Kimberly-Clark

Your Employee Life and Accident Coverage (Salaried and Hourly Standard Plan)

Summary Plan Description

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Introduction

About Your Summary Plan Description (SPD)

Financial protection against death and accidental injury is important. That's one reason Kimberly-Clark Corporation (Kimberly-Clark, K-C, or the Company) offers the Group Life Insurance (GLI), Personal Accident Insurance (PAI), and Business Travel Accident (BTA) coverage (including Plant Emergency Response Organization [PERO] coverage), (collectively called "life and accident" or the Plan).

This material constitutes your Summary Plan Description (SPD) of the Plan in effect on January 1, 2013. It describes the benefits provided under insurance contracts with the Minnesota Life Insurance Company (the Insurance Company for the GLI coverages) and Zurich-American Insurance Company (the Insurance Company for the PAI and BTA [including PERO] coverages).

This SPD is intended to be a brief description and, as such, cannot present all the details of eligibility, benefits, and other Plan provisions. In all cases, the provisions of the insurance contracts govern. No description in this SPD is intended to change anything in the Plan or to affect any rights under it.

Participating Employers

This SPD describes the Plan as it applies to Participating Employers. The Plan provides coverage to eligible employees (and their eligible dependents) of Participating Employers and their Participating Units. See the "Administrative Information" section for a list of the Participating Employers and their Participating Units.

Eligibility

Employees

You're eligible for coverages under the Plan as long as you're employed at one of the Participating Employers and its Participating Units that has adopted this Plan, you're **not** classified as a temporary or intermittent employee, and you're classified as a full-time or part-time salaried employee or hourly employee.

See "Whom the Plan Pertains To" under the "Administrative Information" section for a detailed list of the Participating Employers and their Participating Units.

As long as you meet the Plan's eligibility requirements, coverage begins on your coverage effective date. Your coverage effective date may be your date of hire, or it may be after your date of hire. See the "When Coverage Begins" section for details regarding your coverage effective date.

If You're Rehired

You may be enrolled for coverage, terminate employment, and then subsequently return to work for the Company. If you do and you again meet the Plan's eligibility requirements as an active employee, you're again eligible for active coverage. The time that elapses between your termination date and the date on which you're rehired may impact whether your prior coverage is reinstated (or whether you may make new coverage elections if applicable). In addition, Evidence of Insurability (EOI) requirements may apply. See the "When Coverage Begins" section for how the Plan defines coverage effective date.

Dependents

Dependent GLI Eligibility

Your dependents may be eligible for dependent GLI coverage provided they meet the eligibility requirements and you—as an eligible employee—have basic GLI coverage. You're asked to provide the birth date and a valid Social Security number for each dependent you enroll (except if you're enrolling an eligible dependent younger than age one, in which case a Social Security number is not requested). Your eligible dependents include your:

- Legal spouse or common-law spouse (only if the common-law marriage is recognized in the state in which you live), except as provided under "Kimberly-Clark Couples" under this section.
- Same- or opposite-sex domestic partner), except as provided under "Kimberly-Clark Couples" under this section. For your domestic partner to be eligible for coverage under the Plan, you and your domestic partner must meet **all** of the following:
    - You've lived together continuously in the same principal residence for at least six months and intend to do so indefinitely;

- You're financially interdependent on one another;
- You're not related by blood or to the degree of closeness that would prohibit your legal marriage in the state in which you reside;
- Neither of you is legally married to anyone else (as defined under the Defense of Marriage Act); and
- You're each at least 18 years old and mentally competent to enter into a marriage contract.

- Children, including any of the following:
  - Your natural (biological) children;
  - Your stepchildren;
  - Your foster children who are placed with you or your spouse/domestic partner by an authorized placement agency or by a judgment, decree, or other order of any court or competent jurisdiction (requires court-approved custody, and enrollment must be completed by calling the Kimberly-Clark Benefits Center);
  - Your legally adopted children or children placed with you for adoption (provided such children will be eligible children once the adoption is finalized);
  - Children for whom you have legal guardianship (requires court-approved custody, and enrollment must be completed by calling the Benefits Center); and
  - Any children of your domestic partner who meet all of the above criteria in relation to the domestic partner.

  Coverage for your dependent child continues (as long as your own coverage under the Plan continues) until the last day of the month in which he or she turns age 26, regardless of the child's marital status, full-time student status, residency, or financial dependence on you.

  Coverage is available beyond age 26 for unmarried physically or mentally disabled dependents.

Spouse and Domestic Partner PAI Eligibility

Your legal or common-law spouse or your domestic partner is eligible for PAI coverage if you enroll yourself for PAI coverage under the Plan. As with other domestic partner benefits, imputed income applies.

Kimberly-Clark Couples

You cannot be enrolled for GLI or PAI coverage under more than one Kimberly-Clark-sponsored Plan as:

- An employee;
- A retiree;
- A spouse/domestic partner of an eligible employee or retiree; or
- An eligible dependent of an employee.

For example, if you and your spouse/domestic partner work for the Company (known as a K-C couple) and are both eligible for GLI coverages under this Plan, each of you may enroll separately for optional GLI coverage. However, you and your spouse/domestic partner aren't able to elect dependent GLI coverage for each other. Similarly, children of a K-C couple can only be covered for dependent GLI coverage by one person.

Eligibility Upon Retirement

If you retire and meet the eligibility requirements for coverage as a retiree, your GLI coverage under this Plan ends on the last day of the month in which you terminate. A separate Retiree Group Life Insurance (GLI) SPD includes details regarding that Plan's eligibility requirements for retiree life coverage. Please see that separate SPD for details.

Please Note: Not all employees are eligible for retiree life coverage. To be eligible, you must:

- Have an original hire date with the Company prior to January 1, 2012 (doesn't apply to Fullerton hourly organized employees);
- Be employed at one of the Participating Employers and its Participating Units that provides retiree life coverage; and
- Meet certain age and service requirements.

How to Enroll

Overview

When you're first eligible and each year during Annual Enrollment, you have the opportunity to select the GLI and PAI coverage you want for yourself and your eligible dependents, if applicable, under the Plan. It's your responsibility to make your election within the allowed time frame. You have a few ways to enroll:

- **Online:** Your Benefits Resources™ (YBR) Web site;
- **By Mobile:** YBR Mobile from your smart phone (iPhone version iOS4.1+, Android version 2.1+, BlackBerry version OG6+) at **resources.hewitt.com/kcc**. (**Please Note:** YBR Mobile is only available for enrolling during Annual Enrollment); or
- **By Phone:** Kimberly-Clark Benefits Center; Benefits Center representatives are available between 9 am and 5 pm ET, Monday through Friday.

YBR is the preferred method of enrollment. However, you can enroll through the Benefits Center if you don't have Internet access or if you need help during enrollment.

Enrolling When You're First Eligible and During Annual Enrollment

GLI Coverages

There are three kinds of GLI coverage:

- Basic GLI coverage;
- Optional GLI coverage; and
- Dependent GLI coverage.

Basic GLI coverage is provided for you by K-C beginning with your first day of active employment. You don't need to enroll for this coverage.

Optional GLI and dependent GLI coverages are additional coverages that you may elect for yourself and/or your eligible dependents. In certain instances, Evidence of Insurability (EOI) is required when enrolling yourself for optional GLI coverage and/or your dependents for dependent GLI coverage. See "Evidence of Insurability (EOI) Requirements" under the "How GLI Coverage Works" section for details.

PAI Coverage

You can elect PAI coverage for yourself or for you and your spouse/domestic partner. EOI isn't required for this coverage.

BTA, Including Plant Emergency Response Organization (PERO) Coverage

This coverage is automatically provided for you by the Company. You don't need to enroll for this coverage.

Additional Information

You have 30 days from your hire date to complete your enrollment. You're encouraged to review your coverage options and make an election. As long as you enroll within your 30-day enrollment period, coverage begins on your coverage effective date and remains in effect for that plan year (as long as you remain eligible). See the "When Coverage Begins" section for details regarding your coverage effective date.

If you don't enroll within your 30-day enrollment period, you can't enroll for optional GLI, dependent GLI, and/or PAI coverages until:

- The next Annual Enrollment; or
- You experience a permitted election change as described under the "When You Can Change Coverage" section.

Please Note: In certain instances, you need to provide satisfactory EOI to the Insurance Company for the GLI coverages before GLI coverage can begin. See "Evidence of Insurability (EOI) Requirements" under the "How GLI Coverage Works" section for details.

Each fall during Annual Enrollment, you have the opportunity to change your optional GLI, dependent GLI, and/or PAI coverages. If you don't enroll during your Annual Enrollment period, your coverages remain the same. For example, if you have optional GLI coverage of three times your base pay in 2013 and you don't request any changes for 2014, your optional GLI coverage will remain at three times your base pay.

Likewise, if you have $50,000 of PAI coverage for yourself in 2013 and make no change for 2014, your PAI coverage will remain at $50,000.

Once you confirm your election online or by phone, that election is irrevocable and final. See the "When You Can Change Coverage" section for details.

If You Want to Waive Basic GLI Coverage

If you want to waive basic GLI coverage, you must go through the enrollment process and elect No Coverage. If you waive basic GLI coverage and later decide to enroll for any GLI coverage (i.e., basic GLI and/or optional GLI), you can only do so by providing satisfactory EOI. In addition, you can only enroll during Annual Enrollment or if you have a permitted election change (see the "When You Can Change Coverage" section for details).

When Coverage Begins

Coverage Effective Date

As long as you meet the Plan's eligibility and enrollment requirements (enroll within 30 days of your hire date), coverage begins on your coverage effective date.

Your coverage effective date is your date of hire.

Coverage begins on your coverage effective date, provided you're actively at work on that day. If you're not actively at work on your coverage effective date, coverage begins on your first day of active work.

Coverage for your eligible dependents begins on the same day as your coverage begins, or on the day your dependent first becomes eligible (whichever is later). If you're adding an eligible dependent to coverage because of a permitted election change, you must do so within 30 days of the event. See the "When You Can Change Coverage" section for details.

Coverage continues as long as you continue to meet the Plan's eligibility requirements and you continue contributing toward the cost of coverage, if necessary. See the "Cost of Coverage" section for additional cost-related information.

Cost of Coverage

How Cost Is Determined

Here's how your cost is determined.

- **GLI Coverages:** Your basic GLI and optional GLI coverage amounts and the premium you pay for optional GLI coverage is adjusted each January 1, up to Plan limits. This adjustment reflects any non-temporary changes in your annual base pay and your age as of the previous July 1. Basic GLI coverage is provided to you at no cost. You pay for any optional GLI and dependent GLI coverage you elect. See "Paying for Optional GLI and Dependent GLI Coverage" under this section for details.

- **PAI Coverage:** The annual cost of PAI coverage is a flat premium per $10,000 of coverage. This cost applies to coverage for you and coverage for you and your spouse/domestic partner and may vary from year to year.

- **BTA Coverage (Including Plant Emergency Response Organization—PERO):** There's no cost to you for BTA or PERO coverage. This coverage is paid for by the Company.

Paying for Optional GLI and Dependent GLI Coverage

Here's how you pay for these coverages.

- **Optional GLI:** You pay the cost of any optional GLI coverage you elect. Your cost depends on:
    - The coverage option you choose;
    - Your age (which determines the rate charged by the Insurance Company); and
    - Your annual base pay as of the previous July 1.
- **Dependent GLI:** Your cost for dependent GLI coverage for your spouse/domestic partner depends on the amount you elect and your spouse's/domestic partner's age. Your annual cost for dependent GLI coverage for your child(ren) is a flat premium that applies for all covered children as long as they're enrolled. In other words, the annual premium shown on YBR during Annual Enrollment is the total amount you'll pay regardless of how many children you enroll.

You pay the cost of optional GLI and dependent GLI coverage with after-tax dollars deducted from your pay. Go to the YBR Web site to determine the exact amount of your after-tax contribution.

Paying for PAI Coverage

Your cost for PAI coverage depends on the amount of coverage you choose. You pay the full cost of this coverage with before-tax dollars deducted from your pay.

Imputed Income

The Federal government requires you to pay income tax on the value of any Company-paid group term life insurance coverage above $50,000. This taxable value is called imputed income and is added to your taxable earnings each pay period. Your basic GLI coverage is subject to imputed income rules.

If your total basic GLI coverage exceeds $50,000, imputed income is reported on your annual K-C W-2 wage and tax statement. For additional tax information, including more specific rules and examples of how taxes are calculated, refer to Internal Revenue Service (IRS) Publication 15-B. This publication may be obtained on the IRS Web site **irs.gov**.

Imputed Income for Elected Dependent GLI Coverage

The Federal government requires you to pay income tax on the value of dependent GLI coverage. Depending on the age of your spouse/domestic partner or child, the number of children you cover, and the amount of dependent GLI coverage you elect, a portion of the benefit may be considered taxable to you. This taxable portion is called imputed income and is added to your taxable earnings via payroll. Imputed income is an IRS regulation. Consult with your tax advisor to determine if imputed income applies to your election(s).

For additional tax information, including more specific rules and examples of how taxes are calculated, refer to IRS Publication 15-B. This publication may be obtained on the IRS Web site **irs.gov**.

Imputed Income for Elected Domestic Partner PAI Coverage

Coverage will be imputed for domestic partners. Since you pay the entire cost of PAI coverage for your domestic partner on a pre-tax basis, the imputed income will be equal to your premium amount. Imputed income is added to your taxable earnings via payroll and is an IRS regulation. If your domestic partner meets the IRS's definition of a dependent, consult with your tax advisor to determine if imputed income applies to your election(s) and to understand how to adjust your Federal tax return.

When You Can Change Coverage

Changes During Enrollment

You can change your GLI and PAI coverage election(s) or waive your basic GLI coverage during the Annual Enrollment period. Your election takes effect for the next plan year (January 1 through December 31) and can't be changed until the next Annual Enrollment, unless you have a permitted election change. See "Permitted Election Changes" under this section for details.

Permitted Election Changes

You can make a change to your coverage during the plan year if you:

- Transfer to another unit or eligible employee group and your current coverage option under the Plan is not available.
- Have a permitted election change (you can change your level of coverage).

A change may be made as long as it's due to and corresponds with a gain or loss of eligibility for coverage as determined by the Plan Administrator in its sole discretion and it's consistent with the change in status (the change also must follow the Plan's rules). According to the Plan, a permitted election change includes the following:

- A change in status:
    - You get married or the day you first meet the Plan's domestic partnership requirements;
    - You get divorced, become legally separated, have your marriage legally annulled, or dissolve a domestic partnership;
    - Your spouse/domestic partner dies;
    - You or your domestic partner has a baby, adopts, or has a child placed with you or your domestic partner for adoption;
    - Your or your domestic partner's dependent child dies;
    - You, your spouse/domestic partner, your dependent, or your domestic partner's dependent child experiences a change in employment status that results in a gain or loss of coverage (including the start or end of employment; strike or lockout; start of or return from an authorized unpaid leave of absence; and a change in work site);
    - Your dependent child becomes eligible or ineligible for coverage under the Plan (e.g., he or she reaches the Plan's eligibility age limit, gains or loses legal guardianship, or other similar circumstance);

    - Your or your dependent's residence changes (which corresponds to a gain or loss of coverage);
    - Your domestic partner is no longer classified as a domestic partner;
    - Your domestic partner or domestic partner's child gains or loses eligibility for coverage; or
    - You, your spouse/domestic partner, your dependent, or your domestic partner's dependent child experiences any other event that's recognized under applicable law and regulations and is determined by the Plan Administrator—in its sole discretion—as a reason to change coverage under the Plan (no election change may be made for a dependent whose coverage is not affected by a change in status).
- A significant cost change in coverage, including:
    - The Plan Administrator prospectively increases or decreases your contributions due to an increase or decrease in the cost of providing such coverage; and
    - Cost changes occur under a Plan's coverage option.
- A significant curtailment in coverage as follows:
    - There's an increase in the out-of-pocket cost-sharing limits under one of the Plan's coverage options;
    - A coverage option is no longer offered under the Plan;
    - There's an addition to or improvement of a coverage option offered under the Plan; and
    - There's any other similar fundamental loss of coverage.
- A change in coverage under another employer's plan.
- You, your spouse/domestic partner, your dependent, or your domestic partner's dependent child takes or returns from a leave of absence that's 30 days or more under the Family and Medical Leave Act (FMLA).
- You, your spouse/domestic partner, your dependent, or your domestic partner's dependent child takes or returns from a military leave.

A retired employee is also entitled to coverage upon a permitted election change to the extent applicable.

You must request a change in your coverage within 30 days of the permitted election change by calling the Kimberly-Clark Benefits Center.

Increasing GLI Coverage

During Annual Enrollment or within 30 days after a permitted election change you can:

- Enroll for optional GLI coverage; or
- Increase your level of optional GLI coverage.

In either case, you must satisfy Evidence of Insurability (EOI) requirements.

Also during Annual Enrollment or within 30 days after a permitted election change you can:

- Enroll your spouse/domestic partner for GLI coverage;
- Increase your spouse's/domestic partner's dependent GLI coverage;
- Enroll your eligible child for dependent GLI coverage; or
- Increase dependent GLI coverage for your eligible child(ren).

In certain instances, EOI may be required. See "Evidence of Insurability Requirements for Dependent GLI Coverage" under the "How GLI Coverage Works" section for details.

If you aren't actively at work when an increase in coverage is scheduled to take effect (January 1 or, for a permitted election change, the approval date from the Insurance Company), the increase is delayed until you return to work.

Decreasing GLI Coverage

During Annual Enrollment or within 30 days after a permitted election change you can:

- Waive optional GLI or dependent GLI coverage; or
- Decrease your level of optional GLI coverage or your dependent's level of dependent GLI coverage.

You don't have to satisfy any EOI requirements when decreasing coverage. Requests to decrease coverage take effect January 1 for the next plan year, or on the permitted election change date if the decrease is due to a permitted election change.

If you waive or decrease optional GLI coverage or dependent GLI coverage and want to enroll or increase coverage at a later date, EOI requirements apply.

PAI Coverage Changes

You can change your or your spouse's/domestic partner's PAI coverage during the Annual Enrollment period or within 30 days of a permitted election change. Your Annual Enrollment choice takes effect the next plan year (January 1 through December 31) and can't be changed until the next Annual Enrollment, unless you have a permitted election change. See "Permitted Election Changes" under the "When You Can Change Coverage" section for details.

If you want to change your level of PAI coverage during Annual Enrollment or after a permitted election change, you can elect any PAI coverage amount in increments of $10,000, up to the Plan maximum, without having to satisfy EOI requirements.

However, if you aren't actively at work when the coverage change takes effect, the change is delayed until you return to work.

Naming a Beneficiary

Designating a Beneficiary

Here's how to designate a beneficiary.

You can name your beneficiary online by accessing the Your Benefits Resources (YBR) Web site. If you're not able to use YBR, call the Kimberly-Clark Benefits Center to speak with a representative. You must have your YBR/Benefits Center password in order to make a beneficiary designation.

GLI Beneficiary Information

A beneficiary is the person(s), estate, or organization that receives GLI benefits if you die. You're automatically the beneficiary who receives a GLI benefit if your covered dependent dies.

If you don't name a beneficiary, or if your beneficiary dies before you and you haven't named another beneficiary, the Plan pays benefits to your:

- Lawful spouse, if living; or otherwise
- Natural and legally adopted children in equal shares, if living; or otherwise
- Parents in equal shares, if living; or otherwise
- Estate.

PAI Beneficiary Information

When you enroll for PAI coverage, you're asked to name a beneficiary. If you don't or if your beneficiary dies before you and you haven't named another beneficiary, the Plan pays a benefit to your estate.

You're automatically the beneficiary for spouse/domestic partner PAI coverage, and the Plan pays a benefit to you in the event of your covered spouse's/domestic partner's death (if you predecease your spouse/domestic partner, the Plan pays the benefit to your estate). If your covered spouse/domestic partner suffers a dismemberment or a total and permanent disability, the Plan pays a benefit to your spouse/domestic partner.

BTA Beneficiary Information

The beneficiary you designate for your GLI benefit(s) is automatically the beneficiary for your BTA benefit, unless you designate a separate BTA beneficiary. If your designated beneficiary dies before you and you haven't named a beneficiary for GLI or BTA benefits, the Plan pays a benefit to your estate in accordance with state law.

The Plan pays a benefit to you for any BTA claims that are a result of your own accidental dismemberment and to your beneficiary for your accidental death.

Changing Your Beneficiary

It's important to keep your beneficiary information up-to-date. You can change your beneficiary at any time by contacting the Kimberly-Clark Benefits Center either using the YBR Web site or by phone.

How GLI Coverage Works

Company-Provided Basic GLI Coverage

Kimberly-Clark provides you with basic GLI coverage equal to two times your annual base pay (rounded to the nearest $100, up to $2 million), unless you waive this coverage. See "Base Pay" under this section for more information on which pay is included and how coverage is calculated. Your basic GLI coverage is adjusted on January 1 to reflect any non-temporary changes in your base pay as of the previous July 1.

Alternatively, Kimberly-Clark offers a flat $50,000 basic GLI coverage option. This option is only available to you if your two times annual earnings amount is greater than $50,000.

Waiving Basic GLI Coverage

If you wish, you can waive your basic GLI coverage. If you do and later decide to enroll, you must provide satisfactory Evidence of Insurability (EOI). In addition, you can only enroll during Annual Enrollment or if you have a permitted election change (see the "When You Can Change Coverage" section for details).

Optional GLI Coverage

The following optional GLI coverage options provide you additional coverage, up to the Plan's maximum:

- One times annual base pay;
- Two times annual base pay;
- Three times annual base pay; or
- Four times annual base pay.

See "Determining Your Total GLI Coverage Amount" under this section for details.

Optional GLI Coverage Example

If you have basic GLI coverage of $120,000 (assumes annual base pay is $60,000) and you elect optional GLI coverage equal to one times annual base pay, this provides you with a total of $180,000 of coverage ($120,000 basic GLI coverage plus $60,000 optional GLI coverage).

Evidence of Insurability (EOI) Requirements

If the optional GLI coverage that you elect exceeds $1 million, you're required to satisfy EOI. Otherwise, your coverage is reduced so your optional GLI coverage is at or below $1 million. Additionally you must:

- Provide EOI to increase your coverage option after a permitted election change or during Annual Enrollment;
- Provide EOI if your optional GLI coverage exceeds $1 million; and
- Remain in your current coverage until EOI is approved.

The higher level of coverage takes effect on the date of approval for ongoing increases, **or** on January 1 of the new plan year for any increase in coverage you may elect during Annual Enrollment.

EOI isn't required if you're a newly eligible employee (assuming the basic GLI or optional GLI coverage that you elect doesn't exceed $1 million).

Usually, the EOI process requires you to satisfactorily complete a medical questionnaire provided by the Insurance Company for the GLI coverages. The Insurance Company informs you of any additional proof that's required before coverage can begin. This could include a physical examination and medical report from your doctor or another medical professional.

EOI Rules for Optional GLI Coverage Over $1 Million

Your Optional GLI Coverage Is...	Is EOI Required?
Less than $1 million in 2013 and a salary increase causes your coverage amount to be over $1 million in 2014	No
Less than $1 million in 2013 and you elect a higher coverage option for 2014	Yes
Over $1 million in 2013 and you elect a higher coverage option for 2014	Yes

Evidence of Insurability Requirements for Dependent GLI Coverage

You must provide EOI for your spouse/domestic partner if you:

- Apply for dependent GLI coverage after 30 days of the day you're first eligible to elect coverage for your spouse/domestic partner; or
- Elect a coverage amount in excess of $20,000.

Thereafter, when eligible, and regardless of the coverage amount, EOI is required.

EOI isn't required for your dependent children.

Coverage Limits

The maximum GLI coverage is $6 million (basic GLI plus optional GLI coverage). Your basic GLI coverage is limited to $2 million due to the Plan's maximum. If you elect optional GLI coverage, your optional GLI coverage is limited to $4 million. Coverage amounts are rounded to the nearest $100 ($50 is rounded up).

Determining Your Total GLI Coverage Amount

Here's how to calculate your total GLI coverage:

- **Step One:** Multiply your annual base pay, as of the previous July 1, by 2x to get your basic GLI coverage.
- **Step Two:** Multiply the same annual base pay amount by one of the optional coverage levels, which are 1x, 2x, 3x, or 4x, to get your optional GLI coverage.
- **Step Three:** Add your basic GLI coverage determined in Step One and your optional GLI coverage determined in Step Two together. Round that total coverage to the nearest $100 (amounts of $50 and above round up, and amounts below $50 round down).
- **Step Four:** Add together your basic GLI coverage (2x annual base pay) and your optional GLI coverage (1x, 2x, 3x, or 4x annual base pay) to determine your total GLI coverage amount.
- **Step Five:** The resulting coverage level is 2x, 3x, 4x, 5x, or 6x (basic and optional GLI coverages combined).

Base Pay

For purposes of your GLI coverages, your annual base pay is your regular annual base pay (including any shift differential) as of the:

- Preceding July 1; or
- Date you first become eligible for coverage, if later than July 1.

Your annual base pay doesn't include overtime, incentive pay, bonuses, or any adjustments you receive as a result of a temporary assignment.

If you're an hourly paid employee, your annual base pay is your hourly pay rate (including shift differential) times 40 (hours) times 52 (weeks).

In your first year of coverage, your annual base pay is determined from your regular base pay or hourly pay rate (including any shift differential) as of the day you become eligible for GLI coverage (coverage effective date).

Dependent Coverage

Here's how dependent GLI coverage is determined for your eligible dependents.

Spouse/Domestic Partner

Your spouse/domestic partner is eligible for dependent GLI coverage if you have basic GLI coverage.

For your spouse's/domestic partner's dependent GLI coverage, you may elect coverage in increments of $1,000, up to a maximum of the **lesser** of:

- Three times your annual base pay; or
- $150,000.

The three times annual base pay is rounded down to account for the $1,000 increments (i.e., if 3x your pay = $128,794, the maximum dependent GLI coverage for your spouse/domestic partner would be $128,000).

The minimum dependent GLI coverage for your spouse/domestic partner is $10,000, and the maximum without EOI is $20,000. You're automatically the beneficiary of this benefit.

Child(ren)

Your dependent children are eligible for dependent GLI coverage if you have basic GLI coverage. Your dependent children are eligible for coverage from their date of birth up to age 26. Coverage is available beyond age 26 for an unmarried physically or mentally disabled dependent. Dependent children in full-time active military service are eligible.

Dependent GLI coverage options for your child(ren) are:

- No coverage;
- $10,000; and
- $20,000.

You're automatically the beneficiary of this benefit.

If You Become Disabled

If you're enrolled for optional GLI coverage, your employee contribution for this coverage is waived if you:

- Become disabled while you're actively employed; and
- Qualify for Long Term Disability (LTD) benefits.

Your basic GLI and optional GLI coverage continues, but you aren't required to make monthly contributions to pay for your optional GLI coverage during your disability. However, if you have dependent GLI coverage for your eligible dependents, you're still required to pay for your dependent GLI coverage during your disability.

If you retire while on LTD, GLI coverage may be provided as a retirement benefit. See "Retirement" under this section for details. If you terminate employment while on LTD, your coverage continues and you follow the GLI provisions provided for retired employees.

These disability rules apply as long as you're eligible to receive an LTD benefit. If you're not on LTD and you don't return to active employment with K-C, your GLI coverages end. However, you do have the right to convert coverage to an individual policy. See the "Converting GLI Coverage to Individual Coverage" under the "When Coverage Ends" section for additional information.

Retirement

If you retire and you're eligible for retiree life coverage, your GLI coverage continues but may be significantly reduced. See the "Retiree Life Insurance (Retiree GLI)" section for the qualifications, as well as your Retiree Life SPD (if applicable) for more details.

Payment of Benefits

The Plan most often pays benefits in a single lump sum. However, the Insurance Company for the GLI coverages may have other payment methods available. Ask the Insurance Company for an explanation of all available payment methods.

The Kimberly-Clark Benefits Center should be contacted as soon as possible after your or your covered dependent's death to begin the claim process. Instructions, forms, and other assistance is provided. See the "Applying for GLI Benefits" and "Applying for PAI and BTA Benefits" sections for additional information.

The Plan pays benefits as soon as the Insurance Company receives the necessary proof to support the claim. Any death benefit for your loss of life is paid in accordance with the beneficiary designation on file with the Benefits Center.

If your beneficiary is a minor or, in the Insurance Company's opinion, legally unable to give a valid release for payment for any Plan benefit, the benefit is payable to the guardian of the estate of the minor, or to the custodian under the Uniform Transfer to Minors Act, or an adult caretaker, when permitted under applicable state law. Documents appointing a guardian or estate are required.

Accelerated Benefit

If you or your covered dependent becomes terminally ill with a life expectancy of 12 months or less, you may apply for the accelerated benefit.

This option allows you to receive up to 100% of your total GLI coverage amount or 100% of the dependent GLI coverage amount (but no more than $1,000,000) while you (or your covered dependent) are still living. You may use this money for any purpose. The accelerated benefit is available to both active and retired participants, provided there's at least $10,000 of GLI coverage in effect. If you decide to use the accelerated benefit, it will reduce the final death benefit paid to you (in the case of your covered dependent's death) or to your beneficiary.

To apply for the accelerated benefit, your request must include the statement of a currently licensed United States physician that you're terminally ill. The physician's statement must include all medical test results and 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. Details on how to file for the accelerated benefit are included in the "Applying for GLI Benefits" section.

How PAI Coverage Works

PAI Overview

The Plan pays a PAI benefit if you or your covered spouse/domestic partner suffers a covered loss that:

- Results from a covered accident and is from no other cause; and
- Results in death; dismemberment; loss of sight, hearing, or speech; or total and permanent disability within one year of the accident.

The Plan pays a PAI benefit in addition to any other life insurance or accidental death or loss benefits you're eligible to receive. The PAI benefit is based on the principal sum of coverage in effect at the time of the accident and the type of loss.

Accidental Death Benefit

To qualify for a PAI benefit, accidental death must occur within 365 days of the injury.

If the conveyance in which you're riding disappears, is wrecked, or sinks, and you aren't found within 365 days of the event, the Plan presumes that you've died as the result of the injury, provided the conveyance is covered under the Plan. The Plan also pays a PAI benefit if you're exposed to weather because of an accident and this exposure results in your loss of life.

Total and Permanent Disability (TPD)

The Plan considers your disability to be "total and permanent" and therefore covered by the Plan if your disability:

- Starts within 365 days from the date of an accident;
- Continues for 12 consecutive months after the accident; and
- Is expected to last for the rest of your life.

With respect to you or your gainfully employed spouse/domestic partner, a total and permanent disability means the complete and permanent inability because of accidental injury to engage in any business, occupation, or employment for which you or your spouse/domestic partner is qualified by reason of training, education, or experience. With respect to a non-gainfully employed spouse/domestic partner, it means the complete and permanent inability because of accidental injury to engage in the usual ordinary activities of an individual of like age and sex.

PAI Coverage Options

You can choose coverage for yourself only or coverage for yourself and your spouse/domestic partner. Here are the coverage options:

- **For You Only:** You can choose coverage for yourself only. You can choose coverage amounts in increments of $10,000.
- **For Yourself and Your Spouse/Domestic Partner:** If you choose coverage for your spouse/domestic partner, the amount of his or her coverage must also be in increments of $10,000, up to 50% of the amount of coverage you choose for yourself (rounded up to the next higher $10,000).

Minimum and Maximum Coverages

The minimum coverage you can choose for yourself or your spouse/domestic partner is $10,000. The maximum coverage you can choose for yourself is $750,000 and the maximum coverage you can choose for your spouse/domestic partner is $380,000 ($375,000, rounded up to the nearest $10,000). The chart below shows examples of the maximum amount of coverage you can choose for your spouse/domestic partner based on your coverage amount.

Your Coverage Amount	Maximum Spouse/Domestic Partner Coverage Amount
$10,000	$10,000
$80,000	$40,000
$90,000	$50,000

Flight Crew PAI Coverage

Full-time Kimberly-Clark Corporation pilots, co-pilots, and crew members are eligible for special flight crew PAI coverage. Your flight crew PAI coverage amount (full benefit) is $50,000.

If you're a crew member, you have PAI coverage while you're flying as a pilot or crew member on any aircraft bearing a standard Airworthiness Certificate. In addition, the pilot must have a valid Pilot's Certificate and proper clearance for the aircraft he or she is piloting.

The Plan pays a PAI benefit for accidental loss of life, accidental dismemberment, or total and permanent disability as defined by the Plan. Payments for accidental dismemberment are detailed under "PAI Benefit Schedule" under this section. The maximum PAI benefit payable for any loss under this additional flight crew PAI coverage is $50,000.

Kimberly-Clark Corporation pays the full cost of flight crew PAI coverage.

PAI Benefit Schedule

The Plan pays a PAI benefit according to the following schedule.

Covered Loss/Injury	Plan Pays
Your Death	Principal Sum*
Both Hands or Both Feet	Principal Sum
One Hand and One Foot	Principal Sum
Speech and Hearing	Principal Sum
Total Sight of Both Eyes	Principal Sum
Total Sight of One Eye and One Hand or One Foot	Principal Sum
One Hand or One Foot	Half the Principal Sum
Total Sight of One Eye	Half the Principal Sum
Speech or Hearing	Half the Principal Sum
Thumb and Index Finger of the Same Hand	One Quarter of the Principal Sum
You Suffer a Total and Permanent Disability	Principal Sum

* "Principal sum" means the total amount of your elected PAI coverage at the time of the covered loss.

If you suffer more than one covered loss, the Plan pays a PAI benefit for the one loss, sustained as a result of any one accident, which has the greatest benefit value. For a loss to be covered, it must occur within 365 days of the accident. A loss is defined as follows.

- **Loss of Hand or Foot:** The complete severance through or above a wrist or ankle joint.
- **Loss of Thumb and Index Finger:** The actual severance through or above the metacarpophalangeal joint (joining the thumb or finger to the hand).
- **Loss of Sight:** The entire and irrecoverable loss of sight.
- **Loss of Speech or Hearing:** The total and permanent loss of speech or hearing.

Enhanced PAI Benefits

The Plan provides the following enhanced PAI benefits:

Seat Belt Benefit

If you die as the direct result of an automobile accident injury, the Plan pays an additional seat belt benefit equal to 10% of the principal sum, up to a maximum of $50,000. The Plan pays this benefit provided, at the time of the automobile accident, you were:

- Either operating or riding as a passenger in the automobile (designed for use primarily on public road);
- Wearing an original, equipped, factory-installed, or manufacturer-authorized and unaltered seat belt or lap/shoulder restraint; and
- Not under the influence of alcohol or a controlled substance.

The Insurance Company for the PAI coverages requires additional proof to determine eligibility for the seat belt benefit.

Monthly Coma Benefit

If you're injured within 365 days of a covered accident and as a result of your injury you're in a coma for at least 31 consecutive days, the Plan pays an additional monthly coma benefit equal to 1% of the principal sum. The Plan pays this coma benefit each month that you remain in a coma following the initial 31-day period.

The coma benefit ends on the day (whichever occurs first):

- You're no longer in a coma;
- You've received the coma benefit for 100 months; or
- The total amount you've received as the result of the accident is equal to the total amount of the principal sum.

The total amount the Plan pays for all benefits will not exceed the amount allowable by the principal sum.

Home Alteration and Vehicle Modification Benefit

If you're injured and you receive a dismemberment benefit, the Plan pays an additional home alteration and vehicle modification benefit equal to the one-time cost of:

- Alterations needed to make your primary residence wheelchair accessible and habitable; and
- Modifications needed to make your motor vehicle accessible or driveable.

You must need a wheelchair to be ambulatory on a permanent basis, and the injury which caused the dismemberment benefit must be the same injury that requires your use of the wheelchair.

Alterations must be made by people who are experienced in such alterations and they must be recommended by a recognized organization that provides support and assistance to wheelchair users. Proof of payment must be provided to the Insurance Company for the PAI coverages. The maximum benefit the Plan pays is the lesser of:

- 10% of the principal sum; or
- $25,000.

Hearing Aid or Prosthetic Appliance Benefit

If you're injured and you receive a dismemberment benefit, the Plan pays an additional hearing aid or prosthetic appliance benefit equal to the one-time actual cost of the hearing aid or prosthetic appliance (which can include an artificial limb or eye). You must require the use of a hearing aid or prosthetic appliance within one year of your injury, and the injury which caused the dismemberment benefit must be the same injury which requires your use of a hearing aid or prosthetic device.

A legally qualified physician or surgeon must prescribe your hearing aid or prosthetic appliance, and you must provide proof of payment to the Insurance Company for the PAI coverages. The maximum benefit the Plan pays is the lesser of:

- 10% of the principal sum; or
- $10,000.

The Plan doesn't pay this additional hearing aid or prosthetic appliance benefit for any ordinary living, traveling, or clothing expenses.

Rehabilitation Benefit

If you're injured and you receive a dismemberment benefit, the Plan pays an additional rehabilitation benefit for the reasonable and customary expenses you incur for rehabilitation training, provided:

- A licensed physician prescribes your treatment program;
- The Insurance Company for the PAI coverages approves your program before your rehabilitation training begins;
- The injury which caused the dismemberment benefit is the same injury for which you require the rehabilitation training; and
- The rehabilitation training prepares you for an occupation for which you would not have engaged in except for the injury.

Reasonable and customary means the common charges made by other providers in the same locality for the treatment you receive, subject to the insurance contract. The Insurance Company makes the final determination as to what's reasonable and customary. The maximum benefit the Plan pays is the lesser of:

- The actual cost of the expenses for two years following the date of the accident;
- 10% of the principal sum; or
- $25,000.

Higher Education Benefit

If you're enrolled for PAI coverage for yourself and your spouse/domestic partner and you die as the result of a covered accident, the Plan pays an additional higher education benefit. The Plan pays this benefit for each of your children who are enrolled:

- As a full-time student in an accredited college, university, or trade school; or
- At the twelfth-grade level and who enroll in an accredited college, university, or trade school within one year from the date of the accident.

The Plan pays a benefit equal to 10% of the principal sum, up to a maximum of $50,000, and pays this benefit annually for four consecutive years so long as the child(ren) continues his or her education. Written proof of full-time student enrollment and attendance is required each year before the Plan pays this benefit.

If at the time of the accident there are no dependent children who qualify for the higher education benefit, the Plan pays an additional $1,000 to your designated beneficiary.

Payment of PAI Benefits

The Plan pays a PAI benefit for covered losses after the Insurance Company for the PAI coverages receives acceptable written proof of loss. Written proof of loss must be submitted, if reasonably possible, no later than 90 days after the date of loss. The Plan pays a benefit for a covered total and permanent disability one year after the disability begins. The Plan pays the PAI benefit in a lump sum, unless you elect the monthly installment payment option with interest (as provided in the insurance contract).

When the Plan Doesn't Pay PAI Benefits

The Plan doesn't pay PAI benefits for any loss that's caused by:

- An intentionally self-inflicted injury.
- Suicide (in Missouri, while sane) or attempted suicide.
- War or any act of war, declared or undeclared, that occurs in the United States or Libya.
- Service in the armed forces of any country (U.S. military service for less than 30 days, such as reserve duty, doesn't constitute service in the armed forces).
- Travel in an aircraft (other than civil aircraft), or a transport-type aircraft that's operated by the armed forces of the U.S. or the armed forces of any foreign government.
- Travel as an aircraft pilot or crew member (unless you're a K-C pilot or crew member on a Company-owned or leased aircraft).
- Illness, disease, or any bacterial infection other than a bacterial infection occurring in consequence of an accidental cut or wound.

How BTA (Including PERO) Coverage Works

BTA Overview

The Plan provides financial protection while you're traveling on Company business. Travel between K-C locations, even within the city where you're employed, is covered. The Plan doesn't provide financial protection while you're commuting between your home and your main place of work.

When you're traveling, the Plan covers you in the event of your:

- Accidental death;
- Accidental dismemberment; and
- Total and permanent disability (TPD).

When you're at work (whether or not during business travel), the Plan covers you in the event of:

- Accidental injuries you may receive as a result of an intentional act of violence that's carried out by another person; and
- An intentional act of violence that may arise out of your performance of some duty or duties that pertain to your occupation at K-C.

The Plan pays a BTA benefit in a lump sum, unless you elect installments. (See "Payment of BTA and PERO Benefits" under this section for details.) However, no more than 100% of your BTA benefit is paid for all losses caused by any one accident.

Accidental Death BTA Benefit

To qualify for a BTA benefit, your accidental death must occur within 365 days of the injury.

If the conveyance in which you're riding disappears, is wrecked, or sinks, and you aren't found within 365 days of the event, the Plan presumes that you've died as the result of the injury, provided the conveyance is covered under the Plan. The Plan also pays a BTA benefit if you're exposed to weather because of an accident and this exposure results in your loss of life.

Total and Permanent Disability (TPD) BTA Benefit

The Plan considers your disability to be "total and permanent" and therefore covered by the Plan if your disability:

- Starts within 365 days from the date of an accident;
- Continues for 12 consecutive months after the accident; and
- Is expected to last for the rest of your life.

A total and permanent disability means the complete and permanent inability because of accidental injury to engage in any business, occupation, or employment for which you're qualified by reason of training, education, or experience.

Maximum BTA Payments

If more than one K-C employee is injured or dies as the result of an aircraft accident while traveling on Company business, the maximum amount that the Plan pays in BTA benefits for all covered K-C employees involved is $12,000,000.

BTA Coverage Amount

The Plan pays a BTA benefit according to a schedule. See "BTA Benefit Schedule" under this section for details. The BTA benefit amount equals your principal sum of coverage or a portion of your principal sum of coverage, depending on the covered loss/injury. Your principal sum of coverage equals four times your current annual base pay. Your annual base pay doesn't include:

- Overtime;
- Incentive pay;
- Bonuses; or
- Any adjustments received as a result of a temporary assignment.

BTA Benefit Schedule

The Plan pays a BTA benefit according to the following schedule.

Covered Loss/Injury	Plan Pays
Your Death	Principal Sum*
Both Hands or Both Feet	Principal Sum
One Hand and One Foot	Principal Sum
Speech and Hearing	Principal Sum
Total Sight of Both Eyes	Principal Sum
Total Sight of One Eye and One Hand or One Foot	Principal Sum
One Hand or One Foot	Half the Principal Sum
Total Sight of One Eye	Half the Principal Sum
Speech or Hearing	Half the Principal Sum

Covered Loss/Injury	Plan Pays
Thumb and Index Finger of the Same Hand	One Quarter of the Principal Sum
You Suffer a Total and Permanent Disability	Principal Sum

*See "BTA Coverage Amount" under this section for details on how the Plan determines your principal sum of coverage.

If you suffer more than one covered loss, the Plan pays a BTA benefit for the one loss, sustained as a result of any one accident, which has the greatest benefit value. For a loss to be covered, it must occur within 365 days of the accident. A loss is defined as follows.

- **Loss of Hand or Foot:** The complete severance through or above a wrist or ankle joint.
- **Loss of Thumb and Index Finger:** The actual severance through or above the metacarpophalangeal joint (joining the thumb or finger to the hand).
- **Loss of Sight:** The entire and irrecoverable loss of sight.
- **Loss of Speech or Hearing:** The total and permanent loss of speech or hearing.

Enhanced BTA Benefits

The Plan provides the following enhanced BTA benefits:

Seat Belt Benefit

If you die as the direct result of an automobile accident injury, the Plan pays an additional seat belt benefit equal to 10% of the death benefit, up to a maximum of $50,000. The Plan pays this benefit provided, at the time of the automobile accident, you were:

- Either operating or riding as a passenger in the automobile (designed for use primarily on public road);
- Wearing an original, equipped, factory-installed, or manufacturer-authorized and unaltered seat belt or lap/shoulder restraint; and
- Not under the influence of alcohol or a controlled substance.

The Insurance Company for the BTA coverage requires additional proof to determine eligibility for the seat belt benefit.

Monthly Coma Benefit

If you're injured within 365 days of a covered accident and as a result of your injury you're in a coma for at least 31 consecutive days, the Plan pays an additional monthly coma benefit equal to 1% of the benefit amount. The Plan pays this coma benefit each month that you remain in a coma following the initial 31-day period.

The coma benefit ends on the day (whichever occurs first):

- You're no longer in a coma;
- You've received the coma benefit for 100 months; or
- The total amount you've received as the result of the accident is equal to the total amount owed under the insurance contract.

The total amount the Plan pays for all benefits will not exceed the amount allowable by the insurance contract.

Home Alteration and Vehicle Modification Benefit

If you're injured and you receive a dismemberment benefit, the Plan pays an additional home alteration and vehicle modification benefit equal to the one-time cost of:

- Alterations needed to make to your primary residence wheelchair accessible and habitable; and
- Modifications needed to make your motor vehicle accessible or driveable.

You must need a wheelchair to be ambulatory on a permanent basis, and the injury which caused the dismemberment benefit must be the same injury that requires your use of the wheelchair.

Alterations must be made by people who are experienced in such alterations and they must be recommended by a recognized organization that provides support and assistance to wheelchair users. Proof of payment must be provided to the Insurance Company for the BTA coverage. The maximum benefit the Plan pays is the lesser of:

- 10% of the dismemberment benefit; or
- $25,000.

Hearing Aid or Prosthetic Appliance Benefit

If you're injured and you receive a dismemberment benefit, the Plan pays an additional hearing aid or prosthetic appliance benefit equal to the one-time actual cost of the hearing aid or prosthetic appliance (which can include an artificial limb or eye). You must require the use of a hearing aid or prosthetic appliance within one year of your injury, and the injury which caused the dismemberment benefit must be the same injury which requires your use of a hearing aid or prosthetic device.

A legally qualified physician or surgeon must prescribe your hearing aid or prosthetic appliance, and you must provide proof of payment to the Insurance Company for the BTA coverage. The maximum benefit the Plan pays is the lesser of:

- 10% of the dismemberment benefit; or
- $10,000.

The Plan doesn't pay this additional hearing aid or prosthetic appliance benefit for any ordinary living, traveling, or clothing expenses.

Rehabilitation Benefit

If you're injured and you receive a dismemberment benefit, the Plan pays an additional rehabilitation benefit for the reasonable and customary expenses you incur for rehabilitation training, provided:

- A licensed physician prescribes your treatment program;
- The Insurance Company for the BTA coverage approves your program before your rehabilitation training begins;
- The injury which caused the dismemberment benefit is the same injury for which you require the rehabilitation training; and
- The rehabilitation training prepares you for an occupation for which you would not have engaged in except for the injury.

Reasonable and customary means the common charges made by other providers in the same locality for the treatment you receive, subject to the insurance contract. The Insurance Company makes the final determination as to what's reasonable and customary. The maximum benefit the Plan pays is the lesser of:

- The actual cost of the expenses for two years following the date of the accident;
- 10% of the dismemberment benefit; or
- $25,000.

The Plant Emergency Response Organization (PERO) Benefit

A PERO benefit is provided through the Plan's BTA coverage for certain locations. The locations eligible for this benefit, are:

- Chester;
- Mobile; and
- Owensboro.

The PERO is an organized group of trained employees who respond to site emergencies as directed. Emergencies include:

- Fires;
- Natural disasters;
- Chemical spills or releases;
- Emergency rescues; and
- Dispensing of first aid for which the responding members are trained.

You're eligible for this PERO benefit if:

- You're a member in good standing of the PERO; and
- You work at one of the previously named locations above (these locations have corporate approval for this program).

The Plan pays this benefit if you die while you're actively engaged in an emergency activity that pertains to your PERO responsibilities and death:

- Occurs as the result of an accidental bodily injury that you sustain while performing your PERO duties, including accidental exposure to the AIDS virus or HIV virus and exposure to weather; and
- Results directly from that injury and no other cause, and death occurs within 365 days of the injury.

The Plan pays a PERO benefit equal to your principal sum of coverage. Your principal sum of coverage is shown in the PERO death benefit schedule below.

PERO Death Benefit Schedule

Classification	Principal Sum
• Salaried Non-Production Employees • Salaried Production Employees • Hourly Employees	Five Times Your Annual Earnings, Up to $250,000

To be eligible for a death benefit, death must occur within 365 days of the injury.

Annual Earnings

The Plan defines your annual earnings as:

- **Salaried Non-Production Employees:** Twelve times your non-temporary monthly base salary rate, including any shift differential, as shown in K-C's payroll records as of the preceding date of your loss. Your annual earnings don't include bonuses, commissions, or remuneration of any other reason.
- **Hourly or Salaried Production Employees:** 2,080 times your non-temporary hourly base rate of pay, including any shift differential, as shown in K-C's payroll records as of the date of your loss. Your annual earnings don't include bonuses, commissions, or remuneration of any other reason.

The PERO Dismemberment Benefit

The PERO dismemberment benefit is based on your principal sum of coverage. The following schedule shows the type of loss and the applicable portion of your principal sum of coverage that the Plan pays for each type of loss.

Covered Loss/Injury	Plan Pays
Both Hands or Both Feet	Principal Sum
One Hand and One Foot	Principal Sum
Speech and Hearing	Principal Sum
Total Sight of Both Eyes	Principal Sum
Total Sight of One Eye and One Hand or One Foot	Principal Sum
One Hand or One Foot	Half of Principal Sum
Total Sight of One Eye	Half of Principal Sum
Speech or Hearing (in both ears)	Half of Principal Sum
Thumb and Index Finger of the Same Hand	One Quarter of the Principal Sum

The dismemberment loss must occur within 365 days from the date of the accident. If you suffer more than one covered loss, the Plan pays up to the amount of your death benefit for all losses that result from injuries you may sustain in the same accident. A loss is defined as follows.

- **Loss of Hand or Foot:** The complete severance through or above a wrist or ankle joint.
- **Loss of Sight:** The entire and irrecoverable loss of sight.
- **Loss of Speech or Hearing:** The total and permanent loss of speech or hearing.
- **Loss of Thumb and Index Finger:** The actual severance through or above the metacarpophalangeal joint (joining the thumb or finger to the hand).

If more than one loss results from the same accident, only one benefit is paid. This will be the larger benefit. Benefits paid for dismemberment losses are paid directly to you.

The PERO benefit doesn't have a total and permanent disability benefit provision.

Payment of BTA and PERO Benefits

The Plan pays BTA and PERO benefits for covered losses after the Insurance Company for the BTA coverage receives acceptable written proof of loss. Written proof of loss must be submitted, if reasonably possible, no later than 90 days after the date of loss. The Plan pays a benefit for a covered total and permanent disability one year after the disability begins. The Plan pays BTA and PERO benefits in a lump sum, unless you elect the monthly installment payment option with interest (as provided in the insurance contract).

When the Plan Doesn't Pay BTA or PERO Benefits

The Plan doesn't pay BTA or PERO benefits for any loss that's caused by:

- An intentionally self-inflicted injury.
- Suicide (in Missouri, while sane) or attempted suicide.
- War or any act of war, declared or undeclared, that occurs in the United States or Libya.
- Service in the armed forces of any country.
- Travel in an aircraft (other than civil aircraft), or a transport-type aircraft that's operated by the armed forces of the U.S. or the armed forces of any foreign government.
- Travel as an aircraft pilot or crew member (unless you're a K-C pilot or crew member on a Company-owned or leased aircraft).
- Illness, disease, or any bacterial infection other than a bacterial infection occurring in consequence of an accidental cut or wound and accidental exposure to blood borne pathogens (including the AIDS virus or HIV virus for PERO only).
- Skydiving, parasailing, hang-gliding, bungee-jumping, or any similar activity.
- An accident while commuting between your home and your principal place of work.

Additionally, if you die as the result of an accident involving a non-commercial Company aircraft, any BTA benefits payable from the Plan are reduced by up to $100,000 for any death benefits that are payable under a K-C non-commercial Company aviation insurance policy.

The Plan also doesn't pay a PERO benefit for any loss that's caused by:

- Travel or flight in any aircraft; or
- An injury for which a BTA benefit is being paid.

Applying for GLI Benefits

How to File a GLI Claim

Your beneficiary should contact the Kimberly-Clark Benefits Center as soon as possible after your death to begin the claim process. The Benefits Center provides your beneficiary with the proper form and will request other supporting documents such as:

- A certified copy of the death certificate; and
- Your beneficiary's age and Social Security number.

Your beneficiary should return the completed form and other documents to the Benefits Center. If he or she is a minor, documents appointing a guardian are required. If your beneficiary is an estate, a certificate of the administrative appointment is required.

If your covered dependent dies, you're the beneficiary. The Plan pays a benefit to you, if living, otherwise the Plan pays the benefit to your estate.

Applying for an Accelerated Benefit (GLI)

If you want to apply for an accelerated benefit, contact the Kimberly-Clark Benefits Center for the forms necessary to begin the claim process. The Benefits Center provides you with the proper claim form and will request a letter or other medical documentation from your doctor specifying life expectancy. Return the completed claim form and all other required documents to the Insurance Company for the GLI coverages. The Insurance Company may request additional documentation.

If a GLI Claim Is Denied

If the Plan denies a claim for benefits, you or your beneficiary receives a written notice from the Insurance Company (or the Kimberly-Clark Benefits Center if the claim is denied because of an eligibility requirement). You or your beneficiary receives the notification within 90 days explaining the specific reason for the denial. If a claim is denied because of incomplete information, the notice indicates the additional information required. If additional time is required to make a decision on the claim, you or your beneficiary is notified of the delay within 90 days. This notice also indicates the special circumstances that require the extension and the date by which a decision is expected. This extension period may not exceed 90 days beyond the end of the first 90-day period.

How to Appeal a Denied GLI Claim

Eligibility Issues

If you experience an issue due to eligibility, request a review of the issue by contacting the Kimberly-Clark Benefits Center. If the Benefits Center representative can't resolve your issue, you're mailed a Claim Initiation Form. Complete, sign, and return the Claim Initiation Form as indicated on the form.

Benefit Claim Issues

You or your beneficiary may request a review of a denied benefits claim by writing to the Insurance Company for the GLI coverages at the address listed under the "Administrative Information" section (or Benefits Center if your claim is based on eligibility). The appeal must be made within 60 days (180 days for disability claims) after you receive notice of the denial of the claim. You may submit written comments, documents, records, and other information relating to your claim. Upon request, and at no charge, you may obtain reasonable access to, and copies of, all documents, records, and information relevant to your benefit claim. The review or appeal will be a "fresh" look at your claim without reference to the denial decision. It will be conducted by a party not involved in the original denial decision, and by an individual who isn't a subordinate of the party involved in the initial decision. Your appeal will be given a full and fair review, and a written decision, including reasons, will generally be provided within 60 days. If there are special circumstances requiring an extension of time, you or your beneficiary will receive a notice within 60 days of receipt of the appeal indicating that the decision will be delayed. A final decision will be made within 120 days of the receipt of the appeal.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after you have followed the Plan's claim and appeal procedure.

You lose your right to sue if you fail to follow the Plan's claim and appeal procedures in a timely fashion.

No litigation may be brought more than three years after the end of the time within which proof of loss is required. Some states may have different litigation periods. In states where the litigation period is more than three years, you have until the time period set by the state in which you reside to begin litigation.

No action at Law or Equity shall be brought to recover under the Plan until the appeal rights herein provided have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part. (In layman's terms, you must complete the claims and appeals procedure as outlined above before you can bring a suit against the Plan.)

K-C has final authority to make determinations regarding eligibility, and the Insurance Company has the final authority to make determinations regarding payment of benefits and other terms of the Plan.

Applying for PAI and BTA Benefits

How to File a PAI or BTA Claim

You or your beneficiary should contact the Kimberly-Clark Benefits Center as soon as possible after a covered loss to begin the claim process. The Benefits Center provides you or your beneficiary with the proper form and will request other supporting documents necessary to file a claim.

Return the completed form and other required documents to the Claims Coordinator, John P. Haffner & Associates. See the "Administrative Information" section for details. To file a claim for benefits, written proof of the covered loss must be furnished, if reasonably possible, no later than 90 days after the covered loss.

Proof of Loss (PAI or BTA Claims)

Death or Dismemberment PAI or BTA Claims

Written proof of loss either for death or dismemberment claims includes:

- A copy of the accident report; and
- Other documents as requested.

In the case of death, a certified copy of the death certificate and your beneficiary's age and Social Security number are required to process a claim. If a beneficiary is a minor, documents appointing a guardian are required. If the beneficiary is your estate, a certificate of the administrative appointment is required.

Total and Permanent Disability PAI or BTA Claims

If it isn't possible to give proof of loss within 90 days after the loss, the proof must be given as soon as reasonably possible. Except in the absence of legal capacity, proof of claim may not be given later than one year after the time proof is otherwise required.

Proof of continued disability and regular attendance of a physician must be given to the Insurance Company for the PAI and BTA coverages or its designated agent within 30 days of the request for the proof. The proof must cover the:

- Date the disability started;
- Cause of the disability; and
- Degree of disability.

PAI or BTA Claims

From the date your notice of claim is received, the Insurance Company for the PAI and BTA coverages has 90 days in which to review the claim and determine whether or not benefits are payable in accordance with the terms and provisions of the insurance contract. Under special circumstances the Insurance Company may require an extension of the 90-day period. If this is the case, you receive written notice of the necessary extension from the Insurance Company prior to the end of the initial 90 days. This extension period allows the Insurance Company an additional 90 days to review your claim.

During the extension period, the Insurance Company may require you to take a medical examination, at its own expense, or it may require additional information to make a determination on your claim. If additional information is required, you receive a written request, specifying the nature of the information needed and an explanation as to why it's needed. If a medical examination is necessary, you're given the time of appointment and the doctor's name and location. It's important to keep any appointments made since rescheduling exams delays the claim process.

Once the claim has been approved, you or your beneficiary receives the appropriate benefit from the Insurance Company.

If Your PAI or BTA Claim Is Denied

If your claim for benefits is denied, in whole or in part, you receive written notice of such denial within the 90-day period stated above (or 180 days if the extension period is required.) Each written notice of the denial shall set forth:

- The specific reason(s) for the denial of the claim.
- A specific reference to the provision(s) of the insurance contract upon which the denial is based.
- A description of any additional information or material needed and why.
- Notice of your rights to have the denial reviewed by the Insurance Company for the PAI and BTA coverages, and to bring suit under the Employee Retirement Income Security Act of 1974 (ERISA) if the review also results in an adverse benefit determination.

PAI and BTA Claim Review Procedure

Eligibility Issues

If you experience an issue due to eligibility, request a review of the issue by contacting the Kimberly-Clark Benefits Center. If the Benefits Center representative can't resolve your issue, you're mailed a Claim Initiation Form. Complete, sign, and return the Claim Initiation Form as indicated on the form.

Benefit Claim Issues

You or your beneficiary may request a review of a denied benefits claim by writing to the Insurance Company for the PAI and BTA coverages at the address listed under the "Administrative Information" section (or Benefits Center if your claim is based on eligibility). The appeal must be made within 60 days (180 days for disability claims) after you receive notice of the denial of the claim. You may submit written comments, documents, records, and other information relating to your claim. Upon request, and at no charge, you may obtain reasonable access to, and copies of, all documents, records, and information relevant to your benefit claim. The review or appeal will be a "fresh" look at your claim without reference to the denial decision. It will be conducted by a party not involved in the original denial decision, and by an individual who isn't a subordinate of the party involved in the initial decision. Your appeal will be given a full and fair review, and a written decision, including reasons, will generally be provided within 60 days. If there are special circumstances requiring an extension of time, you or your beneficiary will receive a notice within 60 days of receipt of the appeal indicating that the decision will be delayed. A final decision will be made within 120 days of the receipt of the appeal.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after you have followed the Plan's claim and appeal procedure.

You lose your right to sue if you fail to follow the Plan's claim and appeal procedures in a timely fashion.

No litigation may be brought more than three years after the end of the time within which proof of loss is required. Some states may have different litigation periods. In states where the litigation period is more than three years, you have until the time period set by the state in which you reside to begin litigation.

No action at Law or Equity shall be brought to recover under the Plan until the appeal rights herein provided have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part. (In layman's terms, you must complete the claims and appeals procedure as outlined above before you can bring a suit against the Plan.)

K-C has final authority to make determinations regarding eligibility, and the Insurance Company has the final authority to make determinations regarding payment of benefits and other terms of the Plan.

When Coverage Ends

When GLI Coverage Ends for You and Your Dependents

Your GLI coverage ends at the end of the month in which any one of the following occurs:

- Your employment terminates for any reason (including layoff), unless you're eligible for GLI coverage because you have a total and permanent disability (TPD) as determined by the Plan.
- You're no longer an eligible employee (for example, you transfer to a class of employees not covered under the Plan or coverage for the class of employees for which you're a member terminates).
- You discontinue making your optional GLI and/or dependent GLI coverage contributions (in which case you only have the Company-provided basic GLI coverage).
- The Company's group life insurance contract ends or terminates.
- The Plan is discontinued.

Dependent GLI coverage for your spouse/domestic partner and/or dependent child(ren) ends at the end of the month in which any one of the following occurs:

- Termination of all dependent GLI coverage under the group contract.
- When a dependent becomes covered as an eligible employee.
- When such person is no longer a defined dependent.
- When your coverage terminates.

Converting GLI Coverage to Individual Coverage

You may convert all or a portion of your GLI coverage without Evidence of Insurability (EOI) to an individual life policy with the current Insurance Company for the GLI coverages if your coverage ends because:

- You terminate employment without qualifying for retirement coverage;
- You terminate employment and no longer have a total and permanent disability (TPD); or
- You transfer to a class of employees not eligible for coverage under the Plan.

You may convert up to a maximum of $10,000 of your GLI coverage if you were covered by the Plan for at least five years in a row and your coverage ends because:

- The Plan is discontinued;
- The GLI contract ends; or
- Coverage for the class of employees of which you're a member terminates.

You also may convert all or portion of your spouse's/domestic partner's and/or dependent's coverage to an individual policy if his or her coverage ceases because:

- Your employment ceases;
- You're no longer in a class eligible for such insurance;
- He or she ceases to be a dependent; or
- You die.

To convert coverage, complete an application and submit the first premium payment within 31 days of the day coverage terminates. The individual policy is issued without a medical examination or EOI requirement. The premiums, paid entirely by you, are at a rate based on your class of risk and age at the time of issue. These rates may be higher than the rates you're currently paying. For more information, contact the Insurance Company.

If you (or your dependent) die during the conversion period, regardless of whether you apply for an individual policy for yourself (or your dependent), the Insurance Company pays a death benefit equal to the amount you're (or your dependent is) entitled to convert.

Portability Option (GLI Coverage)

If you leave K-C or retire, you may be able to take your basic GLI, optional GLI, and/or dependent GLI (spouse/domestic partner and/or child) coverage(s) with you and continue to pay group term life rates directly to the current Insurance Company for the GLI coverages. These rates may be higher than the rates you're currently paying. If you elect to continue your own GLI coverage, you also can continue coverage for your spouse domestic/partner and/or children.

You can't continue your basic GLI or optional GLI coverage if:

- You've attained the age of 70;
- You've converted your insurance to an individual policy; or
- Due to a sickness or injury, you weren't actively at work on the date prior to your termination of employment or retirement.

There are maximums on the amount of coverage that can be ported. To learn more about your portability options, contact the current Insurance Company. See the "Contact Information" section for whom to call.

When PAI Coverage Ends

PAI coverage ends at the end of the month any of the following occurs:

- Your employment terminates for any reason (including layoff).
- You're no longer an eligible employee (for example, you transfer to a class of employees not covered under the Plan or coverage for the class of employees for which you're a member terminates).
- The Plan is discontinued.
- The group insurance contract terminates.
- You discontinue your coverage contributions.

Upon divorce or if your domestic partner no longer meets the Plan's eligibility requirements, any PAI coverage for your former spouse/domestic partner ends as of the last day of the month in which you divorce or in which the domestic partner no longer satisfies the Plan's eligibility requirements.

When BTA Coverage Ends

BTA (including PERO) coverage ends on the day any of the following occurs:

- Your employment terminates for any reason (including layoff).
- You're no longer an eligible employee (for example, you transfer to a class of employees not covered under the Plan or coverage for the class of employees for which you're a member terminates).
- The Plan is discontinued.
- The group insurance contract terminates.

No conversion policy is available for BTA.

Converting PAI Coverage to Individual Coverage

If your coverage is terminated, you may convert all or a part of your or your spouse's/domestic partner's PAI coverage amounts (up to $350,000) to an individual policy. To do so, submit an application to the Insurance Company for the PAI coverages and pay the first premium payment to the Insurance Company within 31 days of the date coverage terminates. The policy is issued (without providing EOI) at the Insurance Company's regular rates. Contact the Insurance Company at **800-834-1959** for details.

Retiree Life Insurance (Retiree GLI)

Eligibility

You may be eligible for retiree GLI coverage if you were hired before January 1, 2012 (date not applicable for Fullerton hourly organized employees) and:

- You retire or terminate employment on or after age 55 with at least 15 years of vesting service under the Kimberly-Clark Corporation Pension Plan (Pension Plan) (at least 10 years of vesting service for Fullerton hourly organized employees).
- You're a K-C salaried or hourly employee, you don't have a pension benefit under the Pension Plan, and you retire or terminate employment on or after age 55 with at least 15 years of vesting service under any other Kimberly-Clark Corporation Retirement Plan (at least 10 years of vesting service for Fullerton hourly organized employees).
- You retire at any age with a total and permanent disability (TPD) benefit under the Pension Plan, and you have at least 15 years of vesting service under the Pension Plan (at least 10 years of vesting service for Fullerton hourly organized employees).

If you terminate employment or you're no longer eligible for retiree GLI coverage, you must be rehired into an eligible class for at least one year before you regain eligibility for retiree GLI coverage upon retirement (doesn't apply for Fullerton hourly organized employees).

Salaried employees of former Safeskin Corporation are eligible for retiree GLI coverage based only on service after the acquisition by K-C.

Salaried employees of Ballard Medical Products are eligible for retiree GLI coverage upon retirement or termination on or after age 55 with at least 15 years of vesting service. Eligibility for retiree GLI coverage for such employees who were age 45 or older as of the date of acquisition by K-C in 1999 takes into account service prior to acquisition. For all other salaried employees, pre-acquisition service with Ballard Medical Products is not taken into account.

Hourly and salaried production employees at the following locations are **not** eligible for retiree GLI coverage:

- Avent Del Rio.
- Beaverton.
- Belmont.
- Fenton.
- Jackson.
- La Grange.
- Lake Forest.

- Lexington.
- Ogden.
- Paris.
- Pomona.

Administrative Information

Plan Details

This SPD is intended to meet the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. It covers the principal aspects of the Plan's insurance contracts. The Plan is maintained as a sub-plan under the Kimberly-Clark Corporation Health and Welfare Benefits Plan, as it applies to the Participating Employers and their Participating Units listed in this SPD. The following chart highlights details of the Plan.

Plan Detail	Description
Plan Name	Kimberly-Clark Corporation Health and Welfare Benefits Plan
Plan Type	The Plan described in this SPD includes three coverages as follows: • GLI is considered an insurer-administered group life insurance coverage as that term is used by the Department of Labor (DOL). • PAI is considered an insurer-administered welfare plan - accident plan as that term is used by the DOL. • BTA is considered an insurer-administered welfare plan - accidental death and dismemberment as that term is used by the DOL. If you have any questions or you need further information about the Plan, contact the Kimberly-Clark Benefits Center. A copy of the insurance contracts and Plan document can be obtained from the Insurance Company or Plan Administrator. A reasonable fee may be charged for the copies.
Plan Number	590
Employer Identification Number	39-0394230 (assigned by the Internal Revenue Service to the Plan Sponsor)
Plan Year	January 1—December 31

Plan Detail	Description
Plan Sponsor and Plan Administrator	Kimberly-Clark Corporation Employee Benefits Department P.O. Box 59051 Knoxville, TN 37950-9051 865-541-7000
Benefits Administration Committee	Kimberly-Clark Corporation Benefits Administration Committee P.O. Box 59051 Knoxville, TN 37950-9051
Benefits Administrator	Kimberly-Clark Benefits Center 4 Overlook Point P.O. Box 1497 Lincolnshire, IL 60069-1497 800-551-2333
Insurance Company (for GLI Coverage)	Minnesota Life Insurance Company 400 Robert Street St. Paul, MN 55101-2098
Claims Coordinator (for BTA and PAI Coverages)	John P. Haffner & Associates Glen Center, Suite Six 341 Cumnor Avenue Glen Ellyn, IL 60137
Insurance Company and Claims Administrator (for BTA and PAI Coverages)	Zurich American Insurance Company Zurich Towers 1400 American Lane Schaumburg, IL 60196
Contract Numbers	• GLI Coverage: 33682-G • PAI Coverage: GTU 3809147 • BTA Coverage: GTU 3809148

Plan Detail	Description
Agent for Service of Legal Process	Legal process should be directed to: General Counsel Kimberly-Clark Corporation World Headquarters 351 Phelps Drive Irving, TX 75038 Service of process may also be made upon K-C as the Plan Administrator.

Benefits Administration Committee

The Benefits Administration Committee (Committee) is established to act in certain matters regarding the Plan. As part of its duties, the Committee interprets the Plan, adopts rules and procedures for operating the Plan and handling claims, decides questions of eligibility for participation, and directs payments under the Plan. The Committee may delegate any of these functions to a third party. The Committee shall exercise its powers in its sole discretion.

Whom the Plan Pertains To

The Plan, including the information contained here, pertains to the Participating Units that have adopted the Plan. As of January 1, 2013, the following have adopted this Plan.

Participating Employer	Participating Units
Avent, Inc.	Salaried and hourly non-organized employees
I-Flow Corporation	Salaried and hourly non-organized employees
Jackson Products, Inc.	Salaried and hourly non-organized employees
Kimberly-Clark Corporation	Salaried and hourly non-organized employees
Kimberly-Clark Financial Services, Inc.	Salaried employees
Kimberly-Clark Global Sales, LLC.	Salaried employees
Kimberly-Clark International Services Corporation	Salaried employees

Participating Employer	Participating Units
Kimberly-Clark Pennsylvania, LLC	Salaried employees
Kimberly-Clark Worldwide, Inc.	Salaried employees Hourly organized employees at Fullerton

Who's a Participating Salaried and Hourly Non-Organized Employee

Salaried employees and hourly non-organized employees who are participating in the Plan include those on temporary assignment at another Company or in other classifications. It excludes those employees on temporary assignment from another Company or classification in the U.S.

Who's a Participating Hourly Organized Employee

Hourly organized employees who are participating in the Plan include hourly organized employees at the:

- Fullerton Mill represented by the Association of Western Pulp and Paper Workers and Local #672.

Any other entity of the Company whose participation in the Plan is approved also is a Participating Employer with respect to its employees. You may examine or receive from the Plan Administrator, upon written request, information as to whether a particular entity is a Participating Employer in the Plan, and if so, that organization's address or a complete list of companies sponsoring the Plan.

Plan Subject to Collective Bargaining

Certain Plan provisions are subject to the contractual agreement between K-C and your union and its local. Copies of the labor agreement are available for inspection and may be obtained from your Human Resources representative, team leader, union leader, or the Plan Administrator.

When the Plan May Be Amended or Terminated

K-C expects the Plan to continue indefinitely. However, subject to the collective bargaining process, the Company reserves the right to make changes to and even discontinue the Plan. If the Board of Directors were to terminate the Plan or designate a partial termination with respect to a specific group of employees, each employee will have no further rights or obligations except for payment of claims prior to the date of the termination. The form and administration of the Plan may be changed by the Plan Administrator.

Employment Rights Not Guaranteed

Your participation in the Plan doesn't give you the right to be retained in employment with the Company or its affiliates or subsidiaries, nor does it interfere with the right of the Company to discharge or terminate you without regard to the effect the termination would have on your rights under this Plan.

The Use of Social Security Numbers

You'll be asked to provide your Social Security number for Plan purposes. The Company and the Insurance Company has the right to use your Social Security number for the purpose of administering the Plan, including paying benefits under the Plan and for tax-reporting purposes.

All covered dependents must provide a valid Social Security number or, if the dependent is unable to obtain a valid Social Security number, he or she must provide an Individual Taxpayer Identification Number (ITIN). Failure to provide one of these numbers in a timely manner will result in ineligibility for coverage under this Plan.

If a state law restricts the Company's or the Insurance Company's use of Social Security numbers for the purpose of administering your benefits and coverage, they will follow the precedent that ERISA preempts such state laws.

Change of Address

It's your responsibility to notify K-C of any change in your mailing address. K-C is not responsible for correspondence or claim payments that are delayed or don't reach you because your address isn't correct.

For your own protection, an address change must either be made by you on the K-C intranet using the @myHR Portal or by calling the K-C HR Contact Center. K-C uses your address as it appears with the K-C HR Contact Center for all mailings concerning your benefits. You can contact the K-C HR Contact Center at **866-444-4516** to speak with a representative.

Contact Information

Your Resources for Benefits Information

The Company offers you the following ways to access benefit information:

- Your Benefits Resources (YBR) Web site;
- The Kimberly-Clark Benefits Center; and
- YBR Mobile from your smart phone (iPhone version iOS4.1+, Android version 2.1+, BlackBerry version PG6+) at **resources.hewitt.com/kcc**.

Your Benefits Resources (YBR) Web Site

You can look for benefit information, make your benefit elections, and complete most benefit transactions using YBR at **resources.hewitt.com/kcc**. Even if you don't have Internet access at work, you can connect directly to YBR from your home computer. YBR is generally available 24 hours a day, seven days a week (except for the third Sunday of the month when the Web site isn't available between 2 am and 1 pm ET).

As a first-time YBR user, you need to register as a new user and set up a User ID and password for future YBR access. You'll also have the opportunity to answer security questions, which will enable you to access your information in the future if you forget your password. You can even enter a hint to help you remember your password. The password is required for your protection, and it's important for you to keep your password confidential so no one else can access your information.

Paperless Delivery of Benefits Communication

Paperless delivery is one of the easiest and best ways to ensure secure and timely delivery of your benefits communication. For salaried participants, paperless delivery is automatic. For production participants, an election must be made through YBR to receive documents electronically. For electronic delivery, these communications (with a few exceptions) will be delivered to your YBR Secure Mailbox, posted to YBR, or e-mailed to your preferred e-mail address. The K-C Corporate e-mail is the default. To review and update your e-mail, log on to YBR and click on Your Profile, then select Personal Information.

Password Reset

If you attempt to log on with an invalid password more than five times over any period unsuccessfully, you'll lock your account. You won't be able to access your information or use YBR until you request and receive a new password. If you have an e-mail address on file prior to requesting a password reset, your temporary password can be sent to you via e-mail. Otherwise, your temporary password is mailed to you (allow seven to 10 business days for receipt).

You can change your password any time on YBR. Log on using your existing password and choose Log On Information from the Your Profile tab on the YBR Home page. If you don't have Internet access, you can change your password by calling the Kimberly-Clark Benefits Center.

Internet Security

The YBR Web site conforms to Kimberly-Clark's computer security standards for Internet applications. This Web site takes special care to maintain the privacy of your personal and benefits data. All data is encrypted to minimize the risk of eavesdropping, tampering, and forgery over the Internet.

Kimberly-Clark Benefits Center

If you don't have access to a computer, you can call the Kimberly-Clark Benefits Center at **800-551-2333** and use the automated telephone system to make benefit inquiries and simple requests or you can speak to a Benefits Center representative. Benefits Center representatives are available from 9 am to 5 pm ET, Monday through Friday, except holidays. Dial **718-354-1340** outside the U.S. and Canada. Hearing impaired callers should call their local Hearing Impaired Relay Service for assistance in calling the Benefits Center.

Like calls to other customer service centers that process financial transactions, the calls to the Benefits Center are recorded for quality assurance.

Contacting the Benefits Center by Phone

	Phone Number	Benefits Center Hours
United States and Canada	800-551-2333 (toll-free)	9 am to 5 pm ET, Monday through Friday, except holidays
International	718-354-1340 (not toll-free)	
Hearing Impaired	Your local Hearing Impaired Relay Service	

Benefits Center Holiday Schedule*

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

* Other holidays may be scheduled in addition to those listed.

Life and Accident Contacts

You can find contact information for your current coverage on YBR under the My Health tab. If you need contact information for a different Insurance Company, call the Kimberly-Clark Benefits Center.

Contact	Address/Phone	Web Address
Minnesota Life Insurance Company • Basic GLI • Optional GLI • Dependent GLI	400 Robert Street St. Paul, MN 55101-2098 886-293-6047	**lifebenefits.com**
Zurich American Insurance Company • PAI • Spouse/Domestic Partner PAI • BTA (including PERO)	Zurich Document Distribution Center (DDC) P.O. Box 968041 Schaumburg, IL 60196-8041 Overnight Mailing Address: Zurich North America Commercial Claims/Accident and Health 58 South Service Road Melville, NY 11747-2341 886-841-4771 or 800-887-9111 Fax: 631-845-2235	N/A
John P. Haffner & Associates • PAI Coverages: Claims Coordinator • BTA (including PERO): Claims Coordinator	John P. Haffner & Associates Glen Center, Suite Six 341 Cumnor Avenue Glen Ellyn, IL 60137	N/A

Your Rights Under ERISA

Receive Information About Your Plan and Benefits

The Plan adheres to the requirements under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. As a participant in the Plan, you're entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants be entitled to the following:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as in worksites and union halls, all documents governing the Plan. These may include insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA) at:

  Public Disclosure Room
  Employee Benefits Security Administration
  U.S. Department of Labor
  200 Constitution Avenue, NW, Room N 15
  Washington, D.C. 20210

- Obtain, upon written request to the Plan Administrator**,** copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest Form 5500 annual report, and an updated SPD. The Plan Administrator may make a reasonable charge for the copies.

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

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 your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce your ERISA rights. For instance:

- If you request a copy of the Plan documents or the latest annual report from the Plan and don't receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control.
- If you have exercised your appeal rights herein provided and your claim for benefits is denied or ignored—in whole or in part—you may file suit in a state or Federal court. No action at Law or Equity shall be brought to recover under the Plan until the appeal rights herein provided have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part.
- If you disagree with the Plan's decision, you may file suit in a Federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money or if you're discriminated against for asserting your ERISA rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.
- If you file suit against the Plan, the court decides who should pay court costs and legal fees. If you're successful, the court may order the person you've sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by:

- Calling the publications hotline of the EBSA at **866-444-3272**;
- Logging in to the Internet at **dol.gov/ebsa**; or
- Contacting the EBSA field office nearest you.

Glossary

Active Employee (Active Employment)

You're an active employee if you're regularly employed or on an authorized leave of absence and receiving pay through the Company's payroll department. You're not considered an active employee if you're classified by the Company as an independent contractor, regardless of how an independent contractor may be classified by any court; or Federal, state, local, domestic, or foreign governmental agency.

If you're absent from work due to your illness or your hospital confinement, you're treated as an active employee and coverage under the Plan in effect on the date of your absence continues. You must, however, be considered actively at work for coverage under the Plan to begin, or an increase or change in coverage under the Plan to take effect.

Actively at Work

You must be actively at work for:

- Coverage under the Plan to begin; or
- An increase or change in coverage under the Plan to take effect.

You're considered actively at work if you're performing the customary duties of your job at the Company's normal place of business or at another place of business to which the Company requires you to travel.

If you're not actively at work on the date coverage would otherwise begin, or on the date an increase in your amount of coverage would otherwise take effect, you won't be eligible for the coverage or the increase in coverage until you return to active work. However, if you're absent on a non-work day, coverage won't be delayed provided you were actively at work on the work day that immediately preceded the non-work day. A non-work day is a day on which you're not regularly scheduled to work, including:

- Scheduled time off for vacations;
- Personal holidays;
- Weekends;
- Holidays; and
- Approved leaves of absence for non-medical reasons.

A non-work day doesn't include:

- Time off for a medical leave of absence;
- Temporary layoff;
- Employer suspension of operations (in total or in part);
- A strike; or
- Any time off due to an illness or injury, including sick days, short term disability, or long term disability.

Beneficiary

A beneficiary is the person(s), estate, or organization that receives a GLI benefit or other death benefit if you die.

Change in Status

A change in status enables you to change your coverage under the Plan. If you, your dependent, your domestic partner, or your domestic partner's child experiences a change in status and you want to change your coverage election because of that change, you must do so within 30 days of the event and it must correspond with a gain or loss of eligibility for coverage.

Committee

The Benefits Administration Committee.

Company

A Participating Employer and its Participating Units who participate in the Plan. Please also see the "Administrative Information" section for a list of the Participating Employers and their Participating Units.

Domestic Partner (Domestic Partnership)

For your domestic partner to be eligible for coverage under the Plan, you and your domestic partner must meet all of the following:

- You've lived together continuously in the same principal residence for at least six months and intend to do so indefinitely;
- You're financially interdependent on one another;
- You're not related by blood or to the degree of closeness that would prohibit your legal marriage in the state in which you reside;
- Neither of you is legally married to anyone else (as defined under the Defense of Marriage Act); and
- You're each at least 18 years old and mentally competent to enter into a marriage contract.

You and your domestic partner are considered financially interdependent if you're jointly responsible for each other's common welfare and living expenses and intend to remain so indefinitely. You can document such interdependence by providing documentation of any of the following arrangements:

- Common ownership of real estate property (for example, owning a house);
- A joint bank or credit account;
- An Affidavit of Domestic Partnership; or
- Any such other proof that the Committee considers sufficient to establish financial interdependency under the circumstances of your particular situation.

Domestic Partner's Child

Your domestic partner's child includes a child of your domestic partner and is defined as a:

- Natural born or legally adopted child of your domestic partner; and
- Child for whom your domestic partner has legal guardianship, including:
    - Those for whom you have legal guardianship; and
    - Foster children who have been placed with you or your domestic partner by an authorized placement agency or by a judgment, decree, or other order of any court of competent jurisdiction.

Unless the child is your natural child, the Plan treats your domestic partner's child the same as it would your stepchild, although imputed income applies to your domestic partner's child for certain coverages unless that child is also your IRS dependent.

Employee

The Plan considers you to be an employee if you're a full-time or part-time active employee. If you're classified as a temporary or intermittent employee, you're not considered an employee and therefore not eligible for coverage under the Plan. Employees must meet the Plan's eligibility requirements to be considered an eligible employee for coverage purposes.

Employee Retirement Income Security Act of 1974 (ERISA)

The Employee Retirement Income Security Act of 1974, as amended, establishes certain rights and protections for participants, as well as rules for employers to qualify benefit plans for special tax considerations. See the "Your Rights Under ERISA" section for details.

Evidence of Insurability (EOI)

A health and medical questionnaire and/or medical examination upon which the Insurance Company will determine your or a family member's insurability for coverage.

Participating Employer

This is any employer, including Kimberly-Clark Corporation and those of its subsidiaries and affiliated companies, who participates in the Plan. A list of the Participating Employers and their Participating Units is included in the "Administrative Information" section.

Spouse

The Plan follows Federal law. According to Federal law, the spouse of an employee is defined as the person to whom the employee is legally married, which includes a common-law spouse between a man and a woman (Pub.L.No. 104-199). A common-law spouse is included in this definition only if the common-law marriage is recognized in the state in which you currently reside. It's your responsibility to understand your state's laws relative to marriage. Federal law doesn't recognize same-sex marriage, even if it's recognized by your state.