Accident Insurance – Low Plan

Summary Plan Description (SPD) for Full-time active employees, including Qwest Term Full-time employees

Effective January 1, 2027

To request a paper copy of this SPD, call the Lumen Health and Life Service Center at 833-925-0487, or print this document.

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Introduction

Lumen Technologies, Inc. (Lumen or the Company) is pleased to include the Certificate of Accident Insurance (Certificate of Coverage) in this Summary Plan Description (SPD), collectively referred to as SPD. The Accident Insurance benefits available is a benefit option under the Lumen Welfare Benefits Plan (Welfare Benefits Plan or the Plan).

This SPD must be read in conjunction with the **Lumen Welfare Benefits Plan 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, 2027. If you are a Covered Person in the Accident Insurance benefit option on or after January 1, 2027, this SPD supersedes and replaces, in its entirety, any other SPD describing the Accident Insurance benefit 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 documents (such as Summary of Material Modifications (SMMs), amendments and Summary of Benefits Coverages (SBCs), and materials you receive at Annual Enrollment) are collectively referred to as, and constitute, the official Plan Document and describe your eligibility, benefits as well as rights and responsibilities under the Plan. The Plan is an insured benefit provided by Metropolitan Life Insurance Company (MetLife). This Welfare Benefits Plan is subject to and covered by the federal law known as the Employee Retirement Income Security Act (ERISA).

This SPD is for Lumen Full-time active employees and Qwest Term Full-time active employees.

This is an important document

This SPD explains how the Plan works and describes the Accident Insurance benefits and rights as well as your obligations under the Plan. All of the specific rules governing the Plan are contained in the Plan Document. You, your dependents, beneficiaries, and your lawyer or other legal representative may examine the Plan Document and other documents relating to the Plan during regular business hours, or by appointment at a mutually convenient time in the office of the Plan Administrator.

We encourage you to read this SPD in its entirety. Many sections of this SPD are related to other sections of the document. Thus, you may not have all of the information you need by reading just one section.

You should retain this SPD and all SPDs, plus any attachments (for example SMMs, amendments, SBCs, Annual Enrollment Guides and addendums) in a safe place for future reference. If you have questions after reading this SPD, please contact the Claims Administrator or the Plan Administrator.

For questions about the Plan, you can also call the Lumen Health and Life Service Center at 833-925-0487 or 317-671-8494 (International callers).

Company's reserved rights

The Company reserves the right to amend or terminate any of the Benefits provided in the Plan, with respect to all participant classes of Covered Persons, retired or otherwise without prior notice to or consultation with any Covered Persons, subject to applicable laws and if applicable, 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 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 **Lumen Welfare Benefit Plan 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 (referred to the Service Center) 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 in this SPD**.

The required forum for legal disputes

After the claims and appeals procedures are exhausted as explained, 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 to the United States District Court in Denver, CO.

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 Accident Insurance Plan (Low) 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, Certificate of Coverage, and the **Lumen Welfare Benefits Plan 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 in 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 **Lumen Welfare Benefits Plan General Information SPD**. All uses of we, us, and our in this document, are references to the Claims Administrator, Plan Administrator or Lumen. References to you and your are references to people who are Covered Persons as the term is defined in the **Lumen Welfare Benefits Plan General Information SPD**.

You are encouraged to keep all of the SPDs and any attachments (Summary of Material Modifications (SMMs), amendments, Summary of Benefits Coverage (SBCs), 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.

Benefits are explained in this SPD

The Plan provides Accident Insurance benefits as described in the Certificate of Coverage that follows in this SPD for non-union and union represented Full-time active employees or Qwest Term Full-Time active employees who elect to enroll in the Plan. This SPD must be read in conjunction with the **Lumen Welfare Benefits Plan General Information SPD** which explains details of coverage and provides a listing of the other benefit options under the Plan. This SPD provides information about the Plan, including, but not limited to, the following:

- Eligibility
- When coverage begins and ends
- How to appeal a claim
- The Plan's right to restitution
- Circumstances that may affect your Plan benefits
- Plan information (e.g., Plan sponsor and EIN, administration, contact information, Plan number, etc.)
- A statement of your ERISA rights

Eligibility for insurance and description of benefits

The Certificate of Coverage describes the eligibility requirements for benefits insured by MetLife under the Plan. It also includes a detailed description of the terms of the insurance coverage provided by MetLife under the Plan and the maximum benefits that can be paid.

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 Plans 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 Plans 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 Plans obligations under the Plan.

Contributions and funding

Participants pay the entire cost of the Plan coverage. No portion of the Plan is paid by Lumen. The Plan benefits are fully insured.

While on an unpaid leave of absence, you will be direct billed for the cost to continue coverage through MetLife for supplemental health care coverages (Accident Insurance, Critical Illness Insurance and/or Hospital Indemnity Insurance). This is separate from the Lumen Health and Life Service Center direct bill which is for medical, dental, vision, and/or optional life benefits only. Failure to pay the cost when due will result in the cancellation of your coverage in the Plan. If you have questions regarding your benefits under the Plan or direct billing, please contact the Lumen Health and Life Service Center or MetLife.

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 your 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 former spouse through a Court Order. Lumen does not allow former spouses or former domestic partners to continue coverage. While a court may order that health coverage must be maintained for a former spouse or former domestic partner, that is not the responsibility of Lumen 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 the 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.

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.

Note: All Covered Persons 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.

Inform the Plan of changes

You must notify the Plan of a change in your address, telephone number and personal email address as well as notifying the Plan of other changes to your name and/or marital status. To do this, you must contact the Lumen Health and Life Service Center.

A word about your privacy

In determining benefits and eligibility, the Plan will use confidential or personal health information. Please keep in mind it is very important for you to follow the Plans procedures, as summarized in this SPD, in order to obtain Plan benefits and to help keep your personal 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 Plans procedures for claiming a benefit or resolving an issue involving Plan benefits, there is no guarantee 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.

Health plan coverage is not health care advice

Please keep in mind that the sole purpose of the Plan is to provide payment of certain Accident Insurance 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.

You must follow Plan procedures

Please keep in mind that it is very important for you to follow the Plans procedures, as summarized in this SPD, in order to obtain Plan Benefits and to help keep your personal 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 Plans procedures. If you do not follow the Plans 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.

No conversion rights when coverage ends

There are no individual conversion rights to this insurance benefit after the coverage ends. If you are on an unpaid leave of absence, you may continue coverage by making timely monthly payments through direct billing from the Claims Administrator. **Note**: Some benefits may not be available when you are not an actively-at-work Full-time employee.

General Plan information

Plan Name:	Lumen Welfare Benefit Plan
Plan Sponsor:	Lumen Technologies, Inc. 214 East 24th Street Vancouver, WA 98663
Employer Identification Number:	72-0651161
Plan Number:	513
Coverage:	Accident Insurance (Low)
Type of Administration:	The Accident Insurance benefits provided under the Plan are insured by MetLife, which is liable for any benefits under the Plan. The group policy specifies the circumstances under which MetLife is liable for Accident Insurance benefits.
Plan Administrator:	Lumen Employee Benefits Committee 214 East 24th Street Vancouver, WA 98663
Claims Administrator:	MetLife P.O. Box 981282 El Paso, TX 79998-1282 Group No: 85300 Website Address: metlife.com/mybenefits 800-GETMET8 (800-438-6388)
Agent for Service of Legal Process	Lumen Technologies, Inc. Assistant General Counsel | ERISA 931 N. 14th Street Denver, CO 80202

Legal process may also be served on: Lumen Technologies, Inc.
214 East 24th Street
Vancouver, WA 98663

Plan fiduciary

The ERISA named fiduciary of the Welfare Benefits Plan is the Lumen Employee Benefits Committee. The Company has designated the Claims Administrator - the insurer, MetLife - as the ERISA claims fiduciary for purposes of all claims arising under the Plan.

Circumstances that may affect your Plan benefits

Under certain circumstances all or a portion of your benefits under the Plan may be denied, reduced, suspended, terminated or otherwise affected. These circumstances are addressed in this SPD and include:

- The Plan is changed, amended or terminated or the contract with MetLife amended or terminated.
- You attain the maximum benefit available under the Plan.
- You misrepresent or falsify any information required under the Plan; you will not be permitted to benefit under the Plan from your own misrepresentation.
- You have been overpaid a benefit and the Plan seeks recovery of the overpayment.
- Your coverage under the Plan is terminated for one of a variety of reasons, for example, failure to submit required documentation timely or, if applicable, to pay a premium.
- Not being an active Full-time employee (e.g., transfer to Part-time status, out on a leave status, etc.).

Claims and appeals for benefits and time limitation on civil actions

You should refer to Claims Information in the ERISA Information section at the end of the Certificate of Coverage to understand how to file a claim for benefits and, if denied or partially denied, how to appeal the denial.

You cannot bring any legal proceeding or action against the Plan, the Plan Administrator, Claims Administrator or the Company until you first complete and exhaust all the claims and appeals requirements described in Claims Information in the ERISA section. Once you have exhausted the administrative remedies, you can bring any legal proceedings or action within 12 months or one year of the date the Claims Administrator notified you of the final decision on your appeal, unless otherwise provided in the Certificate of Coverage. No person has the right to file a civil action, proceeding or lawsuit against the Plan or any person acting with respect to the Plan, including, but not limited to, the Company, any participating company, the Lumen Employee Benefits Committee or any other fiduciary, or any third party service provider, after the last day of the 12th month following the later of (a) the 60th day after receipt by the claimant of written notification of the adverse benefit determination on appeal or (b) the date on which the adverse benefit determination on appeal was issued with respect to such Plan benefit claim.

If you wish to appeal a denied or partially denied **service claim**, please review the Certificate of Coverage within this SPD for more details. If you wish to appeal a denied or partially denied **eligibility or participation claim**, please continue to read.

How to appeal a denied eligibility or 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 Level I appeal decision, you have the right to request a Level II appeal from the Plan Administrator within 180 days from the receipt of the Level I appeal determination. The chart outlines both the timeline for filing an appeal and for receiving responses from the Plan Administrator.

Eligibility or Participation Claim

Type of Claim or Appeal	Timing
If your claim is incomplete, the Plan Administrator must notify you within:	30 days
You must then provide completed claim information to the Plan Administrator within:	45 days
The Plan 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 (Level I appeal):	180 days after receiving the adverse benefit determination
The Plan Administrator must notify you of Level I appeal decision within:	30 days after receiving the Level I appeal
You must appeal the Level I appeal (file a Level II appeal) within:	180 days after receiving the Level I appeal decision
The Plan Administrator must notify you of the Level II appeal decision within:	60 days after receiving the Level II appeal (up to an additional 30 days may be required, if necessary to review further)

Time deadline to file a benefit claim and the time deadline to file a benefit-related lawsuit

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

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

- Within 180 days of an adverse decision by the Plan Administrator, or
- The earlier of:
  - Within 180 days of the effective date of an election that is later claimed to be erroneous, or
  - 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 SPD.

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 or 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 administratively possible. Interest shall not be payable with respect to a benefit corrected or adjusted. It is your responsibility to confirm the accuracy of statements, summaries, etc. made by the Plan or our designees, including the Claims Administrator(s), in accordance with the terms of this SPD and other Plan documents.

Records and information and your obligation to furnish information

At times, the Plan, the Claims Administrator or the Plans Administrator may need information from you. You agree to furnish the Plan, the Claims Administrator and/or the Plan 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, if applicable.

The Plan agrees that such information and records will be considered confidential. The Company and the Claims Administrator and the Plan Administrator have the right to release any and all records which are necessary to implement and administer the terms of the Plans, for appropriate healthcare review or quality assessment, or as we are required by law or regulation.

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

If you request healthcare 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, the Company and the Plan or the Claims Administrator will designate other persons or entities to request records or information from or related to you and/or your dependents and will release those records as necessary. Our designees have the same rights to this information as the Company has.

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

Interpretation of the Plan

The Plan Administrator has delegated to the Claims Administrator, MetLife, its discretionary authority to make all final determinations regarding claims and appeals for benefits under the Plan. This discretionary authority includes, but is not limited to:

- 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 determination, findings and determining all facts related to the Plan and its Benefits;
- Having the power to decide all disputes and questions arising under the Plan.

Any decision made by the Claims Administrator in the exercise of this authority, including review of denials of benefit, is conclusive and binding on all parties. Any court reviewing the Claims Administrator's determinations shall uphold such determination unless the claimant proves the determinations are arbitrary and capricious.

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 Plan. 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.

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 Lumen Welfare Benefits 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. This benefit option is a supplemental and excepted benefit not subject to the mandated requirements of the Affordable Care Act (ACA).

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 Plans 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.

METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK, NEW YORK

NOTICE

Notice Effective Date: **The later of January 1, 2027 or the Certificate Effective Date shown on the insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife.**

Please read this notice carefully with your coverage documents. It describes administrative changes to certain requirements in order for benefits to be payable for the benefits listed below under your Certificate of Accident Insurance. An administrative change to a specific benefit described below only applies to your coverage if the benefit is included in your Certificate.

Concussion Benefit:

The timeframe for how long after an Accident, an Injury must be diagnosed by a Physician as a concussion, is increased to 365 days (1 year).

Broken Tooth Benefit:

We will not apply any restriction that: “No benefit will be payable for an Injury to a tooth that is not a sound, natural tooth”.

Therapy Services Benefit:

The timeframe for how long after an Accident, Therapy Services must be provided, is increased to 730 days (2 years).

Surgery Benefits:

The timeframe for how long after an Accident, a Covered Surgery must be performed by a Physician, is increased to 730 days (2 years).

Outpatient Surgery Benefit:

The timeframe for how long after an Accident, Outpatient Surgery must be performed by a Physician in an Outpatient Surgery Facility, is increased to 730 days (2 years).

General Anesthesia Benefit:

The above increased timeframe of 730 days (2 years) also applies to the General Anesthesia Benefit when General Anesthesia is administered during a Surgery for which a benefit is payable under Your Certificate.

Your coverage continues to be subject to all Proof requirements, and to all other conditions, maximums, limitations, and exclusions provided in your coverage documents.

METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK, NEW YORK

Certificate Rider

Group Policy No.: **0085300**

Policyholder: **Lumen Technologies**

Rider Effective Date: **The later of January 1, 2019 or the Effective Date of Your Certificate**

Your Certificate is changed as follows:

In the Exclusions section of the Certificate, the following language is deleted:

- A Covered Person while incarcerated in any type of penal or detention facility.

This Certificate Rider is to be attached to and made a part of the Certificate.

Timothy J. Ring
Secretary

Michel Khalaf
President & CEO

METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK, NEW YORK

OBSERVATION UNIT BENEFIT CERTIFICATE RIDER

Group Policy No.: **0085300**

Policyholder: **Lumen Technologies**

Rider Effective Date: **The later of January 1, 2027 or the Certificate Effective Date shown on the insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife.**

This Certificate Rider adds an Observation Unit Benefit to the Hospital Benefits section of Your Certificate of Accident Insurance. This Rider is subject to the terms and provisions of the Group Policy and Your Certificate, unless specifically stated in this Rider.

Your Certificate is changed as follows:

- The Accident - Hospital Benefits section of the Schedule of Insurance is changed to add the following:

Observation Unit Benefit	**Benefit**
For You	$150
For Your Spouse or Domestic Partner	$150
For Your Dependent Child	$150

- The Definitions section is changed as follows:
  - The definition of **Observation Unit** is added as follows:

    Observation Unit means an area within a Hospital, which is separate from an Emergency Room, where a Covered Person's condition can be observed and monitored to determine if an inpatient Hospital admission is required. The Observation Unit must:
    - be under the direct supervision of a Physician or registered professional nurse (R.N.);
    - have nurses or healthcare professionals specifically assigned to it; and
    - provide care 7 days per week, 24 hours per day.

    The term Observation Unit does not include an area within a Hospital in which patients are receiving routine pre-operative and post-operative care.

- The Hospital Benefits section is changed to add the following benefit:

  OBSERVATION UNIT BENEFIT

  If a Covered Person sustains an Injury and is placed in an Observation Unit for less than 20 hours to treat the Injury, We will pay the Observation Unit Benefit shown in the Schedule above, subject to the following:
  - The care in the Observation Unit must begin within 180 days after the Accident occurs.

OBSERVATION UNIT BENEFIT CERTIFICATE RIDER (Continued)

- We will not pay the Observation Unit Benefit for any day on which the Admission Benefit or Confinement Benefit is payable for the Covered Person.

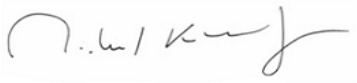
- We will pay the Observation Unit Benefit no more than:
  - 1 time per Covered Person, per Accident.

If a Covered Person is treated for an Injury in an Observation Unit for more than 20 continuous hours, the Covered Person will be considered admitted to the Hospital as an inpatient and the Admission Benefit or Confinement Benefit requirements will apply.

WHEN THIS RIDER ENDS

This Rider will end if insurance under the Certificate ends in accordance with the When Insurance Ends section of the Certificate; however, this Rider will continue if Your insurance is continued under the Continuation of Insurance section of the Certificate.

This Certificate Rider is to be attached to and made a part of Your Certificate.



Michel Khalaf
President & CEO

METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK, NEW YORK

POST-TRAUMATIC STRESS DISORDER BENEFIT CERTIFICATE RIDER

Group Policy No.: **0085300**

Policyholder: **Lumen Technologies**

Rider Effective Date: **The later of January 1, 2027 or the Certificate Effective Date shown on the insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife.**

The Post-Traumatic Stress Disorder Benefit Certificate Rider is added to the Certificate of Accident Insurance. The Post-Traumatic Stress Disorder Benefit provides a benefit when a Covered Person sustains an Accident, while this Rider is in effect, and is diagnosed by a Physician, with Post-Traumatic Stress Disorder. This Rider is subject to the terms and provisions of the Group Policy and the Certificate unless specifically stated within this Rider.

The Post-Traumatic Stress Disorder Benefit is added to the Accidental Injury Benefits section of the Certificate.

SCHEDULE OF INSURANCE

Post-Traumatic Stress Disorder Benefit	**Amount**
For You	$200
For Your Spouse or Domestic Partner	$200
For Your Dependent Child	$200

DEFINITIONS

DSM-5-TR means the current version of the Diagnostic and Statistical Manual of Mental Disorders and which sets forth the clinical criteria to establish a diagnosis of Post-Traumatic Stress Disorder.

Post-Traumatic Stress Disorder ("PTSD"), for purposes of this Rider, means a psychiatric disorder diagnosed by a Physician which satisfies the DSM-5-TR criteria and there is documentation that satisfies the following criteria:

- the Covered Person sustained an Accident and a Physician has diagnosed the Covered Person with a Post-Traumatic Stress Disorder that is a direct result of such Accident;
- the Covered Person is experiencing recurrent, involuntary, and intrusive memories of the Accident;
- the Covered Person is experiencing recurrent distressing dreams, dissociative reactions or flashbacks related to the Accident;
- the Covered Person is experiencing psychological distress or physiological reactions to cues that resemble or remind the Covered Person of the Accident;
- the Covered Person is displaying behaviors of avoidance of stimuli or external reminders associated with the Accident;
- the Covered Person is experiencing negative alterations in cognition, mood, or behavior that begin or worsen after the Accident;
- the Covered Person is experiencing severe impairments in social, occupational and other areas of daily functioning;
- the Covered Person's symptoms have continued for at least one month following the Accident; and
- the symptoms of the Post-Traumatic Stress Disorder are not attributable to any of the following:
  - medication;
  - alcohol or substance abuse; or
  - another medical condition or mental illness disorder.

POST-TRAUMATIC STRESS DISORDER BENEFIT

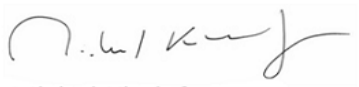
If a Covered Person has an Accident that results in a diagnosis of Post-Traumatic Stress Disorder, We will pay the benefit amount shown in this Rider, subject to all of the following:

- The diagnosis of Post-Traumatic Stress Disorder must be:
  - documented by a Physician who is a medical provider with mental health specific licensing or credentials to diagnose and treat Post-Traumatic Stress Disorder within 365 days following the Accident; and
  - made in the United States, Canada or Mexico.
- We receive the following documentation:
  - A Written report from a Physician who is a medical provider with mental health specific licensing or credentials to diagnose and treat Post-Traumatic Stress Disorder that includes a psychological evaluation for Post-Traumatic Stress Disorder, and which substantiates that such diagnosis is the direct result of an Accident.
  - The Covered Person is currently receiving, or has received, active care from a Physician who is a medical provider with mental health specific licensing or credentials to diagnose and treat Post-Traumatic Stress Disorder.
  - The Accident, which resulted in the Covered Person being diagnosed with Post-Traumatic Stress Disorder, took place while the Covered Person's coverage was in effect under this Rider.
- The Accident, that results in a loss that is Post-Traumatic Stress Disorder, is not excluded as described in the Exclusions section of the Certificate.
- We will pay the Post-Traumatic Stress Disorder Benefit no more than 1 time per Covered Person, per Accident.

WHEN THIS RIDER ENDS

This Rider will end if insurance under the Certificate ends in accordance with the When Insurance Ends section of the Certificate; however, this Rider will continue if Your insurance is continued under the Continuation of Insurance section of the Certificate.

This Rider is to be attached to and made a part of Your Certificate.



Michel Khalaf
President & CEO

METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK, NEW YORK

CERTIFICATE OF ACCIDENT INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents are insured for the benefits described in this Certificate, subject to the provisions of this Certificate. References to coverage for Your Dependents throughout this Certificate only apply if insurance is in effect for Your Dependents. Please refer to the Covered Person Specifications page and Eligibility Provisions: Dependent Insurance section for details.

This Certificate is issued to You under the Group Policy. This Certificate includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.** The Group Policy is a contract between MetLife and the Group Policyholder. It may be changed or ended without Your consent or notice to You.

Group Policyholder:	Lumen Technologies
Group Policy Number:	0085300
MetLife Toll Free Number:	1-800-GETMET8

Important Notice: The insurance evidenced by this Certificate provides limited benefits. Subject to its terms, conditions and limitations, this Certificate provides benefits for Accidental Injuries. The benefit amounts are shown in the Schedule and are not based on any medical expenses that are incurred. You should have medical coverage in force when You enroll for this insurance.

This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other minimum essential coverage) may result in an additional payment with Your taxes.

30-Day Right to Examine Certificate. Please read this Certificate carefully. If You are not satisfied for any reason, You may return this Certificate to Us within 30 days from the date You receive it. If You return it within the 30 day period, this Certificate will be void from the beginning. We will refund any premium or Contribution paid within 30 days after We receive Your notice of cancellation.

Maryland Residents: The Group Policy providing coverage under this Certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

NOTICE FOR RESIDENTS OF MAINE

If You were a resident of Maine on Your Certificate effective date, this notice applies to You.

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as non-payment of a Contribution that is due. You may make this designation by completing a "Third Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this Certificate to obtain a Third Party Notice Request Form.

Within 90 days after cancellation of coverage for nonpayment of premium, You, any person authorized to act on Your behalf, or any covered Dependent may request reinstatement of the Certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

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COVERED PERSON SPECIFICATIONS

Certificate Effective Date:	The later of January 1, 2027 or the Certificate Effective Date shown on the insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife
Group Policyholder:	Lumen Technologies
Group Policy Number:	0085300
MetLife Contact Information:	1-800-GETMET8
Your Name:	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife
Your Certificate Number:	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife
Coverage for Your Dependents	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife

This Covered Person Specifications page is part of Your Certificate. Please keep it with Your Certificate.

SCHEDULE OF INSURANCE

IMPORTANT NOTE: Payment of the benefits listed in this Schedule is subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate. PLEASE READ THE ENTIRE CERTIFICATE CAREFULLY.

The listing of benefits for Dependents only applies if insurance is in effect for Your Dependents under this Certificate. Please refer to the Covered Person Specifications page and the Eligibility Provisions: Dependent Insurance section of this Certificate for details.

PARALYSIS BENEFIT:	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
Two limbs (paraplegia or hemiplegia)	$7,500	$7,500	$7,500
Four limbs (quadriplegia)	$15,000	$15,000	$15,000

ACCIDENTAL INJURY BENEFITS:

Fracture Benefit*	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
Fracture Benefit For Closed Reduction:			
Face or Nose (except mandible or maxilla)	$750	$750	$750
Skull fracture – depressed (except bones of face or nose)	$3,000	$3,000	$3,000
Skull fracture – non-depressed (except bones of face or nose)	$1,500	$1,500	$1,500
Lower Jaw, Mandible (except alveolar process)	$500	$500	$500
Upper Jaw, Maxilla (except alveolar process)	$750	$750	$750
Upper Arm between Elbow and Shoulder (humerus)	$750	$750	$750
Shoulder Blade (scapula), Collarbone (clavicle, sternum)	$500	$500	$500
Forearm (radius and/or ulna), Hand, Wrist (except fingers)	$500	$500	$500
Rib	$500	$500	$500
Finger, Toe	$100	$100	$100
Vertebrae, Body of (excluding vertebral processes)	$1,500	$1,500	$1,500
Vertebral Processes	$500	$500	$500
Pelvis (includes ilium, ischium, pubis, acetabulum except coccyx)	$1,500	$1,500	$1,500
Hip, Thigh (femur)	$3,000	$3,000	$3,000
Coccyx	$500	$500	$500
Leg (tibia and/or fibula)	$3,000	$3,000	$3,000
Kneecap (patella)	$500	$500	$500
Ankle	$800	$800	$800
Foot (except toes)	$800	$800	$800

SCHEDULE OF INSURANCE (Continued)

	For You	For Your Spouse or Domestic Partner	For Your Dependent Child(ren)
Fracture Benefit For Open Reduction:			
Face or Nose (except mandible or maxilla)	$1,500	$1,500	$1,500
Skull fracture – depressed (except bones of face or nose)	$6,000	$6,000	$6,000
Skull fracture – non-depressed (except bones of face or nose)	$3,000	$3,000	$3,000
Lower Jaw, Mandible (except alveolar process)	$1,000	$1,000	$1,000
Upper Jaw, Maxilla (except alveolar process)	$1,500	$1,500	$1,500
Upper Arm between Elbow and Shoulder (humerus)	$1,500	$1,500	$1,500
Shoulder Blade (scapula), Collarbone (clavicle, sternum)	$1,000	$1,000	$1,000
Forearm (radius and/or ulna), Hand, Wrist (except fingers)	$1,000	$1,000	$1,000
Rib	$1,000	$1,000	$1,000
Finger, Toe	$150	$150	$150
Vertebrae, Body of (excluding vertebral processes)	$3,000	$3,000	$3,000
Vertebral Processes	$1,000	$1,000	$1,000
Pelvis (includes ilium, ischium, pubis, acetabulum except coccyx)	$3,000	$3,000	$3,000
Hip, Thigh (femur)	$6,000	$6,000	$6,000
Coccyx	$1,000	$1,000	$1,000
Leg (tibia and/or fibula)	$3,000	$3,000	$3,000
Kneecap (patella)	$1,000	$1,000	$1,000
Ankle	$1,000	$1,000	$1,000
Foot (except toes)	$1,000	$1,000	$1,000

***Chip Fracture Benefit** for any of the above: Benefit is 25% of the applicable benefit for the bone involved.

Dislocation Benefit*	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
Full Dislocation Benefit for Closed Reduction:			
Lower Jaw	$500	$500	$500
Collarbone (sternoclavicular)	$750	$750	$750
Collarbone (acromioclavicular and separation)	$500	$500	$500
Shoulder (glenohumeral)	$500	$500	$500
Rib	$500	$500	$500
Elbow	$500	$500	$500
Wrist	$500	$500	$500
Bone or Bones of the Hand (other than fingers)	$500	$500	$500
Hip	$3,000	$3,000	$3,000
Knee (except patella)	$1,500	$1,500	$1,500
Ankle - Bone or Bones of the Foot (other than toes)	$750	$750	$750
One Toe or Finger	$75	$75	$75

	For You	For Your Spouse or Domestic Partner	For Your Dependent Child(ren)
Full Dislocation Benefit for Open Reduction:			
Lower Jaw	$1,000	$1,000	$1,000

SCHEDULE OF INSURANCE (Continued)

Collarbone (sternoclavicular)	$1,500	$1,500	$1,500
Collarbone (acromioclavicular and separation)	$1,000	$1,000	$1,000
Shoulder (glenohumeral)	$1,000	$1,000	$1,000
Rib	$1,000	$1,000	$1,000
Elbow	$1,000	$1,000	$1,000
Wrist	$1,000	$1,000	$1,000
Bone or Bones of the Hand (other than fingers)	$1,000	$1,000	$1,000
Hip	$6,000	$6,000	$6,000
Knee (except patella)	$3,000	$3,000	$3,000
Ankle - Bone or Bones of the Foot (other than toes)	$1,500	$1,500	$1,500
One Toe or Finger	$150	$150	$150

***Partial Dislocation Benefit** for any of the above: Benefit is 25% of the applicable benefit for joint involved.

Burn Benefit: **Benefit for 2nd Degree Burn** **Percentage of total surface skin area that is burnt**	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
Less than 10%	$75	$75	$75
At least 10% but less than 25%	$125	$125	$125
At least 25% but less than 35%	$375	$375	$375
35% or more	$750	$750	$750

Burn Benefit: **Benefit for 3rd Degree Burn** **Percentage of total surface skin area that is burnt**	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
Less than 10%	$750	$750	$750
At least 10% but less than 25%	$1,250	$1,250	$1,250
At least 25% but less than 35%	$3,750	$3,750	$3,750
35% or more	$7,500	$7,500	$7,500

Concussion Benefit	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
	$250	$250	$250

Coma Benefit	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
	$7,500	$7,500	$7,500

Laceration Benefit:	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
Repaired without stitches	$35	$35	$35
Repaired with stitches			
Total of all lacerations is less than two inches (5.08 cm) long	$60	$60	$60
Total of all lacerations is two to six inches (5.08 to 15.24 cm) long	$150	$150	$150
Total of all lacerations is over six inches (over 15.24 cm) long	$300	$300	$300

SCHEDULE OF INSURANCE (Continued)

Broken Tooth Benefit:	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
Crown	$150	$150	$150
Extraction	$75	$75	$75
Filling	$25	$25	$25

Eye Injury Benefit	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
	$250	$250	$250

ACCIDENT - MEDICAL TREATMENT AND SERVICES BENEFITS

Air Ambulance Benefit	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
	$1,000	$1,000	$1,000

Ground Ambulance Benefit	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
	$200	$200	$200

Emergency Care Benefit	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
Emergency Room	$150	$150	$150
Physician’s Office	$50	$50	$50
Urgent Care	$75	$75	$75

Non-Emergency Initial Care Benefit	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
	$50	$50	$50

Medical Testing Benefit	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
	$200	$200	$200

SCHEDULE OF INSURANCE (Continued)

Physician Follow-Up Visit Benefit	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
	$50	$50	$50

Transportation Benefit	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
	$300	$300	$300

Therapy Services Benefit:	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
Cognitive behavioral therapy	$50	$50	$50
Occupational therapy	$50	$50	$50
Physical therapy	$50	$50	$50
Respiratory therapy	$50	$50	$50
Speech therapy	$50	$50	$50
Vocational therapy	$50	$50	$50
Acupuncture	$50	$50	$50
Chiropractic therapy	$50	$50	$50

Pain Management Benefit (for Epidural Anesthesia)	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
	$50	$50	$50

Prosthetic Device Benefit	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
One device only	$500	$500	$500
More than one device	$1,000	$1,000	$1,000

Medical Appliance Benefit:	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
Brace	$50	$50	$50
Cane	$50	$50	$50
Crutches	$50	$50	$50
Walker – expected use less than 1 year	$100	$100	$100
Walker – expected use 1 year or longer	$250	$250	$250
Walking boot	$50	$50	$50
Wheel chair or motorized scooter – expected use less than 1 year	$100	$100	$100
Wheel chair or motorized scooter – expected use 1 year or longer	$500	$500	$500
Other medical device used for mobility	$50	$50	$50
Medical Appliance Benefit Limit: Limit for all Medical Appliances combined, per Covered Person, per Accident	$500	$500	$500

Modification Benefit	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
	$750	$750	$750

Blood/Plasma/Platelets Benefit	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**

	$350	$350	$350

SCHEDULE OF INSURANCE (Continued)

Surgery Benefits:	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
Surgical Repair Benefit:			
Cranial	$1,250	$1,250	$1,250
Hernia	$125	$125	$125
Ruptured Disc	$625	$625	$625
Skin Graft Benefit (only payable for a burn for which the Burn Benefit was paid)	50% of the Burn Benefit that was paid	50% of the Burn Benefit that was paid	50% of the Burn Benefit that was paid
Torn cartilage in knee	$625	$625	$625
Torn, ruptured or severed tendon/ligament/rotator cuff			
One tendon/ligament/rotator cuff	$625	$625	$625
Two or more tendons/ligaments/rotator cuffs	$1,250	$1,250	$1,250
Thoracic cavity or abdominal pelvic cavity	$1,250	$1,250	$1,250
Exploratory Surgery Benefit for any of the procedures listed above	$125	$125	$125

Other Outpatient Surgery Benefit	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
	$250	$250	$250

ACCIDENT - HOSPITAL BENEFITS

Admission Benefit (for the day of admission)	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
	$1,000	$1,000	$1,000

ICU Supplemental Admission Benefit (for the day of admission)	**For You**	**For Your Spouse or Domestic Partner**	**For Your Dependent Child(ren)**
	$1,000	$1,000	$1,000

SCHEDULE OF INSURANCE (Continued)

Confinement Benefit	For You	For Your Spouse or Domestic Partner	For Your Dependent Child(ren)
	$100 per day	$100 per day	$100 per day

ICU Supplemental Confinement Benefit	For You	For Your Spouse or Domestic Partner	For Your Dependent Child(ren)
	$300 per day	$300 per day	$300 per day

Inpatient Rehabilitation Benefit	For You	For Your Spouse or Domestic Partner	For Your Dependent Child(ren)
	$100 per day	$100 per day	$100 per day

OTHER BENEFITS

Health Screening Benefit	For You	For Your Spouse or Domestic Partner	For Your Dependent Child(ren)
	$50	$50	$50

Lodging Benefit	For You	For Your Spouse or Domestic Partner	For Your Dependent Child(ren)
	$100 per day	$100 per day	$100 per day

DEFINITIONS

As used in this Certificate, the terms listed below will have the meanings set forth below. Other terms may be defined where they are used. When defined terms are used in this Certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Accident means an act or event which:
- is unforeseen, unexpected and unanticipated;
- is definite as to time and place;
- is not a Sickness; and
- occurs while insurance is in effect under this Certificate.

The term Accident includes unavoidable exposure to the elements if such exposure was a direct result of an Accident.

Accidental or **Accidentally** means happening by Accident.

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:
- the Group Policyholder's place of business;
- an alternate place approved by the Group Policyholder; or
- a place to which the Group Policyholder's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Group Policyholder approved vacations, holidays or temporary business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Certificate means this Certificate including any riders attached to it.

Coma means a continuous state of profound unconsciousness lasting for a period of 14 or more consecutive days, characterized by the absence of purposeful response to commands, including:
- eye opening;
- verbal response; and
- motor response.

Confined or Confinement means the assignment to a bed as a resident inpatient in a Hospital (including an Intensive Care Unit of a Hospital) on the advice of a Physician or confinement in an observation area within a Hospital for a period of no less than 20 continuous hours on the advice of a Physician.

Contribution means the amount You must pay towards the total premium charged by Us for insurance under this Certificate.

Covered Person means You and, if insured under the Group Policy for the insurance described in this Certificate, Your Dependents.

Covered Surgery means any of the following procedures:
- cranial Surgery;
- skin graft to treat a burn for which the Burn Benefit was paid;
- Surgery to treat a hernia;
- thoracic cavity and abdominal pelvic cavity Surgery;
- Surgery to treat a Ruptured Disc;
- Surgery to treat torn cartilage in the knee (meniscus); or
- Surgery to treat a torn, ruptured or severed tendon, ligament or rotator cuff.

DEFINITIONS (Continued)

Dependent means Your Spouse or Domestic Partner, and/or Dependent Child. No person can be insured for Accident Insurance under the Group Policy as both an employee and a Dependent.

Dependent Child means the following:

- Your biological child, while such child is younger than the Dependent Child Age Limit;
- Your adopted child, while such child is younger than the Dependent Child Age Limit;
- Your stepchild, including a child of Your Domestic Partner, while such child is younger than the Dependent Child Age Limit;
- Your grandchild, in Your legal custody and residing with You, while such child is younger than the Dependent Child Age Limit;

- any other child while such child is under the Dependent Child Age Limit as follows: (a) a child for whom You or Your Spouse are a legal guardian, (b) Your or Your Spouse's foster child, (c) a child for whom You or Your Spouse are chiefly responsible to provide support, (d) a child who resides with You as a regular member of Your household, (e) a child for whom You or Your Spouse are legally required to provide insurance, or (f) a child who was able to be claimed by You or Your Spouse as a dependent for Federal Income Tax purposes. Any other child also includes a grandchild who: (a) was able to be claimed by You or Your Spouse as a dependent for Federal Income Tax purposes, (b) resides with You, (c) is in Your or Your Spouse's custody, (d) is supported by You or Your Spouse, or (e) is a child of Your Dependent Child while the Dependent Child is under the Dependent Child Age Limit; or
- a Dependent Child who is a disabled child and whose age exceeds the Dependent Child Age Limit on the Certificate Effective Date who: (a) has been diagnosed with a developmental disability, mental illness or disorder, or physical disability, (b) is incapable of self-sustaining employment, and (c) is chiefly dependent on You or Your Spouse for support and maintenance. Coverage for a disabled child will take effect in accordance with the Eligibility Provisions: Dependent Insurance section of Your Certificate without regard to whether such child is under a Medical Restriction.

The term Dependent Child does not mean an unborn or stillborn child.

A person cannot be insured for Accident Insurance as a Dependent Child of more than one employee under the Group Policy.

Dependent Child Age Limit means:

- the end of the calendar month in which the Dependent Child reaches age 26.

Dependent Insurance means insurance under this Certificate for Your Dependents.

Dismemberment means any of the following:

- Loss of an arm: the arm is permanently severed at or above the elbow.
- Loss of a hand: the hand is permanently severed at or above the wrist joint.
- Loss of a finger: the finger is permanently severed at the joint proximate to the first interphalangeal joint where it is attached to the hand.
- Loss of a foot: the foot is permanently severed at or above the ankle joint.
- Loss of a leg: the leg is permanently severed at or above the knee.
- Loss of a toe: the toe is permanently severed at the joint proximate to the first interphalangeal joint where it is attached to the foot.

Domestic Partner means each of two people, one of whom is You, who:

1. have registered as each other's domestic partner or civil union partner with a government agency where such registration is available; or
2. are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
   - 18 years of age or older;
   - unmarried;
   - the sole domestic partner of the other;
   - sharing a Primary Residence with the other; and
   - not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

   A Domestic Partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and Signed by You.

Emergency Room means an area within a Hospital that is dedicated to the provision of emergency care. This area must:

- be staffed and equipped to handle trauma;
- be supervised and provide treatment by Physicians; and
- provide care seven days per week, 24 hours per day.

Full-Time means Active Work on the Group Policyholder's regular work schedule for the class of employees to which You belong. The work schedule must be at least 30 hours per week.

Group Policy means the policy of insurance issued by Us to the Group Policyholder under which this Certificate is issued.

Group Policyholder means Lumen Technologies.

Hospital means a short-term, acute care, general facility which:
- is primarily engaged in providing, by or under the continuous supervision of Physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine;
- has facilities for major Surgery either on its premises or through contractual arrangement with another Hospital;
- has a requirement that every patient must be under the care of a Physician or dentist;
- provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- is duly licensed by the agency responsible for licensing such Hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitative care.

Injury means any bodily harm:
- that results directly from an Accident; and
- is not specifically excluded as set forth in the section titled Accident - Exclusions.

Intensive Care Unit or **ICU** means a place which:
- is a specifically dedicated area of a Hospital that is restricted to patients who are critically ill or injured and who require intensive, comprehensive monitoring and care;
- is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
- is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- is under close observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis; and
- has a Physician assigned to the intensive care unit on a full-time basis.

The term Intensive Care Unit includes Hospital units with the following names: Intensive Care Unit; Coronary Care Unit; Neonatal Intensive Care Unit; Pulmonary Care Unit; Burn Unit; or Transplant Unit.

Medical Restriction means a person is:
- restricted to the person's home under a Physician's care;
- receiving or applying to receive disability benefits from any source;
- an inpatient in a Hospital;
- receiving care in a hospice facility, an intermediate care facility or a long-term care facility; or
- receiving chemotherapy, radiation therapy or dialysis.

Other Outpatient Surgery means Surgery performed on an outpatient basis, other than a Surgery for which the Surgery Benefit is payable.

Outpatient Surgery Facility means a facility mainly engaged in performing outpatient Surgery. It must:
- be accredited as an ambulatory surgery facility by either the Joint Commission or the Accreditation Association for Ambulatory Care;
- be approved as an ambulatory Surgery facility by Medicare; or
- meet all of the following criteria:
  - maintains all appropriate licensing for a facility that provides ambulatory Surgery;
  - is staffed by Physicians and nurses, under the supervision of a Physician;
  - has permanent operating and recovery rooms;
  - is staffed and equipped to provide emergency care; and
  - has written back-up arrangements with a local Hospital for emergency care.

Physician means:
- a person licensed to practice medicine and prescribe and administer drugs or to perform Surgery in the jurisdiction where such services are performed; or
- a medical practitioner who is licensed to provide a service for which a benefit is payable under this Certificate, according to the laws and regulations of the jurisdiction where such service is performed, and who is acting within the scope of such license.

The term Physician does not include:
- You;
- Your Spouse or Domestic Partner or anyone to whom You are related by blood or marriage;
- anyone with whom You are residing;
- Your adopted or stepchild;
- anyone with whom You share a business interest; or
- Your employee.

Primary Residence means the dwelling where a person lives for the majority of the time, whether the person owns or rents the dwelling.

Proof means Written evidence satisfactory to Us that a claimant has satisfied the conditions and requirements for any benefit described in this Certificate. When a claim is made for any benefit described in this Certificate, Proof must establish:
- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Except as provided in the Examinations and Autopsy provisions of this Certificate, Proof must be provided at the claimant's expense.

Rehabilitation Facility means a facility that:
- provides rehabilitation care services on an inpatient basis; and
- maintains all required licenses and certifications.

Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by an Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of an organized staff of Physicians.

The term Rehabilitation Facility does not include:
- a nursing home;
- an extended care facility, unless the Covered Person is receiving rehabilitation care services on an inpatient basis at the extended care facility;
- a Skilled Nursing Facility, unless the Covered Person is receiving rehabilitation care services on an inpatient basis at the facility;
- a rest home or home for the aged;
- a hospice care facility;
- a place for alcoholics or drug addicts; or
- an assisted living facility.

Ruptured Disc means a tear in the spinal disc capsule. It does not include a bulging disc.

Schedule means the Schedule of Insurance that appears in this Certificate, and the Covered Person Specifications page.

Sickness means:
- a physical illness, physical infirmity or physical disease;
- pregnancy; or
- infection, but not an infection received through an Accidental cut or wound.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record. The signature may be transmitted by paper or electronic media, provided it is consistent with applicable law.

Skilled Nursing Facility means a facility that provides skilled, intermediate or custodial care that meets all of the following requirements:
- if licensing or certification is required, maintains all appropriate licensing or certification under the laws where it is located as a skilled or intermediate nursing facility;
- has 24 hour a day nursing care provided by any of the following who is licensed under the laws where the services are performed: a registered professional nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.);
- has 24 hour a day care performed by an awake, and trained or certified staff supervised by a nurse who is an R.N, L.P.N. or L.V.N.;
- keeps a Written record of services performed for each client;
- has established procedures to obtain emergency medical care; and
- services are not limited to provision of food, shelter, and other residential services such as laundry.

Spouse means Your lawful spouse.

Surgery means a procedure performed by a Physician involving an incision of the Covered Person's skin or tissue that, in and of itself, is intended to be curative, palliative or exploratory.

Urgent Care Facility means a health care facility:

- that is separate from a Hospital or a separate unit within a Hospital; and
- the primary purpose of which is the offering and provision of immediate, short-term medical care, for urgent care.

United States means the United States of America, its territories and its possessions.

We, Us and **Our** mean Metropolitan Life Insurance Company.

Write, Written or **Writing** means a record that may be transmitted by paper or electronic media, and that is consistent with applicable law.

You and **Your** means an employee who is insured under the Group Policy for the insurance described in this Certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS

CLASS 1

All Active Full-Time Employees

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the Accident Insurance available for Your eligible class.

If You are in an eligible class on the date insurance becomes available for the class, You will be eligible for insurance on the date You complete any applicable eligibility waiting period set by the Group Policyholder.

If you enter an eligible class after the date insurance becomes available to members of that class, You will be eligible for insurance on the date You complete any applicable eligibility waiting period set by the Group Policyholder.

ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing the required form. You must also provide Written permission to deduct Contributions from Your pay for such insurance, if You are required to make such Contributions.

DATE YOUR INSURANCE TAKES EFFECT

Provided that You are Actively at Work in an eligible class, insurance under this Certificate will take effect for You on the Certificate effective date. If You are not Actively at Work in an eligible class on the date insurance would otherwise take effect, insurance will take effect on the date You return to Active Work in an eligible class.

BENEFIT CHANGES

Once Your insurance takes effect, You may only change Your benefits in accordance with the options available through the Group Policyholder. Please contact Us or the Group Policyholder for more information.

If You are not Actively at Work in an eligible class on the date an increase in benefits would otherwise take effect, the increase will not take effect until You return to Active Work in a class that is eligible for the increase.

ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE

ELIGIBLE CLASS FOR DEPENDENT INSURANCE

All Class 1 employees of the Group Policyholder as specified in the Eligibility Provisions: Insurance For You section of this Certificate are eligible for Dependent Insurance.

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

If You are in a class of employees who are eligible for Dependent Insurance on the date Your insurance takes effect, You will be eligible for Dependent Insurance on the later of the following:

- the date Your insurance takes effect; and
- the date an individual becomes Your first Dependent.

If You enter a class of employees who are eligible for Dependent Insurance after the date Your insurance takes effect, You will be eligible for Dependent Insurance on the later of the following:

- the date You enter a class eligible for Dependent Insurance; and
- the date an individual becomes Your first Dependent.

ENROLLMENT PROCESS

If You become eligible for Dependent Insurance, You may enroll for such insurance by providing Us with any information We require for each Dependent to be insured. You must also provide Written permission to deduct Contributions from Your pay for Dependent Insurance, if You are required to make such Contributions.

DATE DEPENDENT INSURANCE TAKES EFFECT

Newborn Children

A Dependent Child born to You while insurance is in effect under the Certificate will be covered:

- from the moment of birth and does not need to be enrolled if Dependent Insurance is already in effect for at least one other Dependent Child; or
- for 60 days from the moment of birth if Dependent Insurance is not already in effect for at least one other Dependent Child. To continue coverage beyond the first 60 days You must notify Us of the child's birth and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the newborn child.

The effective date of insurance for a newborn child will be determined without regard to whether the child is under a Medical Restriction.

ELIGIBILITY PROVISIONS: DEPENDENT INSURANCE (Continued)

Adopted Children

A Dependent Child adopted by You or Placed for Adoption with You while insurance is in effect under the Certificate will be covered:

- from the moment of birth if Placement for Adoption or adoption occurs within 60 days after the child's birth; or
- from the date of adoption or Placement for Adoption if the child is adopted by You or Placed for Adoption with You more than 60 days after the child's birth.

The child does not need to be enrolled if Dependent Coverage is already in effect for at least one other Dependent Child. If Dependent Coverage is not already in effect for at least one other Dependent Child, then to continue the child's coverage beyond the first 60 days of coverage, You must notify Us of the child's adoption or Placement for Adoption and give Written permission to deduct Contributions from Your pay for Dependent Insurance for the adopted child. You must do this within 60 days of the date the child is adopted by You or Placed for Adoption with You. Coverage will continue unless the child's placement is disrupted prior to legal adoption.

The effective date of insurance for a newly adopted child will be determined without regard to whether the child is under a Medical Restriction.

Placed for Adoption or **Placement for Adoption** means

- the assumption and retention by You of a legal obligation for total or partial support of a child in anticipation of Your adoption of the child; or
- a child placed in Your home following execution of an act of voluntary surrender in favor of You or Your legal representative.

Other Dependents

Dependent Insurance for a Dependent who is not under a Medical Restriction will take effect on the later of:

- the date You are enrolled for Dependent Insurance for such Dependent; or
- the date a person becomes Your Dependent.

If a Dependent is under a Medical Restriction on the date insurance for such Dependent would otherwise take effect, insurance for the Dependent will take effect on the date the Dependent is no longer under a Medical Restriction.

PARALYSIS BENEFITS

Payment of the Paralysis Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

PARALYSIS BENEFIT

If a Covered Person sustains an Injury that is Paralysis, We will pay the Paralysis Benefit shown in the Schedule that applies to the type of Paralysis that the Covered Person sustained, subject to all of the following:

- Paralysis must be documented by a Physician within 180 days after the Accident occurs.
- If a Covered Person sustains an Injury that is Paralysis that falls under more than one classification on the Schedule, We will only pay the benefit that applies to the classification that pays the highest benefit.
- We will pay the Paralysis Benefit no more than one time per Covered Person, per Accident.

Paralysis means the permanent total and irrecoverable loss of movement of 2 or more limbs:

- that has lasted for a continuous period of not less than 90 days as confirmed by a Physician; or
- as a result of transected spinal cord with supporting clinical and radiological evidence and no expectation of return to function.

The term Paralysis does not include a Dismemberment or Coma.

ACCIDENTAL INJURY BENEFITS

Payment of the Accidental Injury Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

FRACTURE BENEFIT

If a Covered Person sustains an Injury that is a Fracture, We will pay the Fracture Benefit, shown in the Schedule that is applicable to the type of Fracture sustained by the Covered Person, subject to all of the following:

- The Injury must be diagnosed and treated as a Fracture by a Physician within 180 days after the Accident occurs.
- The Fracture must require, and be corrected by, open (surgical) or closed (non-surgical) reduction by a Physician. Closed reduction includes immobilization.
- We will pay no more than one Fracture Benefit per bone, per Accident.
- If more than one bone is Fractured in a single Accident, the amount We will pay for all Fractures combined will be no more than 2 times the highest Fracture Benefit that would otherwise be payable for any one of the bones involved.
- If an Injury is a Chip Fracture, We will pay the Chip Fracture Benefit instead of the Fracture Benefit. The Chip Fracture Benefit will be 25% of the Fracture Benefit shown in the Schedule for the bone involved.
- If the same Fracture is treated with both open reduction and closed reduction, We will pay no more than the Fracture Benefit payable for the open reduction.

Fracture means a break in a bone of a body part that is listed on the Schedule under Fracture Benefit, which can be detected by an x-ray or a similar diagnostic exam.

Chip Fracture means a Fracture in which a small fragment of the bone is broken off.

DISLOCATION BENEFIT

If a Covered Person sustains an Injury that is a Dislocation, We will pay the Dislocation Benefit, shown in the Schedule, that is applicable to the type of Dislocation the Covered Person sustained, subject to all of the following:

- The Injury must be diagnosed and treated as a Dislocation by a Physician within 180 days after the Accident occurs.
- The Dislocation must require, and be corrected by, open (surgical) or closed (non-surgical) reduction by a Physician.
- If more than one joint is Dislocated in a single Accident, the amount We will pay for all Dislocations combined will be no more than 2 times the highest Dislocation Benefit that would otherwise be payable for any one of the joints involved.
- The Partial Dislocation Benefit will be 25% of the Dislocation Benefit shown in the Schedule for a Full Dislocation of the joint involved.
- If a Partial Dislocation Benefit was paid, or becomes payable, and the Covered Person subsequently sustains an Injury that is a Full Dislocation, We will reduce what We pay for the Full Dislocation by the amount that was paid, or is payable, for the Partial Dislocation.
- For each joint, We will pay no more than one Full Dislocation Benefit amount for all Injuries combined that are Dislocations of that same joint, regardless of whether the Injuries are sustained in the same Accident. Once the Covered Person has received an amount equal to one Full Dislocation Benefit for a joint, no further Dislocation Benefits will be paid for that same joint, even if the Covered Person subsequently sustains an Injury that is a Dislocation of that same joint in a new Accident.
- We will only pay benefits for those Dislocations specifically listed in the Schedule.

Dislocation means a separated joint of a body part that is listed on the Schedule under Dislocation Benefit. The term Dislocation does not include vertebral subluxation complex (misaligned vertebrae).

Full Dislocation means a Dislocation in which the joint is completely separated.

Partial Dislocation means a Dislocation in which the joint is not completely separated.

ACCIDENTAL INJURY BENEFITS (Continued)

BURN BENEFIT

If a Covered Person sustains an Injury that is a second or third degree burn, We will pay the Burn Benefit, shown in the Schedule, that is applicable to the size and severity of the burn, subject to all of the following:

- The burn must be treated by a Physician within 96 hours after the Accident occurs.
- If a burn meets more than one of the burn classifications shown in the Schedule, the amount We pay will be based on the classification of the burn that pays the highest benefit.
- We will pay the Burn Benefit no more than one time per Covered Person, per Accident.
- No benefit is payable for a first degree burn.

CONCUSSION BENEFIT

If a Covered Person sustains an Injury that is a concussion, We will pay the Concussion Benefit shown in the Schedule, subject to all of the following:

- The Injury must be diagnosed as a concussion by a Physician within 96 hours after the Accident occurs.
- We will pay the Concussion Benefit no more than 1 time per Covered Person, per calendar year.

COMA BENEFIT

If a Covered Person sustains an Injury that is a Coma or results in the Covered Person being placed in a medically induced Coma, We will pay the Coma Benefit shown in the Schedule, subject to all of the following:

- The Coma must begin within 180 days after the Accident occurs.
- We will pay the Coma Benefit no more than 1 time per Covered Person, per Accident.

LACERATION BENEFIT

If a Covered Person sustains an Injury that is a Laceration and receives treatment from a Physician to repair it, We will pay the Laceration Benefit, shown in the Schedule, that is applicable to the length of the Laceration and the treatment received as follows:

- if the Laceration is repaired with stitches, We will pay the Laceration Benefit repaired with stitches; or
- if the Laceration is not repaired with stitches, We will pay the Laceration Benefit repaired without stitches.

Payment of the Laceration Benefit is subject to all of the following:

- The Laceration must be treated by a Physician within 96 hours after the Accident occurs.
- A Laceration repaired with sutures or staples will be deemed to be a Laceration repaired with stitches for purposes of this Laceration Benefit.
- If the Covered Person has more than one Laceration, the amount We pay will be based on the total length of all Lacerations received in any one Accident that are repaired with stitches. If some, but not all, of the Lacerations require repair with stitches, We will not pay any benefit for the Laceration or Lacerations that are repaired without stitches.
- We will pay the Laceration Benefit no more than:
  - one time per Covered Person, per Accident; and
  - no more than 3 times per Covered Person, per calendar year.

Laceration means a cut.

ACCIDENTAL INJURY BENEFITS (Continued)

BROKEN TOOTH BENEFIT

If a Covered Person sustains an Injury that is a broken tooth and the tooth is repaired by a dental crown or filling, or is extracted, We will pay the Broken Tooth Benefit, shown in the Schedule, that is applicable to the dental crown, filling and/or extraction, subject to all of the following:

- No benefit will be payable for an Injury to a tooth that is not a sound, natural tooth.
- No benefit will be payable for an Injury caused by biting or chewing.
- The dental services must begin within 180 days after the Accident occurs.
- Regardless of the number of teeth involved, We will pay the Broken Tooth Benefit for no more than 1 dental crown, no more than 1 dental filling, and no more than 1 dental extraction per Covered Person, per Accident.

EYE INJURY BENEFIT

If a Covered Person sustains an Injury to an eye, We will pay the Eye Injury Benefit shown in the Schedule, subject to all of the following:

- The Injury to the eye must require Surgery or the removal of a foreign object by a Physician within 180 days after the Accident occurs.
- We will pay the Eye Injury Benefit no more than 1 time per Covered Person, per Accident.

ACCIDENT - MEDICAL TREATMENT & SERVICES BENEFITS

Payment of the Accident – Medical Treatment and Services Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

AIR AMBULANCE BENEFIT

We will pay the Air Ambulance Benefit shown in the Schedule if a licensed professional air ambulance service is required to transport a Covered Person by air to or from a Hospital or between medical facilities, where treatment for an Injury is received, subject to both of the following:

- The air ambulance transportation must be within 90 days after the Accident occurs.
- We will pay the Air Ambulance Benefit no more than 1 time per Covered Person, per Accident.

GROUND AMBULANCE BENEFIT

We will pay the Ground Ambulance Benefit shown in the Schedule if a licensed professional ambulance service is required to transport a Covered Person by ground to or from a Hospital or between medical facilities, where treatment for an Injury is received, subject to both of the following:

- The ambulance transportation must be within 90 days after the Accident occurs.
- We will pay the Ground Ambulance Benefit no more than 1 time per Covered Person, per Accident.

EMERGENCY CARE BENEFIT OR NON-EMERGENCY INITIAL CARE BENEFIT

If a Covered Person sustains an Injury and receives initial care from a Physician for the Injury in an Emergency Room, a Physician's office or an Urgent Care Facility, within 96 hours after the Accident occurs, We will pay the Emergency Care Benefit, shown in the Schedule that is applicable to the place where care is received.

If a Covered Person sustains an Injury and receives initial care from a Physician for the Injury in an Emergency Room, a Physician's office or an Urgent Care Facility, more than 96 hours but less than 180 days after the Accident occurs, We will pay the Non-Emergency Initial Care Benefit shown in the Schedule.

Payment of the Emergency Care Benefit and the Non-Emergency Initial Care Benefit is subject to both of the following:

- We will never pay both the Emergency Care Benefit and the Non-Emergency Care Benefit for the same Covered Person, for the same Accident.
- If We pay either the Emergency Care Benefit or the Non-Emergency Initial Care Benefit, We will pay the benefit no more than 1 time per Covered Person, per Accident.

MEDICAL TESTING BENEFIT

If a Covered Person sustains an Injury and receives any of the following medical tests to evaluate the Injury, We will pay the Medical Testing Benefit shown in the Schedule:

- x-rays;
- magnetic resonance imaging (MRI) or magnetic resonance (MR);
- ultrasound;
- nerve conduction velocity test (NCV);
- computed tomography scan (CT) or computed axial tomography (CAT); or
- electroencephalogram (EEG).

Payment of the Medical Testing Benefit is subject to all of the following:

- The test must be ordered by a Physician and be performed within 180 days after the Accident occurs.
- We will pay the Medical Testing Benefit no more than 2 times per Covered Person, per Accident.

PHYSICIAN FOLLOW-UP VISIT BENEFIT

If a Covered Person sustains an Injury and receives follow-up care, for the Injury, that is recommended by a Physician or is a second opinion, We will pay the Physician Follow-Up Visit Benefit shown in the Schedule, subject to all of the following:

- Treatment must:
  - begin within 180 days after the Accident occurs and be provided within 365 days after the Accident occurs;
  - be specific to the Injury;
  - occur on an outpatient basis in a Physician's office, an Urgent Care Facility or a Hospital; and
  - not be for routine examinations, preventive testing, or any treatment for which a benefit is payable under the Therapy Services Benefit, Emergency Care Benefit or Non-Emergency Initial Care Benefit, or Health Screening Benefit.
- We will pay the Physician Follow-Up Visit Benefit no more than:
  - 2 times per Covered Person, per Accident; and
  - 6 times per Covered Person, per calendar year.

TRANSPORTATION BENEFIT

We will pay the Transportation Benefit shown in the Schedule when a Covered Person travels more than 50 miles one way for follow-up treatment of an Injury for which We pay a benefit under this Certificate, at a Hospital or other treatment facility, subject to all of the following:

- Mileage is measured from the Covered Person’s Primary Residence to the facility where the follow-up treatment is provided.
- The follow-up treatment must be prescribed by a Physician and not available within 50 miles of the Covered Person’s Primary Residence.
- You must submit Proof that the follow-up treatment was provided.
- We will not pay the Transportation Benefit if the Ground Ambulance Benefit or Air Ambulance Benefit is payable for the trip.
- We will pay the Transportation Benefit no more than:
  - 1 time per Covered Person, per Accident; and
  - 2 times per Covered Person, per calendar year.

THERAPY SERVICES BENEFIT

If a Covered Person sustains an Injury and receives Therapy Services, We will pay the Therapy Services Benefit shown in the Schedule that applies to the type of Therapy Service received, subject to all of the following:

- Therapy Services must:
  - begin within 180 days after the Accident occurs and be provided within 365 days after the Accident occurs;
  - be provided on an outpatient basis;
  - be prescribed by a Physician; and
  - be provided by a practitioner licensed to provide the type of Therapy Services provided and operating within the scope of such license.
- We will pay the Therapy Services Benefit for Therapy Services received no more than 10 times per Covered Person, per Accident.
- We will not pay a Therapy Services Benefit for Therapy Services received by the Covered Person on the same day for which the Inpatient Rehabilitation Benefit is payable.

Therapy Services means any of the following:

- cognitive behavioral therapy;
- occupational therapy;
- physical therapy;
- respiratory therapy;
- speech therapy;
- vocational therapy;
- acupuncture; or
- chiropractic therapy.

PAIN MANAGEMENT BENEFIT (FOR EPIDURAL ANESTHESIA)

If a Covered Person sustains an Injury and receives epidural anesthesia to manage the pain from the Injury, We will pay the Pain Management Benefit shown in the Schedule, subject to all of the following:

- The epidural anesthesia must be administered within 180 days after the Accident occurs.
- Epidural anesthesia to manage the pain from the Injury must be prescribed by a Physician.
- We will pay the Pain Management Benefit no more than 1 time per Covered Person, per Accident.

PROSTHETIC DEVICE BENEFIT

If a Covered Person sustains an Injury that is a loss of a limb, hand, foot or sight in an eye and receives a Prosthetic Device as a result of the loss, We will pay the Prosthetic Device Benefit, shown in the Schedule, that is applicable to the number of Prosthetic Devices the Covered Person receives, subject to all of the following:

- The Prosthetic Device must be received within 365 days after the Accident occurs.
- No benefit will be payable for replacement of a Prosthetic Device.
- No benefit will be payable for more than one Prosthetic Device for the same body part.
- We will not pay the Prosthetic Device Benefit for a joint replacement such as an artificial hip or knee.
- We will pay the Prosthetic Device Benefit no more than 1 time per Covered Person, per Accident.

Prosthetic Device means an artificial device that replaces a missing body part. The term Prosthetic Device does not include hearing aids, dental aids (including false teeth), eyeglasses, or cosmetic prostheses such as wigs.

MEDICAL APPLIANCE BENEFIT

If a Covered Person sustains an Injury for which a Physician prescribes the use of a Medical Appliance as an aid in personal locomotion or mobility, We will pay the Medical Appliance Benefit, shown in the Schedule, for the type of Medical Appliance that the Physician prescribes, subject to all of the following:

- The use of such Medical Appliance must begin within 180 days after the Accident occurs.
- The amount We will pay for all Medical Appliances combined, per Covered Person, per Accident, will be no more than the Medical Appliances Benefit Limit shown in the Schedule.
- We will not pay the Medical Appliance Benefit for the replacement of a Medical Appliance.

Medical Appliance means any of the following:

- brace for the neck, back or leg;
- cane;
- crutches;
- walker;
- walking boot that extends above the ankle;
- wheelchair or motorized scooter for medical purposes; and
- any other medical device used for mobility.

MODIFICATION BENEFIT

If a Covered Person sustains an Injury for which We paid a Paralysis Benefit under this Certificate, We will pay the Modification Benefit shown in the Schedule for modifications made to the Covered Person's Primary Residence or vehicle, subject to all of the following:

- A Physician must certify that because of the Injury, the modification is necessary to help enable the Covered Person to live in his or her Primary Residence or travel in his or her primary vehicle.
- The modification must be made within 365 days after the Accident occurs.
- We will pay the Modification Benefit no more than 1 time per Covered Person, per Accident.

BLOOD / PLASMA / PLATELETS BENEFIT

If a Covered Person sustains an Injury for which the Covered Person receives a transfusion of blood, plasma or platelets, We will pay the Blood/Plasma/Platelets Benefit shown in the Schedule, subject to all of the following:

- The blood, plasma or platelets must be prescribed by a Physician on an emergency basis or provided while the Covered Person is undergoing Surgery and must be administered within 180 days after the Accident.
- We will pay the Blood/Plasma/Platelets Benefit no more than 1 time per Covered Person, per Accident.

ACCIDENT – MEDICAL TREATMENT & SERVICES BENEFITS (Continued)

SURGERY BENEFITS

If a Covered Person undergoes Covered Surgery to treat an Injury, while Confined or in an Outpatient Surgery Facility, We will pay the applicable benefit shown in the Schedule under Surgery Benefits, for the type of Covered Surgery the Covered Person undergoes, subject to all of the following:

- The Covered Person must be treated by a Physician for the Injury within 180 days after the Accident occurs.
- The Covered Surgery must be performed by a Physician within 365 days after the Accident occurs.
- If the Covered Surgery is performed with repair, We will pay the Surgical Repair Benefit shown in the Schedule for the applicable procedure.
- If the Covered Surgery performed is Exploratory Surgery, We will pay the Exploratory Surgery Benefit shown in the Schedule.
- If as a result of the same Accident, the Covered Person has more than one Covered Surgery performed at the same time, We will only pay a benefit for one Covered Surgery, which will be the Covered Surgery with the highest benefit amount.
- If as a result of the same Accident, the Covered Person has a Covered Surgery and an Other Outpatient Surgery performed at the same time, We will only pay one benefit which will be the benefit that pays the higher amount.
- We will pay Surgery Benefits no more than 1 time per Covered Person, per Accident.

Exploratory Surgery means a Covered Surgery performed without surgical repair. For Surgery to treat torn cartilage in the knee, if cartilage is shaved or trimmed from the knee, the Surgery will be considered Exploratory Surgery and not a Surgery with repair.

OTHER OUTPATIENT SURGERY BENEFIT

If a Covered Person sustains an Injury and undergoes Other Outpatient Surgery to treat the Injury in an Outpatient Surgery Facility, We will pay the Other Outpatient Surgery Benefit shown in the Schedule, subject to all of the following:

- The Covered Person must be treated by a Physician for the Injury within 180 days after the Accident occurs.
- The Surgery must be performed by a Physician in an Outpatient Surgery Facility within 365 days after the Accident occurs.
- If as a result of the same Accident, the Covered Person has a Covered Surgery and an Other Outpatient Surgery performed at the same time, We will only pay one benefit which will be the benefit that pays the higher amount.
- We will pay the Other Outpatient Surgery Benefit no more than 1 time per Covered Person, per Accident.

HOSPITAL BENEFITS

Payment of the Hospital Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

ACCIDENT – HOSPITAL ADMISSION BENEFITS

Admission Benefit

If a Covered Person is admitted to a Hospital for treatment of an Injury, We will pay the Admission Benefit shown in the Schedule, for the day of admission, subject to all of the following:

- The admission must occur within 180 days after the Accident occurs.
- The Admission Benefit is not payable for Emergency Room treatment, outpatient treatment, or a stay of less than 20 hours in an observation area.
- We will only pay the Admission Benefit for a Covered Person for one Hospital admission at a time, even if the admission is caused by more than one Accident and/or Injury.
- We will pay the Admission Benefit no more than 1 time per Covered Person, per Accident.

ICU Supplemental Admission Benefit

If a Covered Person, upon initial admission to a Hospital for treatment of an Injury, is admitted to an ICU, We will pay the ICU Supplemental Admission Benefit shown in the Schedule, in addition to the Admission Benefit, if the admission meets the requirements for payment of the Admission Benefit, subject to both of the following additional requirements:

- The admission must occur within 180 days after the Accident occurs.
- If the Covered Person moves to an ICU after initial admission to a Hospital, We will not pay the ICU Supplemental Admission Benefit.

ACCIDENT - HOSPITAL CONFINEMENT BENEFITS

Confinement Benefit

If a Covered Person is Confined in a Hospital for treatment of an Injury, We will pay the Confinement Benefit shown in the Schedule for each day, after the day of admission to the Hospital, the Covered Person is Confined in the Hospital, subject to all of the following:

- The initial Confinement must begin within 180 days after the Accident occurs.
- The Confinement Benefit is payable for up to 15 days per Covered Person, per Accident, and may be used over a two-year period following the date of the Accident.
- We will only pay the Confinement Benefit for a Covered Person for one Hospital Confinement at a time, even if the Confinement is caused by more than one Accident and/or Injury.
- We will only pay one Confinement Benefit per day.

ICU Supplemental Confinement Benefit

If a Covered Person is Confined in a Hospital for treatment of an Injury, We will pay the ICU Supplemental Confinement Benefit shown in the Schedule in addition to the Confinement Benefit, for each day the Covered Person is Confined in an Intensive Care Unit and meets the requirements for payment of the Confinement Benefit, subject to both of the following additional requirements:

- Confinement in the Intensive Care Unit must begin within 180 days after the Accident occurs.
- The ICU Supplemental Confinement Benefit is payable for up to 15 days per Covered Person, per Accident.

INPATIENT REHABILITATION BENEFIT

If a Covered Person is transferred to a Rehabilitation Facility immediately after a period of Confinement for treatment of an Injury for which We paid an Admission Benefit or Confinement Benefit, We will pay the Inpatient Rehabilitation Benefit shown in the Schedule, subject to all of the following:

- We will pay the Inpatient Rehabilitation Benefit for each day of the Covered Person's continuous stay as a resident inpatient in a Rehabilitation Facility, up to a maximum stay of 15 days per Covered Person, per Accident but not to exceed 30 days per calendar year.
- The Covered Person's inpatient stay in the Rehabilitation Facility must start within 365 days after the Accident.
- After the Covered Person is discharged from the Rehabilitation Facility, We will not pay the Inpatient Rehabilitation Benefit for a subsequent admission to a Rehabilitation Facility for treatment of the same Injury for which We already paid the Inpatient Rehabilitation Benefit.
- We will not pay the Inpatient Rehabilitation Benefit for any day for which We paid a Confinement Benefit.

OTHER BENEFITS

Payment of the Other Benefits described in this section are subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

HEALTH SCREENING BENEFIT

If a Covered Person takes one of the screening/prevention measures listed below while insured under this Certificate, upon submission of Proof, We will pay the Health Screening Benefit shown in the Schedule for the day that the measure is taken, subject to all of the following:

- We will only pay the Health Screening Benefit 1 time per Covered Person, per calendar year.
- We will not pay a Health Screening Benefit for a screening/prevention measure if benefits are paid or payable for that same screening/prevention measure under another section of this Certificate.

The screening/prevention measures for which a Health Screening Benefit may be paid are:

- routine health check-up exam
- biopsies for cancer
- blood chemistry panel
- blood test to determine total cholesterol
- blood test to determine triglycerides
- bone marrow testing
- breast MRI
- breast ultrasound
- breast sonogram
- cancer antigen 15-3 blood test for breast cancer (CA 15-3)
- cancer antigen 125 blood test for ovarian cancer (CA 125)
- carcinoembryonic antigen blood test for colon cancer (CEA)
- carotid doppler
- chest x-rays
- clinical testicular exam
- colonoscopy
- complete blood count (CBC)
- dental exam
- digital rectal exam (DRE)
- Doppler screening for cancer
- Doppler screening for peripheral vascular disease
- echocardiogram
- electrocardiogram (EKG)
- electroencephalogram (EEG)
- endoscopy
- eye exam
- fasting blood glucose test
- fasting plasma glucose test
- flexible sigmoidoscopy
- hearing test
- hemoccult stool specimen
- hemoglobin A1C
- human papillomavirus (HPV) vaccination
- immunization
- lipid panel

- mammogram
- oral cancer screening
- pap smears or thin prep pap test
- prostate-specific antigen (PSA) test
- serum cholesterol test to determine LDL and HDL levels
- serum protein electrophoresis
- skin cancer biopsy
- skin cancer screening
- skin exam
- stress test on bicycle or treadmill
- successful completion of smoking cessation program
- tests for sexually transmitted infections (STIs)
- thermography
- two hour post-load plasma glucose test
- ultrasounds for cancer detection
- ultrasound screening of the abdominal aorta for abdominal aortic aneurysms
- virtual colonoscopy
- coronavirus testing

LODGING BENEFIT

If a Covered Person is Confined in a Hospital for treatment of an Injury, and a companion who accompanies the Covered Person while the Covered Person is so Confined stays in a Lodging for which a charge is made, We will pay the Lodging Benefit shown in the Schedule subject to all of the following:

- We will pay the Lodging Benefit for each day the companion stays in a Lodging while the Covered Person is Confined in a Hospital for treatment of an Injury.
- We will pay the Lodging Benefit for up to 15 days per Covered Person per calendar year.
- The Lodging Benefit is only payable for a day for which We are paying a Hospital Admission or Confinement Benefit for a Covered Person.
- You must submit Proof that the companion incurred an expense for staying at a Lodging for each day of the stay.

Lodging means an establishment licensed under the laws where it is located, such as a motel, hotel, or other facility that provides sleeping accommodations to the general public in exchange for a fee and is located at least 50 miles from the Covered Person’s Primary Residence.

EXCLUSIONS

We will not pay benefits for any loss for a Covered Person caused by the Covered Person's Sickness, or the diagnosis or treatment of such Sickness, except for the Covered Person's use of:

- any drug, medication or sedative that is taken or used as prescribed by a Physician; or
- an "over the counter" drug, medication or sedative taken as directed.

We will not pay benefits for any loss for a Covered Person caused or contributed to by:

- the Covered Person's voluntary use, by any means, of:
  - any drug, medication or sedative, unless it is:
    - taken or used as prescribed by a Physician; or
    - an "over the counter" drug, medication or sedative taken as directed;
  - alcohol in combination with any drug, medication, or sedative; or
  - poison, gas, or fumes;
- the Covered Person's suicide or attempted suicide (while sane or insane);
- the Covered Person's intentionally self-inflicted injury;
- war, whether declared or undeclared; or act of war;
- the Covered Person's active participation in an insurrection, rebellion, riot, or terrorist act;
- the Covered Person's engagement in any activity that constitutes a felony under the laws of the jurisdiction in which the activity occurred;
- the Covered Person's infection, other than infection occurring in an external wound resulting from an Injury;
- food poisoning;
- the Covered Person's operation, while intoxicated, of a motor vehicle involved in the incident. For purposes of this exclusion:
  - intoxicated means that the Insured's blood alcohol level met or exceeded .08%; and
  - motor vehicle means any vehicle that is powered by a motor, including, but not limited to: an automobile; a boat; a motorcycle; a truck; an all-terrain vehicle; or a snow mobile;
- dental or plastic Surgery for cosmetic purposes, except when such Surgery is performed to:
  - treat an Injury;
  - correct a disorder of normal bodily function or structure that was caused by an Injury for which coverage is not otherwise excluded under this Certificate; or
  - reconstruct a part of the body which was disfigured or removed as a result of an Injury for which coverage is not otherwise excluded under this Certificate;
- the Covered Person's mental illness, or the diagnosis or treatment of such mental illness, except for the Covered Person's use of:
  - any drug, medication or sedative that is taken or used as prescribed by a Physician; or
  - an "over the counter" drug, medication or sedative taken as directed;
- activities required by the Covered Person's service in the armed forces or any auxiliary unit of the armed forces of any country or international authority;
- the Covered Person's travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight;
- the Covered Person parachuting or otherwise exiting from a motorized or non-motorized aircraft while such aircraft is in flight, except for self-preservation;
- the Covered Person riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- the Covered Person participating in any semi-professional or professional competitive athletic activity for which any type of compensation or remuneration is received; or
- the Covered Person bungee jumping, base jumping, hang gliding, para-kiting, sail-gliding, scuba diving deeper than 130 feet; spelunking; or mountaineering including rock climbing using ropes and any other climbing equipment. For the purposes of this exclusion the term mountaineering does not include backpacking, mountain biking, hiking or trail running.

EXCLUSIONS (Continued)

In addition, We will not pay benefits for:

- a Covered Person while incarcerated in any type of penal or detention facility; or
- any of the following outside of the United States, Canada or Mexico:
  - any medical or healthcare treatment, services or transportation described in the Accident – Medical Treatment & Services Benefits section of this Certificate;
  - any inpatient admission or stay in any medical or health care facility.

WHEN INSURANCE ENDS

Please Note: If insurance ends under this section, in certain cases it may be continued as stated in the Continuation of Insurance section of this Certificate. Please see that section for details.

Termination of a Covered Person's insurance in accordance with this section, will be without prejudice to an existing claim.

DATE YOUR INSURANCE ENDS

Your insurance under this Certificate will end on the earliest of:
- the date the Group Policy ends;
- the date You die;
- the date insurance ends for Your class;
- the end of the period for which the last full premium has been paid for Your insurance;
- the end of the calendar month in which You notify Us that You wish to cancel Your insurance;
- the end of the calendar month in which You cease to be in an eligible class, subject to the Change in Class provision of the Eligibility Provisions: Insurance for You section; or
- the end of the calendar month in which Your employment ends.

For residents of Massachusetts:

If You are a resident of Massachusetts and Your insurance under this Certificate is ending under the above provision because Your employment has ended, instead of insurance ending on the date Your employment ends, the following timelines apply:

- If Your employment ends for any reason other than a Plant Closing or a Partial Plant Closing, Your insurance will end 31 days after the date Your employment ends. However, if during such 31 day period You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate, insurance under this Certificate will end on the date You become entitled to such other benefits.

- If Your employment ends due to a Plant Closing or a Partial Plant Closing Your insurance will end 90 days after the date Your employment ends. However, if during such 90 day period, You become entitled to benefits under another policy that are similar to the benefits provided under this Certificate insurance under this Certificate will end on the date You become entitled to such other benefits.

DATE DEPENDENT INSURANCE ENDS

A Dependent's insurance under this Certificate will end on the earliest of:
- the date Your insurance under this Certificate ends;
- the date Dependent Insurance ends under the Group Policy for all employees or for Your class;
- the end of the calendar month in which the person ceases to be a Dependent;
- the end of the calendar month in which You cease to be in a class that is eligible for Dependent Insurance;
- the end of the calendar month in which the Dependent is no longer eligible as described in the Eligible Classes for Dependent Insurance provision; or
- the end of the period for which the last full premium has been paid for insurance for the Dependent.

CHANGE IN CLASS

If there is more than one class eligible for insurance under the Group Policy, and each class has its own certificate, instead of receiving a new certificate when You move between classes, You will remain insured under this Certificate if:
- You move to a class that is eligible for Accident Insurance under the Group Policy; and
- the benefits available to Your new class are identical to the benefits available under this Certificate.

In all other cases when You move between classes, Your insurance under this Certificate will end on the date You are no longer a member of the class eligible for insurance under this Certificate.

CONTINUATION OF INSURANCE

AT YOUR OPTION: CONTINUATION WITH PREMIUM PAYMENT

If Your insurance ends under the Date Your Insurance Ends provision of this Certificate, in certain situations, it may be continued for You and Your Dependents, as described in this provision. This is referred to in this provision as "Continued Insurance". Evidence of insurability will not be required to obtain Continued Insurance. For purposes of this provision, insurance in effect under the Group Policy for which the Group Policyholder remits premium is referred to in this provision as "Group Billed Insurance".

Except as described below, Continued Insurance is subject to all of the conditions, maximums, limitations, exclusions and Proof requirements contained in the provisions of this Certificate.

Requirements for Continued Insurance

Continued Insurance will be available to You if:

- Your Group Billed Insurance ends for any reason other than:
  - non-payment of premium or Contribution; or
  - the end of the Group Policy, provided that Continued Insurance will be available to You if You do not become eligible, within 30 days after the end of the Group Policy, for accident insurance under another policy of group insurance available through the Group Policyholder;
- We receive Your completed Written request for Continued Insurance on a form approved by Us within 31 calendar days after Your Group Billed Insurance ends; and
- You pay premiums required for Continued Insurance by the due date specified in the premium notice sent to You.

Changes in Continued Insurance

You may elect to decrease Your insurance after the date that Continued Insurance goes into effect for You if a lower benefit option is available. In addition, You may end insurance for any or all of Your Dependents. Please contact Us for information. You may not increase insurance once Continued Insurance goes into effect.

Contributions for Continued Insurance

The Contribution that You must pay for Continued Insurance is the amount of Your Contribution for Your Group Billed Insurance before it ended, plus any amount of premium that the Group Policyholder paid. The Contribution that You must pay for Continued Insurance will be determined on the same basis as premium rates charged for Group Billed Insurance. We have the right to change premium rates in accordance with the terms set forth in the Group Policy. All payments for Continued Insurance must be made directly to Us by the due date specified in the premium notice We send to You.

End of Continued Insurance

Continued Insurance will end on the earliest of the following dates:

- the date You die;
- if You do not pay a Contribution that is required for Continued Insurance, the end of the period for which the last full premium has been paid for Your insurance;
- with respect to Continued Insurance for a Dependent:
  - the date Continued Insurance for You ends for any reason;
  - the end of the calendar month in which the Dependent no longer meets the definition of a Dependent; or
  - the end of the calendar month in which the Dependent is no longer eligible as described in the Eligibility Provisions: Dependent Insurance section of this Certificate.

FOR INTELLECTUALLY OR PHYSICALLY DISABLED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if that child is incapable of self-sustaining employment because of a mental or physical disability as defined by applicable law. Proof of such disability must be sent to Us within 31 days after the date the Dependent Child attains the age limit and at reasonable intervals after such date, but no more often than annually after the two year period following such Dependent Child's attainment of the limiting age.

Except as stated in the Date Dependent Insurance Ends provision of the When Insurance Ends section of this Certificate, insurance will continue while such Dependent Child:

- remains incapable of self-sustaining employment because of a mental or physical disability; and
- continues to qualify as a Dependent Child, except for the age limit.

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify under the Family and Medical Leave Act of 1993 (FMLA) or similar state laws for continuation of insurance. Please contact the Group Policyholder for information regarding the FMLA or any similar state law.

CLAIMS

NOTICE OF CLAIM

You must give Us notice of a claim under this Certificate by Writing to Us or calling Us at the toll free number shown on the face page of this Certificate within 30 days of the date of the loss.

CLAIM FORM

When We receive notice of a claim under this Certificate, We will provide You or the claimant (for a death claim) with a claim form. If We do not provide the claim form within 15 days from the date We received notice of claim, Our claim form requirements will be satisfied if We are provided with the required Proof in support of the claim.

PROOF OF LOSS

Proof must be provided to Us not later than 90 days after the date of the loss. If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible, but in no event, other than in the absence of the legal capacity of the claimant, later than 12 months from the date of the loss.

PAYMENT OF BENEFITS

When We receive the claim form and Proof, We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this Certificate and the Group Policy.

Unless You have assigned this insurance, all benefits to be paid under this Certificate will be paid to You, except as follows:

- If You are not alive to receive benefits that are payable to You, We will pay any benefits in accordance with the provision below titled Your Beneficiary.
- If You are living when benefits are to be paid to You, but You are not legally competent to claim or receive the benefits, We may pay up to $10,000 to anyone related to You by blood or marriage who We believe is entitled to payment of the benefits. If We make such a payment in good faith, We will not be liable to anyone for the amount We pay. Any remaining benefits will be paid to Your legal representative.

If benefits have been assigned, We will pay benefits in accordance with the Assignment provision of the General Provisions section.

YOUR BENEFICIARY

A beneficiary may be named by You to receive any benefit that becomes payable to You under this Certificate that You are not alive to receive.

You may request to change Your beneficiary at any time. A beneficiary change request must be made to Us in Writing. Once the request is recorded, the change will take effect as of the date You sign the request, whether or not You are living when We receive the request. The change will be subject to any legal restrictions. It will also be subject to any payment We made or action We took before We recorded the change. If You designated two or more beneficiaries and their shares are not specified, they will share the benefit payable equally.

If there is no beneficiary designated or no surviving beneficiary at Your death, We will determine the beneficiary according to the following order:

1. Your Spouse or Domestic Partner, if alive;
2. Your child(ren), if there is no surviving Spouse or Domestic Partner;
3. Your parent(s), if there is no surviving child;
4. Your sibling(s), if there is no surviving parent; or
5. Your estate, if there is no surviving sibling.

Instead of making payment in the order above, We may pay Your estate. Any payment made in good faith will discharge Our liability to the extent of such payment. If a beneficiary or a Payee is a minor or incompetent to receive payment, We will pay that person's guardian.

AUTHORIZATIONS

We may require that You provide authorization for Us to obtain medical information and any other information pertinent to Your claim.

EXAMINATIONS

During the pendency of a claim, at Our expense and as often as is reasonably necessary, We may require a Covered Person to have an independent examination by a Physician of Our choice.

During the pendency of a claim, at Our expense and as often as is reasonably necessary, We may have Our representatives conduct telephone or in-person interviews with You regarding Your claim.

AUTOPSY

At Our expense, We have the right to make a reasonable request for an autopsy and/or exhumation where permitted by law. Any such request will set forth the reasons We are requesting the autopsy or exhumation.

TIME LIMIT ON LEGAL ACTIONS

A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends three years after the date such Proof is required to be filed.

GENERAL PROVISIONS

ENTIRE CONTRACT

Your insurance is provided under a contract of group insurance with the Group Policyholder. The entire contract with the Group Policyholder is made up of the following:

- the Group Policy and its Exhibits, which include the Certificate(s);
- the Group Policyholder's application; and
- any amendments and/or endorsements to the Group Policy.

INCONTESTABILITY: STATEMENTS MADE BY YOU

Any statement made by You will be considered a representation and not a warranty. We will not use such a statement to void insurance, reduce benefits or defend a claim unless the following requirements are met:

- the statement is in a form that is in Writing;
- You have Signed the form; and
- a copy of the form has been given to You or Your beneficiary.

We will not use Your statements which relate to insurability to contest this insurance after it has been in force for 2 years, unless the statement is fraudulent. In addition, We will not use such statements to contest a benefit increase after the benefit increase has been in force for 2 years, unless such statement is fraudulent.

MISSTATEMENTS

If Your or Your Dependent's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or Contributions.

ASSIGNMENT

The benefits under the Group Policy are not assignable prior to a claim, except as required by law.

CONFORMITY WITH LAW

If the terms and provision of this Certificate do not conform to any applicable law, this Certificate shall be interpreted to so conform.

STANDARD OF TIME

All insurance becomes effective and terminates at 12:01 A.M. Eastern Standard Time, or at 12:01 A.M. Eastern Daylight Time if Daylight Savings Time is then being observed.

ACCESS TO DISCOUNTS FOR SERVICES

You will receive access to discounts for certain services, where available.

THIS IS THE END OF THE CERTIFICATE. WHAT FOLLOWS IS ADDITIONAL INFORMATION.

ERISA INFORMATION

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE LUMEN TECHNOLOGIES ACCIDENT INSURANCE BENEFITS PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR:
Lumen Technologies
100 CENTURYLINK DRIVE
MONROE, LA 71203

EMPLOYER IDENTIFICATION NUMBER: 720651161

PLAN NUMBER: 513

COVERAGE: Accident Insurance

PLAN NAME: Lumen Welfare Benefits Plan

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

MetLife is liable for any benefits under the Plan. The group policy specifies the time when and the circumstances under which MetLife is liable for Accident Insurance benefits.

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan administrator at the above address. For disputes seeking payment of benefits, service of legal process may be made upon MetLife by serving MetLife's agent designated to accept service of process.

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for benefits insured by MetLife under the Plan. It also includes a detailed description of the terms of the insurance coverage provided by MetLife under the Plan and the maximum benefits that can be paid.

PLAN TERMINATION OR CHANGES

The group policy sets forth those situations in which the Employer and/or MetLife have the right to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the insurance described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event your insurance ends in accordance with the DATE YOUR INSURANCE ENDS subsection of your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in your MetLife certificate.

CONTRIBUTIONS

You must make contributions to the cost of Accident Insurance benefits. The total premium rate for insurance provided under the Plan by MetLife is set by MetLife.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each and ending on the following .

QUALIFIED DOMESTIC RELATIONS ORDERS/QUALIFIED MEDICAL CHILD SUPPORT ORDERS

You and your beneficiaries can obtain, without charge, from the Plan Administrator a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and Qualified Medical Child Support Orders (QMCSO).

CLAIMS INFORMATION

Accident Insurance Benefits Claims

Routine Questions

If there is any question about a claim payment, an explanation may be requested from MetLife which is able to provide the necessary information.

Claim Submission

For claims for Accident Insurance benefits, the claimant must report the claim to MetLife and, if requested by MetLife, complete the appropriate claim form. Claim forms requested by MetLife must be submitted in accordance with the instructions on the claim form.

Initial Determination

After you submit a claim for Accident Insurance benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criteria was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

• Name of Employee

• Name of the Plan

• Reference to the initial decision

• An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criteria was relied upon in denying the claim on

appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The 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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

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

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 the above rights. For instance, if you request a copy of Plan documents or the latest annual report and do not receive them within 30 days, you may file suit in a

Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay 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 your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, 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, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

FUTURE OF THE PLAN

It is hoped that the Plan will be continued indefinitely, but Lumen Technologies reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of Lumen Technologies shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.