependents participating in the Combined HRA — including any remaining Benefit Credits that were allocated on behalf of the decedent. Any claims for Eligible Medical Expenses incurred by the deceased Participant prior to his or her death must be submitted within 180 days following the date of death.

OneExchange Access

This Plan provides access to a private medical exchange, OneExchange. Any medical coverage that Participants purchase through OneExchange, or through a public exchange, is an individual policy owned by the Participant and any benefits provided under such policy are not benefits provided under, or governed by, this Plan. Rather the terms of the applicable policy will govern such benefits and the insurance carrier will administer the policy.

Purchasing Coverage through OneExchange

To be eligible to enroll in the HRA, the Retiree must purchase medical coverage through OneExchange or, for participants who are under age 65, through OneExchange or through a public marketplace exchange. To access OneExchange and purchase coverage, a Participant must contact OneExchange directly through their website at https://medicare.oneexchange.com/login or by telephone at 855-885-5730 — for a Medicare-eligible Retiree; and at 855-885-5757 — for a non-Medicare eligible Retiree.

Newly-eligible Retirees will receive a personalized enrollment package (in print or online) for assistance in electing applicable benefits through the OneExchange platform for themselves and their Eligible Dependents. The deadline for initial enrollment in the Plan is 30 days from a Retirement Date. If the newly-eligible Retiree (or surviving Spouse of a deceased Retiree) returns his or her elections to OneExchange before the end of the 30-day deadline, the Participant's elections will go into effect immediately. However, Retirees may experience a gap in coverage if they fail to complete their enrollment before their Retirement Date, so Retirees are advised to begin their enrollment at least 60 days before their planned Retirement Date.

If the Retiree or surviving Spouse does not make a timely election, it is assumed all coverage is waived by the Retiree or surviving Spouse. The next opportunity to enroll in coverage would be at a future open enrollment period unless the Retiree experiences a Qualifying Status Change Event. In this case, the Retiree or surviving Spouse should contact the Plan Administrator within 30 days of the event. Individuals who do not opt into the HRA and enroll in medical coverage by age 65 will not have the opportunity to enroll in the HRA (nor will they be eligible for Benefit Credits) at a later time. Refer to the *Eligibility for HRA Contributions* and the *Enrollment in the HRA* sections for additional information.

Annual Open Enrollment

One Exchange and the public marketplace exchanges offer individuals the opportunity to make new choices for medical coverage purchased through the applicable exchange. This election period—referred to as annual open enrollment—is announced by OneExchange either by a paper kit mailed to the home or delivered online. Annual open enrollment is generally held in the fall and the choices made during this time go into effect the following Plan Year. Participants are not required to make a change to their election unless they wish to do so or the insurance carrier requires the change; however, enrollment in medical coverage through OneExchange (or, if a Participant is under age 65, through a public marketplace exchange) is required for Participants to receive their annual Benefit Credit into the HRA. In addition, if a Retiree or Eligible Dependent fails to enroll by the first day of the month in which he or she attains age 65 or enrolled prior to such time and later opts out of the HRA, the individual is not eligible to participate in the HRA upon a later enrollment. Please refer to the *Eligibility for HRA Contributions* section for more information.

Retiree Life Insurance

Eligibility

The Plan Sponsor provides paid Basic Retiree Life Insurance and/or Retiree paid Optional Life Insurance if he or she is a member of an eligible class (as defined in the insurance certificates attached as Appendix A on his or her Retirement Date.

Terms and Definitions

Terms starting with capital letters can be found throughout this document and in the Insurance Certificates attached as Appendix A. Most terms are defined within the text or in this section as follows:

- **Base Pay:** The annual base rate of pay (or authorized annual salary), including any portion of any annual merit salary adjustment distributed as a lump sum award, but excluding bonuses, commission, overtime, and all other compensation. Base Pay is determined as of the last day of active employment prior to Retirement; provided, however that with respect to all individuals who retired prior to January 1, 2017, base pay (or authorized annual salary) shall be defined as provided in the Plan document in effect at the Participant's Retirement Date.
- **Beneficiary:** An individual, institution, trustee, or estate that receives, or may become eligible to receive, benefits under the Plan. Beneficiary rules are further defined in the insurance certificate.
- **Carrier:** The insurance company who administers the Retiree Life Insurance Benefits and who is the claims fiduciary for issues other than Plan eligibility. The Carrier is the Claims Submission Agent and also reviews appeals to any denied claims.

Retiree Life Coverage during Total Disability

Employees of a Participating Company who are determined to be totally disabled by the Carrier of the group long-term disability ("LTD") plan offered by the Participating Company who are receiving LTD benefits under the plan, retain their right to continue their basic life insurance coverage under that group plan in accordance with the rules of the plan. These Employees are not eligible for Retiree Life Insurance coverage until the earlier of the date of their voluntary election to retire and terminate LTD benefits, or the date when maximum duration of LTD benefits is exhausted, typically at age 65.

Individuals who are eligible for benefits under class 8 or 9 who are Involuntarily Terminated while on LTD will not be eligible for Retiree Life Insurance when their LTD payments end for any reason, unless the individual met the eligibility for Retiree Life Insurance benefits at the time of their termination of employment.

Plan Funding

Benefits provided to eligible Retirees under the Plan are provided through a life insurance policy, the premiums of which are currently funded through a combination of a Participating Company's and a Retiree's contributions made and invested in the VEBA Trusts. The fully insured benefits are provided under insurance policies as documented by an insurance certificate. Duties and obligations of the VEBA Trust and the named fiduciaries of the Plan are further described in Chapters 2 and 11 of this document.

Retiree contributions to the Plan are required for Optional Retiree Life Insurance coverage. Retirees enrolled in this coverage will be sent a monthly invoice for collection of these premiums. Failure to make prompt payment will result in termination of insurance coverage retroactive to the last payment date.

Reduction or Elimination of Coverage

- **Insurance Classes 13a, 13b, 14 and 16 Only:** Each Retiree who is eligible for Basic Retiree

Life Insurance, a member of one of the classes defined above, and a Legacy NU Retiree, may — on his or her Retirement Date or at any time thereafter — elect to surrender any portion or all of his or her Basic Retiree Life coverage (not to exceed $40,000) and receive additional pension annuity income instead. The Basic Retiree Life Insurance is surrendered to provide an additional monthly benefit using the formula described in the applicable provisions of the Pension Plan. An election to surrender Basic Retiree Life Insurance coverage to provide additional pension annuity income will be effective as soon as practicable following the Retiree's election. Any resulting additional pension annuity income will be subject to the survivor annuity benefits under the Pension Plan, subject to applicable reduction for survivor benefits, and other rules of the Pension Plan.

A Retiree's decision to surrender his or her Basic Retiree Life Insurance coverage in exchange for additional pension annuity income is irrevocable, and the pension annuity income received is taxable income to the Retiree.

Retirees may reduce or eliminate their Optional Retiree Life Insurance coverage under the Plan at any time by contacting Eversource's HRConnect Line for Retirees at 888-232-6236.

- **Rehired Retirees in Insurance Classes 13A, 13B, 14 and 16:** Should an individual eligible to make this election be rehired by a Participating Company, Basic Retiree Life Insurance coverage does not terminate upon a Retiree's rehire with the Participating Company. A rehired Retiree receiving Basic Employee Life Insurance coverage as an active employees will have the amount of such coverage reduced by the amount of the Basic Retiree Life Insurance coverage in place at the time of rehire, including any amount that has been surrendered in exchange for additional pension annuity income under the Pension Plan.

  The amount of Basic Retiree Life Insurance coverage will not change unless the Retiree's Base Pay and eligibility for this benefit on his or her subsequent Retirement Date warrants an increase in coverage.

  If the Retiree is a K-Vantage Employee on his or her subsequent Retirement Date, he or she will not be eligible for additional Basic Retiree Life Insurance, regardless of any change in his or her Base Pay.

  Optional Retiree Life Insurance coverage will terminate upon rehire. Determination of Optional Retiree Life Insurance coverage available to the Retiree upon his or her subsequent Retirement Date will be determined based upon the Plan rules and the Retiree's current status without regard to any previous coverage surrendered upon rehire.

- **Rehired Retirees in Insurance Classes 8, 9, 10 and 11:** If a Retiree is rehired by a Participating Company and is eligible for benefits provided under class 8, 9, 10 or 11 in addition to Basic Employee Life Insurance as an active employee, the Retiree will become ineligible for Basic Retiree Life Insurance coverage until such Retiree's subsequent termination of employment. Upon termination of employment, the Retiree will be eligible for Basic Retiree Life Insurance.

Naming a Beneficiary

Eligible Retirees are asked to name a Beneficiary who will receive the Retiree Life Insurance benefits upon the Retiree's death.

The Carrier for Retiree Life Insurance is the Beneficiary record-keeper. Retirees may complete their Beneficiary designation using a form acceptable to the Carrier, either paper or online. Adding new Beneficiary information or updating existing information replaces any prior Beneficiary designation. Beneficiary selection may be changed at any time by contacting the Carrier directly.

Retirees are encouraged to review their Beneficiary designation periodically and especially after Qualifying Status Change Events (such as marriage or divorce) to verify their designation is complete and reflective of their intent.

If no Beneficiary designation has been made for Basic Retiree Life Insurance and/or Optional Retiree Life Insurance upon the death of a Retiree,

benefit payments will be made in accordance with Beneficiary designation rules under the Participating Company's group life insurance plan in which the Retiree participated as an active employee immediately prior to his or her Retirement Date provided the Participating Company continues to maintain the plan. The Beneficiary designated for Basic Retiree Life Insurance benefits will automatically be the Beneficiary for Optional Retiree Life Insurance benefits. In absence of a Beneficiary designation for the Plan, and if the group life insurance plan in which the Retiree was enrolled as an employee prior to his or her Retirement Date terminated, the Beneficiary will follow the preferential beneficiary designation order defined in the insurance certificate in Appendix A.

Imputed Income

The IRS treats the value of group life insurance coverage provided by a Participating Company in excess of $50,000 as a taxable benefit. The value of life insurance coverage in excess of $50,000 is determined using the IRS Premium Table under Section 79 of the Internal Revenue Code and imputed as income to the Participant. Retirees with coverage in excess of $50,000 may have annual imputed income for Basic Retiree Life Insurance.

Life Insurance Claims and Appeals

The Plan Administrator has delegated authority to the Carrier for claims administration. The claims and appeals filing procedure for Retiree Life Insurance benefits can be found in the insurance certificate in Appendix A. The Plan Administrator retains authority to determine Plan eligibility.

When Coverage Changes or Ends

An Eligible Retiree will cease being a Participant in the Plan on the earlier of:

- The date the Participant ceases to be an Eligible Retiree for any reason;
- The date the Participant is rehired by the Employer as an active employee except that certain classes of Retirees may continue to have Retiree Life Insurance coverage as described in the *Retiree Life Insurance* section;
- The date of death (subject to HRA survivorship rights described in the *Retiree Life Insurance* section);
- The effective date of any amendment terminating eligibility under the Plan;
- The date the Plan is terminated;
- The date the Participant opts out of the Plan;
- For purposes of the HRA, upon failure to enroll in medical coverage through OneExchange or for Retirees under age 65, other medical coverage purchased on a public marketplace exchange as described in the *Enrollment in the HRA* section. Also, if a Participant fails to opt to participate in the HRA, or fails to enroll in coverage through OneExchange by the first day of the month in which the Participant attains age 65, the Participant will be ineligible to participate in the HRA in the future and any balance in the Participant's HRA Account will be forfeited after 180 days.

An Eligible Dependent will cease being a Participant in the Plan on the earlier of:

- The date the Participant ceases to be an Eligible Dependent for any reason;
- In the case of an Eligible Dependent Spouse, the date of divorce from the Eligible Retiree;
- The date of death (subject to HRA survivorship rights described in the *Retiree Life Insurance* section);
- In the case of a non-Spouse Dependent, the date he or she reaches age 26 unless proper documentation proving total disability is provided;
- The effective date of any amendment terminating eligibility under the Plan; or
- The date the Plan is terminated;
- The date of death;
- The date the Participant opts out of the Plan;
- For purposes of the HRA, upon failure to enroll in medical coverage through OneExchange or other medical coverage purchased on a public marketplace exchange as described in the *OneExchange Access* section. Also, if a Participant fails to opt to participate in the HRA, or fails to enroll in coverage through OneExchange by the first day of the month in which the Participant attains age 65, such Participant will be ineligible to participate in the HRA in the future and any balance in the Participant's HRA Account will be forfeited after 180 days.

Claims Procedure

Claims under this Plan

A Participant must complete a reimbursement form and submit it to the Claims Submission Agent (in writing or such other form as the Claims Submission Agent prescribes). The Claims Submission Agent will require substantiation of the claim, which may include the following information:

- The name of the person for whom the medical expense was incurred;
- The nature of the medical expense;
- The date the medical expense was incurred;
- The amount of the medical expense and the reimbursement requested;
- A statement that the medical expense(s) has not otherwise been reimbursed and is not reimbursable through any other source;
- Any bills or invoices from an independent third party showing that the medical expense(s) was incurred and the amount of such expense; and
- Any other documentation as the Claims Submission Agent may require.

The Claims Submission Agent will determine if enough information has been submitted to allow proper consideration of the claim. If not, more information may be requested from the Participant.

Claims Appeal Process

If a claim for reimbursement is wholly or partially denied, the Participant will be notified in writing within 30 days after the Claims Submission Agent receives the claim. If the Claims Submission Agent determines that an extension of this time period is necessary due to matters beyond the control of the Plan, the Claims Submission Agent will notify the Participant within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because the Participant failed to provide sufficient information to allow the claim to be decided, he or she will be notified and will have at least 45 days to provide the additional information. The notice of denial will contain:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- A description of any additional information necessary for a Participant to perfect a claim, why the information is necessary, and the Participant's time limit for submitting the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- A description of the Participant's right to request all documentation relevant to the claim.

If the request for reimbursement under the Plan is denied in whole or in part and the Participant does not agree with the decision of the Claims Submission Agent, he or she may file a written appeal. The written appeal should be filed with Eversource at the address provided in the *Other Plan Information* section no later than 180 days after receipt of the denial notice. The Participant filing the appeal should submit all information identified in the notice of denial as necessary to perfect the claim, and any additional information that he or she believes would support the claim. No later than 60 days after Eversource receives the Participant's request for appeal, Eversource will notify the Participant in writing of the decision on appeal. The notice will contain the same type of information provided in the first notice of denial provided by the Claims Submission Agent.

Note that the Participant cannot file suit in federal court until the Participant has exhausted these appeals procedures.

Any claim or action that is filed in a court or other tribunal against or with respect to the Plan and/or

the Plan Administrator must be brought within the following timeframes:

- For any claim or action relating to HRA Account benefits, the claim or action must be brought within 18 months of the date of the denied appeal.
- For all other claims (including eligibility claims), the claim or action must be brought within two years of the date when the Participant knows or should know of the actions or events that gave rise to the claim.

Legal Rights

Resolution of Overpayments and Right to Audit

If it is later determined that a Participant received an overpayment or a payment was made in error, he or she will be required to refund the overpayment or erroneous reimbursement to the Participating Company.

The Plan Sponsor retains the right to perform regular audits of HRA Accounts. If during such an audit it is determined that an under age 65 Participant who elected to participate in the HRA purchased coverage outside of OneExchange, or through a public marketplace exchange (such as through another entity's group health plan), or did not purchase Medical coverage at all, he or she will be required to reimburse the Participating Company for those HRA reimbursements and shall forfeit the Benefit Credits improperly credited to the Participant's HRA Account.

If the Participant does not refund the overpayment or erroneous payment, the Plan Sponsor reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any future amounts due from the Plan Sponsor or a Participating Company. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for the Participant.

COBRA Rights

Under a federal law called "COBRA," Eligible Dependents under the Plan who are the Spouse, former Spouse, or dependent Child of a Participant may elect to continue coverage under the Plan for a limited time after the date they would otherwise lose coverage because of a divorce or legal separation from the Participant, the Participant's death, or a dependent Child ceasing to be an Eligible Dependent. These are called "qualifying events."

Note that the Eligible Dependents are required to notify the Plan Administrator in writing of a divorce, legal separation, or a dependent child losing dependent status within 60 days of the event or they will lose the right to continue coverage under the Plan. If an Eligible Dependent elects to continue coverage, he or she is entitled to the level of coverage under the Plan in effect immediately preceding the qualifying event.

In order to continue coverage, the qualified beneficiary must continue to be enrolled in coverage through OneExchange. The Third Party Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event.

Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary's HRA Account is exhausted;
- The date the qualified beneficiary notifies the Third Party Administrator that he or she wishes to discontinue coverage;
- The date any required monthly premium is not paid when due or during the applicable grace period;
- The date that he or she becomes covered under another group health Plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the qualified beneficiary; or
- The date Eversource ceases to provide any group health Plan.

Your Rights Under ERISA

General Rights

Participants are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA). ERISA provides that all Plan Participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies;
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report;
- Continue coverage under any group health Plan subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA) for the Participant and the Participant's Eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. The Participant and the Participant's Eligible Dependents may have to pay for such coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Participants. No one, including the Plan Sponsor or any other person, may discriminate against a Participant in any way to prevent such Participant from obtaining a benefit or exercising his or her rights under ERISA.

Enforce Your Rights

If a Participant's claim for a benefit is denied or ignored, the Participant has 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 schedules.

Under ERISA, there are steps a Participant can take to enforce the above rights. For instance, if a Participant requests a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, the Participant 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 a Participant has a claim for benefits which is denied or ignored, in whole or in part, the Participant may file suit in a state or federal court. In addition, if a Participant disagrees with the Plan's decision, or lack thereof, concerning the qualified status of a medical child support order, the Participant may file suit in federal court.

If the Plan's fiduciaries misuse the Plan's money, or if a Participant is discriminated against for asserting his or her rights, the Participant may seek assistance from the U.S. Department of Labor or file suit in Federal court. The court will decide who should pay court costs and legal fees. If a Participant is successful, the court may order the person the Participant sued to pay these costs and fees. If the Participant loses, the Court may order the Participant to pay these costs and fees, for example, if it finds the claim is frivolous.

Assistance with Questions

If a Participant has any questions about this Plan, the Participant should contact the Plan Administrator. If a Participant has any questions about this statement or about his or her rights under ERISA, including COBRA, HIPAA, and other laws affecting the Plan, or need assistance in obtaining documents from the Plan Administrator, the Participant should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. A Participant may also obtain certain

publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration: (866) 444-EBSA or visiting their website at www.dol.gov/ebsa.

Not a Contract

The language in this SPD is not intended to create — nor is it to be construed — as a contract between the Plan Sponsor, any Participating Company, and the Participant. All questions pertaining to the validity, construction, and operation of the Plan shall be determined in accordance with the laws of the state of Connecticut, except as pre-empted by federal law. This booklet and its accompanying inserts and supplements — as updated by any future Summary of Material Modification (SMM) — constitute the Summary Plan Description (SPD) and the Plan Document for the Plan.

Health Insurance Portability and Accountability Act

Compliance with HIPAA Privacy Standards

Application
If any benefits under this Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

Disclosure of Protected Health Information (PHI)
The Plan shall not disclose PHI to any member of the Plan Sponsor's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present, or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

PHI Used and Disclosed for Administrative Purposes
Protected Health Information disclosed to members of the Plan Sponsor's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for premiums of a health care Plan. Genetic information will not be used or disclosed for underwriting purposes.

Separation of the Plan and the Plan Sponsor
The Plan shall disclose PHI only to members of the Plan Sponsor's workforce who are designated and authorized to receive PHI, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Plan Sponsor's workforce" shall refer to all employees and other persons under the control of the Plan Sponsor. Only designated employees in the Human Resources department of the Plan Sponsor will be given access to PHI, as well as the privacy official of the Plan, and employees or persons who receive PHI relating to payments under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

- An authorized member of the Plan Sponsor's workforce who receives PHI shall use or disclose the PHI only to the extent necessary to perform his or her duties with respect to the Plan. The permitted workforce members may only use the PHI for Plan administrative functions that the Plan Sponsor performs for the Plan.
- In the event that any member of the Plan Sponsor's workforce uses or discloses PHI other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy official. The privacy official shall take appropriate action to effectively resolve any issues of noncompliance with these Plan document provisions, including:
  - Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
  - Appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;
  - Mitigation of any harm caused by the breach, to the extent practicable; and

  - Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- The Plan Sponsor will handle any complaint relating to non-compliance. The privacy official will address the non-compliance with the employee. The Plan Sponsor will also impose appropriate disciplinary action up to and including termination.

Certification

The Plan Administrator will disclose PHI to the Plan Sponsor only upon its receipt of a certification to the Plan Administrator that it agrees to:

- Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
- Ensure that any agents or subcontractors to whom it provides PHI received from the Plan Administrator agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit Plan of the Plan Sponsor;
- Report to the Plan Administrator any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;
- Make available PHI to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
- Make available PHI for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- Make available the PHI required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan Administrator available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- If feasible, return or destroy all PHI received from the Plan Administrator that the Plan Sponsor still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure the adequate separation between the Plan and members of the Plan Sponsor's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in Section 11.4 above.

Other Plan Information

Plan Administrator – HRA and Retiree Life Insurance

The Plan Administrator of the HRA and the Retiree Life Insurance is Eversource Energy Service Company. All correspondence to the Plan Administrator may be addressed as follows:

P.O. Box 270
Hartford, CT 06141-0270

Communications with the Plan Administrator by telephone should be made by calling Eversource's HRConnect Line for Retirees at 888-232-6236.

Claims Submission Agent – HRA

The Claims Submission Agent for the HRA is Willis Towers Watson (OneExchange). A Participant can submit reimbursement forms with supporting documentation to the Claims Submission Agent by fax to 855-321-2605 or by mail to:

Willis Towers Watson
P.O. Box 981155
El Paso, TX 79998-1155

Participants can also contact the Claims Submission Agent at (Medicare eligible Participants): 855-885-5730 and Non-Medicare eligible Participants at 855-885-5757.

Third Party Administrator – HRA

The Third Party Administrator for the HRA is Willis Towers Watson. Medicare-eligible Participants can contact the Third Party Administrator at 855-885-5730 and Non-Medicare eligible Participants can call 855-885-5757. The address is:

Towers Watson
10975 South Sterling View Drive
South Jordan, UT 84905

Claims Submission Agent and Third Party Administrator – Retiree Life

The Claims Submission Agent and Third Party Administrator for the Retiree Life Insurance is Minnesota Life. Correspondence to the Life Insurance Claims Administrator may be addressed as follows:

Minnesota Life
400 Robert Street North
St. Paul, Minnesota 55101-2098

Communication with the Life Insurance Claims Administrator for life insurance benefits may be made by contacting Minnesota Life through the Eversource's HRConnect Line for Retirees at 888-232-6236 (1-800-842-9710 for hearing impaired).

Plan Year

The Plan Year is the twelve-month period from January 1 to December 31.

Plan Identification

This Plan is a welfare plan, as described by ERISA. The Plan is identified to the IRS and the Department of Labor as follows:

Plan Number: 510

Plan Name: Group Health and Welfare Benefits Plan for Retirees of Eversource

The HRA benefits are provided by employer contributions to the VEBA Trusts. The Retiree Life Insurance for classes 8-16 are fully insured and administered under contracts with Minnesota Life Insurance Company - A Securian Company (Policy Number: 33835-G) ("Minnesota Life").

Participating Companies

- NSTAR Electric
- NSTAR Gas
- Connecticut Light & Power
- Public Service Company of New Hampshire
- Western Massachusetts Electric
- Eversource Energy Service Company
- Yankee Gas

A complete list of the Companies participating in the Plan and their addresses is available upon written request to the Plan Administrator made to HRConnect.

Agent for Service of Legal Process

The Plan Administrator has designated the following as the agent for service of legal process for the Plan. Legal process may be served at the following addresses:

CT Corporation
One Corporate Center, Floor 11
Hartford, CT 06103-3220

Trustee for the VEBA

The Trustee's address is:

BNY Mellon
500 Grant Street, Suite 151-0410
Pittsburgh, PA 15258BNY

Appendix A

The following documents in Appendix A are the insurance certificates provided by the benefit carrier, Minnesota Life Insurance Company - A Securian Company.

Group Term Life Certificate of Insurance

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Effective July 1, 2015
Classes 8, 9, 10 and 11

POLICYHOLDER: Eversource Energy Service Company

POLICY NUMBER: 33835-G

Read Your Certificate Carefully

You are insured under the group policy shown on the specifications page attached to this certificate. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. You may examine the group policy at the principal office of the policyholder during regular working hours.

Right to Cancel

It is important to us that you are satisfied with this certificate after it is issued. If you are not satisfied with this certificate, you may cancel it by delivering or mailing a written notice or sending a telegram to Minnesota Life Insurance Company (Minnesota Life), 400 Robert Street North, St. Paul, Minnesota 55101-2098 and returning the certificate before midnight of the 30th day after you received this certificate.

Notice given by mail and return of the certificate by mail are effective on being postmarked, properly addressed, and postage prepaid. If you return this certificate, you will receive, within 10 days of the date we receive a notice of cancellation, a full refund of any premiums you have paid. Upon cancellation of this certificate, it will be void as if it had never been issued.

Secretary President

TABLE OF CONTENTS

GROUP TERM LIFE CERTIFICATE OF INSURANCE

GENERAL INFORMATION

POLICYHOLDER: Eversource Energy Service Company **POLICY NO.:** 33835-G

ASSOCIATED COMPANIES: All subsidiaries and affiliates reported to Minnesota Life by the policyholder for inclusion in the policy.

POLICY EFFECTIVE DATE: This specifications page represents the plan in effect on July 1, 2015.

This certificate and/or certificate specifications page replaces any and all certificates and/or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and/or certificate specifications page previously issued to you with this new certificate and/or specifications page.

ENROLLMENT PERIOD: Not applicable for noncontributory insurance; 31 days from the first day of eligibility for contributory insurance.

WAITING PERIOD: None

MINIMUM HOURS PER WEEK REQUIRED: Not applicable

GROUP: The group is composed of employees of the policyholder and its associated companies who reside in the United States who are in the following classifications:

Class 8: Non-represented employees eligible for benefits under the NSTAR Pension Plan, or successor plan, who meet the following eligibility requirements:

Disabled non-represented employees who have completed 10 or more years of continuous service prior to becoming disabled and who are receiving disability benefits from any policyholder sponsored disability benefit plan.

Employees who retire on or after January 1, 2000 who meet one or more of the following eligibility requirements:

(a) Attainment of age 55 with 20 years of continuous service; or
(b) Employed by Boston Edison on July 29, 1999 and attained the age of 62 with 10 years of continuous service.

Class 9: All eligible employees represented by Local 369 who meet the following eligibility requirements:

Disabled employees represented by Local 369 who have completed 10 or more years of continuous service prior to becoming disabled and who are receiving disability benefits from any policyholder sponsored disability benefit plan.

Employees who retire on or after January 1, 2006 who meet one or more of the following retiree eligibility requirements:

(a) Attainment of age 55 with 20 years of continuous service; or
(b) Attainment of age 62 with 10 years of continuous service; or
(c) Age plus years of continuous service totaling 85 or more; or
(d) Attainment of age 45 with 20 years of continuous service and resign for cause or terminate without fault; or
(e) were previously represented by Locals 333, 338 or 339 (now Local 369) and as of April 30, 2003
have a combined age and years of continuous service totaling 75 years or more; or
(f) Are eligible and approved for disability retirement under the NSTAR Pension Plan, or successor plan.

Class 10: All eligible retirees represented by Local 12004 who retire on or after April 1, 2006 and who meet the following eligibility requirements:

(a) Attainment of age 55 with 20 years of continuous service; or
(b) Attainment of age 62 with 10 years of continuous service; or
(c) Age plus years of continuous service totaling 85 or more; or
(d) Age 45 with 20 years of service and resign for cause or terminate without fault.

Class 11: Closed group of grandfathered Eversource retirees and disabled employees as reported by the policyholder and on file with Minnesota Life.

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE TERM LIFE INSURANCE:

Basic Life Insurance

Eligible Class	Amount of Basic Life Insurance
Classes 8, 9 and 10	An amount determined by the retired employee's age as shown in the following table: Age of Retired Employee: 55-59*, 60-64, 65 and over Age of Retired Employee: 55-59*, 60-64, 65 and over * Applies to classes 9 and 10: Includes retired employees under age 55 if eligible under rule of 85, and employees of class 9(f) who are eligible and approved for disability retirement under the NSTAR Pension Plan, or successor plan, but have not attained age 55. Upon attainment of age 55 coverage amount is as detailed in above table. *Applies to classes 8, 9: Includes employees terminated on LTD who are eligible for LTD benefits program but have not attained age 55.
Class 9 – disability retirees	For an employee who retires due to disability, the amount of life insurance for the 12 month period immediately following his or her date of disability retirement shall be the amount of insurance inforce on the day immediately preceding the employee's date of disability retirement. Coverage will not be reduced for any reason during the initial 12 months after date of disability retirement. Employees subject to the rule of 85 Coverage will reduce from four times annual earnings to two times annual earnings upon disability retirement. After 12 months of disability retiree benefits of two times annual earnings, the amount of insurance will be as provided in the schedule of benefits applicable to all other eligible retirees of Local 369, as described above. All other retirees: Coverage will not be reduced during this 12 month period. After 12 months of disability retiree benefits the amount of insurance will be as provided in the schedule of benefits applicable to all other eligible retirees of Local 369, as described above.
Class 11	An amount determined by the policyholder's employment practices not to exceed the amount reported by the policyholder to Minnesota Life on the census file dated October of 2009.

GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

CONTRIBUTORY/NONCONTRIBUTORY: Basic insurance is noncontributory insurance

GUARANTEED ISSUE AMOUNT: Guaranteed issue is the maximum amount of insurance an employee can receive without evidence of insurability when first eligible under the plan provided enrollment is made within the enrollment period. The amounts are as follows:

All basic insurance is guaranteed issue.

ADDITIONAL INFORMATION

SUICIDE EXCLUSION FOR LIFE INSURANCE: Does not apply to life insurance under this certificate.

ACCELERATED BENEFITS APPLICATION: The accelerated benefit factor referred to in the "Payment of Accelerated Benefit" section of the Accelerated Benefit Rider shall be 100%. This means the entire life insurance amount may be received as an accelerated benefit, subject to the maximum shown in the rider.

SUPPLEMENT TO THE CERTIFICATE

Accelerated Benefits	Applies to all classes.

Definitions

age

Attained age as of most recent birthday.

application

Your application for insurance under the group policy and, if required, your evidence of insurability application.

associated company

Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and agreed to by us to participate under the group policy.

certificate effective date

The date your coverage under this certificate becomes effective.

contributory insurance

Insurance for which you are required to make premium contributions.

earnings

Your basic rate of compensation not including commissions, overtime or premium pay, bonuses, or any other additional compensation.

employee

An individual who is employed or retired by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner's principal work is the conduct of the partnership's business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

employer

The policyholder or any designated associated companies.

evidence of insurability

Evidence satisfactory to us of the good health of the prospective insured and any other underwriting information we require.

insured

A person who is eligible for and becomes insured according to the terms of this certificate.

non-work day

A day on which you are not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long term disability.

noncontributory insurance

Insurance for which you are not required to make premium contributions.

policyholder

The owner of the group policy as shown on the specifications page attached to this certificate.

specifications page

The outline which summarizes your coverage under the policyholder's plan of insurance.

waiting period

The period, if any, of continuous employment with the employer required prior to becoming eligible for coverage under this certificate. The waiting period is shown on the specifications page attached to this certificate.

we, our, us

Minnesota Life Insurance Company.

you, your, certificate holder

An insured employee.

General Information

What is your agreement with us?

You are insured under the group policy shown on the specifications page attached to this certificate. Your application as defined under this certificate is attached and is a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your life insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application as defined in this certificate will be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application attached to your certificate.

This certificate is issued in consideration of your application and the payment of the required premium.

Can this certificate be amended?

Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.

Who is eligible for insurance?

You are eligible if you:

(1) are a member of the group and of an eligible class as defined in the group policy; and
(2) work for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page attached to this certificate; and
(3) have satisfied the waiting period as shown on the specifications page attached to this certificate; and
(4) meet the actively at work requirement as shown in the section entitled "What is the actively at work requirement?".

Are retired employees eligible for insurance?

If the policyholder's plan of insurance, as reflected in the specifications page attached to this certificate, does not specifically provide insurance for retired employees, a retired employee shall not be eligible to become insured, nor have his or her insurance continued. If the policyholder's plan of insurance specifically provides insurance for retired employees, the minimum hours per week and actively at work requirements will not apply to such persons.

What is the actively at work requirement?

To be eligible to become insured or to receive an increase or decrease in the amount of insurance, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer's normal place of business, or at other places the employer's business requires you to travel.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase or decrease in your amount of insurance would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, you are eligible to continue to be insured only while you remain actively at work.

When will we require evidence of insurability?

Evidence of insurability will be required if:

(1) the specifications page attached to this certificate states that evidence of insurability is required; or
(2) the insurance is contributory and you do not enroll within the enrollment period shown on the specifications page attached to this certificate; or
(3) the insurance for which you previously enrolled did not go into effect or was terminated because you failed to make a required premium contribution; or
(4) during a previous period of eligibility, you failed to submit required evidence of insurability or that which was submitted was not satisfactory to us; or
(5) you are insured by an individual policy issued under the terms of the conversion right section.

When does insurance become effective?

Insurance becomes effective on the date that all of the following conditions have been met:

(1) you meet all eligibility requirements; and
(2) if required, you apply for the insurance on forms which are approved by us; and
(3) we are satisfied with your evidence of insurability, if we require evidence; and
(4) we receive the required premium.

Can your coverage be continued during sickness, injury, leave of absence or temporary layoff?

Yes. The employer may continue your noncontributory insurance or allow you to continue your contributory insurance when you are absent from work due to sickness, injury, leave of absence, or temporary layoff.

Continuation of your insurance is subject to certain time limits and conditions as stated in the group policy. If you stop active work for any reason, you should discuss with the employer what arrangements may be made to continue your insurance.

Premiums

When and how often are your premium contributions due?

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a monthly basis. We apply premiums consecutively to keep the insurance in force.

How is the premium determined?

The premium will be the premium rate multiplied by the number of $1,000 units of insurance in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

We may change the premium rate:

(1) on any premium due date following the expiration of any rate guarantee period, or following the date that the amount of insurance in force for any one coverage changes by more than 15% from that which was used to determine the current rates (active employee coverage and retiree coverage are considered separate coverages, as are basic life, supplemental life, spouse life, child life and AD&D) or

(2) anytime, if the policy terms are amended or the total amount of insurance in force changes by 15% from the volume that was used to determine the current rates or more.

Death Benefit

What is the amount of the death benefit?

The amount of the death benefit is the amount of insurance shown on the specifications page attached to this certificate.

Can you request a change in the amount of your contributory insurance?

Yes. If the policyholder's plan of insurance, as reflected in the specifications page attached to the group policy, allows for a choice of amounts of insurance for your class, you can request an increase or a decrease in the amount of your contributory insurance within the limitations of the policyholder's plan of insurance, including any limitations on when and how often such requests may be made.

If you request an increase in the amount of your contributory insurance, we will require evidence of insurability, unless otherwise noted on the specifications page.

When will changes in your coverage amount be effective?

Requested increases and decreases in the amount of your contributory insurance, if approved, are effective on the date we approve the increase. Requested decreases in the amount of your contributory insurance are effective on the date we receive your request for a decrease or if different, according to the administrative practices of the employer.

Requests for a change made during a special enrollment period offered by the employer will not become effective prior to the general effective date of elections made during that enrollment.

Increases and decreases in insurance amounts which result from a change in your eligible class or earnings will be effective as shown on the specifications page attached to this certificate.

All increases in the amount of insurance are subject to the actively at work requirement.

When will the death benefit be payable?

We will pay the death benefit upon receipt at our home office of written proof satisfactory to us that you died while insured under this certificate. All payments by us are payable from our home office.

The death benefit will be paid in a single sum or by any other method agreeable to us and the beneficiary. We will pay interest on the death benefit from the date of your death until the date of payment. Interest will be at an annual rate determined by us, but never less than 0.1% per year compounded annually, or the minimum required by state law, whichever is greater.

Payment of the death benefit will extinguish our liability under the certificate for which the death benefit has been paid.

To whom will we pay the death benefit?

We will pay the death benefit to the beneficiary or beneficiaries. A beneficiary is named by you to receive the death benefit to be paid at your death. You may name one or more beneficiaries. You cannot name the policyholder or an associated company of the policyholder as a beneficiary.

You may also choose to name a beneficiary that you cannot change without the beneficiary's consent. This is called an irrevocable beneficiary.

If there is more than one beneficiary, each will receive an equal share, unless you have requested another method in writing. To receive the death benefit, a beneficiary must be living on the date of your death. In the event a beneficiary is not living on the date of your death, that beneficiary's portion of the death benefit shall be equally distributed to the remaining surviving beneficiaries. In the event of the simultaneous deaths of you and a beneficiary, the death benefit will be paid as if you survived the beneficiary.

If there is no eligible beneficiary, or if you do not name one, we will pay the death benefit to:

(1) your lawful spouse, if living, otherwise;
(2) your natural or legally adopted child (children) in equal shares, if living, otherwise;
(3) your parents in equal shares, if living, otherwise;
(4) your siblings in equal shares, if living, otherwise;
(5) the personal representative of your estate.

Can you add or change beneficiaries?

Yes. You can add or change beneficiaries if all of the following are true:

(1) your coverage is in force; and
(2) we have written consent of all irrevocable beneficiaries; and
(3) you have not assigned the ownership of your insurance.

A request to add or change a beneficiary must be made in writing. All requests are subject to our approval. A change will take effect as of the date it is signed, but will not affect any payment we make or action we take before receiving your notice.

Termination

When does your coverage terminate?

Your coverage ends on the earliest of the following:

(1) the date the group policy ends; or
(2) the date you no longer meet the eligibility requirements; or
(3) the date the group policy is amended so you are no longer eligible; or
(4) 31 days (the grace period) after the due date of any premium contribution which is not paid; or
(5) the last day for which premium contributions have been paid following your written request to cease participation under this certificate.

If your coverage under the group policy terminates due to non-payment of premiums, your coverage may be reinstated if all premiums due are paid and received by us within 31 days of the date of termination and during your lifetime.

Can your insurance be reinstated after termination?

Yes. When your coverage terminates because you are no longer eligible, and you become eligible again within the time frame shown on the specifications page, your coverage may be reinstated.

Provided you are not then covered by an individual policy issued under the terms of the conversion right section, your coverage under the group policy shall be reinstated automatically, without evidence of insurability or satisfaction of any waiting period. Your amount of insurance will be that which applies to the classification to which you then belong, on the date you again become eligible. If the policyholder's plan of insurance provides for contributory insurance under the group policy, your amount of contributory insurance will be limited to that for which you were insured immediately prior to the loss of coverage.

When does the group policy terminate?

The policyholder may terminate the group policy by giving us 31 days prior written notice. We reserve the right to terminate the group policy on the earliest of the following to occur:

(1) 31 days (the grace period) after the due date of any premiums which are not paid; or
(2) on any subsequent policy anniversary after the date the number of employees insured is less than any minimum established by us or as required by applicable state law; or
(3) 31 days after we provide the policyholder with notice of our intent to terminate the group policy.

Conversion Right

What is the conversion right?

You may be able to convert this insurance to a new individual life insurance policy if all or part of your life insurance under the group policy terminates.

You may convert up to the full amount of terminated insurance if termination occurs because you move from one existing eligible class to another, or you are no longer in an eligible class.

Limited conversion is available if, after you have been insured for at least five years, insurance is terminated because:

(1) the group policy is terminated; or
(2) the group policy is changed to reduce or terminate your insurance.

In such case, you may convert up to the full amount of terminated insurance, but not more than the maximum. The maximum is the lesser of:

(a) $10,000; and
(b) the amount of life insurance which terminated minus any amount of group life insurance for which you become eligible under any group policy issued or reinstated by us or any other carrier within 31 days of the date the insurance terminated under the group policy.

Neither the conversion right nor the limited conversion right is available if your coverage under the group policy terminates due to failure to make, when due, required premium contributions.

Under both the conversion right and the limited conversion right, you may convert your insurance to any type of individual policy of life insurance then customarily issued by us for purposes of conversion, except term insurance. The individual policy will not include any supplemental benefits, including, but not limited to, any disability benefits, accidental death and dismemberment benefits, or accelerated benefits.

You will be notified of your right to convert your group life insurance. If notification is made within 15 days before or after the event that results in termination or reduction of the group life coverage, you will have 31 days from the date the insurance terminates to elect conversion. If the notice is given more than 15 days but less than 90 days after the event, the time allowed for the exercise of the conversion right shall be extended to 15 days after such notice is sent. If the notice is not given within 90 days, the time allowed for the exercise of the conversion right expires 90 days after the terminating event. Such notice shall be mailed to you at your last known address.

How do you convert your insurance?

You convert your insurance by applying for an individual policy and paying the first premium within 31 days after your group insurance terminates. No evidence of insurability will be required.

How is the premium for the individual policy determined?

We base the premium for the individual policy on the plan of insurance, your age, and the class of risk to which you belong on the date of the conversion.

When is the individual policy effective?

The individual policy takes effect 31 days after the group insurance provided under the group policy terminates.

What happens if you die during the 31-day period allowed for conversion?

If you die during the 31-day period allowed for conversion, we will pay a death benefit regardless of whether or not an application for coverage under an individual policy has been submitted. The death benefit will be the amount of insurance you would have been eligible to convert under the terms of the conversion right section.

We will return any premium you paid for an individual policy to your beneficiary named under the group policy. In no event will we be liable under both the group policy and the individual policy.

Additional Information

What if your age has been misstated?

If your age has been misstated, the death benefit payable will be that amount to which you are entitled based on your correct age. A premium adjustment will be made so that the actual premium required at your correct age is paid.

Is there a suicide exclusion?

The specifications page attached to this certificate indicates what insurance, if any, is subject to the suicide exclusion outlined below.

When applicable, this suicide exclusion limits our liability to an amount equal to the premiums paid if you, whether sane or insane, die by suicide within two years of the effective date of your insurance.

If there has been an increase in your amount of insurance for which you were required to apply or for which we required evidence of insurability, and if you die by suicide within two years of the effective date of the increase, our liability with respect to that increase will be limited to the premiums paid and attributable to such increase.

When does your insurance become incontestable?

Except for the non-payment of premiums, after your insurance has been in force during your lifetime for two years from the effective date of your coverage, we cannot contest your coverage.

However, if there has been an increase in the amount of insurance for which you were required to apply or for which we required evidence of insurability, then, to the extent of the increase, any loss which occurs within two years of the effective date of the increase will be contestable.

Any statements you make in your application as defined under this certificate will be considered representations and not warranties. Also, any statement you make will not be used to void your insurance, nor defend against a claim, unless the statement is contained in the application attached to your certificate.

Can your insurance be assigned?

Yes. However, we will not be bound by an assignment of the certificate or of any interest in it unless it is made as a written instrument, and you file the original instrument or a certified copy with us at our home office, and we send you an acknowledged copy.

We are not responsible for the validity of any assignment. You are responsible for ensuring that the assignment is legal in your state and that it accomplishes your intended goals. If a claim is based on an assignment, we may require proof of interest of the claimant. A valid assignment will take precedence over any claim of a beneficiary.

Is the policyholder required to maintain records?

Yes. The policyholder is required to maintain adequate records of any information necessary for us to administer this certificate. We own the records relating to the insurance provided by this certificate, and can obtain them from the policyholder at any reasonable time.

If a clerical error is made in keeping records on the insurance under the group policy, it will not affect otherwise valid insurance. A clerical error does not continue insurance which is otherwise stopped. If an error causes a change in premium payment, we will make a fair adjustment.

Will the provisions of this certificate conform with state law?

Yes. If any provision in this certificate, or in the provisions of the group policy, is in conflict with the laws of the state governing the certificates or the group policy, the provision will be deemed to be amended to conform to such laws.

Accelerated Benefits Certificate Supplement

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Benefits received under this Accelerated Benefits Certificate Supplement may be taxable. You should seek assistance from a personal tax advisor prior to requesting an accelerated payment of death benefits.

The accelerated benefit in this life insurance product may provide benefits to pay for long-term care services, but it is NOT part of a long-term care or nursing home insurance policy and the amount this product pays the certificate holder may not be enough to cover his or her medical, nursing home or other bills. The certificate holder may use the money he or she receives from this product for any purpose. The receipt of any accelerated benefit payment may be taxable. The certificate holder should seek assistance from a personal tax advisor prior to requesting an accelerated benefit. Receipt of accelerated death benefits MAY AFFECT MEDICAID and SUPPLEMENTAL SECURITY INCOME ("SSI") ELIGIBILITY. The mere fact that the certificate holder owns a policy with an option to accelerate the death benefit may affect his or her eligibility for these government programs. In addition, exercising the option to accelerate death benefits and receiving those benefits before the certificate holder applies for those programs, or while he or she is receiving government benefits, may affect his or her denial or continued eligibility. The certificate holder should contact the Medicaid Unit of his or her local Division of Medical Assistance and the Social Security administration for more information.

General Information

This certificate supplement is subject to every term, condition, exclusion, limitation, and provision of your certificate unless otherwise expressly provided for herein.

What does this supplement provide?

This supplement provides for the accelerated payment of either the full or a partial amount of an insured's death benefit provided under your certificate. If an insured has a terminal condition as defined in this supplement, you may request an accelerated payment of the applicable death benefit.

Definitions

accelerated benefit

The amount of the death benefit we will pay if the insured is eligible under this supplement.

death benefit

The amount of the insured's life insurance as shown on the specifications page attached to your certificate.

immediate family

Your spouse, children, parents, grandparents, grandchildren, brothers and sisters, and their spouses.

insured

For purposes of this supplement, an insured employee, an insured spouse, or an insured dependent child.

physician

An individual who is licensed to practice medicine or treat illness in the state in which treatment is received. This does not include you or a member of your immediate family.

Terminal Condition

What is a terminal condition?

A terminal condition is a condition caused by sickness or accident which directly results in a life expectancy of 12 months or less.

What evidence do we require of the insured's terminal condition?

We must be given evidence that satisfies us that the insured's life expectancy, because of sickness or accident, is 12 months or less. That evidence must include certification by a physician.

Do we have the right to obtain independent medical verification?

Yes. We retain the right to have the insured medically examined at our own expense to verify the insured's medical condition. We may do this as often as reasonably required while accelerated benefits are being considered or paid.

Payment of Accelerated Benefit

How do we calculate the accelerated benefit?

We will multiply the death benefit by the accelerated benefit factor to determine the accelerated benefit available.

How do we calculate the accelerated benefit factor?

The accelerated benefit factor will be stated as a percentage of the insured's death benefit. When we calculate this factor, we will consider the insured's age and gender.

We will also base our calculation on certain assumptions, which we may change from time to time, including but not limited to assumptions about:

(1) expected future premiums; and
(2) the insured's life expectancy.

What are the conditions for the payment of an accelerated benefit?

We will consider the payment of an accelerated benefit, subject to all of the following conditions:

(1) coverage must be in force and all premiums due must be fully paid; and
(2) application must be made in writing and in a form which is satisfactory to us. We will tell you what form is required; and
(3) you must be the sole owner of the certificate; and
(4) the insured's insurance must not have an irrevocable beneficiary.

Who may request an accelerated payment of the death benefit?

You may request an accelerated payment of the insurance on your life or on the life of a spouse or dependent child insured under your certificate.

Is the request for an accelerated benefit voluntary?

Yes. An accelerated benefit will be made available on a voluntary basis only. An accelerated benefit under this supplement is not intended to cause an involuntary reduction of the death benefit ultimately payable to the named beneficiary. Therefore, payment of the death benefit cannot be accelerated under this supplement if the insured:

(1) is required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; or
(2) is required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

Is there a minimum or maximum death benefit eligible for an accelerated benefit?

Yes. The minimum death benefit to be eligible for an accelerated benefit under this supplement is $10,000. The maximum death benefit to be eligible for an accelerated benefit is $1,000,000.

Do you have to take the entire accelerated benefit?

No. You may choose to receive a partial accelerated benefit. If you do so, the insured's remaining coverage will stay in force.

If you elect to receive only a partial accelerated benefit amount available under this supplement, the insured's remaining death benefit under the certificate must be at least $25,000.

You may reapply for the payment of the remaining amount of insurance at any time. However, we may ask for further satisfactory evidence that the insured meets all requirements for the accelerated benefit.

What is the effect on the insured's coverage of the receipt of an accelerated benefit?

If you elect to accelerate the full amount of an insured's death benefit, the insured's coverage and all other benefits under the certificate and any certificate supplements for that insured will end. If such termination causes a certificate holder's covered spouse or dependent children to lose coverage, each of them will be allowed to convert any such insurance to a policy of individual life insurance according to the conversion right section of the certificate to which this supplement is attached.

If a partial accelerated benefit is chosen, coverage will remain in force and premiums will be reduced accordingly. The remaining amount of insurance under your certificate will be the full amount of insurance minus the amount of insurance that was accelerated.

How will we pay the accelerated benefit?

We will pay the accelerated benefit in one lump sum or in any other mutually agreeable manner.

To whom will we pay accelerated benefits?

All accelerated benefits will be paid to you unless you validly assign them otherwise. If you die before all payments have been made, we will pay the remainder to the beneficiary named under this certificate. Payment will be made in one lump sum which will be the present value of the payments that remain, using the interest rate we use to determine the payments.

Termination

When does an insured's coverage under this supplement terminate?

An insured's coverage ends on the date the insured is no longer covered for life insurance under the group policy.

When does this supplement terminate?

This supplement will terminate on the earlier of:

(1) the date we receive a written request from the policyholder to cancel the Accelerated Benefits Policy Rider; or
(2) the date the group policy is terminated.

Secretary President

Your Rights Under ERISA

The following section contains information provided to you by the Plan Administrator of your Plan to meet the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It does not constitute a part of the insurance policy issued in connection with the Plan. All inquiries relating to the following material should be referred directly to your Plan Administrator. This information should be attached to your certificate of insurance. Together they comprise your Summary Plan Description (SPD).

Summary Plan Description

General Information

Name of Plan	Group Welfare Benefits Plan for Employees of NSTAR
Plan Sponsor	NSTAR, 800 Boylston Street, Boston, MA 02090 Address:
Employer ID	Employer Identification Number (EIN): 04-3466300
Plan Number	Plan Number: 501
Type of Plan	Welfare Plan providing life insurance and associated benefits for employees.
Administration of Plan	The Plan is administered by the Plan Administrator through an insurance policy(ies) purchased from Minnesota Life Insurance Company, 400 Robert Street North, St. Paul, MN 55101. Generally, the Plan Administrator oversees the operation and records of a plan.
Plan Administrator	NSTAR - Senior Vice President – Human Resources Address: At the above address
Agent for Service of Legal Process	NSTAR – Clerk of the Corporation Address: One NSTAR Way, Westwood, MA 02090
Plan Year	January 1 – December 31
Plan Funding	The Plan has an insurance policy(ies) with Minnesota Life Insurance Company. The premiums for the policy(ies) are paid by employer and employee contributions.
Interpretation, Amendment and Termination	The plan sponsor reserves the right to interpret, change or terminate the Plan's operation in the future. In the event of termination, benefits would be discontinued as described in the certificate.

Claim Procedures

Under Department of Labor (DOL) regulations, claimants are entitled to full and fair review of any claims made under the Plan. The procedures described in this section are intended to comply with DOL regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions.

A. Presenting Claims for Benefits

Claim forms may be obtained from the Employer.

Contact your Plan Administrator if you have any questions or need claim forms. Read the instructions on those forms carefully, and be sure all the questions are answered and that you include any required attachments when the completed forms are returned. After your claim has been processed by Minnesota Life, you will be notified in writing if any benefits are denied in whole or in part, or if any additional information is required.

During all steps of the claims appeal procedure, you can write or call the appropriate Plan Administrator and ask to see all plan documents affecting your claim. In addition you may have an attorney or other representative write letters or otherwise act on your behalf, but the Plan Administrator reserves the right to require written authorization from you.

B. Claims Denial Procedure

If all or part of your claim for benefits is denied, Minnesota Life will notify you in writing within 90 days (45 days for any disability claims) of receiving your claim. If special circumstances require more time, the review period may be extended up to an additional 90 days (30 days for disability claims). You will be notified in writing of this extension within the original review period.

The notice of extension will include a description of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the information needed to resolve those issues, and it shall specify a timeframe, no less than 45 days, in which the necessary information must be provided. Where the timeframe to process a claim is extended because the claim was incomplete, the extension time is calculated from the date the extension notice is sent to the claimant to the date the person responds to the request for additional information. If the person does not provide needed information to the Plan within 45 days of the date on the notice the Plan may close the claim and no further consideration will take place.

Any denial of a claim for benefits will be provided by Minnesota Life and consist of a written explanation which will include (i) the specific reasons for the denial, (ii) reference to the pertinent Plan provisions upon which the denial is based, (iii) a description of any additional information you might be required to provide and explanation of why it is needed, and (iv) an explanation of the Plan's claim review procedure.

Disability Claims Only – The following will also be included:

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision.

- Explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant’s medical circumstances, if applicable.

C. Appealing the Denial of a Claim

You, your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to Minnesota Life. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure. A request for a review must be filed by 60 days (180 days for any disability claims) after receipt of the written notice of denial of a claim. The full and fair review will be held and a decision rendered by Minnesota Life, no later than 60 days (45 days for disability claims) after receipt of the request for review.

If special circumstances require more time, the review period may be extended up to an additional 60 days (45 days for disability claims). You will be notified in writing of this extension within the original appeal period.

The notice of extension will include a description of the missing information and shall specify a timeframe, no less than 60 days (180 days for disability claims), in which the necessary information must be provided. Where the timeframe to process an appeal is extended because the claim was incomplete, the time for the benefit determination is put on hold from the date the extension notice is sent to the claimant until the date the person responds to the request for additional information. If the person does not provide needed information to the Plan within the 60 days (180 days for disability claims) of the date on the notice the Plan will close the appeal and no further consideration will take place.

A decision on appeal is adverse if it is a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the claimant is no longer eligible to participate in a plan.

Written notification of the Plan's decision on a disability or non-disability appeal shall be provided to the claimant and will include the following:

- Explanation of the specific reasons for the denial
- A specific reference to pertinent Plan provisions on which the denial was based
- A statement regarding your right, upon request and free of charge, to reasonable access to review or copy pertinent documents
- A statement of the right to sue in federal court.

Disability Claims Only

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision
- Explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, if applicable.

D. Legal Action Following Appeals

After completing all mandatory appeal procedures, you have the right to further appeal adverse benefit determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the Statement of ERISA Rights section for more details. No such action may be filed against the Plan after two years from the date the Plan gives you a final determination on your appeal. Also, no legal action may be brought if you do not file a claim for a benefit and seek timely review of a denial of that claim.

Statement of ERISA Rights

The Statement of ERISA rights is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including the insurance contract, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

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

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

No one, including your Employer, 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 in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials for the Plan and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay the cost 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 your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

Group Term Life Certificate of Insurance

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Effective July 1, 2015
Class 12

POLICYHOLDER: Eversource Energy Service Company

POLICY NUMBER: 33835-G

Read Your Certificate Carefully

You are insured under the group policy shown on the specifications page attached to this certificate. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. You may examine the group policy at the principal office of the policyholder during regular working hours.

Right to Cancel

It is important to us that you are satisfied with this certificate after it is issued. If you are not satisfied with this certificate, you may cancel it by delivering or mailing a written notice or sending a telegram to Minnesota Life Insurance Company (Minnesota Life), 400 Robert Street North, St. Paul, Minnesota 55101-2098 and returning the certificate before midnight of the 30th day after you received this certificate.

Notice given by mail and return of the certificate by mail are effective on being postmarked, properly addressed, and postage prepaid. If you return this certificate, you will receive, within 10 days of the date we receive a notice of cancellation, a full refund of any premiums you have paid. Upon cancellation of this certificate, it will be void as if it had never been issued.

Secretary President

TABLE OF CONTENTS

GROUP TERM LIFE CERTIFICATE OF INSURANCE

GENERAL INFORMATION

POLICYHOLDER: Eversource Energy Service Company **POLICY NO.:** 33835-G

ASSOCIATED COMPANIES: All subsidiaries and affiliates reported to Minnesota Life by the policyholder for inclusion in the policy.

POLICY EFFECTIVE DATE: This specifications page represents the plan in effect on July 1, 2015

This certificate and/or certificate specifications page replaces any and all certificates and/or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and/or certificate specifications page previously issued to you with this new certificate and/or specifications page.

ENROLLMENT PERIOD: Not applicable for noncontributory insurance; 31 days from the first day of eligibility for contributory insurance.

WAITING PERIOD: None.

MINIMUM HOURS PER WEEK REQUIRED: An active employee must be working the minimum number of hours at the policyholder's regular place of business as required by his or her class as determined by the policyholder.

GROUP: The group is composed of employees of the policyholder and its associated companies who reside in the United States who are in the following classifications:

Class 12: Closed group of former officers of Commonwealth Energy Company.

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE TERM LIFE INSURANCE:

Basic Life Insurance

Eligible Class	Amount of Basic Life Insurance
Class 12	An amount determined by the retired employee's age as shown in the following table:

Age of Retired Employee	Amount of Basic Life Insurance
55-59	$100,000
60-64	$80,000
65 and over	$70,000

GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

CONTRIBUTORY/NONCONTRIBUTORY: Basic insurance is noncontributory insurance.

GUARANTEED ISSUE AMOUNT: Guaranteed issue is the maximum amount of insurance an employee can receive without evidence of insurability when first eligible under the plan provided enrollment is made within the enrollment period. The amounts are as follows:
All basic insurance is guaranteed issue.

EVIDENCE OF INSURABILITY: Evidence of insurability is required as stated in the certificate and for an amount of insurance greater than the guaranteed issue amount.

ADDITIONAL INFORMATION

SUICIDE EXCLUSION FOR LIFE INSURANCE: Does not apply to life insurance under this certificate.

ACCELERATED BENEFITS APPLICATION: The accelerated benefit factor referred to in the "Payment of Accelerated Benefit" section of the Accelerated Benefit Rider shall be 100%. This means the entire life insurance amount may be received as an accelerated benefit, subject to the maximum shown in the rider.

SUPPLEMENT TO THE CERTIFICATE

Accelerated Benefits

Definitions

age

Attained age as of most recent birthday.

application

Your application for insurance under the group policy and, if required, your evidence of insurability application.

associated company

Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and agreed to by us to participate under the group policy.

certificate effective date

The date your coverage under this certificate becomes effective.

contributory insurance

Insurance for which you are required to make premium contributions.

earnings

Your basic rate of compensation not including commissions, overtime or premium pay, bonuses, or any other additional compensation.

employee

An individual who is employed or retired by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner's principal work is the conduct of the partnership's business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

employer

The policyholder or any designated associated companies.

evidence of insurability

Evidence satisfactory to us of the good health of the prospective insured and any other underwriting information we require.

insured

A person who is eligible for and becomes insured according to the terms of this certificate.

non-work day

A day on which you are not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long term disability.

noncontributory insurance

Insurance for which you are not required to make premium contributions.

policyholder

The owner of the group policy as shown on the specifications page attached to this certificate.

specifications page

The outline which summarizes your coverage under the policyholder's plan of insurance.

waiting period

The period, if any, of continuous employment with the employer required prior to becoming eligible for coverage under this certificate. The waiting period is shown on the specifications page attached to this certificate.

we, our, us

Minnesota Life Insurance Company.

you, your, certificate holder

An insured employee.

General Information

What is your agreement with us?

You are insured under the group policy shown on the specifications page attached to this certificate. Your application as defined under this certificate is attached and is a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your life insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application as defined in this certificate will be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application attached to your certificate.

This certificate is issued in consideration of your application and the payment of the required premium.

Can this certificate be amended?

Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.

Who is eligible for insurance?

You are eligible if you:

(1) are a member of the group and of an eligible class as defined in the group policy; and
(2) work for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page attached to this certificate; and
(3) have satisfied the waiting period as shown on the specifications page attached to this certificate; and
(4) meet the actively at work requirement as shown in the section entitled "What is the actively at work requirement?".

Are retired employees eligible for insurance?

If the policyholder's plan of insurance, as reflected in the specifications page attached to this certificate, does not specifically provide insurance for retired employees, a retired employee shall not be eligible to become insured, nor have his or her insurance continued. If the policyholder's plan of insurance specifically provides insurance for retired employees, the minimum hours per week and actively at work requirements will not apply to such persons.

What is the actively at work requirement?

To be eligible to become insured or to receive an increase or decrease in the amount of insurance, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer's normal place of business, or at other places the employer's business requires you to travel.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase or decrease in your amount of insurance would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, you are eligible to continue to be insured only while you remain actively at work.

When will we require evidence of insurability?

Evidence of insurability will be required if:

(1) the specifications page attached to this certificate states that evidence of insurability is required; or
(2) the insurance is contributory and you do not enroll within the enrollment period shown on the specifications page attached to this certificate; or
(3) the insurance for which you previously enrolled did not go into effect or was terminated because you failed to make a required premium contribution; or
(4) during a previous period of eligibility, you failed to submit required evidence of insurability or that which was submitted was not satisfactory to us; or
(5) you are insured by an individual policy issued under the terms of the conversion right section.

When does insurance become effective?

Insurance becomes effective on the date that all of the following conditions have been met:

(1) you meet all eligibility requirements; and
(2) if required, you apply for the insurance on forms which are approved by us; and
(3) we are satisfied with your evidence of insurability, if we require evidence; and
(4) we receive the required premium.

Can your coverage be continued during sickness, injury, leave of absence or temporary layoff?

Yes. The employer may continue your noncontributory insurance or allow you to continue your contributory insurance when you are absent from work due to sickness, injury, leave of absence, or temporary layoff.

Continuation of your insurance is subject to certain time limits and conditions as stated in the group policy. If you stop active work for any reason, you should discuss with the employer what arrangements may be made to continue your insurance.

Premiums

When and how often are your premium contributions due?

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a monthly basis. We apply premiums consecutively to keep the insurance in force.

How is the premium determined?

The premium will be the premium rate multiplied by the number of $1,000 units of insurance in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

We may change the premium rate:

(1) on any premium due date following the expiration of any rate guarantee period, or following the date that the amount of insurance in force for any one coverage changes by more than 15% from that which was used to determine the current rates (active employee coverage and retiree coverage are considered separate coverages, as are basic life, supplemental life, spouse life, child life and AD&D) or

(2) anytime, if the policy terms are amended or the total amount of insurance in force changes by 15% from the volume that was used to determine the current rates or more.

Death Benefit

What is the amount of the death benefit?

The amount of the death benefit is the amount of insurance shown on the specifications page attached to this certificate.

Can you request a change in the amount of your contributory insurance?

Yes. If the policyholder's plan of insurance, as reflected in the specifications page attached to the group policy, allows for a choice of amounts of insurance for your class, you can request an increase or a decrease in the amount of your contributory insurance within the limitations of the policyholder's plan of insurance, including any limitations on when and how often such requests may be made.

If you request an increase in the amount of your contributory insurance, we will require evidence of insurability, unless otherwise noted on the specifications page.

When will changes in your coverage amount be effective?

Requested increases and decreases in the amount of your contributory insurance, if approved, are effective on the date we approve the increase. Requested decreases in the amount of your contributory insurance are effective on the date we receive your request for a decrease or if different, according to the administrative practices of the employer.

Requests for a change made during a special enrollment period offered by the employer will not become effective prior to the general effective date of elections made during that enrollment.

Increases and decreases in insurance amounts which result from a change in your eligible class or earnings will be effective as shown on the specifications page attached to this certificate.

All increases in the amount of insurance are subject to the actively at work requirement.

When will the death benefit be payable?

We will pay the death benefit upon receipt at our home office of written proof satisfactory to us that you died while insured under this certificate. All payments by us are payable from our home office.

The death benefit will be paid in a single sum or by any other method agreeable to us and the beneficiary. We will pay interest on the death benefit from the date of your death until the date of payment. Interest will be at an annual rate determined by us, but never less than 0.1% per year compounded annually, or the minimum required by state law, whichever is greater.

Payment of the death benefit will extinguish our liability under the certificate for which the death benefit has been paid.

To whom will we pay the death benefit?

We will pay the death benefit to the beneficiary or beneficiaries. A beneficiary is named by you to receive the death benefit to be paid at your death. You may name one or more beneficiaries. You cannot name the policyholder or an associated company of the policyholder as a beneficiary.

You may also choose to name a beneficiary that you cannot change without the beneficiary's consent. This is called an irrevocable beneficiary.

If there is more than one beneficiary, each will receive an equal share, unless you have requested another method in writing. To receive the death benefit, a beneficiary must be living on the date of your death. In the event a beneficiary is not living on the date of your death, that beneficiary's portion of the death benefit shall be equally distributed to the remaining surviving beneficiaries. In the event of the simultaneous deaths of you and a beneficiary, the death benefit will be paid as if you survived the beneficiary.

If there is no eligible beneficiary, or if you do not name one, we will pay the death benefit to:

(1) your lawful spouse, if living, otherwise;
(2) your natural or legally adopted child (children) in equal shares, if living, otherwise;
(3) your parents in equal shares, if living, otherwise;
(4) your siblings in equal shares, if living, otherwise;
(5) the personal representative of your estate.

Can you add or change beneficiaries?

Yes. You can add or change beneficiaries if all of the following are true:

(1) your coverage is in force; and
(2) we have written consent of all irrevocable beneficiaries; and
(3) you have not assigned the ownership of your insurance.

A request to add or change a beneficiary must be made in writing. All requests are subject to our approval. A change will take effect as of the date it is signed, but will not affect any payment we make or action we take before receiving your notice.

Termination

When does your coverage terminate?

Your coverage ends on the earliest of the following:

(1) the date the group policy ends; or
(2) the date you no longer meet the eligibility requirements; or
(3) the date the group policy is amended so you are no longer eligible; or
(4) 31 days (the grace period) after the due date of any premium contribution which is not paid; or
(5) the last day for which premium contributions have been paid following your written request to cease participation under this certificate.

If your coverage under the group policy terminates due to non-payment of premiums, your coverage may be reinstated if all premiums due are paid and received by us within 31 days of the date of termination and during your lifetime.

Can your insurance be reinstated after termination?

Yes. When your coverage terminates because you are no longer eligible, and you become eligible again within the time frame shown on the specifications page, your coverage may be reinstated.

Provided you are not then covered by an individual policy issued under the terms of the conversion right section, your coverage under the group policy shall be reinstated automatically, without evidence of insurability or satisfaction of any waiting period. Your amount of insurance will be that which applies to the classification to which you then belong, on the date you again become eligible. If the policyholder's plan of insurance provides for contributory insurance under the group policy, your amount of contributory insurance will be limited to that for which you were insured immediately prior to the loss of coverage.

When does the group policy terminate?

The policyholder may terminate the group policy by giving us 31 days prior written notice. We reserve the right to terminate the group policy on the earliest of the following to occur:

(1) 31 days (the grace period) after the due date of any premiums which are not paid; or
(2) on any subsequent policy anniversary after the date the number of employees insured is less than any minimum established by us or as required by applicable state law; or
(3) 31 days after we provide the policyholder with notice of our intent to terminate the group policy.

Conversion Right

What is the conversion right?

You may be able to convert this insurance to a new individual life insurance policy if all or part of your life insurance under the group policy terminates.

You may convert up to the full amount of terminated insurance if termination occurs because you move from one existing eligible class to another, or you are no longer in an eligible class.

Limited conversion is available if, after you have been insured for at least five years, insurance is terminated because:

(1) the group policy is terminated; or
(2) the group policy is changed to reduce or terminate your insurance.

In such case, you may convert up to the full amount of terminated insurance, but not more than the maximum. The maximum is the lesser of:

(a) $10,000; and
(b) the amount of life insurance which terminated minus any amount of group life insurance for which you become eligible under any group policy issued or reinstated by us or any other carrier within 31 days of the date the insurance terminated under the group policy.

Neither the conversion right nor the limited conversion right is available if your coverage under the group policy terminates due to failure to make, when due, required premium contributions.

Under both the conversion right and the limited conversion right, you may convert your insurance to any type of individual policy of life insurance then customarily issued by us for purposes of conversion, except term insurance. The individual policy will not include any supplemental benefits, including, but not limited to, any disability benefits, accidental death and dismemberment benefits, or accelerated benefits.

You will be notified of your right to convert your group life insurance. If notification is made within 15 days before or after the event that results in termination or reduction of the group life coverage, you will have 31 days from the date the insurance terminates to elect conversion. If the notice is given more than 15 days but less than 90 days after the event, the time allowed for the exercise of the conversion right shall be extended to 15 days after such notice is sent. If the notice is not given within 90 days, the time allowed for the exercise of the conversion right expires 90 days after the terminating event. Such notice shall be mailed to you at your last known address.

How do you convert your insurance?

You convert your insurance by applying for an individual policy and paying the first premium within 31 days after your group insurance terminates. No evidence of insurability will be required.

How is the premium for the individual policy determined?

We base the premium for the individual policy on the plan of insurance, your age, and the class of risk to which you belong on the date of the conversion.

When is the individual policy effective?

The individual policy takes effect 31 days after the group insurance provided under the group policy terminates.

What happens if you die during the 31-day period allowed for conversion?

If you die during the 31-day period allowed for conversion, we will pay a death benefit regardless of whether or not an application for coverage under an individual policy has been submitted. The death benefit will be the amount of insurance you would have been eligible to convert under the terms of the conversion right section.

We will return any premium you paid for an individual policy to your beneficiary named under the group policy. In no event will we be liable under both the group policy and the individual policy.

Additional Information

What if your age has been misstated?

If your age has been misstated, the death benefit payable will be that amount to which you are entitled based on your correct age. A premium adjustment will be made so that the actual premium required at your correct age is paid.

Is there a suicide exclusion?

The specifications page attached to this certificate indicates what insurance, if any, is subject to the suicide exclusion outlined below.

When applicable, this suicide exclusion limits our liability to an amount equal to the premiums paid if you, whether sane or insane, die by suicide within two years of the effective date of your insurance.

If there has been an increase in your amount of insurance for which you were required to apply or for which we required evidence of insurability, and if you die by suicide within two years of the effective date of the increase, our liability with respect to that increase will be limited to the premiums paid and attributable to such increase.

When does your insurance become incontestable?

Except for the non-payment of premiums, after your insurance has been in force during your lifetime for two years from the effective date of your coverage, we cannot contest your coverage.

However, if there has been an increase in the amount of insurance for which you were required to apply or for which we required evidence of insurability, then, to the extent of the increase, any loss which occurs within two years of the effective date of the increase will be contestable.

Any statements you make in your application as defined under this certificate will be considered representations and not warranties. Also, any statement you make will not be used to void your insurance, nor defend against a claim, unless the statement is contained in the application attached to your certificate.

Can your insurance be assigned?

Yes. However, we will not be bound by an assignment of the certificate or of any interest in it unless it is made as a written instrument, and you file the original instrument or a certified copy with us at our home office, and we send you an acknowledged copy.

We are not responsible for the validity of any assignment. You are responsible for ensuring that the assignment is legal in your state and that it accomplishes your intended goals. If a claim is based on an assignment, we may require proof of interest of the claimant. A valid assignment will take precedence over any claim of a beneficiary.

Is the policyholder required to maintain records?

Yes. The policyholder is required to maintain adequate records of any information necessary for us to administer this certificate. We own the records relating to the insurance provided by this certificate, and can obtain them from the policyholder at any reasonable time.

If a clerical error is made in keeping records on the insurance under the group policy, it will not affect otherwise valid insurance. A clerical error does not continue insurance which is otherwise stopped. If an error causes a change in premium payment, we will make a fair adjustment.

Will the provisions of this certificate conform with state law?

Yes. If any provision in this certificate, or in the provisions of the group policy, is in conflict with the laws of the state governing the certificates or the group policy, the provision will be deemed to be amended to conform to such laws.

Accelerated Benefits Certificate Supplement

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Benefits received under this Accelerated Benefits Certificate Supplement may be taxable. You should seek assistance from a personal tax advisor prior to requesting an accelerated payment of death benefits.

The accelerated benefit in this life insurance product may provide benefits to pay for long-term care services, but it is NOT part of a long-term care or nursing home insurance policy and the amount this product pays the certificate holder may not be enough to cover his or her medical, nursing home or other bills. The certificate holder may use the money he or she receives from this product for any purpose. The receipt of any accelerated benefit payment may be taxable. The certificate holder should seek assistance from a personal tax advisor prior to requesting an accelerated benefit. Receipt of accelerated death benefits MAY AFFECT MEDICAID and SUPPLEMENTAL SECURITY INCOME ("SSI") ELIGIBILITY. The mere fact that the certificate holder owns a policy with an option to accelerate the death benefit may affect his or her eligibility for these government programs. In addition, exercising the option to accelerate death benefits and receiving those benefits before the certificate holder applies for those programs, or while he or she is receiving government benefits, may affect his or her denial or continued eligibility. The certificate holder should contact the Medicaid Unit of his or her local Division of Medical Assistance and the Social Security administration for more information.

General Information

This certificate supplement is subject to every term, condition, exclusion, limitation, and provision of your certificate unless otherwise expressly provided for herein.

What does this supplement provide?

This supplement provides for the accelerated payment of either the full or a partial amount of an insured's death benefit provided under your certificate. If an insured has a terminal condition as defined in this supplement, you may request an accelerated payment of the applicable death benefit.

Definitions

accelerated benefit

The amount of the death benefit we will pay if the insured is eligible under this supplement.

death benefit

The amount of the insured's life insurance as shown on the specifications page attached to your certificate.

immediate family

Your spouse, children, parents, grandparents, grandchildren, brothers and sisters, and their spouses.

insured

For purposes of this supplement, an insured employee, an insured spouse, or an insured dependent child.

physician

An individual who is licensed to practice medicine or treat illness in the state in which treatment is received. This does not include you or a member of your immediate family.

Terminal Condition

What is a terminal condition?

A terminal condition is a condition caused by sickness or accident which directly results in a life expectancy of 12 months or less.

What evidence do we require of the insured's terminal condition?

We must be given evidence that satisfies us that the insured's life expectancy, because of sickness or accident, is 12 months or less. That evidence must include certification by a physician.

Do we have the right to obtain independent medical verification?

Yes. We retain the right to have the insured medically examined at our own expense to verify the insured's medical condition. We may do this as often as reasonably required while accelerated benefits are being considered or paid.

Payment of Accelerated Benefit

How do we calculate the accelerated benefit?

We will multiply the death benefit by the accelerated benefit factor to determine the accelerated benefit available.

How do we calculate the accelerated benefit factor?

The accelerated benefit factor will be stated as a percentage of the insured's death benefit. When we calculate this factor, we will consider the insured's age and gender.

We will also base our calculation on certain assumptions, which we may change from time to time, including but not limited to assumptions about:

(1) expected future premiums; and
(2) the insured's life expectancy.

What are the conditions for the payment of an accelerated benefit?

We will consider the payment of an accelerated benefit, subject to all of the following conditions:

(1) coverage must be in force and all premiums due must be fully paid; and
(2) application must be made in writing and in a form which is satisfactory to us. We will tell you what form is required; and
(3) you must be the sole owner of the certificate; and
(4) the insured's insurance must not have an irrevocable beneficiary.

Who may request an accelerated payment of the death benefit?

You may request an accelerated payment of the insurance on your life or on the life of a spouse or dependent child insured under your certificate.

Is the request for an accelerated benefit voluntary?

Yes. An accelerated benefit will be made available on a voluntary basis only. An accelerated benefit under this supplement is not intended to cause an involuntary reduction of the death benefit ultimately payable to the named beneficiary. Therefore, payment of the death benefit cannot be accelerated under this supplement if the insured:

(1) is required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; or
(2) is required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

Is there a minimum or maximum death benefit eligible for an accelerated benefit?

Yes. The minimum death benefit to be eligible for an accelerated benefit under this supplement is $10,000. The maximum death benefit to be eligible for an accelerated benefit is $1,000,000.

Do you have to take the entire accelerated benefit?

No. You may choose to receive a partial accelerated benefit. If you do so, the insured's remaining coverage will stay in force.

If you elect to receive only a partial accelerated benefit amount available under this supplement, the insured's remaining death benefit under the certificate must be at least $25,000.

You may reapply for the payment of the remaining amount of insurance at any time. However, we may ask for further satisfactory evidence that the insured meets all requirements for the accelerated benefit.

What is the effect on the insured's coverage of the receipt of an accelerated benefit?

If you elect to accelerate the full amount of an insured's death benefit, the insured's coverage and all other benefits under the certificate and any certificate supplements for that insured will end. If such termination causes a certificate holder's covered spouse or dependent children to lose coverage, each of them will be allowed to convert any such insurance to a policy of individual life insurance according to the conversion right section of the certificate to which this supplement is attached.

If a partial accelerated benefit is chosen, coverage will remain in force and premiums will be reduced accordingly. The remaining amount of insurance under your certificate will be the full amount of insurance minus the amount of insurance that was accelerated.

How will we pay the accelerated benefit?

We will pay the accelerated benefit in one lump sum or in any other mutually agreeable manner.

To whom will we pay accelerated benefits?

All accelerated benefits will be paid to you unless you validly assign them otherwise. If you die before all payments have been made, we will pay the remainder to the beneficiary named under this certificate. Payment will be made in one lump sum which will be the present value of the payments that remain, using the interest rate we use to determine the payments.

Termination

When does an insured's coverage under this supplement terminate?

An insured's coverage ends on the date the insured is no longer covered for life insurance under the group policy.

When does this supplement terminate?

This supplement will terminate on the earlier of:

(1) the date we receive a written request from the policyholder to cancel the Accelerated Benefits Policy Rider; or
(2) the date the group policy is terminated.

Secretary President

Your Rights Under ERISA

The following section contains information provided to you by the Plan Administrator of your Plan to meet the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It does not constitute a part of the insurance policy issued in connection with the Plan. All inquiries relating to the following material should be referred directly to your Plan Administrator. This information should be attached to your certificate of insurance. Together they comprise your Summary Plan Description (SPD).

Summary Plan Description

General Information

Name of Plan	Group Welfare Benefits Plan for Employees of NSTAR
Plan Sponsor	NSTAR, 800 Boylston Street, Boston, MA 02090 Address:
Employer ID	Employer Identification Number (EIN): 04-3466300
Plan Number	Plan Number: 501
Type of Plan	Welfare Plan providing life insurance and associated benefits for employees.
Administration of Plan	The Plan is administered by the Plan Administrator through an insurance policy(ies) purchased from Minnesota Life Insurance Company, 400 Robert Street North, St. Paul, MN 55101. Generally, the Plan Administrator oversees the operation and records of a plan.
Plan Administrator	NSTAR - Senior Vice President – Human Resources Address: At the above address
Agent for Service of Legal Process	NSTAR – Clerk of the Corporation Address: One NSTAR Way, Westwood, MA 02090
Plan Year	January 1 – December 31
Plan Funding	The Plan has an insurance policy(ies) with Minnesota Life Insurance Company. The premiums for the policy(ies) are paid by employer and employee contributions.
Interpretation, Amendment and Termination	The plan sponsor reserves the right to interpret, change or terminate the Plan's operation in the future. In the event of termination, benefits would be discontinued as described in the certificate.

Claim Procedures

Under Department of Labor (DOL) regulations, claimants are entitled to full and fair review of any claims made under the Plan. The procedures described in this section are intended to comply with DOL regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions.

A. Presenting Claims for Benefits

Claim forms may be obtained from the Employer.

Contact your Plan Administrator if you have any questions or need claim forms. Read the instructions on those forms carefully, and be sure all the questions are answered and that you include any required attachments when the completed forms are returned. After your claim has been processed by Minnesota Life, you will be notified in writing if any benefits are denied in whole or in part, or if any additional information is required.

During all steps of the claims appeal procedure, you can write or call the appropriate Plan Administrator and ask to see all plan documents affecting your claim. In addition you may have an attorney or other representative write letters or otherwise act on your behalf, but the Plan Administrator reserves the right to require written authorization from you.

B. Claims Denial Procedure

If all or part of your claim for benefits is denied, Minnesota Life will notify you in writing within 90 days (45 days for any disability claims) of receiving your claim. If special circumstances require more time, the review period may be extended up to an additional 90 days (30 days for disability claims). You will be notified in writing of this extension within the original review period.

The notice of extension will include a description of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the information needed to resolve those issues, and it shall specify a timeframe, no less than 45 days, in which the necessary information must be provided. Where the timeframe to process a claim is extended because the claim was incomplete, the extension time is calculated from the date the extension notice is sent to the claimant to the date the person responds to the request for additional information. If the person does not provide needed information to the Plan within 45 days of the date on the notice the Plan may close the claim and no further consideration will take place.

Any denial of a claim for benefits will be provided by Minnesota Life and consist of a written explanation which will include (i) the specific reasons for the denial, (ii) reference to the pertinent Plan provisions upon which the denial is based, (iii) a description of any additional information you might be required to provide and explanation of why it is needed, and (iv) an explanation of the Plan's claim review procedure.

Disability Claims Only – The following will also be included:

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision.

- Explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant’s medical circumstances, if applicable.

C. Appealing the Denial of a Claim

You, your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to Minnesota Life. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure. A request for a review must be filed by 60 days (180 days for any disability claims) after receipt of the written notice of denial of a claim. The full and fair review will be held and a decision rendered by Minnesota Life, no later than 60 days (45 days for disability claims) after receipt of the request for review.

If special circumstances require more time, the review period may be extended up to an additional 60 days (45 days for disability claims). You will be notified in writing of this extension within the original appeal period.

The notice of extension will include a description of the missing information and shall specify a timeframe, no less than 60 days (180 days for disability claims), in which the necessary information must be provided. Where the timeframe to process an appeal is extended because the claim was incomplete, the time for the benefit determination is put on hold from the date the extension notice is sent to the claimant until the date the person responds to the request for additional information. If the person does not provide needed information to the Plan within the 60 days (180 days for disability claims) of the date on the notice the Plan will close the appeal and no further consideration will take place.

A decision on appeal is adverse if it is a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the claimant is no longer eligible to participate in a plan.

Written notification of the Plan's decision on a disability or non-disability appeal shall be provided to the claimant and will include the following:

- Explanation of the specific reasons for the denial
- A specific reference to pertinent Plan provisions on which the denial was based
- A statement regarding your right, upon request and free of charge, to reasonable access to review or copy pertinent documents
- A statement of the right to sue in federal court.

Disability Claims Only

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision
- Explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, if applicable.

D. Legal Action Following Appeals

After completing all mandatory appeal procedures, you have the right to further appeal adverse benefit determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the Statement of ERISA Rights section for more details. No such action may be filed against the Plan after two years from the date the Plan gives you a final determination on your appeal. Also, no legal action may be brought if you do not file a claim for a benefit and seek timely review of a denial of that claim.

Statement of ERISA Rights

The Statement of ERISA rights is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including the insurance contract, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

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

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

No one, including your Employer, 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 in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials for the Plan and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay the cost 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 your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

Group Term Life Certificate of Insurance

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Effective July 1, 2015
Classes 13a, 13b, 14, 15 and 16

POLICYHOLDER: Northeast Utilities Service Company

POLICY NUMBER: 33835-G

Read Your Certificate Carefully

You are insured under the group policy shown on the specifications page attached to this certificate. This certificate summarizes the principal provisions of the group policy that affect you. The provisions summarized in this certificate are subject in every respect to the group policy. You may examine the group policy at the principal office of the policyholder during regular working hours.

Right to Cancel

It is important to us that you are satisfied with this certificate after it is issued. If you are not satisfied with this certificate, you may cancel it by delivering or mailing a written notice or sending a telegram to Minnesota Life Insurance Company (Minnesota Life), 400 Robert Street North, St. Paul, Minnesota 55101-2098 and returning the certificate before midnight of the 30th day after you received this certificate.

Notice given by mail and return of the certificate by mail are effective on being postmarked, properly addressed, and postage prepaid. If you return this certificate, you will receive, within 10 days of the date we receive a notice of cancellation, a full refund of any premiums you have paid. Upon cancellation of this certificate, it will be void as if it had never been issued.

Secretary President

TABLE OF CONTENTS

GROUP TERM LIFE CERTIFICATE OF INSURANCE

GENERAL INFORMATION

POLICYHOLDER: Eversource Energy Service Company **POLICY NO.:** 33835-G

ASSOCIATED COMPANIES: All subsidiaries and affiliates reported to Minnesota Life by the policyholder for inclusion in the policy.

POLICY EFFECTIVE DATE: This specifications page represents the plan in effect on July 1, 2015.

This certificate and/or certificate specifications page replaces any and all certificates and/or certificate specifications pages previously issued to you under the group policy. Please replace any certificate and/or certificate specifications page previously issued to you with this new certificate and/or specifications page.

ENROLLMENT PERIOD: Not applicable for noncontributory insurance; 31 days from the first day of eligibility for contributory insurance.

WAITING PERIOD: None.

MINIMUM HOURS PER WEEK REQUIRED: Not applicable.

GROUP: The group is composed of employees of the policyholder and its associated companies who reside in the United States who are in the following classifications:

Class 13a:	Retired employees eligible for the NUSCO Retirement Plan, or successor plan, who retired January 1, 1993 through December 31, 2002.
Class 13b:	Retired employees eligible for the NUSCO Retirement Plan, or successor plan, who retired January 1, 2003 or later.
Class 14:	Closed group of retired employees of Public Service Company of New Hampshire (PSNH) enrolled in employee term life coverage on the date prior to retirement. Retirees must have been age 50 as of June 1, 1992.
Class 15:	Retired employees who retired as K-Vantage retirees under the Eversource 401k Plan who retired January 1, 2006 or later.
Class 16:	Closed group of retired employees eligible for the NUSCO Retirement Plan, or successor plan, who retired prior to January 1, 1993.

PLAN OF INSURANCE

EMPLOYEE BENEFIT SCHEDULE

EMPLOYEE TERM LIFE INSURANCE:

Basic Life Insurance

Eligible Class	Amount of Basic Life Insurance
Class 13a, 13b and 16	75% of the employee's base pay on the last actively at work day prior to his or her retirement. If the base pay is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. The maximum benefit amount is $40,000. Note: The retiree may elect to surrender up to $40,000 of the life insurance benefit to receive additional pension annuity income instead.
Class 14	75% of the employee's base pay on the last actively at work day prior to his or her retirement. If the base pay is not a multiple of $1,000, it will be rounded to the next higher multiple of $1,000. The maximum benefit amount is $500,000. Note: The retiree may elect to surrender up to $40,000 of the life insurance benefit to receive additional pension annuity income instead.
Classes 15	None

Optional Life Insurance

An amount elected by the employee from the following options:

Eligible Class	Amount of Optional Life Insurance
Class 13a	50% of the employee's optional life benefit that exceeds two times base pay. If this amount is not a multiple of $1,000, it will be rounded down to the next lower multiple of $10,000. The maximum benefit amount is $375,000.
Classes 13b and 15	25% of the employee's optional life benefit. If this amount is not a multiple of $1,000, it will be rounded down to the next lower multiple of $10,000. The maximum benefit amount is the lesser of four times annual earnings or $375,000.
Class 14	50% of the employee's amount of optional life insurance. If this amount is not a multiple of $1,000, it will be rounded down to the next lower multiple of $10,000.
Class 16	None

GENERAL PROVISIONS FOR EMPLOYEE INSURANCE

CONTRIBUTORY/NONCONTRIBUTORY: Basic insurance is noncontributory insurance; optional insurance is contributory insurance.

GUARANTEED ISSUE AMOUNT: Guaranteed issue is the maximum amount of insurance an employee can receive without evidence of insurability when first eligible under the plan provided enrollment is made within the enrollment period. The amounts are as follows:

For basic insurance:

All basic insurance is guaranteed issue.

For optional insurance:

For employees in an eligible class immediately prior to the effective date of the group policy:

An amount equal to the amount of contributory insurance for which the employee was insured under the prior carrier's group policy on the day immediately preceding the effective date of this certificate.

For employees who first become eligible after the effective date of the group policy provided enrollment is made within the 31 day enrollment period:

Classes 13a, 13b, 14 and 15:

All optional life insurance is guaranteed issue.

EVIDENCE OF INSURABILITY: Evidence of insurability is required as stated in the certificate and for an amount of insurance greater than the guaranteed issue amount.

ADDITIONAL INFORMATION

SUICIDE EXCLUSION FOR LIFE INSURANCE:

The suicide exclusion does not apply to life insurance under this certificate.

ACCELERATED BENEFITS APPLICATION:

The accelerated benefit factor referred to in the "Payment of Accelerated Benefit" section of the Accelerated Benefit Rider shall be 100%. This means the entire life insurance amount may be received as an accelerated benefit, subject to the maximum shown in the rider.

SUPPLEMENT TO THE CERTIFICATE

Accelerated Benefits	Applies to all classes.

Definitions

age

Attained age as of most recent birthday.

application

Your application for insurance under the group policy and, if required, your evidence of insurability application.

associated company

Any company which is a subsidiary or affiliate of the policyholder which is designated by the policyholder and agreed to by us to participate under the group policy.

certificate effective date

The date your coverage under this certificate becomes effective.

contributory insurance

Insurance for which you are required to make premium contributions.

earnings

Your basic rate of compensation not including commissions, overtime or premium pay, bonuses, or any other additional compensation.

employee

An individual who is employed or retired by the policyholder or by an associated company. A sole proprietor will be considered the employee of the proprietorship. A partner in a partnership will be considered an employee so long as the partner's principal work is the conduct of the partnership's business. The term employee does not include temporary employees nor corporate directors who are not otherwise employees.

employer

The policyholder or any designated associated companies.

evidence of insurability

Evidence satisfactory to us of the good health of the prospective insured and any other underwriting information we require.

insured

A person who is eligible for and becomes insured according to the terms of this certificate.

non-work day

A day on which you are not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays, and approved leaves of absence for non-medical reasons.

Non-work day does not include time off for medical leave of absence, temporary layoff, employer suspension of operations in total or in part, strike, and any time off due to sickness or injury including sick days, short-term disability, or long term disability.

noncontributory insurance

Insurance for which you are not required to make premium contributions.

policyholder

The owner of the group policy as shown on the specifications page attached to this certificate.

specifications page

The outline which summarizes your coverage under the policyholder's plan of insurance.

waiting period

The period, if any, of continuous employment with the employer required prior to becoming eligible for coverage under this certificate. The waiting period is shown on the specifications page attached to this certificate.

we, our, us

Minnesota Life Insurance Company.

you, your, certificate holder

An insured employee.

General Information

What is your agreement with us?

You are insured under the group policy shown on the specifications page attached to this certificate. Your application as defined under this certificate is attached and is a part of this certificate. This certificate summarizes the principal provisions of the group policy that affect your life insurance coverage. The provisions summarized in this certificate are subject in every respect to the group policy.

Any statements made in your application as defined in this certificate will be considered representations and not warranties. Also, any statement made will not be used to void your insurance nor defend against a claim unless the statement is contained in the application attached to your certificate.

This certificate is issued in consideration of your application and the payment of the required premium.

Can this certificate be amended?

Yes. We retain the right to amend this certificate at any time without your consent. Any amendment will be without prejudice to any claim incurred for benefits prior to the date of the amendment.

Who is eligible for insurance?

You are eligible if you:

(1) are a member of the group and of an eligible class as defined in the group policy; and
(2) work for the employer for at least the number of hours per week shown as the minimum hours per week requirement on the specifications page attached to this certificate; and
(3) have satisfied the waiting period as shown on the specifications page attached to this certificate; and
(4) meet the actively at work requirement as shown in the section entitled "What is the actively at work requirement?".

Are retired employees eligible for insurance?

If the policyholder's plan of insurance, as reflected in the specifications page attached to this certificate, does not specifically provide insurance for retired employees, a retired employee shall not be eligible to become insured, nor have his or her insurance continued. If the policyholder's plan of insurance specifically provides insurance for retired employees, the minimum hours per week and actively at work requirements will not apply to such persons.

What is the actively at work requirement?

To be eligible to become insured or to receive an increase or decrease in the amount of insurance, you must be actively at work, fully performing your customary duties for your regularly scheduled number of hours at the employer's normal place of business, or at other places the employer's business requires you to travel.

If you are not actively at work on the date coverage would otherwise begin, or on the date an increase or decrease in your amount of insurance would otherwise be effective, you will not be eligible for the coverage or increase until you return to active work. However, if the absence is on a non-work day, coverage will not be delayed provided you were actively at work on the work day immediately preceding the non-work day.

Except as otherwise provided for in this certificate, you are eligible to continue to be insured only while you remain actively at work.

When will we require evidence of insurability?

Evidence of insurability will be required if:

(1) the specifications page attached to this certificate states that evidence of insurability is required; or
(2) the insurance is contributory and you do not enroll within the enrollment period shown on the specifications page attached to this certificate; or
(3) the insurance for which you previously enrolled did not go into effect or was terminated because you failed to make a required premium contribution; or
(4) during a previous period of eligibility, you failed to submit required evidence of insurability or that which was submitted was not satisfactory to us; or
(5) you are insured by an individual policy issued under the terms of the conversion right section.

When does insurance become effective?

Insurance becomes effective on the date that all of the following conditions have been met:

(1) you meet all eligibility requirements; and
(2) if required, you apply for the insurance on forms which are approved by us; and
(3) we are satisfied with your evidence of insurability, if we require evidence; and
(4) we receive the required premium.

Can your coverage be continued during sickness, injury, leave of absence or temporary layoff?

Yes. The employer may continue your noncontributory insurance or allow you to continue your contributory insurance when you are absent from work due to sickness, injury, leave of absence, or temporary layoff.

Continuation of your insurance is subject to certain time limits and conditions as stated in the group policy. If you stop active work for any reason, you should discuss with the employer what arrangements may be made to continue your insurance.

Premiums

When and how often are your premium contributions due?

Unless the policyholder and we have agreed to some other premium payment procedure, any premium contributions you are required to make for contributory insurance are to be paid by you to the policyholder on a monthly basis. We apply premiums consecutively to keep the insurance in force.

How is the premium determined?

The premium will be the premium rate multiplied by the number of $1,000 units of insurance in force on the date premiums are due. The premium may also be computed by any other method on which the policyholder and we agree.

We may change the premium rate:

(1) on any premium due date following the expiration of any rate guarantee period, or following the date that the amount of insurance in force for any one coverage changes by more than 15% from that which was used to determine the current rates (active employee coverage and retiree coverage are considered separate coverages, as are basic life, supplemental life, spouse life, child life and AD&D) or

(2) anytime, if the policy terms are amended or the total amount of insurance in force changes by 15% from the volume that was used to determine the current rates or more.

Death Benefit

What is the amount of the death benefit?

The amount of the death benefit is the amount of insurance shown on the specifications page attached to this certificate.

Can you request a change in the amount of your contributory insurance?

Yes. If the policyholder's plan of insurance, as reflected in the specifications page attached to the group policy, allows for a choice of amounts of insurance for your class, you can request an increase or a decrease in the amount of your contributory insurance within the limitations of the policyholder's plan of insurance, including any limitations on when and how often such requests may be made.

If you request an increase in the amount of your contributory insurance, we will require evidence of insurability, unless otherwise noted on the specifications page.

When will changes in your coverage amount be effective?

Requested increases and decreases in the amount of your contributory insurance, if approved, are effective on the date we approve the increase. Requested decreases in the amount of your contributory insurance are effective on the date we receive your request for a decrease or if different, according to the administrative practices of the employer.

Requests for a change made during a special enrollment period offered by the employer will not become effective prior to the general effective date of elections made during that enrollment.

Increases and decreases in insurance amounts which result from a change in your eligible class or earnings will be effective as shown on the specifications page attached to this certificate.

All increases in the amount of insurance are subject to the actively at work requirement.

When will the death benefit be payable?

We will pay the death benefit upon receipt at our home office of written proof satisfactory to us that you died while insured under this certificate. All payments by us are payable from our home office.

The death benefit will be paid in a single sum or by any other method agreeable to us and the beneficiary. We will pay interest on the death benefit from the date of your death until the date of payment. Interest will be at an annual rate determined by us, but never less than 0.1% per year compounded annually, or the minimum required by state law, whichever is greater.

Payment of the death benefit will extinguish our liability under the certificate for which the death benefit has been paid.

To whom will we pay the death benefit?

We will pay the death benefit to the beneficiary or beneficiaries. A beneficiary is named by you to receive the death benefit to be paid at your death. You may name one or more beneficiaries. You cannot name the policyholder or an associated company of the policyholder as a beneficiary.

You may also choose to name a beneficiary that you cannot change without the beneficiary's consent. This is called an irrevocable beneficiary.

If there is more than one beneficiary, each will receive an equal share, unless you have requested another method in writing. To receive the death benefit, a beneficiary must be living on the date of your death. In the event a beneficiary is not living on the date of your death, that beneficiary's portion of the death benefit shall be equally distributed to the remaining surviving beneficiaries. In the event of the simultaneous deaths of you and a beneficiary, the death benefit will be paid as if you survived the beneficiary.

If there is no eligible beneficiary, or if you do not name one, we will pay the death benefit to:

(1) your lawful spouse, if living, otherwise;
(2) your natural or legally adopted child (children) in equal shares, if living, otherwise;
(3) your parents in equal shares, if living, otherwise;
(4) your siblings in equal shares, if living, otherwise;
(5) the personal representative of your estate.

Can you add or change beneficiaries?

Yes. You can add or change beneficiaries if all of the following are true:

(1) your coverage is in force; and
(2) we have written consent of all irrevocable beneficiaries; and
(3) you have not assigned the ownership of your insurance.

A request to add or change a beneficiary must be made in writing. All requests are subject to our approval. A change will take effect as of the date it is signed, but will not affect any payment we make or action we take before receiving your notice.

Termination

When does your coverage terminate?

Your coverage ends on the earliest of the following:

(1) the date the group policy ends; or
(2) the date you no longer meet the eligibility requirements; or
(3) the date the group policy is amended so you are no longer eligible; or
(4) 31 days (the grace period) after the due date of any premium contribution which is not paid; or
(5) the last day for which premium contributions have been paid following your written request to cease participation under this certificate.

If your coverage under the group policy terminates due to non-payment of premiums, your coverage may be reinstated if all premiums due are paid and received by us within 31 days of the date of termination and during your lifetime.

Can your insurance be reinstated after termination?

Yes. When your coverage terminates because you are no longer eligible, and you become eligible again within the time frame shown on the specifications page, your coverage may be reinstated.

Provided you are not then covered by an individual policy issued under the terms of the conversion right section, your coverage under the group policy shall be reinstated automatically, without evidence of insurability or satisfaction of any waiting period. Your amount of insurance will be that which applies to the classification to which you then belong, on the date you again become eligible. If the policyholder's plan of insurance provides for contributory insurance under the group policy, your amount of contributory insurance will be limited to that for which you were insured immediately prior to the loss of coverage.

When does the group policy terminate?

The policyholder may terminate the group policy by giving us 31 days prior written notice. We reserve the right to terminate the group policy on the earliest of the following to occur:

(1) 31 days (the grace period) after the due date of any premiums which are not paid; or
(2) on any subsequent policy anniversary after the date the number of employees insured is less than any minimum established by us or as required by applicable state law; or
(3) 31 days after we provide the policyholder with notice of our intent to terminate the group policy.

Conversion Right

What is the conversion right?

You may be able to convert this insurance to a new individual life insurance policy if all or part of your life insurance under the group policy terminates.

You may convert up to the full amount of terminated insurance if termination occurs because you move from one existing eligible class to another, or you are no longer in an eligible class.

Limited conversion is available if, after you have been insured for at least five years, insurance is terminated because:

(1) the group policy is terminated; or
(2) the group policy is changed to reduce or terminate your insurance.

In such case, you may convert up to the full amount of terminated insurance, but not more than the maximum. The maximum is the lesser of:

(a) $10,000; and
(b) the amount of life insurance which terminated minus any amount of group life insurance for which you become eligible under any group policy issued or reinstated by us or any other carrier within 31 days of the date the insurance terminated under the group policy.

Neither the conversion right nor the limited conversion right is available if your coverage under the group policy terminates due to failure to make, when due, required premium contributions.

Under both the conversion right and the limited conversion right, you may convert your insurance to any type of individual policy of life insurance then customarily issued by us for purposes of conversion, except term insurance. The individual policy will not include any supplemental benefits, including, but not limited to, any disability benefits, accidental death and dismemberment benefits, or accelerated benefits.

You will be notified of your right to convert your group life insurance. If notification is made within 15 days before or after the event that results in termination or reduction of the group life coverage, you will have 31 days from the date the insurance terminates to elect conversion. If the notice is given more than 15 days but less than 90 days after the event, the time allowed for the exercise of the conversion right shall be extended to 15 days after such notice is sent. If the notice is not given within 90 days, the time allowed for the exercise of the conversion right expires 90 days after the terminating event. Such notice shall be mailed to you at your last known address.

How do you convert your insurance?

You convert your insurance by applying for an individual policy and paying the first premium within 31 days after your group insurance terminates. No evidence of insurability will be required.

How is the premium for the individual policy determined?

We base the premium for the individual policy on the plan of insurance, your age, and the class of risk to which you belong on the date of the conversion.

When is the individual policy effective?

The individual policy takes effect 31 days after the group insurance provided under the group policy terminates.

What happens if you die during the 31-day period allowed for conversion?

If you die during the 31-day period allowed for conversion, we will pay a death benefit regardless of whether or not an application for coverage under an individual policy has been submitted. The death benefit will be the amount of insurance you would have been eligible to convert under the terms of the conversion right section.

We will return any premium you paid for an individual policy to your beneficiary named under the group policy. In no event will we be liable under both the group policy and the individual policy.

Additional Information

What if your age has been misstated?

If your age has been misstated, the death benefit payable will be that amount to which you are entitled based on your correct age. A premium adjustment will be made so that the actual premium required at your correct age is paid.

Is there a suicide exclusion?

The specifications page attached to this certificate indicates what insurance, if any, is subject to the suicide exclusion outlined below.

When applicable, this suicide exclusion limits our liability to an amount equal to the premiums paid if you, whether sane or insane, die by suicide within two years of the effective date of your insurance.

If there has been an increase in your amount of insurance for which you were required to apply or for which we required evidence of insurability, and if you die by suicide within two years of the effective date of the increase, our liability with respect to that increase will be limited to the premiums paid and attributable to such increase.

When does your insurance become incontestable?

Except for the non-payment of premiums, after your insurance has been in force during your lifetime for two years from the effective date of your coverage, we cannot contest your coverage.

However, if there has been an increase in the amount of insurance for which you were required to apply or for which we required evidence of insurability, then, to the extent of the increase, any loss which occurs within two years of the effective date of the increase will be contestable.

Any statements you make in your application as defined under this certificate will be considered representations and not warranties. Also, any statement you make will not be used to void your insurance, nor defend against a claim, unless the statement is contained in the application attached to your certificate.

Can your insurance be assigned?

Yes. However, we will not be bound by an assignment of the certificate or of any interest in it unless it is made as a written instrument, and you file the original instrument or a certified copy with us at our home office, and we send you an acknowledged copy.

We are not responsible for the validity of any assignment. You are responsible for ensuring that the assignment is legal in your state and that it accomplishes your intended goals. If a claim is based on an assignment, we may require proof of interest of the claimant. A valid assignment will take precedence over any claim of a beneficiary.

Is the policyholder required to maintain records?

Yes. The policyholder is required to maintain adequate records of any information necessary for us to administer this certificate. We own the records relating to the insurance provided by this certificate, and can obtain them from the policyholder at any reasonable time.

If a clerical error is made in keeping records on the insurance under the group policy, it will not affect otherwise valid insurance. A clerical error does not continue insurance which is otherwise stopped. If an error causes a change in premium payment, we will make a fair adjustment.

Will the provisions of this certificate conform with state law?

Yes. If any provision in this certificate, or in the provisions of the group policy, is in conflict with the laws of the state governing the certificates or the group policy, the provision will be deemed to be amended to conform to such laws.

Accelerated Benefits Certificate Supplement

Minnesota Life Insurance Company - A Securian Company
400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

Benefits received under this Accelerated Benefits Certificate Supplement may be taxable. You should seek assistance from a personal tax advisor prior to requesting an accelerated payment of death benefits.

The accelerated benefit in this life insurance product may provide benefits to pay for long-term care services, but it is NOT part of a long-term care or nursing home insurance policy and the amount this product pays the certificate holder may not be enough to cover his or her medical, nursing home or other bills. The certificate holder may use the money he or she receives from this product for any purpose. The receipt of any accelerated benefit payment may be taxable. The certificate holder should seek assistance from a personal tax advisor prior to requesting an accelerated benefit. Receipt of accelerated death benefits MAY AFFECT MEDICAID and SUPPLEMENTAL SECURITY INCOME ("SSI") ELIGIBILITY. The mere fact that the certificate holder owns a policy with an option to accelerate the death benefit may affect his or her eligibility for these government programs. In addition, exercising the option to accelerate death benefits and receiving those benefits before the certificate holder applies for those programs, or while he or she is receiving government benefits, may affect his or her denial or continued eligibility. The certificate holder should contact the Medicaid Unit of his or her local Division of Medical Assistance and the Social Security administration for more information.

General Information

This certificate supplement is subject to every term, condition, exclusion, limitation, and provision of your certificate unless otherwise expressly provided for herein.

What does this supplement provide?

This supplement provides for the accelerated payment of either the full or a partial amount of an insured's death benefit provided under your certificate. If an insured has a terminal condition as defined in this supplement, you may request an accelerated payment of the applicable death benefit.

Definitions

accelerated benefit

The amount of the death benefit we will pay if the insured is eligible under this supplement.

death benefit

The amount of the insured's life insurance as shown on the specifications page attached to your certificate.

immediate family

Your spouse, children, parents, grandparents, grandchildren, brothers and sisters, and their spouses.

insured

For purposes of this supplement, an insured employee, an insured spouse, or an insured dependent child.

physician

An individual who is licensed to practice medicine or treat illness in the state in which treatment is received. This does not include you or a member of your immediate family.

Terminal Condition

What is a terminal condition?

A terminal condition is a condition caused by sickness or accident which directly results in a life expectancy of 12 months or less.

What evidence do we require of the insured's terminal condition?

We must be given evidence that satisfies us that the insured's life expectancy, because of sickness or accident, is 12 months or less. That evidence must include certification by a physician.

Do we have the right to obtain independent medical verification?

Yes. We retain the right to have the insured medically examined at our own expense to verify the insured's medical condition. We may do this as often as reasonably required while accelerated benefits are being considered or paid.

Payment of Accelerated Benefit

How do we calculate the accelerated benefit?

We will multiply the death benefit by the accelerated benefit factor to determine the accelerated benefit available.

How do we calculate the accelerated benefit factor?

The accelerated benefit factor will be stated as a percentage of the insured's death benefit. When we calculate this factor, we will consider the insured's age and gender.

We will also base our calculation on certain assumptions, which we may change from time to time, including but not limited to assumptions about:

(1) expected future premiums; and
(2) the insured's life expectancy.

What are the conditions for the payment of an accelerated benefit?

We will consider the payment of an accelerated benefit, subject to all of the following conditions:

(1) coverage must be in force and all premiums due must be fully paid; and
(2) application must be made in writing and in a form which is satisfactory to us. We will tell you what form is required; and
(3) you must be the sole owner of the certificate; and
(4) the insured's insurance must not have an irrevocable beneficiary.

Who may request an accelerated payment of the death benefit?

You may request an accelerated payment of the insurance on your life or on the life of a spouse or dependent child insured under your certificate.

Is the request for an accelerated benefit voluntary?

Yes. An accelerated benefit will be made available on a voluntary basis only. An accelerated benefit under this supplement is not intended to cause an involuntary reduction of the death benefit ultimately payable to the named beneficiary. Therefore, payment of the death benefit cannot be accelerated under this supplement if the insured:

(1) is required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; or
(2) is required by a government agency to use this option in order to apply for, obtain, or keep a government benefit or entitlement.

Is there a minimum or maximum death benefit eligible for an accelerated benefit?

Yes. The minimum death benefit to be eligible for an accelerated benefit under this supplement is $10,000. The maximum death benefit to be eligible for an accelerated benefit is $1,000,000.

Do you have to take the entire accelerated benefit?

No. You may choose to receive a partial accelerated benefit. If you do so, the insured's remaining coverage will stay in force.

If you elect to receive only a partial accelerated benefit amount available under this supplement, the insured's remaining death benefit under the certificate must be at least $25,000.

You may reapply for the payment of the remaining amount of insurance at any time. However, we may ask for further satisfactory evidence that the insured meets all requirements for the accelerated benefit.

What is the effect on the insured's coverage of the receipt of an accelerated benefit?

If you elect to accelerate the full amount of an insured's death benefit, the insured's coverage and all other benefits under the certificate and any certificate supplements for that insured will end. If such termination causes a certificate holder's covered spouse or dependent children to lose coverage, each of them will be allowed to convert any such insurance to a policy of individual life insurance according to the conversion right section of the certificate to which this supplement is attached.

If a partial accelerated benefit is chosen, coverage will remain in force and premiums will be reduced accordingly. The remaining amount of insurance under your certificate will be the full amount of insurance minus the amount of insurance that was accelerated.

How will we pay the accelerated benefit?

We will pay the accelerated benefit in one lump sum or in any other mutually agreeable manner.

To whom will we pay accelerated benefits?

All accelerated benefits will be paid to you unless you validly assign them otherwise. If you die before all payments have been made, we will pay the remainder to the beneficiary named under this certificate. Payment will be made in one lump sum which will be the present value of the payments that remain, using the interest rate we use to determine the payments.

Termination

When does an insured's coverage under this supplement terminate?

An insured's coverage ends on the date the insured is no longer covered for life insurance under the group policy.

When does this supplement terminate?

This supplement will terminate on the earlier of:

(1) the date we receive a written request from the policyholder to cancel the Accelerated Benefits Policy Rider; or
(2) the date the group policy is terminated.

Secretary President

Your Rights Under ERISA

The following section contains information provided to you by the Plan Administrator of your Plan to meet the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It does not constitute a part of the insurance policy issued in connection with the Plan. All inquiries relating to the following material should be referred directly to your Plan Administrator. This information should be attached to your certificate of insurance. Together they comprise your Summary Plan Description (SPD).

Summary Plan Description

General Information

Name of Plan	Northeast Utilities Service Company (NUSCO) Flexible Benefits Plan
Plan Sponsor	Northeast Utilities Service Company Address: 107 Selden Street, Berlin, CT 06037 800-841-8684
Employer ID	Employer Identification Number (EIN): 06-0810627
Plan Number	Plan Number: 525
Type of Plan	Welfare Plan providing life insurance and associated benefits for employees.
Administration of Plan	The Plan is administered by the Plan Administrator through an insurance policy(ies) purchased from Minnesota Life Insurance Company, 400 Robert Street North, St. Paul, MN 55101. Generally, the Plan Administrator oversees the operation and records of a plan.
Plan Administrator	Senior Vice President – Human Resources Address: At the above address and phone number
Agent for Service of Legal Process	CT Corporation Systems Address: One Corporate Center, Hartford, CT 06103-3220
Plan Year	January 1 – December 31
Plan Funding	The Plan has an insurance policy(ies) with Minnesota Life Insurance Company. The premiums for the policy(ies) are paid by employer and employee contributions.
Interpretation, Amendment and Termination	The plan sponsor reserves the right to interpret, change or terminate the Plan's operation in the future. In the event of termination, benefits would be discontinued as described in the certificate.

Claim Procedures

Under Department of Labor (DOL) regulations, claimants are entitled to full and fair review of any claims made under the Plan. The procedures described in this section are intended to comply with DOL regulations by providing reasonable procedures governing the filing of benefit claims, notification of benefit decisions, and appeal of adverse benefit decisions.

A. Presenting Claims for Benefits

Claim forms may be obtained from the Employer.

Contact your Plan Administrator if you have any questions or need claim forms. Read the instructions on those forms carefully, and be sure all the questions are answered and that you include any required attachments when the completed forms are returned. After your claim has been processed by Minnesota Life, you will be notified in writing if any benefits are denied in whole or in part, or if any additional information is required.

During all steps of the claims appeal procedure, you can write or call the appropriate Plan Administrator and ask to see all plan documents affecting your claim. In addition you may have an attorney or other representative write letters or otherwise act on your behalf, but the Plan Administrator reserves the right to require written authorization from you.

B. Claims Denial Procedure

If all or part of your claim for benefits is denied, Minnesota Life will notify you in writing within 90 days (45 days for any disability claims) of receiving your claim. If special circumstances require more time, the review period may be extended up to an additional 90 days (30 days for disability claims). You will be notified in writing of this extension within the original review period.

The notice of extension will include a description of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the information needed to resolve those issues, and it shall specify a timeframe, no less than 45 days, in which the necessary information must be provided. Where the timeframe to process a claim is extended because the claim was incomplete, the extension time is calculated from the date the extension notice is sent to the claimant to the date the person responds to the request for additional information. If the person does not provide needed information to the Plan within 45 days of the date on the notice the Plan may close the claim and no further consideration will take place.

Any denial of a claim for benefits will be provided by Minnesota Life and consist of a written explanation which will include (i) the specific reasons for the denial, (ii) reference to the pertinent Plan provisions upon which the denial is based, (iii) a description of any additional information you might be required to provide and explanation of why it is needed, and (iv) an explanation of the Plan's claim review procedure.

Disability Claims Only – The following will also be included:

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision.

- Explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant’s medical circumstances, if applicable.

C. Appealing the Denial of a Claim

You, your beneficiary (when an appropriate claimant), or a duly authorized representative may appeal any denial of a claim for benefits by filing a written request for a full and fair review to Minnesota Life. In connection with such a request, documents pertinent to the administration of the Plan may be reviewed, and comments and issues outlining the basis of the appeal may be submitted in writing. You may have representation throughout the review procedure. A request for a review must be filed by 60 days (180 days for any disability claims) after receipt of the written notice of denial of a claim. The full and fair review will be held and a decision rendered by Minnesota Life, no later than 60 days (45 days for disability claims) after receipt of the request for review.

If special circumstances require more time, the review period may be extended up to an additional 60 days (45 days for disability claims). You will be notified in writing of this extension within the original appeal period.

The notice of extension will include a description of the missing information and shall specify a timeframe, no less than 60 days (180 days for disability claims), in which the necessary information must be provided. Where the timeframe to process an appeal is extended because the claim was incomplete, the time for the benefit determination is put on hold from the date the extension notice is sent to the claimant until the date the person responds to the request for additional information. If the person does not provide needed information to the Plan within the 60 days (180 days for disability claims) of the date on the notice the Plan will close the appeal and no further consideration will take place.

A decision on appeal is adverse if it is a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the claimant is no longer eligible to participate in a plan.

Written notification of the Plan's decision on a disability or non-disability appeal shall be provided to the claimant and will include the following:

- Explanation of the specific reasons for the denial
- A specific reference to pertinent Plan provisions on which the denial was based
- A statement regarding your right, upon request and free of charge, to reasonable access to review or copy pertinent documents
- A statement of the right to sue in federal court.

Disability Claims Only

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision
- Explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, if applicable.

D. Legal Action Following Appeals

After completing all mandatory appeal procedures, you have the right to further appeal adverse benefit determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the Statement of ERISA Rights section for more details. No such action may be filed against the Plan after two years from the date the Plan gives you a final determination on your appeal. Also, no legal action may be brought if you do not file a claim for a benefit and seek timely review of a denial of that claim.

Statement of ERISA Rights

The Statement of ERISA rights is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including the insurance contract, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

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

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

No one, including your Employer, 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 in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials for the Plan and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay the cost 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 your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

MINNESOTA LIFE

400 Robert Street North • St. Paul, Minnesota 55101-2098

GROUP TERM LIFE CERTIFICATE OF INSURANCE