American Express
Life Insurance Plan
Summary Plan Description

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Life Insurance

American Express Company (which is referred to, along with its participating affiliates when appropriate, as the "Company") sponsors the American Express Life Insurance Plan (the "Life Insurance Plan" or the "Plan"), which provides you with basic life insurance of one times your annual salary at no cost ("Basic Life Insurance Coverage"). The Life Insurance Plan also offers you the opportunity to purchase:

- Optional life insurance protection for yourself and your eligible dependents ("Optional Life Insurance Coverage"); and
- Accidental Death & Dismemberment ("AD&D") coverage ("AD&D Coverage").

This document is the Summary Plan Description ("SPD") for the Life Insurance Plan. The Life Insurance Plan is considered a "component plan" under the American Express Welfare Benefits Plan (the "Welfare Benefits Plan"). This SPD, along with the insurance contracts through which benefits are provided, forms part of the "written instrument" for the Welfare Benefits Plan for purposes of section 402(a)(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

In the event that there is a conflict of language between this SPD and the insurance documents regarding the descriptions of benefits offered, the insurance documents will control. If the conflict relates to administration of the Plan, this SPD shall govern. If the conflict relates to eligibility to participate in the coverage, the SPD and the insurance documents will be read together to impose the most restrictive requirements as to eligibility. For example, if the insurance documents contain an eligibility requirement that is not contained in this SPD document, you must satisfy the eligibility requirements in this SPD document and in the insurance document in order to be eligible for benefits under the Plan.

Participation

Eligibility

You're eligible for the Life Insurance Plan if you meet all of the following requirements:

- You're classified by the Company as a regular full-time employee or regular part-time employee scheduled to work 20 or more hours per week;
- You work in the U.S. or are a U.S. paid International Assignee or a U.S. paid Long-Term Business Trip ("LTBT") employee;
- You work for:
  - American Express Company;
  - American Express Travel Related Services Company, Inc.;
  - Amex Services, Inc.;
  - American Express Credit Corp;
  - American Express National Bank;
  - Resy Network; or
  - Tock LLC; and

- More than half of your income from the Company is reported on Form W-2, regardless of whether the use of Form W-2 is subsequently determined to be erroneous.

You're not eligible to participate in the Life Insurance Plan if more than half of your income from the Company is reported on Form 1099.

If you're classified by the Company as a temporary (either full-time or part-time) employee, contingent worker, limited part-time employee, employee paid by fee under contract, other contract employee, co-op employee, trainee or student intern, a self-employed consultant, or work less than 20 hours per week, you're not eligible to participate in the Life Insurance Plan.

If you meet the above requirements, you may also enroll your eligible dependents for life insurance coverage.

Full-time Employees

If you're classified by the Company as a regular full-time employee scheduled to work 30 or more hours per week, you're eligible to participate in the Life Insurance Plan as of your hire date.

Part-time Employees

If you're classified by the Company as a regular part-time employee scheduled to work at least 20 hours per week, you are eligible to participate in the Life Insurance Plan after 90 days of service. Subsequent changes in your work hours may affect your eligibility for benefits.

Dependent Coverage

You may elect Optional Life Insurance Coverage for your eligible spouse, eligible domestic partner and eligible dependent children. Spouse includes your legally married spouse as defined under federal law and your common-law spouse where recognized by state law in the state in which you reside. See the Domestic Partner Coverage Summary (available on U.S. Benefits) for further details.

If both you and your spouse or domestic partner are eligible to participate in the Life Insurance Plan on the basis of your employment with the Company, both of you may elect child life insurance coverage and you may be covered as both an employee and a spouse or domestic partner under the Life Insurance Plan.

You must elect coverage for yourself in order to elect dependent coverage.

Who Qualifies as an Eligible Dependent

Eligible dependents include:

- Your legally married spouse as defined under federal law[1];
- Your common-law spouse where recognized by state law in the state in which you reside (typically the necessary elements of a common-law marriage are cohabitation,

[1] Legally married spouse does not include your divorced spouse, even if the divorce decree states that coverage must be provided. If the court orders you to provide coverage for your divorced spouse, that doesn't make your divorced spouse eligible for coverage. Therefore, you must arrange and/or pay for coverage outside of the Plan.

declaration of marriage, representation of yourselves as husband and wife to the public and filing income tax returns indicating you are married[2]);
- Your eligible domestic partner;
- Your children and your domestic partner's children who are under age 26 regardless of their marital status and whether or not they live with you or you provide any of their support (the minimum age for Life Insurance Plan coverage is 15 days old); and

Your children are:

- Your natural children;
- Your stepchildren;
- Your legally adopted children;
- Children who are placed in your home for adoption;
- and
- Dependent children of your eligible domestic partner.

Domestic Partner Coverage

Domestic partner coverage is available under the Life Insurance Plan if your same-gender or opposite-gender domestic partner meets *all* of the following eligibility requirements at the time you enroll:

- Has resided with you continuously for at least six months in a sole-partner relationship that is intended to be permanent;
- Is unmarried and not related to you by blood; and
- Is at least 18 years of age.

Further details are included in the Domestic Partner Coverage Summary (available on U.S. Benefits).

Covering Dependent Children of Eligible Domestic Partners

Children of your eligible domestic partner may also be eligible for coverage if they otherwise meet the definition of a dependent child. Refer to the Domestic Partner Coverage Summary for further details.

Required Dependent Information

You will need to provide the following information to the Colleague Service Center before dependent coverage will be effective:

- For all dependents: Social Security number and date of birth; and
- For disabled dependents (age 26 and over): proof of your dependent's disability must be provided. You will be asked periodically to verify your child's ongoing disabled status.

[2] You should verify your common law "marital" status with an attorney. Please note that not all states recognize common law marriage, determining whether a common law marriage exists can be complicated, and state laws vary regarding legal rights of common law spouses. The Employee Benefits Administration Committee of American Express Company, in its sole discretion, determines whether you have a qualifying common law spouse for purposes of his or her eligibility for coverage under the Life Insurance Plan.

You also may be asked to submit documentation to the Colleague Service Center to support your elections for eligible dependent coverage. Failure to submit such documentation (birth certificate, marriage certificate, etc.) may result in your coverage and that of your dependents being void as of its effective date with no benefits payable and you may be required to repay any benefits paid.

Enrollment

If you are classified by the Company as a regular full-time or part-time employee scheduled to work 20 hours or more per week, you're automatically covered for Basic Life Insurance Coverage under the Life Insurance Plan.

Once you're eligible, you can elect to participate in Optional Life Insurance Coverage and AD&D Coverage.

How to Enroll During Annual Enrollment

Each year during annual enrollment, you'll have a chance to review your benefit options and make new choices if you need to. After you evaluate your choices, you'll need to make your elections during the annual enrollment period. Your elections will remain in effect for the entire calendar year, unless you experience a qualified status change and change your elections.

There are two ways to enroll in benefits or to make changes to your current elections during annual enrollment. To enroll in coverage or to change your elections, you can:

1. Access U.S. Benefits via The Square or via the internet at www.myamexbenefits.com; or
2. Call the Colleague Service Center at (855) 783-4772 and speak with a Customer Service Representative. Customer Service Representatives are available Monday through Friday, 9:00 a.m. to 7:00 p.m. Eastern Time, except on holidays. Please note that the interactive voice response system will not take elections; you must speak to a Customer Service Representative.

If You Do Not Enroll During Annual Enrollment

Unless communicated otherwise, your enrollment elections will remain in effect from year to year if you do not make any changes during the annual enrollment period. In the event an option in which you participate is eliminated for the following year, your election will automatically default to a predetermined alternative that will be communicated to you, unless you change your elections during annual enrollment.

How to Enroll as a New Hire

If you're a regular full-time employee, you have up to 60 days from your hire date to enroll in the Life Insurance Plan. If you're a regular part-time employee scheduled to work 20 hours or more per week, you must enroll for benefits within 60 days after you complete 90 days of service.

Shortly after you join the Company or become eligible for the Life Insurance Plan, you'll be able to view your enrollment options and costs, as well as important enrollment information, on the U.S. Benefits section of The Square. After you review your benefit options, you'll need to enroll through U.S. Benefits or by calling the Colleague Service

Center and speaking with a Customer Service Representative. You must enroll by the 60th day.

If You Do Not Enroll As a New Hire

If you do not enroll in Optional Life Insurance Coverage or AD&D Coverage within the required 60-day period, you'll automatically receive Basic Life Insurance Coverage equal to one times your annual salary. No other benefits will be available for the remainder of the calendar year, unless you experience a qualified status change and change your elections. Regardless of whether you experience a qualified status change, you may make elections during the next annual enrollment period, but you may be required to provide satisfactory Proof of Good Health for coverage under the Life Insurance Plan. If you are required to provide Satisfactory Proof of Good Health, your coverage will not become effective until you submit satisfactory Proof of Good Health and MetLife approves your application. See the "Providing Proof of Good Health" section below.

When Coverage Begins

If you're a regular full-time employee and enroll within 60 days following your hire date, your coverage starts on the day you begin regular full-time employment with the Company, if you are actively at work on that day. If you are absent for any reason, coverage will begin on the day you start active full-time employment with the Company.

If you're a regular part-time employee scheduled to work 20 hours or more per week and enroll within 60 days following completion of 90 days of service, your coverage begins on the date the 90-day waiting period is completed, if you are actively at work on that day. If you are absent for any reason, coverage will begin on the day you return to active employment with the Company. If you're a part-time employee and change your status to full-time before you complete 90 days of service, you have 60 days from your qualified status change date to enroll in Optional Life Insurance Coverage or AD&D Coverage.

Coverage will not begin until you have provided a copy of Form I-9 (authorization to be employed in the United States). Once you provide the properly completed Form I-9, coverage will begin as of the date you are eligible for benefits.

Following your initial eligibility for benefits, coverage begins as described below:

- Coverage elected during annual enrollment begins on January 1 of the following year, or the day following approval of Proof of Good Health by the insurance carrier, whichever is later; and
- Coverage elected as a result of a qualified status change begins on the date of the qualified status change, or the day following approval of Proof of Good Health by the insurance carrier, whichever is later.

Contributions will be deducted from your pay to cover any retroactive period of coverage based on the effective date of coverage.

When Dependent Coverage Begins

Coverage for your dependents starts the same day your coverage begins, if you have enrolled for dependent coverage.

You may enroll for dependent coverage within 60 days of marriage, eligibility of your domestic partner, or the birth, adoption, placement for adoption or commencement of legal guardianship of your dependent child. In this instance, your dependent's coverage would start on the date you acquired the dependent (except that the minimum age for a child's coverage to begin is 15 days old).

Changing Your Benefit Elections During the Year

There are certain circumstances under which you may make changes to your benefit elections during the year.

If You Experience a Qualified Status Change

In general, the only time you can change or newly elect certain benefits outside the annual enrollment period is if you have a qualified status change. A qualified status change includes:

- Marriage or gain of an eligible domestic partner;
- Birth, adoption, or placement for adoption of a child;
- Divorce or dissolution of a relationship with a domestic partner;
- Death of a spouse, domestic partner, or dependent child;
- A change in your employment status (as defined in Internal Revenue Service ("IRS") regulations) affecting your eligibility for benefits;
- A change in the employment status (as defined in IRS regulations) of your spouse or domestic partner that affects his or her eligibility for benefits;
- A significant increase in cost for one or more of the options under the plan;
- Relocation, only if your Life Insurance Plan option eligibility is affected; or
- Commencement of or return from an unpaid leave of absence.

The benefit change or election you make must be consistent with the qualified status change. For example, if you get married, you can change your coverage level in the Life Insurance Plan to add your spouse. The Colleague Service Center will determine whether an election change is permitted in accordance with applicable IRS regulations.

You must request the benefit change and document the qualified status change within 60 days of the occurrence of the qualified status change (see "Required Dependent Information"). You may be required to provide Proof of Good Health to increase your benefits under the Life Insurance Plan.

If You Are Rehired*

If your employment ends but you are rehired later that same calendar year, your Life Insurance Plan elections in effect on your termination date will be reinstated. If your employment ends and you return to work during a subsequent calendar year, you'll be allowed to elect Optional Life Insurance Coverage or AD&D Coverage based on your eligibility on your rehire date.

If your employment ends and you return to work as a part-time employee, you'll be given credit for time worked toward becoming eligible for benefits (e.g., if you worked 30 days, you'd only need to work 60 more days to be eligible for benefits).

**If you are rehired within 2 years and you had elected portability or conversion of your previous coverage, you are not eligible to re-elect Optional Life Insurance Coverage or AD&D Coverage*

unless you surrender your individual policy or the certificate of coverage for your ported insurance to Metropolitan Life Insurance Company ("MetLife"). If you re-elect coverage and do not surrender your converted or ported coverage, your Optional Life Insurance Coverage and AD&D Coverage under the Plan will not become effective, even though payroll deductions may be taken from your pay. In the event you die prior to surrendering your converted or ported coverage, no benefit will be payable under the Plan.

Cost

Basic life insurance is automatically provided at no cost to you in the amount of one times your annual salary. You may also purchase Optional Life Insurance Coverage for yourself, your eligible spouse or eligible domestic partner, and/or your eligible dependent children, and you may purchase AD&D Coverage for yourself and your spouse or domestic partner. Your contributions for coverage for yourself will be based on the coverage amount you elect and your age and will be made on a before-tax basis. If you live in Puerto Rico, your contributions for coverage will be made on an after-tax basis.

If you elect to cover your eligible spouse or domestic partner and/or eligible dependent children, your contributions for the cost of their coverage will be made on an after-tax basis. Contributions for spouse or domestic partner coverage will be based on the amount of coverage you elect and your spouse's or domestic partner's age. Contributions for coverage for your children will be based on the amount of coverage you elect.

Contribution Amounts

Your enrollment information on U.S. Benefits will state the cost of each benefit you may elect for a given year. These costs represent the amount that will be deducted from your paycheck for the elections you make. Costs are determined annually by the Plan Sponsor. Your cost for some benefits may change during the year as your age, employment status, and/or salary change.

You may also contact the Colleague Service Center to obtain cost information.

Contributions for your coverage will be deducted from your pay for the duration of your coverage, including premiums for retroactive coverage (arrears). Arrears owed are deducted on an after-tax basis from your pay and will carry over into the following calendar year (except for terminated employees). However, employees who owed arrears at termination and are rehired in the same calendar year, will have the prior arrears deducted upon rehire.

Contributions are not prorated for mid-pay period hire dates, mid-pay period qualified status change dates, or termination dates. Contributions for your coverage will not be deducted from your first paycheck, if you were hired in the middle of a pay period. Contributions for your coverage also will not be deducted from your first paycheck after your mid-pay period qualified status change. However, upon termination of employment, contributions for your coverage will be deducted from your last paycheck and will not be prorated to reflect mid-pay period terminations.

Before-tax Contributions

Before-tax contributions (for coverage for yourself) are taken from your paycheck before taxes are calculated and withheld. This means you don't pay taxes on your contributions. As a result, it reduces your taxable income and the amount of taxes you pay. In some states, you will pay state taxes on your contributions.

Before-tax contributions reduce the amount of your pay that is subject to Social Security taxes. To the extent that your earnings are less than the Social Security wage base ($176,100 in 2025), you'll pay less in Social Security taxes and may receive a smaller Social Security benefit when you retire.

How Salary is Defined

Your benefits and cost for coverage (if any) is determined based on your annual salary. At the time of annual enrollment, your next year's annual salary data is not available, so cost information and coverage amounts for the following year for Basic and Optional Life Insurance Coverages and AD&D Coverage are estimated based on your annual salary as of a designated date (usually in October). Therefore, when the following year's benefits become effective, actual costs and coverage amounts will replace the estimates and you may see a difference between your estimated costs and actual costs and estimated coverage levels and actual coverage levels for those benefits.

For the purposes of the Life Insurance Plan, the "salary" of regular full-time and part-time employees is defined as annual salary. For example, if you are hired and begin work on July 1 at an annual salary of $40,000, the salary figure used for the Life Insurance Plan purposes for your year of hire is $40,000 (not a "pro-rated" amount of $20,000). Annual salary does not include overtime, bonuses, shift differentials, tips, or any other compensation elements.

Imputed Income

Imputed income is the taxable cost of your Basic and Optional Life Insurance Coverages over $50,000 (if you live in Puerto Rico, imputed income is the taxable cost of your Basic Life Insurance Coverage over $50,000, because you pay your contributions for Optional Life Insurance Coverage on an after-tax basis). The cost is determined by a set of age-related rates, established by the IRS. Imputed income is added to your paychecks as taxable earnings, as well as to your Form W-2 earnings at the end of the year. You must pay income taxes and Social Security taxes on your imputed income amount.

Waiving Coverage

You may elect to waive your Company-provided Basic Life Insurance Coverage. If your salary is $50,000 or more, and you wish to avoid the associated imputed income, you might want to consider this option.

Employee Life Insurance

You may elect Basic and Optional Life Insurance Coverages of up to nine times your annual salary (one times Basic Life Insurance Coverage plus eight times Optional Life Insurance Coverage), to a maximum of $3 million. This maximum includes the automatic Company-provided Basic Life Insurance Coverage of one times your annual salary, which has a maximum of $1 million.

Amount of Coverage

You have the option to elect Basic and Optional Life Insurance Coverages as follows:

- You may waive your Company-provided Basic Life Insurance Coverage of 1 times annual salary;
- Company-provided Basic Life Insurance Coverage of 1 times annual salary;

- Basic Coverage of 1 times annual salary plus Optional Coverage of 1 times annual salary;
- Basic Coverage of 1 times annual salary plus Optional Coverage of 2 times annual salary;
- Basic Coverage of 1 times annual salary plus Optional Coverage of 3 times annual salary;
- Basic Coverage of 1 times annual salary plus Optional Coverage of 4 times annual salary;
- Basic Coverage of 1 times annual salary plus Optional Coverage of 5 times annual salary;
- Basic Coverage of 1 times annual salary plus Optional Coverage of 6 times annual salary;
- Basic Coverage of 1 times annual salary plus Optional Coverage of 7 times annual salary; or
- Basic Coverage of 1 times annual salary plus Optional Coverage of 8 times annual salary.

Basic Life Insurance and Optional Life Insurance Coverage amounts are rounded to the next higher thousand, as shown below. Assume your annual salary is $27,260, and you chose employee Optional Life Insurance Coverage of two times your annual salary.

Basic Life Insurance Coverage = $28,000 ($27,260 rounded to the next higher thousand)
Optional Life Insurance Coverage = $55,000 ($27,260 x 2 = $54,520, rounded to the next higher thousand)
Total Life Insurance Coverage = $83,000

Things to Consider When Electing Life Insurance Coverage

When you're trying to decide the amount of Basic and Optional Life Insurance Coverages to elect, think about your current financial status, responsibilities and future goals, and consider the following questions:

- Do you have debts (such as college loans or credit card balances) that would need to be paid if you died?
- Do you share responsibility for your personal debt with anyone else, such as your spouse or domestic partner or your parents?
- Do you have any dependents who rely on you for financial support and would need support if you died?
- Do you plan to help your children pay for their education?
- Do you have a mortgage to pay?
- Do you have any additional savings or benefits from other insurance plans that would help support your dependents?

Electing Coverage

When you first become eligible, you can elect Optional Life Insurance Coverage of the lesser of four times your annual salary or $750,000 (based on the next lowest multiple of salary) without providing Proof of Good Health. This amount does not include your Company-provided Basic Life Insurance Coverage of one times annual salary.

For coverage amounts over these limits, you must provide Proof of Good Health.

Providing Proof of Good Health

Generally, providing Proof of Good Health is satisfied by completing a medical questionnaire. This questionnaire can be completed online, through U.S. Benefits, or it will be mailed to you if it cannot be completed online. You must forward the completed questionnaire to MetLife. **Coverage will not begin until you submit satisfactory Proof of Good Health and MetLife approves the coverage.**

In some situations, a physical exam may be required. Other than when you are first hired, you will be responsible for any costs associated with providing Proof of Good Health through a physical exam. These costs typically range from $100 - $150.

While Proof of Good Health is pending, you will be covered for the lesser of four times your annual salary or $750,000 (exclusive of the Basic Life Insurance Coverage amount).

The portion of your coverage that is subject to the Proof of Good Health requirement will not become effective until MetLife approves your application. Normally, payroll deductions for the premiums for that portion of your coverage will not begin until your application is approved. If your premium payments for that portion of your coverage erroneously begin before MetLife approves your application, that does not mean that portion of your coverage is effective. If that occurs and MetLife does not approve your application, any premium payments you have made for that portion of your coverage will be refunded. It is your responsibility to make sure that you submit any required information to MetLife and follow-up with any additional information that MetLife may require.

Increasing or Decreasing Coverage

You may increase or decrease your Optional Life Insurance Coverage or cancel your Basic Life Insurance coverage each year during annual enrollment or if you experience a qualified status change. If you elect to increase your coverage, you will be required to provide Proof of Good Health before the coverage increase will go into effect. If Proof of Good Health is not approved, you will retain your previous coverage amount. Your coverage amount and the contributions related to it will be automatically adjusted to reflect any salary changes, approved coverage changes, or cost increases due to age.

Estate Resolution & Will Preparation Services

If you elect Optional Life Insurance Coverage, Estate Resolution Services and Will Preparation Services will be made available to you and your spouse or domestic partner at no cost. The Estate Resolution Services can assist with probating an estate and the Will Preparation Service includes the preparation of a will, living will or power of attorney free of charge by designated attorneys. For additional information, please contact MetLife Legal Plans at (800) 821-6400.

Funeral Planning

If you elect Basic or Optional Life Insurance Coverages, funeral discount and planning services from Dignity Memorial are available to simplify the process for employees and their beneficiaries and to make it easier to organize an event that will honor a loved one’s life. The end-to-end funeral planning services provide valuable benefits from planning for a loss to support following a loss and helping find closure.

- Available to the insured, their spouse or domestic partner and extended family (children, parents, grandparents and great-grandparents).
- Provides discounts of up to 10% off of funeral, cremation and cemetery services in most states*.
- Unlimited access to Dignity Memorial's planning website, a comprehensive end-of-life planning tool, a funeral planning resource library, a Dignity Memorial funeral home locator tool, bereavement travel services, catering, floral arrangements, Compassion Helpline®, as well as veteran's burial benefits and military funeral honors.

For more information, contact Dignity Memorial by visiting: www.finalwishesplanning.com or call: (866) 853-0954.

***Discounts cannot be applied** for funerals held in the following states**:** KY, NY, SD and WY.

Spouse or Domestic Partner Life Insurance

You may purchase Optional Life Insurance Coverage for your spouse or domestic partner in an amount equal to one to eight times your annual salary (rounded to the next higher $1,000), up to a maximum coverage of $200,000.

You must elect employee Basic Life Insurance Coverage of at least one times your annual salary if you want to purchase Optional Life Insurance Coverage for your spouse or domestic partner.

Amount of Coverage

You have the option to purchase Optional Life Insurance Coverage for your spouse or domestic partner as follows:

- No Optional Life Insurance Coverage;
- Optional Life Insurance Coverage of 1 times employee's annual salary;
- Optional Life Insurance Coverage of 2 times employee's annual salary;
- Optional Life Insurance Coverage of 3 times employee's annual salary;
- Optional Life Insurance Coverage of 4 times employee's annual salary;
- Optional Life Insurance Coverage of 5 times employee's annual salary;
- Optional Life Insurance Coverage of 6 times employee's annual salary;
- Optional Life Insurance Coverage of 7 times employee's annual salary; or
- Optional Life Insurance Coverage of 8 times employee's annual salary.

Electing Coverage

When you first become eligible, you can purchase Optional Life Insurance Coverage for your spouse or domestic partner equal to the lesser of two times your annual salary or $30,000 without providing Proof of Good Health (as described in the "Providing Proof of Good Health" section above). If you decide to increase or newly elect your spouse's or domestic partner's Optional Life Insurance Coverage during annual enrollment, you will be required to provide Proof of Good Health for your spouse or domestic partner before the coverage increase will go into effect. If your spouse's or domestic partner's Proof of Good Health is not approved, your spouse or domestic partner will retain his or her previous coverage level. Your spouse's or domestic partner's Optional Life Insurance

Coverage amount, and the cost related to it, will be automatically adjusted to reflect any salary changes, approved coverage changes, or cost increases due to age.

Children Life Insurance

You may purchase Optional Life Insurance Coverage in the amount of $5,000 or $10,000 for each child older than 14 days. When each child reaches age 26, his or her coverage will end.

You must elect employee Basic Life Insurance Coverage of at least one times your annual salary if you want to purchase Optional Life Insurance Coverage for your children.

Amount of Coverage

You have the option to purchase Optional Life Insurance Coverage for your children as follows:

- No Optional Life Insurance Coverage;
- $5,000 per child; or
- $10,000 per child.

Accelerated Benefit Option

If, while covered under the Plan, you become Terminally Ill, you may request that MetLife pay an Accelerated Benefit Option (“ABO”). You will be considered Terminally Ill if:

- Your life span is drastically limited;
- You are expected to die within 6 months; and
- You are not expected to recover.

Your request for an ABO must state the amount of the benefit requested. You may request an amount up to the maximum ABO percentage, which is 50% (up to $250,000) for Basic Life Insurance Coverage and 50% (up to $250,000) for Optional Life Insurance Coverage, of the amount of employee Basic and Optional Life Insurance Coverages in effect. In no event may you request an ABO in an amount less than $10,000.

You may request an ABO at any time by completing and submitting a Request for ABO Form to MetLife. You can obtain the form by accessing U.S. Benefits. The request must include the statement of a currently licensed U.S. Physician that you are Terminally Ill.

The Physician's statements must include:

- All medical test results;
- Laboratory reports; and
- Any other information on which the statement is based, including the generally accepted prognostic protocol used by the Physician to determine your expected remaining life span. Further, MetLife must accept the Physician's statement.

In considering your request for an ABO, MetLife may require you, at MetLife's expense, to submit to an Independent Medical Exam by a Physician chosen by MetLife. MetLife may suspend its review of a request for an ABO until the Independent Medical Exam has been completed and the results have been submitted to MetLife.

You may request an ABO only once while covered under the Plan.

Receiving Benefits

Upon approval by MetLife, the amount of the ABO will be paid to you in a lump sum. To the extent allowed by law:

- Any ABO paid to you may be exempt from any legal or equitable process for your debts; and
- You will not be required to request an ABO in order to satisfy the claims of creditors.

If you are not the owner of the life insurance coverage by assignment or otherwise, an ABO will not be available.

The amount of ABO that will be payable is equal to the lesser of:

- The amount of ABO you requested; or
- The amount of employee Basic and Optional Life Insurance Coverages that would have been in effect as of the date of your request, multiplied by the same percentage that you selected above when you made the request (e.g., you may choose an ABO benefit of 25% rather than the full 50%).

After your request for an ABO has been approved, the amount of employee Basic and Optional Life Insurance Coverages in effect will be reduced by the amount of the ABO. You are entitled to convert the remaining amount of employee Basic and Optional Life Insurance Coverages to an individual policy.

If Benefits are Denied

MetLife may refuse your request for an ABO if:

- Prior to MetLife's receipt of approval of the request, the group contract ends for your employee group (even though all or part of your employee Basic and Optional Life Insurance Coverages continue for any reason), or the entire amount of your employee Basic and Optional Life Insurance Coverages ends under the group contract for any reason;
- Prior to payment of the ABO, you die;
- You do not meet the requirements for receiving an ABO;
- You have assigned your life insurance benefits;
- MetLife has been notified that all or a portion of your life insurance benefits are to be paid to your former spouse as part of a divorce agreement; or
- You meet the requirements as a result of:
  - Attempted suicide;
  - Injuring yourself on purpose;
  - Alcohol or drug abuse;
  - A war, or warlike action in time of peace; or
  - Any event occurring while you are in violation of criminal law.

If You Become Totally Disabled

If you become Totally Disabled on or after January 1, 2005, you will no longer have your life insurance contributions waived. In addition, your group Basic and Optional Life Insurance Coverages will end on your termination date at which time you may elect to continue your Basic and Optional Life Insurance Coverages through an individual policy with MetLife at your own expense.

Accidental Death & Dismemberment (AD&D) Coverage

You can purchase AD&D Coverage equal to the Basic and Optional Life Insurance Coverages elected for you and/or your spouse or domestic partner. AD&D Coverage is not available by itself, nor is it available for children.

If you elect AD&D Coverage for yourself and/or your spouse or domestic partner, the beneficiary would receive both the full amount of the life insurance benefit and the AD&D benefit in the event of death as the direct result of accidental injury, provided that death occurs within three months of the accident.

AD&D Coverage may be continued for you and your spouse or domestic partner as long as you remain employed by the Company. You cannot convert your AD&D Coverage to an individual policy after you leave the Company or retire.

How Much the Plan Pays

The covered person will be covered for accidents occurring in the course of business or pleasure, at home or on the job, traveling to and from work, 24 hours a day. Coverage while the covered person is on a flight as a passenger in any aircraft licensed to carry passengers is included.

The full amount of the covered person's AD&D Coverage will be paid if, within three months following an accident, the covered person loses, as a direct result of the injury:

- Life;
- Speech and hearing;
- Any combination of a hand, a foot or sight in an eye; or
- Movement of all four limbs (i.e., suffer Quadriplegia).

The covered person will receive one-half of the covered person's AD&D Coverage if, within three months following an accident, the covered person loses, as a direct result of the injury:

- A hand, at or above the wrist joint;
- A foot, at or above the ankle joint;
- An eye, involving irrecoverable and complete loss of sight in the eye;
- Speech or hearing in both ears;
- Movement of the legs and lower body (i.e., suffer Paraplegia); or
- Movement of one side of the body (i.e., suffer Hemiplegia).

The covered person will receive one-quarter of the covered person's AD&D Coverage if, within three months following an accident, the covered person loses, as a direct result of the injury:

- Thumb and Index finger of same hand.

However, the covered person cannot receive more than the covered person's full AD&D Coverage for all losses which result from one accident.

Additional AD&D Benefits

Seat Belt Benefit

MetLife will pay an amount equal to 10% of the full amount of the covered person's AD&D Coverage for the loss of a covered person's life that results from injuries sustained while driving or riding in a private Passenger Car if the covered person's Seat Belt was properly fastened. The amount payable will not: (a) exceed $25,000; or (b) be less than $1,000.

The correct position of the Seat Belt must be certified by the investigating officer. A copy of the police report must be submitted with the claim.

MetLife will not pay a Seat Belt benefit if the covered person was driving while under the influence of alcohol or drugs.

Hospital Benefit

If, as a result of an accident, a covered person is confined in a hospital, MetLife will pay during such confinement, after a four-day waiting period, a monthly amount equal to 1% of the full amount of the covered person's AD&D Coverage, but not more than $2,500 per month.

In no case will such benefit be payable for:

- The first four days of a hospital confinement; or
- More than 12 months during a period of hospital confinement

Payments for periods less than a full month will be made on a pro-rata basis.

Training Benefit for a Dependent Spouse or Domestic Partner

If you die as a result of an accident while your dependent spouse or domestic partner is enrolled in an accredited school for the purpose of training or refreshing skills needed for employment, MetLife will pay the actual cost incurred for enrolling for one year in such school, not to exceed a maximum of $5,000 per academic year and an overall maximum of 2% of the full amount of coverage elected.

Training benefit for a dependent spouse or domestic partner will be paid to your dependent spouse or domestic partner.

If this Training Benefit is in effect on the date you die and there is no spouse or domestic partner who could qualifies for it, MetLife will pay an additional benefit of $1,000 to your beneficiary in a lump sum.

Education Benefit for Dependent Children

If you die as a result of an accident, MetLife will pay on account of each dependent child an annual amount equal to 2% of the full amount of your AD&D Coverage, but not more than $5,000 per year, if such child, on the date of the accident, was:

- Enrolled as a full-time student in a college, university or vocational school above the 12th grade level; or
- At the 12th grade level and subsequently enrolls as a full-time student in a college, university or vocational school within 365 days following the date of the accident.

The education benefit for dependent children is payable for a maximum of four consecutive years as long as the dependent child remains a full-time student.

If this Education Benefit is in effect on the date you die and there is no dependent child who qualifies for it on the date of your death, MetLife will pay an additional benefit of $1,000 to your beneficiary in a lump sum.

The education benefit for dependent children will be paid to each dependent child.

Child Care Center Benefit

If you die as a result of an accident, MetLife will pay on account of each dependent child who:

- Is 12 years of age or under on the date of the accident; and
- Was enrolled in a Child Care Center on the date of the accident

an annual amount equal to the lesser of:

- 3% of the full amount of your AD&D Coverage; and
- The actual amount of Child Care Center benefit costs incurred; however, in no event will such amount be more than $5,000 per year.

The Child Care Center benefit is payable for a maximum of four consecutive years as long as the dependent child remains:

- Enrolled in a Child Care Center; and
- 12 years of age or under.

If this Child Care Center Benefit is in effect on the date you die and there is no dependent child who qualifies for it on the date of your death, MetLife will pay an additional benefit of $1,000 to your beneficiary in a lump sum.

Child Care Center benefits will be paid to any person or persons who have incurred Child Care Center expenses on account of the dependent child.

The Child Care Center benefit will be payable on a quarterly basis, with the first quarter beginning on the first day of the month following the date of your death, and with the first benefit being payable at the end of the first quarter.

What's Not Covered

AD&D benefits will not be paid if death or injury results from one of the following:

- Committing a felony or trying to commit a felony;
- Disease, bodily or mental infirmity, or diagnosis of or treatment for the infirmity;
- Infection, other than infection occurring in an external accidental wound or from food poisoning;
- Suicide or attempted suicide;
- Parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;

- Any aircraft used or designed for use beyond the Earth's atmosphere; or while in any aircraft for the purpose of descent from such aircraft while in flight (except for self-preservation);
- The voluntary intake or use by any means of any drug, medication or sedative, unless it is:
    - taken or used as prescribed by a Physician; or
    - an "over the counter" drug, medication or sedative taken as directed;
- The voluntary intake or use by any means of
    - poison, gas, or fumes;
- War, whether declared or undeclared;
- An act of war, insurrection, rebellion or active participation in a riot; or
- Service in the armed forces, except the U.S. National Guard.

Naming a Beneficiary

You will be asked to name a beneficiary for your employee Basic and Optional Life Insurance Coverages under the Life Insurance Plan (you are automatically the beneficiary for spouse or domestic partner Optional Life Insurance Coverage and children Optional Life Insurance Coverage). Your beneficiary is the person you have designated to receive the proceeds of your insurance in the event of your death.

You may name any person(s) you desire as a beneficiary of your employee Basic and Optional Life Insurance Coverages by entering your beneficiary designation on U.S. Benefits. You may change your beneficiary at any time by accessing U.S. Benefits or by contacting the Colleague Service Center.

If you Don't Name a Beneficiary or your Beneficiaries do not survive you:

If you have not designated a beneficiary under the Plan, or if no beneficiary survives you, benefits will be paid in the following order:

- Spouse or domestic partner
- Child(ren)
- Parent(s)
- Sibling(s)
- Your Estate

If you don't name a beneficiary when you first enroll or if one of beneficiaries you designate pre-deceases you, that beneficiary's portion of the benefit will then be paid to your remaining eligible beneficiary or beneficiaries. If one or more of the beneficiaries you designate dies following your death but before the benefit is paid, payment will then be made to the estate of the beneficiary or beneficiaries.

How Payment is Made

Generally, employee life insurance benefits are paid to your beneficiary. Spouse or domestic partner life insurance benefits and children life insurance benefits, as well as AD&D benefits under the Plan, must be payable to you.

If the beneficiary of your coverage is a minor, benefits will be paid to the court appointed legal guardian of the minor's property or estate or placed into a blocked money market account until the child reaches the age of majority, if no guardianship over the minor will be obtained.

In the event of your death or your dependent's death, and upon receipt of a certified copy of the death certificate by MetLife, the amount of Basic and/or Optional Life Insurance Coverage in effect on the date of death will be paid to you or your beneficiary by one of the following methods:

- Lump sum—If the value of the life insurance is less than $5,000, the beneficiary receives the policy proceeds in one lump sum; or
- Total Control Account — If the benefit amount payable to a beneficiary is $5,000 or more, the claim may be paid by the establishment of a Total Control Account ("TCA"). The TCA is a settlement option or method used to pay claims in full. MetLife establishes an interest-bearing account that provides your beneficiary with immediate access to the entire amount of the insurance proceeds. MetLife pays interest on the balance in the TCA from the date the TCA is established, and the account provides for a guaranteed minimum rate. Your beneficiary can access the TCA balance at any time without charge or penalty, simply by writing drafts in an amount of $250 or more. Your beneficiary may withdraw the entire amount of the benefit payment immediately if he or she wishes. Please note the TCA is not a bank account and not a checking, savings or money market account.

Assigning Life Insurance Benefits

If an assignment of life insurance benefits is made, neither the Company nor MetLife assumes responsibility of any kind or degree for the validity, sufficiency or effect of the assignment. You are strongly urged to discuss this with your personal legal, tax and financial advisors before assigning life insurance benefits.

Once you have assigned your life insurance benefits, you give up all ownership rights to the assignee including conversion, portability, accelerated benefit option, beneficiary changes, and the right to increase or decrease your Optional Life Insurance Coverage amount or to cancel your Basic Life Insurance coverage.

Filing a Claim

To claim employee Basic or Optional Life Insurance Coverage benefits, spouse or domestic partner Optional Life Insurance Coverage benefits, or children Optional Life Insurance Coverage benefits, MetLife must be given written notice of your death or your dependent's death. This notice must contain information sufficient to identify the person for whom a claim is being submitted and must include a certified copy of the death certificate.

To claim employee AD&D Coverage benefits or spouse or domestic partner AD&D Coverage benefits, MetLife must be given written notice and written proof of the claim. This proof must contain information sufficient to identify the person for whom a claim is being submitted and must include a certified copy of the death certificate or proof of the dismemberment.

For more information on filing a claim and instructions on filing an appeal, see the section "Claiming Benefits."

If You Terminate or Retire

You may convert your Basic or Optional Life Insurance Coverages as well as any spouse or domestic partner and/or children Optional Life Insurance Coverage to an individual

policy through MetLife at your own expense. In addition, you may continue your Optional Life Insurance Coverage in excess of one times your annual salary, as well as any spouse or domestic partner and/or children Optional Life Insurance Coverage, if applicable, through MetLife's portability option, also at your own expense (See "Conversion of Coverage" and "Portability").

Conversion of Coverage

If your coverage ends, in most cases you can apply for an individual policy under the conversion privilege within 31 days after your Basic or Optional Life Insurance Coverages or any continuation period ends.

After your employment terminates for any reason, you will automatically receive information about continuing your Basic or Optional Life Insurance Coverages directly from MetLife. If you do not receive these materials, you should contact the Colleague Service Center at (855) 783-4772. If you die during the 31 days after your Basic or Optional Life insurance Coverages end and before applying for an individual policy, or if you die after applying for an individual policy but before the individual policy goes into effect, the amount payable under the group contract is limited to the maximum that could have been converted. This limit applies even if you have not applied for or paid the first premium on the individual policy.

In order to convert, you must file a written application for an individual policy with MetLife and pay the first premium to MetLife within 31 days after group coverage ends.

The application period is based on the date your group coverage terminates and the date of the conversion notice from MetLife. Generally, you have 31 days from the date group coverage ends to apply for conversion. However, if the conversion notice from MetLife is dated more than 15 days after the date of your termination, your application period is extended for an additional 15 days from the date of the conversion notice. If the 15-day extension applies to you, it will not exceed more than 91 days from the date group insurance was terminated.

No Proof of Good Health will be required when converting your Basic or Optional Life Insurance Coverages into an individual policy.

Spouse or domestic partner and children Optional Life Insurance Coverage may be converted to an individual policy; however, you cannot convert AD&D Coverage into an individual policy.

The individual policy will become effective at the end of the 31-day period during which conversion is possible.

The premiums due under the individual policy will be based on your age (nearest birthday) at that date.

The premiums for the individual policy will be at MetLife's then customary rates for the same policy issued to any other person of the same class of risk and age at the time the converted policy is to become effective.

After an individual policy becomes effective, that policy will replace all benefits and privileges provided previously under the discontinued group Basic and Optional Life Insurance Coverages.

If the Basic and Optional Life Insurance Coverages end because such coverages are discontinued for your employee group, you may convert the Basic and Optional Life Insurance Coverages to individual policies. To do so, your Basic and Optional Life Insurance Coverage must have been in effect for five consecutive years prior to the discontinuation date. If you convert, the amount of the coverage you had will be reduced by any group insurance amount for which you become eligible within 31 days of the discontinuation date. The maximum amount that can be converted is $2,000.

Conversion of Coverage After a Divorce or Dissolution of a Domestic Partnership

If you and your spouse get a divorce, or following dissolution of your domestic partnership, your spouse's or domestic partner's Optional Life Insurance Coverage will end. Conversion privileges are available, provided the paperwork is completed and the required premium payment is made within 31 days of the date on which your spouse's or domestic partner's Optional Life Insurance Coverage would otherwise end.

Portability

Employees with Optional Life Insurance Coverage (including spouse or domestic partner and children Optional Life Insurance Coverage) are allowed to continue certain Optional Life Insurance Coverage if coverage ends due to the following reasons:

- Your employment with the Company has ended for any reason; or

- Your employment classification has been changed such that you are no longer eligible for Optional Life Insurance Coverage under the Plan.

The above is subject to the following conditions:

- The Company has not terminated or given MetLife notice of termination of the Plan;
- You make a written request to MetLife to continue such Optional Life Insurance Coverage. The request and the first payment for the cost of your continued Optional Life Insurance Coverage must be received by MetLife during the enrollment period. The enrollment period is the 31-day period after the date your Optional Life Insurance Coverage ends as stated above;
- Portability is only available for spouse or domestic partner Optional Life Insurance Coverage if your spouse or domestic partner is under age 70 as of the application date; and
- Coverage for children can only be continued until the children reach age 26.

A notice and request form will be furnished directly from MetLife.

If you are not given notice in writing, of such right to continue such Optional Life Insurance Coverage within 15 days before or after the first day of the enrollment period, you will have additional time in which to make the request. If such notice is given more than 15 days but less than 90 days after first day of the enrollment period, you will then have 45 days from the date you are given the notice in which to apply. If such notice is not given within 90 days after the first day of the enrollment period, the time in which you may exercise this right will expire at the end of such 90 days.

You may be entitled to apply for a personal policy of life insurance on your own life. If you make a written request and are issued a personal policy, you may not make a request to continue your Optional Life Insurance Coverage.

Such Optional Life Insurance Coverage will be continued under a portability pool established under Group Policy No. 93211-G issued by MetLife to The Chase Manhattan Bank, N.A., Trustee. Your coverage under the pool will automatically include an ABO. It will not include a provision to continue your death benefits during total disability. Your coverage in the pool will become effective on the day following the end of the enrollment period. If you die during the enrollment period, MetLife will pay a death benefit to your beneficiary. The amount of the death benefit will be the amount of Optional Life Insurance Coverage, which you could have continued. This death benefit will be payable even if you did not make a request to continue such Optional Life Insurance Coverage. MetLife will, however, pay only one death benefit either under this provision or under the conversion of coverage right.

The amount you may continue is the amount indicated on your written request. This amount cannot be more than the lesser of (i) the amount of Optional Life Insurance Coverage in effect on your account on the date your Optional Life Insurance Coverage would otherwise end because your employment ended or because your employment classification changed or (ii) $1,000,000.

You pay the full cost for the continued Optional Life Insurance Coverage directly to MetLife. Payments, other than the first, are due on the first day of each calendar month. MetLife will send you a payment notice. A grace period of 31 days will be allowed for each payment. If you do not make the full payment within the grace period, your continued Optional Life Insurance Coverage will end; it will end on the last day of the grace period. Your continued Optional Life Insurance Coverage may not be reinstated.

The payment you make for the continued Optional Life Insurance Coverage will change each year as a result of your advancing age. Such change in your payments will take effect on January 1 of each year. In addition, a review of the financial experience of the portability pool will be made by MetLife annually. The payments you make may change after MetLife's review of the experience of the pool. MetLife will provide you with notice of any change in your payment no later than 31 days immediately preceding the effective date of the change.

Continuation of Coverage-Residents of Minnesota

If you reside in Minnesota and your employment terminates, you may elect to continue both your Basic and Optional Life Insurance Coverages and AD&D Coverage for yourself, your spouse or eligible domestic partner and/or your eligible dependent children through MetLife's portability option.

Coverage may continue to the earliest of the following dates:

- 18 months from your termination date (This applies to Basic Life Insurance Coverage only. Basic Life Insurance Coverage can be converted into an individual policy after the ported policy ends.);
- The end of the period during which you last paid the required contribution when due;
- The date your dependent is no longer eligible for coverage;
- The date you and your dependents become covered under another group life insurance plan;

- The date the Company terminates Optional Life Insurance Coverage; or
- The date your coverage as an employee or covered dependent under the Life Insurance Plan ends.

MetLife will notify you of your right to continue coverage through MetLife's portability option.

When Coverage Ends
Participation in the Life Insurance Plan ends on the day you terminate employment.

Any cost for Plan coverage in force but unpaid at the time of termination or commencement of an unpaid personal leave of absence may be withheld from your final paycheck, or your severance payments, if any.

You may be eligible for an extension of coverage while you are receiving payments under the Severance Pay Plan depending on your years of service with the Company. See the US Employees Guide to Separation Pay for more information.

The Date Coverage Ends
Coverage under the Life Insurance Plan will end on the earliest of the following dates:

- The specific day of the month on which you terminate employment, or if earlier, the last day of your notice period (if you will be receiving serial separation payments);
- The date the Plan is terminated (in the event a portion of the Plan is terminated, the corresponding portion of your coverage (or the coverage of your dependents) will end on the termination date);
- The end of the period for which you last made a contribution for coverage, if you fail to make a contribution when it's due;
- The specific day you (or your dependents) experienced a qualified status change, provided the Colleague Service Center receives your written request for voluntary cancellation of coverage within 60 days after a qualified status change event;
- The last day of the calendar year, in the event you did not elect coverage (for yourself and/or your dependents) for the following year during the annual enrollment period; or
- The date you (or your dependents) cease to be a member of an eligible class (for example, regular full-time or part-time employee or spouse).

Administration Information

This section contains information on the administration and funding of the Life Insurance Plan and your rights as a Plan participant under ERISA.

For further information about the administration of the Plan or for further information about the Plan in general, please contact:

American Express Colleague Service Center
Dept 01645
PO Box 64116
The Woodlands TX 77387-4116
Phone: (855) 783-4772

Plan Administrator

The Plan Administrator is the Employee Benefits Administration Committee ("EBAC") of American Express Company. The address is:

American Express Company
Employee Benefits Administration Committee
200 Vesey Street, Mail Code 01-35-03
New York, NY 10285-3503

The Plan Administrator will make determinations that may be required from time to time in the administration of the Plan. Although EBAC is the Plan Administrator, third parties provide administration and customer service to the Plan.

The EBAC shall have all powers and discretion necessary to administer the Plan, including, without limitation, the power to:

- Interpret the provisions of the Plan;
- Establish and revise the method of accounting for the Plan;
- Establish rules and prescribe any forms required for the administration of the Plan;
- Appoint individuals in the administration of the Plan and engage any other agents considered necessary, including legal counsel and employee benefit consulting firms;
- Determine eligibility for Plan participation; and
- Delegate fiduciary duties on claim determinations.

Plan Sponsor

American Express Company is the Plan Sponsor. The address is:

American Express Company
200 Vesey Street
New York, NY 10285

Employer Identification Number

The employer identification number assigned to American Express Company by the IRS is: 13-4922250.

Formal Plan Name

American Express Welfare Benefits Plan

Plan ID Number

507

Plan Year

January 1 – December 31

Administration/Funding

Insured. Coverage is provided through a group term policy, with no cash value. Benefits are payable upon death only.

Claims Administrator

MetLife
Group Life Claims
Oneida County Industrial Park
5950 Airport Road
Oriskany, NY 13424

Claims Fiduciary

Metropolitan Life Insurance Company (for benefit claims)
EBAC (for administrative claims)

Claiming Benefits

As a participant in the Plan, you may have an inquiry or claim regarding administrative issues or the denial of benefits to which you believe you are entitled. An administrative claim or appeal involves issues such as:

- Enrollment; or
- Eligibility.

A benefit claim or appeal involves issues such as:

- Payment of a claim.

To learn more about the procedures, see the "Filing an Administrative Claim" and "Filing a Benefits Claim" sections.

Filing an Administrative Claim

The Colleague Service Center serves as the reviewer of initial inquiries and first level appeals in connection with administrative claims for the Plan. The rules described in this "Filing an Administrative Claim" section apply if your claim does not involve a claim for benefits. If your claim involves an administrative issue and a claim for benefits, the rules described under "Filing a Benefits Claim" will apply. If you believe that your initial inquiry or claim is of an administrative nature, you may contact the Colleague Service Center at (855) 783-4772 or send written correspondence to the following address:

American Express Colleague Service Center
Attention: Claims and Appeals Management
P.O. Box 7105
Rantoul, IL 61866-7105

The Colleague Service Center will respond to your initial inquiry within 10 business days. You will be contacted in the same manner in which you made your initial inquiry. If you are not satisfied with the decision made in response to your initial administrative inquiry, you may file a first level administrative appeal with the Colleague Service Center within 60 days of receipt of the denial. You must submit a written first level administrative appeal to the Colleague Service Center. To expedite the review process, written first level administrative appeals should include the following information:

1. Full name, as recorded on Plan statements or paycheck;
2. Employee ID number;
3. Daytime and evening phone number(s);
4. Mailing address;
5. General reason for appeal;

6. Administrative rule or eligibility requirement in dispute;
7. History of notification and any contact name or dates;
8. Supporting documentation or records; and
9. Any information or documentation you or your beneficiary believes may support the appeal.

The Colleague Service Center will send you a letter acknowledging receipt of your first level administrative appeal within five business days. If you mistakenly send a benefit appeal to the Colleague Service Center, it will be forwarded to the Claims Administrator. The Colleague Service Center will inform you in writing of where the appeal was forwarded and provide you with the Claim Administrator's toll-free telephone number.

The Colleague Service Center will notify you of its decision within 30 days of receipt of your first level administrative appeal or it may request a 30-day extension in certain circumstances, as long as you are notified within the initial review period. If your administrative appeal is denied, you or your beneficiary will receive a written notice that will include the specific reasons for the denial and the Plan provisions on which the denial is based. If you are not satisfied with the decision made in response to your first level administrative appeal, you may submit a written second level administrative appeal to the EBAC, the Plan Administrator, within 60 days of receipt of your denial. You should include all the information in the checklist with your appeal. A delegate of the Plan Administrator actually reviews second level administrative appeals and makes the determination. You will be notified of the final determination within 60 days of receipt of your second level administrative appeal or within 90 days upon extension.

If you are still not satisfied with the second level administrative appeal decision, you may submit a final written administrative appeal to the EBAC within 60 days of receipt of your denial. The EBAC serves as the claims fiduciary for administrative appeals, and its decision is final and binding. The EBAC will notify you of the final determination within 60 days of receipt of your final written administrative appeal or within 90 days upon extension.

In order to promote efficient claims administration and in order to be consistent with the Company's overall policy regarding arbitration, to the extent permitted by ERISA, the EBAC, a Participant, beneficiary or alternate recipient will, upon completion of the claims process, have the right to compel binding arbitration with respect to any administrative claim or claim for benefits (as described below) or damages. Any such arbitration will generally be governed by the terms and conditions of the American Express Company Employment Arbitration Policy and Employment Arbitration Acknowledgment Form ("Arbitration Policy"). This includes, but is not limited to, the Arbitration Policy's prohibition against claims being arbitrated on a class action basis or on bases involving claims brought in a representative capacity on behalf of any other similarly situated party. In addition, the arbitrator will be bound by the substantive terms of the Plan and ERISA (including, but not limited to, the standard of review required by ERISA, which requires the arbitrator to defer to EBAC (or its delegate) and its factual findings and interpretations unless such findings and interpretations are arbitrary and capricious).

Filing a Benefits Claim

The Claims Administrator listed above serves as the reviewer of initial claim submissions and first and second level benefit appeals in connection with benefit claims for the Plan. If you have a benefits inquiry or claim, you may call or write to the Claims Administrator.

Notification of Benefit Determination

The Claims Administrator must notify you of its initial decision within a specified number of days after its receipt of the claim as indicated in the section "Timeframes for Claim Determinations and First Level Appeals." The Claims Administrator may request an extension due to matters beyond its control, as long as you are notified within the initial review period, and such notification includes the special circumstances that give rise to the need for the extension and the date by which a determination is expected to be made. If an extension is needed because additional information is required, the notice to you must specify what information is needed and the number of days you have to provide this information. If you do not provide the requested information within the time specified, the Claims Administrator may decide your claim without it.

If the Claims Administrator denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because the Claims Administrator did not receive sufficient information, the claim decision will describe the additional information needed and explain why such information is needed.

Appeal of Adverse Benefit Determination

If the Claims Administrator denies your claim, you may appeal the decision. Upon your written request, the Claims Administrator will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your benefit appeal to the Claims Administrator at the address indicated above within the number of days specified in the "Timeframes for Claim Determinations and First Level Appeals" section. Benefit appeals must be in writing and must include the following information:

- Name of employee;
- Member identification number, if applicable;
- Name of the Plan;
- Reference to the initial decision; and
- An explanation of why you are appealing the initial determination.

As part of your benefit appeal, you may submit written comments, documents, records or other information relating to your claim. The claims process does not allow oral presentations or specific questions of the Claims Administrator.

After the Claims Administrator receives your written request appealing the initial determination, the Claims Administrator will conduct a full and fair review of your claim. The review on appeal will take into account all comments, documents, records and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim.

The Claims Administrator will notify you in writing of its final decision within a period of time, as specified in the section "Timeframes for Claim Determinations and First Level Appeals," upon the Claims Administrator's receipt of your written request for review, except that under special circumstances the Claims Administrator may have an extension to provide written notification of its final decision. If such an extension is required, the

Claims Administrator will notify you prior to the expiration of the initial period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you must submit additional information necessary to decide your benefit appeal, the notice to you must specify what information is needed and the number of days you have to provide the information. In this case, the running of the time period for the Claims Administrator's making the determination is tolled (temporarily stopped) from the date on which the notice is sent to you until the date you respond to the notice. If you do not provide the requested information within the time specified, the Claims Administrator may decide your appeal without it.

You will have a number of days as specified in the notice to provide the requested information from the date you receive the notice from the Claims Administrator.

If the Claims Administrator denies the appeal, the Claims Administrator will send you a written decision that states the reason(s) why the appeal is being denied and references any specific Plan provision(s) on which the denial is based.

Second Level of Appeal of Adverse Benefit Determinations

If you receive a denial of your appeal from the Claims Administrator, you may file a second level benefit appeal of that denial within the number of days specified for first level appeals in the section "Timeframes for Claim Determinations and First Level Appeals." Once you have filed and received a determination on two levels of appeals, you have the right to bring a civil action under section 502(a) of ERISA to pursue your claim. If you have any questions about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration of the U.S. Department of Labor (listed in your telephone directory), or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210.

Timeframes for Claim Determinations and First Level Appeals

Generally, you'll receive payment or denial of an application for benefits within certain timeframes from the date a claim is properly filed. When you file an appeal, specific timeframes also apply based on the type of claim, as outlined in the following chart. If payment of a claim or notice of a claim denial is not furnished within these timeframes, you should consider the claim to be denied and, if you so decide, proceed to the next stage of filing claims.

Benefit	Initial submission of claim by Employee	Initial claim determination by Claims Administrator	Deadline for first level appeal after receiving a denial	Determination of appeal
Life	As soon as reasonably possible	90 days from receipt of claim (180 days in special circumstances)	60 days from receipt of notice	60 days from receipt of appeal (120 days in special circumstances)
AD&D	20 days* for written notice; 90 days* for written proof	90 days from receipt of claim (180 days in special circumstances)	60 days from receipt of notice	60 days from receipt of appeal (120 days in special circumstances)

* Assumes the number of days from the date your experience a covered loss under AD&D Coverage.

Mailing Address for Benefit Appeals:

MetLife Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100

*Please make sure to reference the claim number when submitting an appeal

Claims Fiduciary

As described above in the "Filing an Administrative Claim" section, EBAC serves as the claims fiduciary for administrative claims. For benefit claims, the Claims Administrator serves as the claims fiduciary and has the discretionary authority and fiduciary responsibility under ERISA to make claim determinations and to provide a full and fair review of appealed claims including determining any final appeals of claims. The Claims Administrator's duties include the discretionary authority and fiduciary responsibility under ERISA to determine what constitutes a benefit and what constitutes a claim under the Plan.

The Claims Administrator's decisions are conclusive and binding on all parties and are not subject to further review.

Other than its role as claims fiduciary, any services provided by the Claims Administrator will not affect the EBAC's acknowledged status as the Plan Administrator, and accordingly, the EBAC will retain sole fiduciary duties and discretionary authority in connection with its role and duties as Plan Administrator other than the role of claims fiduciary where applicable.

Payment of Claims

MetLife is responsible for the payment of all benefits offered under the Plan. MetLife has the sole authority, discretion and responsibility to interpret and apply the terms of the Plan, including entitlement to benefits and the amount of benefits to be paid under the insurance contract, if any.

The liability of the Company with respect to the Plan is limited to making premium payments and/or forwarding premium payments deducted from covered employees' pay for coverage under the applicable insurance policy. No covered employee, dependent or other person will have any claim or cause of action against the Company as to the payment of benefits under any insurance policy or contract while the Plan is in effect. Each covered person or other claimant entitled to the payment of benefits under the Plan shall look solely to the applicable insurance policy or contract, and not to the Company for payment of such insured benefits.

Proof of Claim

The Claims Administrator reserves the right to require verification of any alleged fact or assertion pertaining to any claim for benefits.

No Assignment of Benefits

Generally, benefits provided under the Plan may not be assigned or transferred in any manner except as required by law. Life insurance can be assigned as a gift.

Subrogation and Reimbursement

If you or your dependents receive benefits under the Plan, the Plan or the insurance company shall be subrogated to the full extent of benefits paid under the Plan. Subrogation means that the Plan or insurance company shall be reimbursed immediately from any amounts that you, your dependents and any attorneys receive—whether by suit, judgment, settlement, compromise or otherwise—from any person, entity, insurer or other plan that is or may be liable for an accident, injury, illness, sickness, or condition that resulted in benefits being paid under the Plan and/or other expenses incurred by you or your dependents as a result of the accident, injury, illness, sickness, or condition.

The Plan or insurance company may file a lien against you, your dependents and others to secure its subrogation and reimbursement rights. A Claims Administrator or other third party acting on behalf of the Plan or insurance company may file such a lien and/or take any other action deemed by such Claims Administrator, the Plan, the insurance company, or other third party to be appropriate to protect the Plan's or the insurance company's rights under the subrogation and reimbursement provisions described in this "Subrogation and Reimbursement" section.

The Plan or insurance company may also make a claim or file a lawsuit in your or your dependents' names to secure their subrogation and reimbursement rights.

Notwithstanding whether amounts received from such persons, entities, insurers or other plans are characterized as reimbursement for medical or dental expenses, disability, pain and suffering or for some other loss, these subrogation and reimbursement rights shall be a first priority claim against any such person, entity, insurer or other plan. The Plan or insurance company will be entitled to be reimbursed for all amounts paid under the Plan before you, your dependents and/or any attorneys are entitled to keep any amounts received. If any balance remains after the Plan or insurance company is fully reimbursed from any amounts received, you, your dependents and attorneys may retain those amounts.

Your and Your Dependents' Duty to Cooperate

You, your dependents and attorneys acting on your or your dependents' behalves must cooperate to secure enforcement of these subrogation and reimbursement rights. You, your dependents and your or their attorneys must take no action including, but not limited to, settlement of any claim, which prejudices or may prejudice these subrogation and reimbursement rights. If requested, you, your dependents and your or their attorneys must complete and sign all forms and papers as are necessary to secure these subrogation and reimbursement rights. You and your dependents must inform the Plan of potential or actual claims that you and your dependents have or may have against persons, entities, insurers or other plans. You must provide this notice within 30 days of the date when any notice is given to any party, including an insurance company or an attorney, of your or your dependents' intention to pursue or investigate a claim to recover damages or obtain compensation due to accident, injury, illness, sickness or condition. Identification of any and all persons, entities, insurers and other plans; date of the accident, injury, illness, sickness or condition; and any other necessary information required by the Plan, its Claims Administrator and attorneys shall be provided as soon as possible and, in all cases, before you or your dependents agree to any settlement or compromise. If the Plan determines that you, your dependents or your or their attorneys have failed to cooperate, you and your dependents will lose any right to continue coverage under the Plan and the Plan will be relieved of any obligation to pay benefits.

If you or your dependents receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you or your dependents will serve as a constructive trustee over the funds. You, your dependents or your or their authorized agent (such as your or their attorney) must hold any funds received from any potentially responsible party that are due and owed to the Plan as stated in this section, separately and alone.

Notifying the Company of a Lawsuit
In the event a lawsuit is brought (or settlement negotiations are entered into with a third-party) that relates to an accident, injury, illness, sickness or condition for which a claim is or will be made under the Plan, the Company must be notified immediately in writing. This written notice should be directed to:

American Express Company
Attn: Vice President of Benefits
200 Vesey Street
New York, NY 10285

The Plan reserves the right to determine when it's appropriate to withhold benefit payments and may do so whenever, in its judgment, there is any risk that the Plan may not be able to successfully exercise its subrogation, reimbursement, or lien rights.

Plan Entitlements
The Plan has the right to:

- Receive that payment instead of you, your dependents, your survivors or your medical care providers. This is called the right of subrogation. It means that the Plan has whatever rights you or your covered dependents have or had to recover expenses that the Plan has paid or will pay;
- Be paid by you, your dependents, or your survivors out of amounts received through the third-party who caused the sickness or accidental injury. That right, called a lien, is automatically created upon payment by the responsible person, the person's carrier or other coverage; and
- Withhold payment of your claims under the Plan until the Plan has received payment under its subrogation or lien rights.

The Plan is entitled to full payment even if a settlement is reached for less than the total claim against the responsible person. It also is entitled to full payment if the settlement agreement specifically allocates the settlement amount to other claims, such as pain and suffering, lost wages, and the like. The Plan does not have a right to receive more than the amount you, your dependents and/or your survivors would otherwise receive.

Attorney's Fees
The Plan will not be responsible for any attorneys' fees or costs incurred by you or your dependents in connection with any claim or lawsuit against any person, entity, insurer or other plan, unless, prior to incurring such fees or costs, the Plan in the exercise of its sole and complete discretion has agreed in writing to pay all or some portion of fees or costs.

Jurisdiction

By accepting benefits under the Plan, you agree that any court proceeding with respect to these subrogation and reimbursement provisions may be brought in any court of competent jurisdiction that the Plan may select and you submit to each such jurisdiction.

Recovery of Excess Payments

As a condition of participating in the Plan, the Company or the insurance company has the right to recover excess payments. Excess payments can occur if benefits paid under the Plan or from other sources combined, exceed those due to you under the Plan. Excess payments may also occur if benefits were paid because of a mistake, because of incorrect information regarding your entitlement to benefits or because benefits were paid after coverage was terminated. The Company or the insurance company may recover any excess amount paid to you by:

- Reducing or suspending future benefit payments;
- Requesting direct payment from you; and
- Any other method allowed by law.

Changing or Ending the Plan

The Company reserves the right to change or end the Plan at any time without notice or consent. Eligible employees and their dependents have no vested rights to any Plan benefits or policies listed in this SPD. The Company also reserves the right to insure any benefits under the Plan or to establish any fund or trust for the payment of benefits under the Plan except as mandated by law. The Company's board of directors may delegate amendment and termination authority to a committee or an individual, and such delegation may include authority for such committee or individual to subdelegate such amendment and termination authority. An amendment to the Plan may be made by the publication of an updated SPD or communication of information regarding changes to Plan.

When the Company Changes or Ends the Plan

The Company's decision to change or end the Plan may be due to changes in federal or state laws governing such employee welfare benefit plans, the requirements of the Internal Revenue Code of 1986, as amended, ERISA, employee needs or Company needs, the provisions of a contract or a policy involving a third party or an insurance company, or for any other reason. If the Company makes a change or decides to end the Plan, it may or may not decide to set up a different Plan to provide similar benefits.

Receiving Payment When the Plan Ends

Generally, if the Plan ends, you will be entitled to receive payment for eligible claims (properly documented) incurred before the Plan is ended, but you will not have any further rights under the Plan. The amount and form of any final benefit you may receive will depend on any contract or insurance provisions affecting the Plan and on Company decisions. Because contributions under the Plan will stop when the Plan ends, the amount available to pay covered claims should not exceed the amount of such claims on the termination date. However, after all benefits have been paid and legal requirements have been met, any remaining money in the Plan will be paid to the Company.

Agent for Service of Legal Process

Process can be served on the Company by directing service to the General Counsel, American Express Company:

General Counsel
American Express Company
200 Vesey Street
New York, NY 10285

Process can also be served on the Plan Administrator.

ERISA Rights

The Plan has been established by the Company for the exclusive benefit of its eligible employees and eligible employees of its participating subsidiaries.

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. You have the right to:

Receive Information About Your Plan and Benefits

You may:

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

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the 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 the Company or any other person, may terminate your employment or otherwise discriminate against you in any way in order to prevent you from obtaining a benefit to which you are entitled or from exercising your rights under ERISA.

EBAC is the fiduciary of the Plan and is the claims fiduciary for administrative claims. The insurance company is the claims fiduciary for benefit claims and determines entitlement to benefits and the amount of benefit to be paid under the Plan, if any.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents from the Plan Administrator or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive them, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court provided that you have exhausted your administrative rights under the Plan. 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 court costs and legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions 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 of the U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Sponsoring Employers

A complete list of employers sponsoring the Plan is available for examination by participants and beneficiaries and may be obtained upon written request to the Plan Administrator.

Glossary

Child Care Center—A facility which is operated and licensed according to state law, and provides care and supervision for children in a group setting on a regular daily basis.

Company— For purposes of the SPD, Company means American Express Company, along with its participating affiliates when appropriate.

Imputed Income— The taxable value of your employee life insurance coverage over $50,000.

Independent Medical Examination— A medical examination you may be required to undergo by a MetLife approved Physician. MetLife will pay for the exam.

Passenger Car—Any validly registered four-wheel private passenger car. It does not include:

- Any commercially licensed car; or
- A private passenger car, which is being used for commercial purposes.

Physician—A person who is legally licensed to practice medicine. A licensed medical

practitioner will be considered a Physician if applicable state law requires that such practitioner be recognized for the purposes of disability certification and the care and treatment provided by the practitioner is within the scope of his or her license.

Proof of Good Health—This is generally accomplished by satisfactorily completing a medical questionnaire. In some situations, a physical exam may be required. MetLife determines whether the proof of good health requirement is met.

Seat Belt—Any child restraint device which meets the definition of the state law or any other restraint device which:

- Meets published federal safety standards;
- Has been installed by the car manufacturer; and
- Has not been altered after such installation.

Terminally Ill—A person is considered terminally ill if:

- He or she suffers from an incurable, progressive and medically recognized disease or condition; and
- To a reasonable medical probability and based on a generally accepted prognostic protocol, will not survive more than six months beyond the date of the request for an ABO.

Totally Disabled—A person is considered Totally Disabled if: You suffer from a disability caused by sickness, disease, injury, pregnancy or related mental impairment for which you are under the care of a Physician, and either:

- During the first two years of long-term disability payments, because of sickness or injury, you're unable to perform any and every duty of your regular job; or
- You're unable to perform all of the material duties of your job on a full-time basis, but are performing at least one of the material duties of the job or any other gainful work on a part-time or full-time basis. (In this situation, your earnings cannot exceed 80% of your earnings prior to disability. Your combined earnings, long-term disability and earnings from gainful employment, may not exceed 100% of your pre-disability salary.)

After the first two years of disability, Total Disability means you cannot perform each of the material duties of any gainful work or service for which you're reasonably qualified, taking into consideration your training, education, experience, and past earnings (except rehabilitative employment).

MetLife determines whether you are Totally Disabled. If you are a participant in the American Express Long-Term Disability Benefit Plan (the "Long-Term Disability Plan") and are considered Totally Disabled for purposes of the Long-Term Disability Plan, you will also be considered Totally Disabled for purposes of this Plan. If you are not a participant in the Long-Term Disability Plan, MetLife's determination of Total Disability will be subject to the same claim procedure that applies to long term disability benefits under the Long-Term Disability Plan.