Lumen Retiree and Inactive Health Plan

Dental Plan

(Administered by MetLife)

Summary Plan Description (SPD) For Retired and Inactive Former Employees

Including:

- CenturyLink Retirees
- Embarq Retirees
- Qwest Post-1990 Management Retirees
- Qwest Post-90 Occupational Retirees
- Inactives
- COBRA Participants

Effective Jan. 1, 2023

This SPD must be read in conjunction with the **General Information SPD**, which explains many details of your coverage and provides a listing of the other Benefit options under the Plan.

You can go online to obtain an electronic copy or call the Lumen Health and Life Service Center at Businessolver, **833-925-0487** or **317-671-8494** (International callers), to request a paper copy of a Summary Plan Description (SPD).

Issued Jan. 1, 2023

LUMEN®

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INTRODUCTION

Lumen Technologies* (hereinafter "Lumen" or "Company") is pleased to provide you with this Summary Plan Description ("SPD"). This SPD presents an overview of the Benefits available under the Dental Plan benefit option of the **Lumen Retiree and Inactive Health Plan* (the "Plan").**

This SPD must be read in conjunction with the *General Information SPD* which explains many details of your coverage and provides a listing of the other benefit options under the Plan.

The effective date of this updated SPD is January 1, 2023. If you are a Covered Person in the Dental Plan benefit option of the Plan on or after January 1, 2023, this SPD supersedes and replaces, in its entirety, any other SPD describing Dental Plan Benefits that you currently may possess. In the event of any discrepancy between this SPD and the official *Plan Document*, the *Plan Document* shall govern.

This SPD, together with other *plan document*s (such as the Summary of Material Modifications (SMMs), the *General Information SPD* and materials you receive at Annual Enrollment (hereafter "*Plan document*s") briefly describe your Benefits as well as rights and responsibilities, under the Lumen Retiree and Inactive Health Plan (the "Plan"). These documents make up your official Summary Plan Description for the Dental Plan benefit option as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This Dental Plan benefit option under the Plan is self-funded; however, certain other benefit plan options under the Plan may be insured.

This SPD is for eligible Lumen Retired and Inactive Former Employees* (including Qwest Represented Occupational Former Employees). *Active Employees should refer to their own applicable Lumen health Care Plan SPDs, with distinct terms and conditions.*

Company's Reserved Rights

The company reserves the right to amend or terminate any of the Benefits provided in this Plan– with respect to all classes of Covered Persons, retired or otherwise – without prior notice to or consultation with any Covered Person, subject to applicable laws and if applicable, the collective bargaining agreements.

The Plan Administrator, the Lumen Employee Benefits Committee, and its delegates(s), has the right and discretion to determine all matters of fact or interpretation relative to the administration of the Dental Plan benefit option—including questions of eligibility, interpretations of the Plan provisions and any other matter. The decisions of the Plan Administrator and any other person or group to whom such discretion has been delegated, including the Claims Administrator, shall be conclusive and binding on all persons. More information about the Plan Administrator and the Claims Administrator can be found in the General Information SPD.

Note: While the Plan has processes in place to prevent errors and mistakes, if a clerical error or mistake happens (however occurring) such error or mistake does not create a right to a Benefit or level of contribution rate under the Plan. You have an obligation to correct any errors or omissions that come to your attention by calling the Lumen Health and Life Service Center (please refer to Service Center throughout the remainder of this document) to correct the error or omission. There are deadlines to file claims and benefit related actions; please refer to the section titled **"Time Deadline to File a Benefit Claim and the Time Deadline to File a Benefit-Related Lawsuit"** on page 17 in this SPD and in the *General Information SPD* for more information about the timing of these deadlines.

The Required Forum for Legal Disputes

After the claims and appeals procedures are exhausted as explained above, and a final decision has been made by the Plan Administrator, if an Eligible Employee wishes to pursue other legal proceedings, the action must be brought in the United States District Court in Denver, Colorado.

How to Use this Document

The SPD is designed to provide you with a general description, in non-technical language of the Benefits currently provided under the Dental Plan benefit option without describing all of the details set forth in the *Plan Document*. The SPD is not the *Plan Document*. Other important details can be found in the *Plan Document* and the *General Information SPD*. The legal rights and obligations of any person having any interest in the Plan are determined solely by the provisions of the Plan. If any terms of the *Plan Document* are in conflict with the contents of the SPD, the *Plan Document* will always govern.

Capitalized terms are defined throughout this SPD and in the *General Information SPD*. All uses of "we," "us," and "our" in this document, are references to the Claims Administrator or Lumen. References to "you" and "your" are references to people who are Covered Persons as the term is defined in the *General Information SPD*.

You are encouraged to keep all of the SPDs and any attachments (summary of material modifications ("SMM"), amendments, Summaries of Benefits Coverage, Annual Enrollment Guides and addendums) for future reference.

Please note that your health care Provider does not have a copy of the SPD and is not responsible for knowing or communicating your Benefits.

See the *General Information SPD* for more information as noted in the section "**GENERAL PLAN INFORMATION**" on page 3 and throughout this SPD.

Exempt Retiree Medical Plan Status Notice

The Lumen Retiree and Inactive Health Plan (the "Plan") meets the requirements of a standalone exempt retiree medical plan under the Section 732 of ERISA and therefore is not required to comply with the Patient Protection and Affordable Care Act (PPACA). However, the Company has decided to voluntarily apply certain provisions of the PPACA to certain benefit options. For example, the Company is making coverage available to the end of the month in which your adult child(ren) attains the age of 26, provided such individual is not otherwise eligible for coverage under another group plan such as one offered by the child's employer. This means that for all Retirees, this voluntary application of PPACA may be changed or ended at any time and does not waive the Plan's status as "exempt" from PPACA.

Health Plan Coverage Is Not Health Care Advice

Please keep in mind that the sole purpose of the Plan is to provide for the payment of certain health care expenses and not to guide or direct the course of treatment of any Employee, or eligible Dependent. Just because your health care Provider recommends a course of treatment does not mean it is approved and payable under the Plan. A determination by the Claims Administrator or the Plan Administrator that a particular course of treatment is not eligible for payment or is not covered under the Plan does not mean that the recommended course of treatments, services or procedures should not be provided to the individual or that they should not be provided in the setting or facility proposed. ***Only you and your health care Provider can decide what is the right health care decision for you.*** *Decisions by the Claims Administrator or the Plan Administrator are solely decisions with respect to Plan coverage and do not constitute health care recommendations or advice.*

Lumen's right to use your Social Security number for administration of benefits

Lumen retains the right to use your Social Security Number for benefit administration purposes, including tax reporting. If a state law restricts the use of Social Security Numbers for benefit administration purposes, Lumen generally takes the position that ERISA preempts such state laws.

GENERAL PLAN INFORMATION

The Dental Plan benefit option is one of the benefit options offered under the Plan. This SPD **must** be read in conjunction with the *General Information SPD* which explains details of your coverage and provides a listing of the other benefit options under the plan.

Refer to the *General Information SPD* for important and general Plan information about your Benefits including, but not limited to, the following sections:

- Eligibility
- When Coverage Begins
- When Coverage Ends
- How to Appeal a Claim
- Circumstances that May Affect Your Plan Benefits
- The Plan's Right to Restitution
- Plan Information (e.g. Plan Sponsor and EIN, administration, contact information, Plan Number, etc.)
- Coordination of Benefits
- A statement of your ERISA Rights
- Your Rights to COBRA and Continuation Coverage
- Notice of HIPAA rights
- General Administrative Provisions
- Required Notice and Disclosure
- Glossary of Defined Terms
- Qualified Medical Child Support Order (QMSCO)

You can go online to lumen.com/healthandlife (if actively working) or lumen.com/healthbenefits to obtain an electronic copy or call the Lumen Health and Life Service Center at **833-925-0487** or **317-671-8494 (International callers)** to request a paper copy of the *General Information SPD*.

You May Not Assign Your Benefits to Your Provider

Participants and Eligible Dependents may not voluntarily or involuntarily assign to a physician, hospital, pharmacy or other health care provider (your "Providers") any right you have (or may have) to:

1. receive any benefit under this Plan
2. receive any reimbursement for amounts paid for services rendered by Providers, or
3. request any payment for services rendered by Providers

The Plan prohibits Participants and Eligible Dependents from voluntarily or involuntarily assigning to Providers any right you have (or may have) to submit a claim for benefits to the Plan, or to file a lawsuit against the Plan, the Company, the Plan Administrator, the Claims Administrator, the appeals administrator or any other Plan fiduciary, administrator, or sponsor with respect to Plan benefits or any rights relating to or arising from participation in the Plan. If Participants and Eligible Dependents attempt to assign any rights in violation of the Plan terms, such attempt will not be effective. It will be void or otherwise treated as invalid and unenforceable.

This Plan provision will not interfere with the Plan's right to make direct payments to a Provider. However, any direct payment to a Provider is provided as a courtesy to the Provider and does not effectuate an assignment of Participants' and Eligible Dependents' rights to the Provider or waive the Plan's rights to enforce the Plan's anti-assignment terms. Any such direct payment to a Provider shall be treated as though paid directly to Participants and Eligible Dependents and shall satisfy the Plan's obligations under the Plan.

Consequences of Falsification or Misrepresentation

You will be given advance written notice that coverage for you or your Dependent(s) will be terminated if you or your Dependent(s) are determined to falsify or intentionally omit information, submit false, altered, or duplicate billings for personal gain, allow another party not eligible for coverage to be covered under the Plan or obtain Plan Benefits, or allow improper use of you or your Dependent's coverage.

Continued coverage of an ineligible person is considered to be a misrepresentation of eligibility and falsification of, or omission to, update information to the Plan, which is in violation of the Code of Conduct and may result in disciplinary action, up to and including termination of employment. This misrepresentation/omission is also

a violation of the *Plan document*, Section 8.3 which allows the Plan Administrator to determine how to remedy this situation. For example, if you divorce, your former spouse is no longer eligible for Plan coverage and this must be timely reported to the Service Center within 45 days, regardless if you have an obligation to provide health insurance coverage to your ex-spouse through a Court Order.

- You and your Dependent(s) will not be permitted to benefit under the Plan from your own misrepresentation. If a person is found to have falsified any document in support of a claim for Benefits or coverage under the Plan, the Plan Administrator may, without anyone's consent, terminate coverage, possibly retroactively, if permitted by law (called "rescission"), depending on the circumstances, and may seek reimbursement for Benefits that should not have been paid out. Additionally, the Claims Administrator may refuse to honor any claim under the Plan or to refund premiums.
- While a court may order that health/dental coverage must be maintained for an ex-spouse/domestic partner, that is not the responsibility of the Company or the Plan.
- You are also advised that by participating in the Plan you agree that suspected incidents of this nature may be turned over to Plan Administrator and/or Corporate Security to investigate and to address the possible consequences of such actions under the Plan. You may be periodically asked to submit proof of eligibility and to verify claims.

Note: *All Participants by their participation in the Plan authorize validation investigations of their eligibility for Benefits and are required to cooperate with requests to validate eligibility by the Plan and its delegates.*

For other loss of coverage events, refer to the *General Information SPD* as applicable.

You Must Follow Plan Procedures

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

Plan Number

The Plan Number for the Retiree and Inactive Lumen Health Plan is 512.

CLAIMS ADMINISTRATORS AND CONTACT INFORMATION

MetLife

MetLife Dental
P.O. Box 981282
El Paso, TX 79998-1282

866-832-5756
Fax Number: 859-389-6505

Group Number: 148069

Website Address: www.metlife.com/mybenefits

Lumen

Lumen Health and Life Service Center
1025 Ashworth Rd
West Des Moines, IA 50265

833-925-0487 or 317-671-8494
(International callers)
or **800-729-7526**

Website Address: lumen.com/healthandlife

(if actively working) or lumen.com/healthbenefits

DENTAL PLAN BENEFIT FEATURES

About Dental Coverage

You may choose to participate in the Basic dental option for your individual and/or family needs for dental care.

The Basic option is a traditional fee-for-service option that covers preventive as well as comprehensive dental work. You pay an annual deductible before the option pays benefits, except for diagnostic and preventive care, which is covered at 100 percent with no deductible.

Your benefit levels are the same no matter which type of provider you use (network or out-of-network), as it is also a Preferred Provider Organization (PPO) Plan, with access to MetLife's Preferred Provider Program (PDP Plus). You will receive dental services at a discounted rate when you use the PDP Plus providers. You will be responsible for any charges above the reasonable and customary (R&C) amounts when you use out-of-network providers.

Finding a MetLife Provider

To find a PPO dental provider in your area, select the Find a Physician or Facility tile on the Lumen Health and Life website lumen.com/healthandlife (if actively working), lumen.com/healthbenefits or www.metlife.com/mybenefits. Remember to identify your MetLife Network when talking with providers—ask if they are a MetLife PPO provider. **Note:** Many providers will say they accept MetLife, but that doesn't always mean they are a network provider.

Pre-treatment Review

If any treatment suggested by your provider is estimated to exceed $300, you should ask your provider to file a Pre-Determination of Benefits form. This form lets you and your provider know – in advance – how much will be paid for that charge. That way, there are no surprises and it can help save money. Here is how it works:

- Using the claim form, your provider tells MetLife what your treatment will be and itemizes each service and its associated cost. (Most providers are familiar with pre-determination procedures and have filled out similar forms before).
- MetLife reviews the treatment plan and determines what the benefit payment will be if the treatment is performed. This estimation does not include reductions in the benefit payment, which will occur for things such as coordination of benefits with other carriers or annual plan maximums. For more information, see "**Coordination of Benefits**" on page 6.
- Following the advice of a dental consultant, MetLife may suggest an alternate procedure as a less expensive way to treat a particular dental problem. If the pre-determined benefit you would receive from the plan is less than your provider estimated cost, you can proceed with the treatment and pay the additional costs. Or, you can discuss an alternate course of treatment with your provider.
- If, for some reason, your provider makes changes in your planned treatment other than those suggested by MetLife, a new form should be submitted for pre-determination.

Note: Pre-determination of benefits does not guarantee benefit payment – all other provisions of the dental option apply.

Coordination of Benefits

The standard Coordination of Benefits approach pays the difference between what the primary carrier paid and the allowable fee. Coordination of Benefits is a cooperative claim payment between two or more insurance carriers that applies when a member is covered under more than one plan. Reimbursement between the carriers can result in a 100% reimbursement of benefit. However, the member will not receive a profit above the 100% reimbursement.

Coordination of Benefits is the method used to determine which of your group health care plans has the primary responsibility to provide benefits, and which group plan pays second. This COB provision generally does not apply to individual policies which are not issued under a group coverage arrangement.

See the *General Information SPD* for more details on Coordination of Benefits or contact the Claims Administrator.

HOW TO FILE A BENEFIT CLAIM

Generally, you are responsible for requesting payment from the Claims Administrator, MetLife, if you use an out-of-network provider and may be asked to pay for services at time of appointment. Network dental providers will submit claims directly to MetLife for you.

> **Deadline to File by:** You must submit a request for payment of benefits within one (1) year after the date of service. If you don't provide this information to MetLife within one year of the date of service, benefits for that dental service will be denied or reduced, at the Claims Administrator's discretion.

Payment of Dental Plan Benefits

MetLife will make a benefit determination and benefits will be paid to the provider directly when you use a network provider. Payment will be made to you when you use an out-of-network provider who requires payment at time of services.

Claim forms are available from the Lumen Health and Life Service Center or website lumen.com/healthandlife (if actively working) lumen.com/healthbenefits or, by calling MetLife Customer Service or visiting the MetLife website at www.metlife.com/mybenefits.

To submit a manual claim, forward completed claim forms to:

MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

Claim forms can also be faxed to **859-389-6505**

Life Benefit Determinations

Post service claims. Post service claims are those claims that are filed for payment of benefits after care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim.

The Claims Administrator will notify you within this 30-day period if additional information is needed to process the claim and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for the denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures. See the “CLAIMS AND APPEALS” section on page 11 in this SPD and the General Information SPD for more information on appeal and procedures.

COVERED DENTAL PLAN BENEFITS

Benefit Summary Chart

This is a summary of expenses covered by the Lumen Dental Plan Benefit option. It is not meant to be an exhaustive list of the services covered by the Plan and is subject to change from time to time. It is your responsibility to confirm whether a dental service or product is covered under the Dental Plan benefit option by calling MetLife Customer Service before services are received.

Maximum Allowable Amount

Dental benefits are based on MetLife’s maximum payment allowance. Deductibles apply to each individual person covered.

Dental Plan: Coverage Comparison	**Basic Plan**
	Passive PPO Network
Annual Deductible	$25 per person for General Care and Major and Restorative; no deductible for Diagnostic, Preventive or Oral Surgery
Annual Maximum Dental Benefit	$1,000 per person (does not include oral surgery)
Diagnostic & Preventive (cleanings & exams)	100%*; no deductible 2 visits per year (cleanings and exams only)
X-Rays	100%*; no deductible
	Adults 1 visit per year
	Children under age 26, 1 visit per 6 months (2 visits per year)
Major & Restorative (crowns, dentures and bridges)	50%* after deductible
Oral Surgery	80%*, no deductible or limit
Orthodontia (adult and child)	Not covered
Orthodontia Lifetime Benefit Maximum	N/A

*Up to the plans maximum allowable amount, Subject to MetLife Preferred Dental Provider pre-negotiated fees or Reasonable and Customary if out of network provider

Maximum Allowable Amount

Dental benefits are based on MetLife’s maximum payment allowance. Deductibles apply to each individual person covered.

In-network services are paid based on negotiated PDP Plus fees which reduces the retired Employee's out of pocket expenses. The out-of-network services are paid based on the R&C (reasonable and customary) values for the area where the provider is located. MetLife participating provider maximum fee is developed from several sources, including but not limited to contracts with providers, input from dental consultants, consideration of the relative simplicity or complexity of the procedure, the billed charges for the same procedures by other providers, and such other information as MetLife in its sole discretion, deems appropriate.

Out-of-network providers' reimbursement is based in part, on the average fee submitted by participating providers.

If you use a provider participating in the MetLife PDP Plus network, you will not be billed for the remaining balance over the maximum allowable amount.

Benefit Provisions

Where this SPD is silent on benefit provisions, benefits are administered according to MetLife's standard guidelines for the self-insured dental option. This Plan is self-insured which means that the financial resources used to pay these claims are provided by Lumen and your premium contributions. MetLife provides administrative claims payment services only.

The guidelines used to determine whether benefits are covered include, but are not limited to: is the service medically appropriate to meet the basic dental needs of the member; consistent with generally accepted treatment guidelines within the dental profession; consistent with the diagnosis of the condition; consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by dental research, the American Dental Association, and the U.S. Food & Drug Administration guidelines.

The following sections discuss the various dental services covered.

Diagnostic and Preventive Care

Diagnostic and preventive care services include the following types of expenses:

- Oral exams twice per year.
- Dental X-rays: Full mouth (once every 5 years), supplementary bitewings (once per year for adults, once every 6 months for child up to the age of 26), and other x-rays as needed to diagnose a specific condition requiring treatment.
- Standard cleaning and scaling of teeth (prophylaxis) twice per year. If dentally necessary, a third cleaning in the calendar year will also be covered.
- Periodontal Cleanings – Two periodontal cleanings (in addition to two preventive and diagnostic cleanings) are covered when periodontal disease has been diagnosed.
- Application of fluoride two times per year.
- Application of sealants (twice per tooth per lifetime for dependent children under age 19).
- Installation and fitting of space maintainers for children under age 19 (once per lifetime).
- Administration of General Anesthetics: General Anesthesia, IV Sedation and other substances or agents such as Nitrous Oxide and Analgesia administered to produce a state of sedation or relaxation or to reduce or eliminate pain.

General Care

Therapeutic services and supplies include the following types of expenses:

- Dental Pathology – Biopsy and examination of oral tissue including a microscopic examination;
- Oral Prophylaxis - cleaning of teeth is covered twice a calendar year. If dentally necessary, a third cleaning in the calendar year will also be covered.
- Endodontics – Procedures to prevent and treat dental diseases of the dental pulp such as root canal therapy;
- Simple Extraction – Pulling teeth;

- Fillings – Silver (amalgam), silicate, plastic, porcelain and composite (white) filings; gold fillings are covered under major/restorative care benefits of dental coverage;
- Root planing and scaling are covered once every 24 months per quadrant. (Note: Periodontal cleanings are in the preventative care section at 100%);
- Periodontics – Includes procedures for the treatment of diseases of the tissues supporting the teeth are covered once every 24 months per quadrant. Surgical periodontal procedures are reviewed for necessity;
- Stainless Steel Crowns once per tooth every 2 years; and

Major and Restorative

Restorative services and supplies include the following types of expenses:

- Crowns and gold fillings to repair a tooth broken down by decay or injury are covered – charges for these restorations are covered only if the tooth cannot be repaired with a less expensive type of filling. If the tooth can be repaired by a less expensive method, only that charge will be covered. Replacement of crowns will be considered for payment, but the existing crown must be over 10 years old and unserviceable.
- Inlays and onlays are also covered once every 5 years – charges for these restorations are covered only if the tooth cannot be repaired with a less expensive type of filling. If the tooth can be repaired by a less expensive method, only that charge will be covered.
- Repairs to broken inlays, crowns, bridgework and dentures once every 12 months.
- Initial installation of full or partial dentures and fixed dentures to replace missing natural teeth. Dentures are subject to the least expensive alternate treatment. Only the charge for the alternate treatment will be covered. If the tooth can be repaired by a less expensive method, only that charge will be covered.
- Full or partial dentures and fixed dentures to replace an existing denture or partial denture that is not serviceable also are covered. But the existing denture or partial denture must be over 5 years old unless damaged beyond repair due to injury while in mouth.
- A permanent denture may replace a temporary one. But in this case, charges for both are limited to the charge for the permanent one. Adding teeth to existing partial removable dentures or to fixed dentures also is covered.
- Limited coverage for surgical placement of implants for age 16 and over. It provides for implant attachments including implant abutments and implant crowns.

Endodontic/Periodontal Treatment

Endodontic and periodontal services include the following types of expenses:

- Periodontal treatment.
- Treatment of gum and mouth tissue diseases, including periodontal scaling and root planing.
- Root-canal therapy.
- Implants and treatment once every 5 years (excluding endodontic implants)
- Tissue regeneration.

Oral Surgery

There is no annual maximum for oral surgery expenses. Pre-treatment review is recommended to ensure availability of benefits for the service(s). Oral surgery includes procedures which involve “cutting,” including but not limited to the following:

- Surgical extractions (i.e., extraction of wisdom teeth).
- Root surgery.
- General anesthesia (must be medically necessary).
- Alveoplasty (surgical preparation for dentures and replanting teeth).

Temporomandibular Joint Dysfunction (TMJ)

Non-surgical services to the temporomandibular joint are covered including follow-up after surgery, x-rays, physical therapy of the jaw, appliances and adjustments to appliances.

EXCLUSIONS: DENTAL PLAN BENEFITS/SERVICES NOT COVERED

The Dental Plan benefit option does not pay for the services listed below. The list of services below, however, is not meant to be an exhaustive list of the services not covered and it is subject to change from time to time and over time. It is your responsibility to confirm whether a dental service or product is covered under the Dental Plan benefit option by calling MetLife Customer Service before services are received.

- Replacement of a congenitally missing tooth.
- Cosmetic services, including personalization or characterization of dentures, bleaching of teeth, facing on pontics or crowns posterior to the second bicuspid or precision attachments.
- Drugs or medicines other than antibiotic injections and desensitizing medications administered by your provider.
- Duplicate prosthetic devices or other dental applications.
- Education and training in personal oral hygiene, dental plaque control or dietary and nutritional counseling.
- Permanent periodontal splinting of teeth.
- Replacement of a lost, missing or stolen prosthetic device or other dental appliance.
- Services for which benefits are available under another group health plan provided by the Company.
- Treatment by anyone other than a qualified and licensed provider, physician, licensed dental hygienist under the supervision of a provider, physician, denturist or other practitioner as licensed.
- Treatment received before becoming covered under this dental plan.
- Use of materials to prevent decay, other than fluorides and sealants.
- Any treatment, service or supply that is not a covered service. This includes services that are not generally accepted in dental practice as necessary for the prevention, diagnosis or treatment of illness or injury. This includes charges for any unnecessary repetition of tests.
- Expenses in excess of eligible expenses.
- Services or supplies that are not covered dental services under the plan.
- Charges for any claim received by the Claims Administrator more than 2 years from the date of service.
- Any treatment, service or supply that would have been covered had the individual obtained coverage required by law, i.e., coverage required under state workers' compensation or motor vehicle insurance laws. An individual who has not complied with such legal requirements will not be eligible for any benefits for that illness, injury or condition, including any re-injury, aggravation, etc.
- Any treatment, service, or supply provided to a member for whom the member would not be held financially responsible in the absence of coverage.
- Any treatment, service or supply that was received as a result of the following:
    1. Violent conflicts. This includes participation in an insurrection, war (whether or not declared), military service, any civil disturbance, riot, piracy, highjack, or any and all acts incident to such events. "Participation" does not include being at the scene of such an event in the performance of your duties for the Company.
    2. Law violations. This means attempting to violate or violating criminal or motor vehicle laws, except where the violation was unwitting, unpremeditated, and without actual (as opposed to implied) criminal intent.
- Any treatment, service or supply that is received as a result of an accident, illness or injury arising out of or related to employment or self-employment for wage or profit.
- Examination or treatment ordered by a court or in connection with legal proceedings unless such examination or treatment otherwise qualify as covered services.
- Charges for broken, canceled, or postponed appointments, or for the completion of claim forms or related documents

required by the Plan for claims administration purposes or other Company-sponsored programs.

- Interest, finance charges, local or state sales taxes.

CLAIMS AND APPEALS

Questions and Appeals – What to Do First

Lumen believes that most claim issues, such as a denied claim, can be addressed informally if promptly and objectively raised with the appropriate Claims Administrator, and that the best time to solve a problem or answer a question is when it first arises, not days, weeks or months later. In no event should it be more than a year after you have been notified and are aware of the issue.

Participants who have had a claim denied, have questions or complaints, etc., may informally contact the Claims Administrator before requesting a formal appeal. If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in *"HOW TO FILE A BENEFIT CLAIM" on page 6*, you may appeal it without first informally contacting the Claims Administrator.

How to Appeal a Denied Service Claim

If a claim for Benefits is denied in part or in whole, you may call the Claims Administrator at 866-832-5756 or www.metlife.com before requesting a formal appeal. If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

When appealing a denied claim, please be aware that there are Service Claim appeals processed by the Claims Administrator as well as Eligibility/Participation appeals processed by the Plan Administrator. Both types of appeal have two levels of appeal processing each with their own requirements as described below.

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your Level 1 appeal in writing within 180 days of receiving the claim denial which is also called an "adverse benefit determination". **Dental claims are typically post-service claims.** You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and SSN
- the provider name;
- the date of dental service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. Most of these are typically medical related claims. **Dental services are typically only post-service claims.** If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;

- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Review of an Appeal

The Claims Administrator will conduct a full and fair review of your appeal. The appeal may be reviewed by:

an appropriate individual(s) who did not make the initial benefit determination; and a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if the Claims Administrator upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Claims Administrator within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. the Claims Administrator will review all claims in accordance with the rules established by the U.S. Department of Labor.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by the Claims Administrator, or if the Claims Administrator fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of the Claims Administrator's determination.

You may request an external review of an adverse benefit determination if the denial is based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address sent out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the MetLife toll-free number or by sending a written request to the address set out in the determination letter.

Please Note this Deadline: A request must be made within four (4) months after the date you received the Claims Administrator's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and SSN;
- your designated representative's name and address, when applicable;
- the service that was denied; and

- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). The Claims Administrator has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

1. a standard external review; and
2. an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by the Claims Administrator of the request;
- a referral of the request by the Claims Administrator to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, the Claims Administrator will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the dental care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the preliminary review, the Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Claims Administrator will assign an IRO to conduct such review. The Claims Administrator will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

The Claims Administrator will provide to the assigned IRO the documents and information considered in making the Claims Administrator's determination. The documents include:

- all relevant dental records;
- all other documents relied upon by the Claims Administrator; and
- all other information or evidence that you or your Provider submitted.

If there is any information or evidence you or your Provider wish to submit that was not previously provided, you may include this information with your external review request and the Claims Administrator will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Claims Administrator. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and the Claims Administrator, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing the Claims Administrator determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the dental care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, the Claims Administrator will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the dental care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the review, the Claims Administrator will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Claims Administrator will assign an IRO in the same manner the Claims Administrator utilizes to assign standard external reviews to IROs. The Claims Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Claims Administrator. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical/dental condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to the Claims Administrator.

You may contact the Claims Administrator at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined by the medical benefit option;

Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify MetLife before non-Urgent Care is provided; and

Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and the Claims Administrator are required to follow.

Urgent Care Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	**24 hours**
You must then provide completed request for Benefits to the Claims Administrator within:	**48 hours** after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	**72 hours**
If the Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	**5 days**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	**15 days**
You must then provide completed request for Benefits information to the Claims Administrator within:	**45 days**
The Claims Administrator must notify you of the benefit determination:	
if the initial request for Benefits is complete, within:	**15 days**
after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination (file a first level appeal) no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	**30 days**
You must then provide completed claim information to the Claims Administrator within:	**45 days**
The Claims Administrator must notify you of the benefit determination:	
if the initial claim is complete, within:	**30 days**
after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

How to Appeal a Denied Eligibility/Participation Claim

After you receive an initial denial of a submitted claim, there are two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Claims Administrator within 180 days from the receipt of the first level appeal determination. The below chart outlines both the timeline for filing an appeal by you and for receiving responses from the Claims Administrator.

Eligibility/Participation Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	**30 days**

Eligibility/Participation Claims	
Type of Claim or Appeal	**Timing**
You must then provide completed claim information to the Claims Administrator within:	**45 days**
The Claims Administrator must notify you of the benefit determination:	
if the initial claim is complete, within:	**30 days**
after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than (First-Level appeal):	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**180 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision for eligibility/participation claim within:	**60 days** after receiving the second level appeal (up to an additional 30 days may be required if necessary)

Time Deadline to File a Benefit Claim and the Time Deadline to File a Benefit-Related Lawsuit

The Health Plan provides that no person has the right to file a civil action, proceeding or lawsuit against the Health Plan or any person acting with respect to the Health Plan, including, but not limited to, the Company, any Participating Company, the Committee or any other fiduciary, or any third party service provider unless it is filed within the timing explained as follows below:

Initial Claim: The time frame for filing an initial claim for a premium Payroll Adjustment is the earlier of:

1. Within 180 days of an adverse decision by the Plan Administrator, or
2. The earlier of:
   a. Within 180 days of the effective date of an election that is later claimed to be erroneous, or
   b. By the last day of the Plan Year of when the election error is claimed to have occurred. If the initial claim is not filed by this deadline, it shall be deemed untimely and denied on that basis. Appeals from a claim denial must also be timely filed as described in the Summary Plan Description.

Agent for Service of Legal Process:
Associate General Counsel
100 CenturyLink Drive
Monroe, LA 71203

Legal process may also be served on:

CT Corporation System
1675 Broadway, Suite 1200
Denver, Colorado 80202

Legal Action Deadline: After you have exhausted or completed the claims and appeals procedures as explained above, you may pursue any other legal remedy, such as bringing a lawsuit or civil action in court provided, that you file a civil action, proceeding or lawsuit against the Plan or the Plan Administrator or the

Claims Administration no later than the last day of the twelfth month following the later of (1) the deadline for filing an appeal under the Plan or (2) the date on which an adverse benefit determination on appeal was issued to you with respect to your Plan benefit claim.

This means that you cannot bring any legal action against the Plan, the Employee Benefits Committee or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action, you must do so no later than the last day of the 12th month from the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan, or the Claims Administrator.

The Required Forum for Legal Disputes. After the claims and appeals procedures are exhausted as explained above, and a final decision has been made by the Plan Administrator, if an Eligible Employee wishes to pursue other legal proceedings, the action must be brought in the United States District Court in Denver, Colorado

SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. The terms of this entire subrogation and reimbursement provision shall apply, and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the Covered Individual identifies the medical/dental benefits the Plan advanced. The Plan's right of full reimbursement shall not be reduced or limited in any way by the Covered Individual's actual or alleged comparative fault or contributory negligence in causing the injury(ies) or accident for which the Plan advanced medical/dental benefits.

See the General Information SPD for more details regarding the Plan's right of recovery or Subrogation.

GENERAL ADMINISTRATIVE PROVISIONS

This section summarizes the legal information about the Plan. For more information refer to the *General Information SPD*.

Plan Document

This Benefits Summary presents an overview of your Benefits. In the event of any discrepancy between this summary and the official *Plan Document*, the *Plan Document* shall govern.

Records and Information and Your Obligation to Furnish Information

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

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you, to furnish the Plan or the Claims Administrator with all information or copies of records relating to the services provided to you. The Plan or the Claims Administrator has the right to request this information at any reasonable time as well as other information concerning your eligibility and Benefits. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed an enrollment form, if applicable.

The Plan agrees that such information and records will be considered confidential. We and the Claims Administrator have the right to release any and all records concerning dental care services which are

necessary to implement and administer the terms of the Plan, for appropriate medical/dental review or quality assessment, or as we are required by law or regulation.

For complete listings of your dental records or billing statements, we recommend that you contact your Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request dental forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we and the Claims Administrator will designate other persons or entities to request records or information from or related to you and will release those records as necessary. Our designees have the same rights to this information as we have.

During and after the term of the Plan, we and our related entities may use and transfer the information gathered under the Plan, including claim information for research, database creation, and other analytic purposes.

Interpretation of Plan

The Plan Administrator, and to the extent it has delegated to the Claims Administrator, have sole and exclusive authority and discretion in:

- Interpreting Benefits under the Plan
- Interpreting the other terms, conditions, limitations, and exclusions set out in the Plan, including this SPD
- Determining the eligibility, rights, and status of all persons under the Plan
- Making factual determinations, finding and determining all facts related to the Plan and its Benefits
- Having the power to decide all disputes and questions arising under the Plan

The Plan Administrator and to the extent it has delegated to the Claims Administrator may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Plan Administrator, or its authorized delegate, may, in its sole discretion, offer Benefits for services that would not otherwise be Covered Health Services. The fact that the Plan Administrator does so in any particular case shall not in any way be deemed to require them to do so in other similar cases.

Right to Amend and Right to Adopt Rules of Administration

The Plan Administrator, the Lumen Employee Benefits Committee, may adopt, at any time, rules and procedures that it determines to be necessary or desirable with respect to the operation of the Plans. The Company, in its separate and distinct role as the Plan Sponsor has the right, within its sole discretion and authority, at any time to amend, modify or eliminate any benefit or provision of the Plan or to not amend the Plan at all, to change contribution levels and/or to terminate the Plan, subject to all applicable laws. The Company has delegated this discretion and authority to amend, modify or terminate the Plan to the Lumen Plan Design Committee.

Circumstances that May Affect Your Benefit

There are limitations that may apply to your Benefit under the Dental Plan benefit option. Some of these are listed in this SPD, but there may be other circumstances that are listed in the *General Information SPD* and you are encouraged to review that document to fully understand your benefit coverage.

Clerical Error

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

Administrative Services

The Plan may, in our sole discretion, arrange for various persons or entities to provide administrative services regarding the Plan, such as claims processing and utilization management services. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Workers' Compensation Not Affected

Benefits provided under the Health Plan do not substitute for and do not affect any requirements for coverage by Worker's Compensation insurance.

Conformity with Statutes

Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered), is hereby amended to conform to the minimum requirements of such statutes and regulations. As a self-funded plan, the Plan generally is not subject to State laws and regulations including, but not limited to, State law benefit mandates. This benefit option is an "excepted benefit" not subject to the mandated requirements of the Affordable Care Act.

Refund of Benefit Overpayments

If the Plan pays Benefits for expenses incurred by a Covered Person, that Covered Person, or any other person or organization that was paid, must refund the overpayment if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person
- All or some of the payment we made exceeded the cost of Benefits under the Plan
- All or some of the payment was made in error.

The refund equals the amount the Plan paid in excess of the amount the Plan should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce

future Benefits including issuing you a Form 1099 for the amount of the overpayment as gross income.

Additionally, if the Covered Person was determined not to be eligible for the Benefits under the Plan, that individual must refund the amount of the excess Benefit payment and the Plan may undertake collection actions, subject to the requirements of applicable law.