Critical Illness Insurance

Summary Plan Description (SPD) for Full-time active employees, including Qwest Term Full-time active 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 Critical Illness Insurance (Certificate of Coverage) in this Summary Plan Description (SPD). The Critical Illness Insurance benefits provided is a benefit available 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 Critical Illness Insurance benefit option on or after January 1, 2027, this SPD supersedes and replaces, in its entirety, any other SPD describing the Critical Illness 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 Summary of Material Modifications (SMMs), amendments and Summary of Benefits Coverage (SBC), 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 Critical Illness 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 classes of Covered Persons, retired or otherwise without prior notice to or consultation with any Covered Person, 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 Critical Illness Insurance Plan benefit option without describing all of the details set forth in the Plan Document. The SPD is not the Plan Document. Other important details can be found in the Plan Document, 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 Critical Illness 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
- Circumstances that may affect your Plan benefits

- The Plans right to restitution
- 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 and paid by MetLife.

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, Claims Administrator.

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 the Company or the Plan.

You are also advised that by participating in the Plan you agree that suspected incidents of this nature may be turned over to Plan Administrator and/or Corporate Security to investigate and to address the possible consequences of such actions under the Plan. You may be periodically asked to submit proof of eligibility and to verify claims.

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

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 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 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 Critical Illness 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:	Critical Illness Insurance
Type of Administration:	The Critical Illness 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 Critical Illness 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 Information 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.**

This Notice applies to the Sudden Cardiac Arrest Covered Condition* included in the Covered Condition Category: Heart Attack. It describes certain administrative changes applicable to the Sudden Cardiac Arrest Covered Condition included in Your Certificate.

In relation to the definition of Sudden Cardiac Arrest, and the Proof requirements that apply to a Clinical Diagnosis of Sudden Cardiac Arrest, We will not apply any requirement that a Covered Person must be pronounced as deceased by a Physician.

In order for this administrative notice to apply, coverage under Your Certificate must be in force on the date a Diagnosis of a Sudden Cardiac Arrest Covered Condition is made.

All other Proof requirements for benefit payment continue to apply, and benefit payment is subject to all other conditions, maximums, limitations, and other exclusions contained in the provisions of the Certificate.

Please carefully read the entirety of Your Certificate.

* In certain states Sudden Cardiac Arrest is referred to as “Sudden Cardiac Death”.

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.**

This Notice only applies if Your Certificate provides coverage for cancer as a Covered Condition. It describes certain administrative changes applicable to exclusions for coverage of cancer.

If included in Your Certificate, in relation to a Diagnosis of cancer as a Covered Condition, We will not apply exclusions for any of the following:

- any cancer in the presence of human immuno-deficiency virus (HIV) for which there is a known increased risk due to the presence of Acquired Immune Deficiency Syndrome (AIDS) or the presence of HIV; or
- Kaposi Sarcoma.

All other Proof requirements for benefit payment continue to apply, and benefit payment is subject to all other conditions, maximums, limitations, and other exclusions contained in the provisions of the Certificate. Please carefully read the entirety of Your Certificate.

MetLife

METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK, NEW YORK

CERTIFICATE RIDER:
AUTISM SPECTRUM DISORDER COVERED CONDITION CATEGORY

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 Rider is added to Your Certificate and provides a benefit for a Covered Person for the Autism Spectrum Disorder Covered Condition Category. This Rider is subject to the terms and provisions of the Group Policy and Your Certificate.

SCHEDULE OF INSURANCE

The Autism Spectrum Disorder Covered Condition Category is added and subject to the terms and conditions of the Schedule of Insurance set forth in Your Certificate.

COVERED CONDITION CATEGORY: AUTISM SPECTRUM DISORDER		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Autism Spectrum Disorder	25% of the Benefit Amount payable no more than 1 time per Covered Person	NONE

ADDITIONAL DEFINITIONS THAT APPLY TO THE AUTISM SPECTRUM DISORDER COVERED CONDITION CATEGORY

Autism Spectrum Disorder Covered Condition means:
- Autism Spectrum Disorder.

Autism Spectrum Disorder means a neurodevelopmental disorder marked by both Domain 1 Deficits and Domain 2 Deficits. The Autism Spectrum Disorder must satisfy the clinical diagnostic criteria for each of the above domains as set forth in the DSM-V.

Domain 1 Deficits means persistent deficits with respect to social communication and social interaction.

Domain 2 Deficits means persistent deficits marked by restricted, repetitive patterns of behavior, interests, or activities.

DSM-V means the Diagnostic and Statistical Manual of Mental Disorders and which sets forth the clinical criteria to establish a Diagnosis of an Autism Spectrum Disorder Covered Condition.

Occurs or Occurrence, with respect to an Autism Spectrum Disorder Covered Condition, means that a Covered Person is Diagnosed by a Physician with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. An Autism Spectrum Disorder Covered Condition will be deemed to Occur on the date the Diagnosis of an Autism Spectrum Disorder Covered Condition is made.

INITIAL BENEFIT FOR AN AUTISM SPECTRUM DISORDER COVERED CONDITION

We will pay the Initial Benefit for an Autism Spectrum Disorder Covered Condition shown on the Schedule, the first time that an Autism Spectrum Disorder Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule set forth in Your Certificate must be satisfied in order for the Initial Benefit to be payable.

ADDITIONAL PROOF REQUIREMENTS FOR AN AUTISM SPECTRUM DISORDER COVERED CONDITION

Proof of an Autism Spectrum Disorder Covered Condition requires the following information:

- a Clinical Diagnosis must be made in Writing by a Physician; and
- medical records which include documentation of standardized developmental, neuropsychological or other related assessments which under general medical standards of care would be used to establish a Diagnosis of an Autism Spectrum Disorder Covered Condition.

We will not pay for any cost incurred for any developmental, neuropsychological or other related assessments to establish a Diagnosis of an Autism Spectrum Disorder Covered Condition.

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 At Your Option: Portability Through Continuation With Premium Payment provision of the Certificate.

If a new Autism Spectrum Disorder Covered Condition Certificate Rider with a later Rider Effective Date is issued to You, this Rider will end as of the Rider Effective Date set forth on the new rider. An Autism Spectrum Disorder Covered Condition benefit will be determined according to the Autism Spectrum Disorder Covered Condition Certificate Rider that was in effect on the date that an Autism Spectrum Disorder Covered Condition Occurred.

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

Timothy J. Ring
Secretary

Michel Khalaf
President & CEO



METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK, NEW YORK

CERTIFICATE OF CRITICAL ILLNESS 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 and it 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: Subject to the provisions of this Certificate, including limitations, exclusions and Proof requirements, this Certificate provides limited benefits in the event You are Diagnosed with certain critical illnesses.

30-Day Right to Examine Certificate. Please read this Certificate carefully. If You are not satisfied for any reason, You may notify the Group Policyholder that You are cancelling Your Certificate within 30 days from the date of delivery by calling the Group Policyholder. If You notify the Group Policyholder that You are cancelling 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.

This is a supplement to health insurance and is not a substitute for Medical Coverage. Lack of Medical Coverage (or other minimum essential coverage) may result in an additional payment with Your taxes. You should have Medical Coverage when You enroll for this insurance.

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CONTRACT. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from MetLife.

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

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

Notification Requirement

The following notification requirement(s) apply to Dependent coverage:

- If You elect coverage for Your Dependent Children, You must provide notification to Your employer, when all of Your Dependent Children: exceed the Dependent Child Age Limit; or, no longer otherwise meet the definition of a Dependent Child.
- If You elect coverage for Your Spouse or Domestic Partner, You must provide notification to Your employer, if Your Spouse or Domestic Partner no longer meets the definition of a Spouse or Domestic Partner.

You should instead provide the notification to Us if Your coverage is being continued under the At Your Option: Portability Through Continuation of Insurance With Premium Payment provision by calling the toll free number shown on this Certificate.

Please refer to the Schedule of Insurance for information regarding Your Benefit Amounts.

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 of Insurance 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 benefits listed only apply to Dependents 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.

BENEFIT AMOUNT AND TOTAL BENEFIT AMOUNT

	For You	**For Your Spouse or Domestic Partner**	**For Your Dependent Children**
Benefit Amount	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife
Total Benefit Amount	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife	See the Insured's corresponding personalized Covered Person Specifications page or the Group Policyholder's participant file which has been provided to MetLife

BENEFIT SEPARATION PERIOD

For an Initial Benefit for a Covered Person	30 days
For a Recurrence Benefit for a Covered Person	90 days

Please refer to the Benefit Separation Period provision in the Limitations section for additional information.

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: BENIGN TUMOR		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Benign Brain Tumor	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person

COVERED CONDITION CATEGORY: CANCER		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Invasive Cancer	100% of the Benefit Amount payable no more than 1 time per Covered Person per Occurrence of each Separate and Unrelated Invasive Cancer	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
Non-Invasive Cancer	25% of the Benefit Amount payable no more than 1 time per Covered Person per Occurrence of each Separate and Unrelated Non-Invasive Cancer	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
Skin Cancer	5% of the Benefit Amount, but not less than $250; payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount, but not less than $250, payable no more than 1 time per Covered Person

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Cardiovascular Disease treated with: Coronary Artery Bypass Graft	50% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: CHILDHOOD DISEASE		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
cerebral palsy	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
cleft lip or cleft palate	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
cystic fibrosis	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
diabetes (type 1)	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
Down syndrome	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
sickle cell anemia	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
spina bifida	100% of the Benefit Amount payable no more than 1 time per Covered Person	None

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: FUNCTIONAL LOSS		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Coma	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
Loss of: Ability to Speak; Hearing; or Sight	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
Paralysis of 2 or more limbs	100% of the Benefit Amount payable no more than 1 time per Covered Person	None

COVERED CONDITION CATEGORY: HEART ATTACK		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Heart Attack	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person
Sudden Cardiac Arrest	50% of the Benefit Amount payable no more than 1 time per Covered Person	None

COVERED CONDITION CATEGORY: INFECTIOUS DISEASE		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
bacterial cerebrospinal meningitis	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
diphtheria	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
encephalitis	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
Legionnaire's disease	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
malaria	25% of the Benefit Amount payable no more than 1 time per Covered Person	None

necrotizing fasciitis	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
osteomyelitis	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
rabies	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
tetanus	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
tuberculosis	25% of the Benefit Amount payable no more than 1 time per Covered Person	None
COVID-19	25% of the Benefit Amount payable no more than 1 time per Covered Person	None

COVERED CONDITION CATEGORY: KIDNEY FAILURE		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Kidney Failure	100% of the Benefit Amount payable no more than 1 time per Covered Person	None

COVERED CONDITION CATEGORY: MAJOR ORGAN TRANSPLANT		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Major Organ Transplant	100% of the Benefit Amount payable no more than 1 time per Covered Person	None

SCHEDULE OF INSURANCE (Continued)

COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
ALS	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
Alzheimer's Disease	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
Multiple Sclerosis	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
muscular dystrophy	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
Parkinson's Disease (Advanced)	100% of the Benefit Amount payable no more than 1 time per Covered Person	None
systemic lupus erythematosus (SLE)	100% of the Benefit Amount payable no more than 1 time per Covered Person	None

COVERED CONDITION CATEGORY: SEVERE BURN		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Severe Burn	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person

COVERED CONDITION CATEGORY: STROKE		
COVERED CONDITION	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Stroke	100% of the Benefit Amount payable no more than 1 time per Covered Person	100% of the Initial Benefit Amount payable no more than 1 time per Covered Person

SCHEDULE OF INSURANCE (Continued)

SUPPLEMENTAL BENEFITS		
BENEFIT	**BENEFIT AMOUNT**	**BENEFIT MAXIMUM**
Health Screening Benefit	For You: $50 per day For Your Spouse or Domestic Partner: $50 per day For Your Dependent Child: $50 per day	We will pay the Health Screening Benefit: 1 time per Covered Person, per Calendar Year

LIMITATIONS

BENEFIT SEPARATION PERIOD

Benefit Separation Period
The Benefit Separation Period is the number of days that must elapse between Occurrences of Covered Conditions for a Covered Person as described below in order for a benefit to be payable.

Initial Benefit Separation Period
The Initial Benefit Separation Period is the number of days that must elapse between an Occurrence of a Covered Condition for which a benefit is payable and an Occurrence of a different Covered Condition in order for an Initial Benefit to be payable for the later Covered Condition.

Once a Covered Condition has Occurred for which a benefit is payable, in order for an Initial Benefit to be payable for an Occurrence of any other Covered Condition that would otherwise qualify for an Initial Benefit payment, the Initial Benefit Separation Period must be satisfied. The Initial Benefit Separation Period is set forth on the Schedule.

In the event another Covered Condition Occurs within the Initial Benefit Separation Period, the following rules will apply:

- If the benefit We paid (Initial Benefit or Recurrence Benefit) for the prior Covered Condition(s) is less than the Initial Benefit amount We would pay for the new Covered Condition, We will pay an additional amount equal to:
  - the amount We would have paid for the new Covered Condition had the Initial Benefit Separation Period been satisfied; minus
  - the amount We paid for the prior Covered Condition(s).
- If the benefit We paid (Initial Benefit or Recurrence Benefit) for the prior Covered Condition is equal to or exceeds the Initial Benefit amount We would pay for the new Covered Condition, an additional amount is not payable.

Examples:
The following examples are provided for illustration purposes to explain how the Initial Benefit Separation Period will be applied and an additional amount is calculated as described above. These examples do not necessarily reflect the benefits of Your specific coverage.

Benefit Amount	$10,000
Initial Benefit Separation Period	90 days
Benefit payable for Covered Condition A, which Occurs on January 1st	Based on the Schedule, the plan pays 50% of the Benefit Amount = $5,000
Initial Benefit that applies to Covered Condition B, which Occurs on February 1st, prior to satisfaction of the Initial Benefit Separation Period	Based on the Schedule, the plan pays 100% of the Benefit Amount = $10,000
Adjustment Calculation for Occurrence of Covered Condition B	$10,000 minus $5,000 (Difference between amount paid for Covered Condition A and amount that would be paid for Covered Condition B). Result: An additional $5,000 would be payable for the Occurrence of Covered Condition B

LIMITATIONS (Continued)

Benefit Amount	$10,000
Initial Benefit Separation Period	90 days
Benefit payable for Covered Condition A, which Occurs on January 1st	Based on the Schedule, the plan pays 100% of the Benefit Amount = $10,000
Initial Benefit that applies to Covered Condition B, which Occurs on February 1st prior to satisfaction of the Initial Benefit Separation Period	Based on the Schedule, the plan pays 25% of the Benefit Amount = $2,500
Adjustment Calculation for Occurrence of Covered Condition B	The amount payable for Covered Condition A ($10,000) exceeded the amount that would be payable for Covered Condition B ($2,500). Result: An additional benefit would not be payable for the Occurrence of Covered Condition B

Recurrence Benefit Separation Period
The Benefit Separation Period that applies to a Recurrence Benefit for a Covered Person for a subsequent Occurrence of the same Covered Condition is subject to all of the following:

- a benefit must have been payable for the prior Occurrence of the Covered Condition; and
- the Recurrence Benefit Separation Period must be satisfied in order for a Recurrence Benefit to be payable.

The Recurrence Benefit Separation Period is set forth on the Schedule. The Recurrence Benefit Separation Period is measured from the date of the most recent Occurrence of the same Covered Condition for which a benefit was payable.

Example:
The following example is provided for illustration purposes to explain how the Recurrence Separation Period will be applied and a Recurrence Benefit is calculated as described above. This example does not necessarily reflect the benefits of Your specific coverage.

Recurrence Benefit Separation Period	180 days
Covered Condition A Occurs on January 1st	Initial Benefit paid for Covered Condition A
Covered Condition A Occurs again on March 1st	The Recurrence Benefit Separation Period is measured from January 1, the date Condition A Occurred. Result: The Recurrence Benefit for Covered Condition A is not paid because the 180 day Recurrence Benefit Separation Period had not been satisfied when Condition A Occurred again.

RULES FOR TOTAL BENEFIT AMOUNT AND REDUCTION FOR PRIOR CLAIMS PAID

The Total Benefit Amount that appears on the Schedule is the maximum aggregate amount that We will pay, per Covered Person, per lifetime, for any and all of the Covered Conditions to which this provision applies.

We will reduce the Total Benefit Amount for a Covered Person by the Benefit Amounts paid for an Occurrence of a Covered Condition under the Group Policy. All Covered Conditions reduce the Total Benefit Amount unless otherwise specifically stated in this Certificate.

We will also reduce the Total Benefit Amount for a Covered Person by the benefits paid for such Covered Person:

- under another certificate of critical illness insurance issued under the Group Policy; or
- under another policy of critical illness insurance previously issued to the Group Policyholder by Us;

for a condition that would be a Covered Condition under this Certificate.

The Supplemental Benefits do not reduce the Total Benefit Amount**.**

GENERAL EXCLUSIONS

The exclusions that appear below apply to all Covered Conditions and benefits set forth in this Certificate. Please note that certain Covered Conditions have additional exclusions that are set forth in the benefit provisions of this Certificate.

We will not pay benefits for any Covered Condition for a Covered Person caused by, or that takes place during:

- the Covered Person's active participation in an insurrection, rebellion, riot or terrorist act;
- the Covered Person's engagement in any illegal occupation or activity that constitutes a felony under the laws of the jurisdiction in which the activity took place;
- the Covered Person's intentionally self-inflicted injury;
- the Covered Person's suicide or attempted suicide (while sane or insane);
- war, whether declared or undeclared; or act of war;
- the Covered Person's operation, while intoxicated, of a motor vehicle involved in the incident. 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. For purposes of this exclusion intoxicated means that the Covered Person's:
  - blood alcohol level met or exceeded .08%; or
  - blood delta-9-tetrahydrocannabinol (THC) level met or exceeded the limit established by the laws of the jurisdiction for drug-impaired driving where the incident took place;
- the Covered Person voluntarily taking or using 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 according to package directions; or
- 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.

In addition, We will not pay benefits for:

- any Covered Condition for which Diagnosis is made outside the United States, Canada or Mexico unless the Diagnosis is confirmed in the United States, in which case the Covered Condition will be deemed to Occur on the date the Diagnosis is made outside the United States, Canada or Mexico.

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.

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.

Benefit Amount means the amount We use to determine the benefit payable for a Covered Condition.

Calendar Year means a period of 12 consecutive months, starting on January 1 and ending on December 31 of the same year.

Certificate means this Certificate including any riders attached to it.

Clinical Diagnosis means a Diagnosis based on the study of symptoms and diagnostic test results.

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

Covered Condition means those conditions or treatments listed in the Schedule for which a benefit is payable as described in this Certificate. A Covered Condition does not include Supplemental Benefits.

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

Dependent means Your Spouse or Domestic Partner and/or Dependent Child.

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; or
- Your grandchild, including such child of Your Domestic Partner, while such child is younger than the Dependent Child Age Limit.
- Your grandchild, including such child of Your Domestic Partner, who is in Your legal custody and residing with You, while such child is younger than the Dependent Child Age Limit.

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

DEFINITIONS (Continued)

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.

Diagnosis or Diagnosed means the establishment of a Covered Condition by a Physician through the use of clinical and/or laboratory findings, and using generally accepted medical standards.

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.

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 a 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.

Initial Benefit means the benefit, as specified in the Schedule, that is payable for a Covered Condition the first time that such condition Occurs for a Covered Person while coverage is in effect under this Certificate and subject to the terms and conditions of this Certificate.

Medical Coverage means coverage under Medicare or an insurance policy, health maintenance organization contract, or employer's plan of self-insurance providing benefits for hospital, surgical and medical expenses or treatment. Medical Coverage does not include Medicaid.

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.

Occurs or **Occurrence** means, for a Covered Person, an Occurrence of a particular Covered Condition as defined in the benefit provision for that Covered Condition while coverage is in effect under this Certificate for such Covered Person.

Physician means:

- a person:
  - who has received a degree of doctor of medicine (M.D.), or doctor of osteopathy (D.O.); or
  - any other person whose services, according to applicable law, must be treated as Physician's services; and
- such person is acting within the scope of a valid license issued in the United States, Canada or Mexico to make a Diagnosis of a Covered Condition or to perform the services required for a Covered Condition for which a claim is made.

The term Physician does not include:

- You;
- Your Spouse or anyone to whom You are related by blood or marriage;
- anyone who is a member of Your household;
- 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.

Recur or Recurrence means another Occurrence of the same Covered Condition for which We have already paid a benefit.

Recurrence Benefit means a benefit, as specified in the Schedule, that is payable for another Occurrence of the same Covered Condition for the same Covered Person for whom We have already paid a benefit while coverage is in effect under this Certificate and subject to the terms and conditions of this Certificate. The Schedule shows the Covered Conditions for which a Recurrence Benefit is payable.

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

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.

Spouse means Your lawful spouse.

Supplemental Benefit(s) are the following:

- Health Screening Benefit.

Surgery means a procedure performed by a Physician involving the cutting of the Covered Person's skin or tissue that in and of itself is intended to be curative or palliative. Surgery does not include endoscopic or non-invasive procedures.

Transplant List means the list maintained by the Organ Procurement and Transportation Network (OPTN).

Treatment Free means that a Covered Person is symptom free and not receiving medical treatment or care from a Physician for the Covered Condition for which We paid an Initial Benefit or Recurrence Benefit. For purposes of this term, medical treatment does not include:

- the Covered Person receiving maintenance drug therapy while in remission; or
- routine medical assessments to verify that a Covered Condition is no longer present or remains in remission.

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 Critical Illness 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 31 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 31 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 if You are required to make such Contributions.

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

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 31 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 31 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 31 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 if You are required to make such Contributions. You must do this within 31 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 representatives.

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.

BENEFIT CHANGES

Benefit changes with respect to a Dependent are subject to the Benefit Changes provision in the Eligibility Provisions: Insurance for You section of this Certificate.

If a Dependent for whom insurance is in effect under this Certificate is under a Medical Restriction on the date that an increase in benefits would otherwise take effect, the increase will not take effect for the Dependent until such Dependent is no longer under a Medical Restriction.

COVERED CONDITION CATEGORY: BENIGN TUMOR

ADDITIONAL DEFINITIONS THAT APPLY TO BENEFITS FOR THE BENIGN TUMOR COVERED CONDITION CATEGORY

Benign Tumor Covered Condition means the following:
- Benign Brain Tumor.

A Benign Tumor Covered Condition does not include any such tumor resulting from:
- neurofibromatosis I or II;
- Von Hippel Lindau disease;
- tuberous sclerosis; or
- Cowden disease.

Benign Brain Tumor means the presence of a non-cancerous tumor located in the brain, or a non-cancerous Meningioma.

Benign Brain Tumor does not include:
- acoustic neuromas;
- tumors of the skull;
- tumors of the spinal cord; or
- pituitary adenomas.

Meningioma means a tumor located on the membranes that cover the brain.

Occurs or Occurrence, with respect to a Benign Tumor Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while the coverage is in effect under this Certificate for such Covered Person. A Benign Tumor Covered Condition will be deemed to Occur on the date that the Diagnosis of a Benign Tumor Covered Condition is made.

Permanent Neurological Deficit means the presence of one, or more, of the following deficits:
- impaired cognition;
- impaired or loss of vision;
- impaired or loss of hearing;
- impaired or loss of the ability to speak and communicate;
- balance disruption; or
- impaired or loss of ability to ambulate independently.

INITIAL BENEFIT FOR A BENIGN TUMOR COVERED CONDITION

We will pay the applicable Initial Benefit for a Benign Tumor Covered Condition shown on the Schedule, the first time that the Benign Tumor Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

COVERED CONDITION CATEGORY: BENIGN TUMOR (Continued)

RECURRENCE BENEFIT FOR A BENIGN TUMOR COVERED CONDITION

For any Benign Tumor Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Benign Tumor Covered Condition if:

- the subsequent Occurrence of the Benign Tumor happens after the Recurrence Benefit Separation Period has been satisfied; and
- the Covered Person has been Treatment Free for a continuous period of 90 days immediately prior to the subsequent Occurrence of the Benign Tumor Covered Condition.

ADDITIONAL PROOF REQUIREMENTS FOR A BENIGN TUMOR COVERED CONDITION

Proof of a Benign Tumor Covered Condition requires the following additional documentation:

- a pathological or Clinical Diagnosis as described below; and
- submission of medical records evidencing that the Benign Tumor Covered Condition:
  - requires treatment by a Physician that is a Surgery or radiation therapy; or
  - resulted in a Permanent Neurological Deficit that is attributable to the Benign Tumor Covered Condition;

A pathological Diagnosis of a Benign Tumor Covered Condition must include the following:

- microscopic (histologic) examination of fixed tissues, including those taken by a biopsy; and
- magnetic resonance imaging (MRI), computerized tomography (CT scan), or other reliable imaging techniques that have been completed as part of the evaluation to Diagnose a Benign Tumor Covered Condition.

We will accept a Clinical Diagnosis of a Benign Tumor Covered Condition only if the following conditions are met:

- under generally accepted medical standards, a pathological Diagnosis cannot be made because it would be medically inappropriate or life-threatening;
- medical diagnostic testing supports the Diagnosis; and
- a Physician is treating the Covered Person for the Benign Tumor Covered Condition.

Such Proof requirements must be documented in a Written report by a Physician.

In the event a Covered Person has been paid a benefit for a Benign Brain Tumor based on a Clinical Diagnosis, but later medical evidence establishes that such Covered Condition is malignant and satisfies the Proof requirements for Invasive or Non-Invasive Cancer, We will pay the applicable benefit for a Cancer Covered Condition reduced by the Benefit Amount that We paid for the Benign Brain Tumor. In the event the Benefit Amount We had already paid for Benign Brain Tumor equals or exceeds the amount that would have been payable for a Cancer Covered Condition, We will not pay an additional benefit.

COVERED CONDITION CATEGORY: CANCER

ADDITIONAL DEFINITIONS THAT APPLY TO BENEFITS FOR THE CANCER COVERED CONDITION CATEGORY

Cancer Covered Condition means the following:
- Invasive Cancer;
- Non-Invasive Cancer; or
- Skin Cancer.

Carcinoma in Situ means a group of abnormal cells that remain in the location where the cells first formed.

Chemotherapy means the administration of drugs or biologics that are prescribed by a Physician to either eliminate the cancerous cells, or prevent or slow the growth of the cancerous cells.

Invasive Cancer means the presence of one or more malignant tumors with invasion of normal tissue and characterized by the uncontrollable and abnormal growth and spread of malignant cells to lymph nodes and/or a body part different from the site of cancer origin. Invasive Cancer includes the following:
- a malignant melanoma for which a pathology report shows a maximum thickness greater than 0.80 millimeters using the Breslow method of determining tumor thickness;
- a cancer that is a leukemia or lymphoma; or
- where a Covered Person has terminal cancer and has a life expectancy of 24 months or less from the date of Diagnosis and will not benefit from, or has exhausted, curative therapy.

Occurs or Occurrence, with respect to a Cancer Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while the coverage is in effect under this Certificate for such Covered Person. A Cancer Covered Condition will be deemed to Occur on the date that the Diagnosis of the Cancer Covered Condition is made.

Non-Invasive Cancer (including Carcinoma in Situ) means the presence of a malignant tumor and characterized by the abnormal growth of malignant cells which are confined to the site of origin without spread to lymph nodes and/or a body part different from the site of cancer origin. Non-Invasive Cancer includes the following:
- a malignant melanoma, for which a pathology report shows a maximum thickness less than or equal to 0.80 millimeters using the Breslow method of determining tumor thickness;
- a tumor of the prostate classified as T1bN0M0, or T1cN0M0; or
- a Carcinoma in Situ classified as TisN0M0.

Non-Invasive Cancer does not include Skin Cancer.

Separate and Unrelated with respect to a Cancer Covered Condition means a Cancer Covered Condition that is:
- not a Recurrence of any previously Diagnosed Cancer Covered Condition;
- not a metastasis of a previously Diagnosed Cancer Covered Condition; and
- distinct in the cause and etiology from any previously Diagnosed Cancer Covered Condition.

Skin Cancer means any malignant growth that arises on the surface of the skin that is any of the following:
- basal cell carcinoma;
- squamous cell carcinoma; or
- malignant melanoma that remains confined to the epidermis.

TNM Classification of Malignant Tumors (**"TNM Staging")** means the classification standards for cancer developed by the American Joint Committee on Cancer.

COVERED CONDITION CATEGORY: CANCER (Continued)

INITIAL BENEFIT FOR A CANCER COVERED CONDITION

We will pay the applicable Initial Benefit for a Cancer Covered Condition shown on the Schedule for a Covered Person:

- the first time a Cancer Covered Condition Occurs for such Covered Person; or
- for a Cancer Covered Condition that is Separate and Unrelated from any prior Cancer Covered Condition for which We paid a benefit.

The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

Related Occurrence for a Cancer Covered Condition
In the event a Covered Person has an initial Occurrence of a Cancer Covered Condition that is not an Invasive Cancer, and the Cancer Covered Condition for which We paid a benefit is subsequently Diagnosed as a Cancer Covered Condition for which We would pay a higher benefit as shown on the Schedule, We will pay the difference between what We paid and the applicable higher Initial Benefit amount. The Initial Benefit Separation Period does not apply to payment of the Initial Benefit for a Related Occurrence for a Cancer Covered Condition as described in this provision.

RECURRENCE BENEFIT FOR A CANCER COVERED CONDITION

For any Cancer Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Cancer Covered Condition for which We have already paid a benefit if:

- the subsequent Occurrence of the Cancer Covered Condition happens after the Recurrence Benefit Separation Period has been satisfied; and
- the Covered Person has been Treatment Free for a continuous period of 90 days immediately prior to the subsequent Occurrence of the Cancer Covered Condition.

ADDITIONAL PROOF REQUIREMENTS FOR A CANCER COVERED CONDITION

Proof of an Occurrence of a Cancer Covered Condition requires the following additional documentation:

- A pathological Diagnosis that is based upon microscopic (histologic) examination of fixed tissues, including those taken by a biopsy, or preparations of blood or bone marrow.
- If a pathological Diagnosis cannot be made because it would be medically inappropriate or life-threatening under generally accepted medical standards, We will accept a Clinical Diagnosis based on the following:
  - medical diagnostic testing that supports the Diagnosis; and
  - the Covered Person is being treated for the Cancer Covered Condition by a Physician.

In the event a Covered Person was paid a benefit for an Occurrence of a Benign Brain Tumor based on a Clinical Diagnosis, but later medical evidence establishes that such Covered Condition is malignant and meets the Proof requirements for a Cancer Covered Condition, We will pay the appropriate benefit for a Cancer Covered Condition reduced by the benefit amount that We already paid for the Benign Brain Tumor. Please refer to the Covered Condition Category: Benign Tumor section of this Certificate for details.

Such Proof requirements must be documented in a Written report by a Physician.

COVERED CONDITION CATEGORY: CANCER (Continued)

SPECIAL EXCLUSIONS APPLICABLE TO A CANCER COVERED CONDITION

We will not pay benefits for a Diagnosis of a Cancer Covered Condition for:

- myelodysplastic syndrome;
- any benign tumor, dysplasia, intraepithelial neoplasia or pre-malignant growth;
- any papillary tumor of the bladder classified as a maximum severity of Ta under TNM Staging;
- any tumor of the prostate classified as T1aN0M0 under TNM Staging;
- any papillary, follicular or medullary tumor of the thyroid that is classified as a T1N0M0 or less under TNM Staging and is one centimeter or less in diameter, unless there is metastasis; or
- any cancer in the presence of human immuno-deficiency virus (HIV) for which there is a known increased risk due to the presence of Acquired Immune Deficiency Syndrome (AIDS) or the presence of HIV.

COVERED CONDITION CATEGORY: CARDIOVASCULAR DISEASE

ADDITIONAL DEFINITIONS THAT APPLY TO THE CARDIOVASCULAR DISEASE COVERED CONDITION CATEGORY

Cardiovascular Disease Covered Condition means the following:

- coronary artery disease where:
  - the arteries of the heart are damaged or diseased, valves of the heart are damaged or diseased, or there is impaired cardiac function due to the presence of plaques, or fatty deposit, buildup on the artery walls that has caused narrowing of the coronary arteries resulting in partial or complete blockage of the arteries; and
  - a treatment listed below is required to treat the coronary artery disease:
    - Coronary Artery Bypass Graft.

Coronary Angioplasty (Percutaneous Coronary Intervention or PCI) means a cardiac catheterization procedure to treat Cardiovascular Disease by utilizing a catheter with a balloon, laser, laser-assisted device, rotational device, stent placement or other mechanical means to unblock an occluded coronary artery.

Coronary Artery Bypass Graft means a heart Surgery procedure to bypass a narrowing or blockage of one or more coronary arteries using venous or arterial grafts. Surgical access to the heart may be done by a procedure that is:

- a Surgery in which a Median Sternotomy is performed; or
- a minimally invasive endoscopic cardiac Surgery procedure is performed.

Coronary Artery Bypass Graft does not include:

- Coronary Angioplasty;
- coronary angiography; or
- any other intra-catheter technique.

Median Sternotomy means a surgical incision in which the sternum, also known as the breastbone, is divided down the middle from top to bottom.

Occurs or **Occurrence**, with respect to a Cardiovascular Disease Covered Condition, means a Covered Person receives the applicable treatment specified in the definition of the term Cardiovascular Disease Covered Condition, and such treatment was performed by a Physician while the coverage is in effect under this Certificate for such Covered Person. A Cardiovascular Disease Covered Condition will be deemed to Occur on the date such treatment was performed.

INITIAL BENEFIT FOR A CARDIOVASCULAR DISEASE COVERED CONDITION

We will pay the applicable Initial Benefit for a Cardiovascular Disease Covered Condition treatment shown on the Schedule, the first time that a Cardiovascular Disease Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

RECURRENCE BENEFIT FOR A CARDIOVASCULAR DISEASE COVERED CONDITION

For any Cardiovascular Disease Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Cardiovascular Disease Covered Condition for which We have already paid a benefit if the subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

RULE FOR MORE THAN ONE OCCURRENCE OF A CARDIOVASCULAR DISEASE COVERED CONDITION

If the Covered Person has more than one Occurrence of a Cardiovascular Disease Covered Condition at the same time, or on the same day, for which a benefit is payable, We will pay the applicable benefit shown on the Schedule for one Cardiovascular Disease Covered Condition, which will be for the Covered Condition that pays the highest Benefit Amount.

ADDITIONAL PROOF REQUIREMENTS FOR A CARDIOVASCULAR DISEASE COVERED CONDITION

Proof of a Cardiovascular Disease Covered Condition requires a Clinical Diagnosis and the following additional documentation:

- submission of medical records that include test results for at least one of the following:
  - cardiac perfusion scan;
  - cardiac catheterization;
  - doppler ultrasound;
  - echocardiogram;
  - electrocardiogram (EKG);
  - angiogram; or
  - positron emission tomography (PET scan); and
- that treatment for the Cardiovascular Disease Covered Condition was performed by a Physician.

Such Proof requirements must be documented in a Written report by a Physician.

SPECIAL EXCLUSIONS APPLICABLE TO A CARDIOVASCULAR DISEASE COVERED CONDITION

We will not pay benefits for a Cardiovascular Disease Covered Condition:

- for a Heart Attack;
- for which the treatment required for payment of a benefit is received outside the United States, Canada or Mexico unless confirmation of the Cardiovascular Disease Covered Condition and treatment received is confirmed in the United States, in which case the Covered Condition will be deemed to Occur on the date the treatment was performed outside the United States, Canada or Mexico; or
- for a cardiac catheterization performed for diagnostic purposes only.

COVERED CONDITION CATEGORY: CHILDHOOD DISEASE

ADDITIONAL DEFINITIONS THAT APPLY TO THE CHILDHOOD DISEASE COVERED CONDITION CATEGORY

Childhood Disease Covered Condition means any of the following:

- cerebral palsy;
- cleft lip or cleft palate;
- cystic fibrosis;
- diabetes type 1 (diabetes type 2 is not a Covered Condition);
- Down syndrome;
- sickle cell anemia (sickle cell trait is not a Covered Condition); or
- spina bifida (spina bifida occulta is not a Covered Condition).

Occurs or Occurrence, with respect to a Childhood Disease Covered Condition, means a Dependent Child is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Dependent Child. A Childhood Disease Covered Condition will be deemed to Occur on the date the Diagnosis of a Childhood Disease Covered Condition is made.

INITIAL BENEFIT FOR A CHILDHOOD DISEASE COVERED CONDITION

We will pay the Initial Benefit shown on the Schedule for a Childhood Disease Covered Condition, the first time that a Childhood Disease Covered Condition Occurs for a Dependent Child who is a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

If more than one Childhood Disease Covered Condition Occurs for a Dependent Child at the same time, We will only pay an Initial Benefit for one Covered Condition which will be for the Childhood Disease Covered Condition that pays the highest Benefit Amount.

ADDITIONAL PROOF REQUIREMENTS FOR A CHILDHOOD DISEASE COVERED CONDITION

A Clinical Diagnosis of a Childhood Disease Covered Condition must be made in Writing by a Physician and substantiated in the medical records.

SPECIAL EXCLUSIONS APPLICABLE TO A CHILDHOOD DISEASE COVERED CONDITION

We will not pay benefits for:

- a suspected or probable Diagnosis of a Childhood Covered Condition; or
- a Childhood Covered Condition that is Diagnosed for a stillborn child.

COVERED CONDITION CATEGORY: FUNCTIONAL LOSS

ADDITIONAL DEFINITIONS THAT APPLY TO THE FUNCTIONAL LOSS COVERED CONDITION CATEGORY

Coma means a continuous state of profound unconsciousness lasting for a period of 14 or more consecutive days, as confirmed by a Physician and characterized by the absence of purposeful response to commands, including:

- eye opening;
- verbal response; and
- motor response.

Coma does not include a medically induced Coma.

Functional Loss Covered Condition means the following:

- Coma;
- Loss of: Ability to Speak; Hearing; Sight; or
- Paralysis.

Loss of: Ability to Speak; Hearing or Sight means the following each of which must last for a continuous period of not less than 90 consecutive days, and is expected to be permanent, as confirmed by a Physician:

- for Loss of Ability to Speak - total loss of audible communication (aphonia), if such loss cannot be corrected to any functional degree by any procedure, air or device;
- for Loss of Hearing - deafness in both ears, such that it cannot be corrected to any functional degree by any procedure, aid or device; or
- for Loss of Sight - loss of sight in both eyes. With correction, visual acuity must be 20/200 or worse in both eyes, or the field of vision must be less than 20 degrees in both eyes. Loss of sight does not include blindness or loss of sight in one eye due to a previous existing blindness in the other eye.

Occurs or **Occurrence**, with respect to a Functional Loss Covered Condition means a Covered Person is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Functional Loss Covered Condition will be deemed to Occur on the date that a Diagnosis of a Functional Loss Covered Condition is made.

Paralysis means the total and irrevocable loss of extremity movement affecting 2 or more limbs and:

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

INITIAL BENEFIT FOR A FUNCTIONAL LOSS COVERED CONDITION

We will pay the applicable Initial Benefit shown on the Schedule for a Functional Loss Covered Condition, the first time that a Functional Loss Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

RECURRENCE BENEFIT FOR A FUNCTIONAL LOSS COVERED CONDITION

For any Functional Loss Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Functional Loss Covered Condition for which We have already paid a benefit if the subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

COVERED CONDITION CATEGORY: FUNCTIONAL LOSS (Continued)

ADDITIONAL PROOF REQUIREMENTS FOR A FUNCTIONAL LOSS COVERED CONDITION

A Clinical Diagnosis of a Functional Loss Covered Condition must be made in Writing by a Physician and must be substantiated in the medical records.

SPECIAL EXCLUSIONS APPLICABLE TO A FUNCTIONAL LOSS COVERED CONDITION

We will not pay benefits for a Functional Loss Covered Condition for any of the following:

- a Functional Loss Covered Condition that is associated with the total and irreversible loss of all brain function (brain death);
- a Functional Loss Covered Condition that is a dismemberment of an extremity; or
- any Functional Loss Covered Condition for which, in general medical opinion or practice, Surgery, an adaptive device or other corrective measure could restore function.

COVERED CONDITION CATEGORY: HEART ATTACK

ADDITIONAL DEFINITIONS THAT APPLY TO THE HEART ATTACK COVERED CONDITION CATEGORY

Heart Attack Covered Condition means the following:
- Myocardial Infarction; or
- Sudden Cardiac Arrest.

Myocardial Infarction means the death of a portion of the heart muscle as a result of obstruction of one or more coronary arteries due to atherosclerosis, spasm, thrombus or emboli.

Myocardial Infarction does not include Sudden Cardiac Arrest.

Sudden Cardiac Arrest means the sudden, unexpected loss of heart function, breathing and consciousness resulting when the heart suddenly, and unexpectedly, stops beating because of an internal electrical disturbance of the heart, which results in a Covered Person being pronounced deceased by a Physician.

Occurs or **Occurrence**, with respect to a Heart Attack Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Heart Attack Covered Condition will be deemed to Occur on the date that a Diagnosis of a Heart Attack Covered Condition is made.

INITIAL BENEFIT FOR A HEART ATTACK COVERED CONDITION

We will pay the applicable Initial Benefit for a Heart Attack Covered Condition shown on the Schedule, the first time a Heart Attack Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

If a Covered Person sustains a Myocardial Infarction and Sudden Cardiac Arrest which Occur at the same time, or on the same day, and for which a Heart Attack Covered Condition benefit is payable, We will pay an Initial Benefit for a single Heart Attack Covered Condition which will be for the Heart Attack Covered Condition that pays the highest Benefit Amount.

RECURRENCE BENEFIT FOR A HEART ATTACK COVERED CONDITION

For any Heart Attack Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Heart Attack Covered Condition for which We have already paid a benefit if the subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

COVERED CONDITION CATEGORY: HEART ATTACK (Continued)

ADDITIONAL PROOF REQUIREMENTS FOR A HEART ATTACK COVERED CONDITION

Proof of a Heart Attack Covered Condition requires a pathological Diagnosis or Clinical Diagnosis as described below.

For a pathological Diagnosis of a Heart Attack Covered Condition, the following additional documentation must be provided:

- for Myocardial Infarction, documentation that shows:
  - an elevation of enzymes, troponins or other biochemical cardiac markers, and
  - two of the three following criteria associated with the Myocardial Infarction:
    - confinement in a Hospital as an inpatient;
    - documentation of electrocardiograph (EKG) changes on one or a series of electrocardiograms taken at the time the Covered Person experiences the Myocardial Infarction that are indicative of an acute Myocardial Infarction; however, if the Covered Person had any prior electrocardiogram(s), the electrocardiogram(s) presented as Proof of Myocardial Infarction must show changes from the Covered Person's last electrocardiogram, and such changes must be indicative of an acute Myocardial Infarction; or
    - documentation of imaging studies such as thallium scans, or echocardiograms which are indicative of an acute Myocardial Infarction; however, if the Covered Person had any prior imaging studies, the imaging studies presented as Proof of Myocardial Infarction must show changes from the Covered Person's last imaging studies, and such changes must be indicative of a Myocardial Infarction.
- for Sudden Cardiac Arrest, additional documentation that shows that the Sudden Cardiac Arrest was caused or contributed to by any of the following, or that the Covered Person had a documented medical history of any of the following:
  - coronary artery disease;
  - Myocardial Infarction;
  - myocarditis;
  - cardiomyopathy;
  - valvular heart disease;
  - congenital heart disease; or
  - cardiac electrical conduction abnormalities.

We will accept a Clinical Diagnosis of a Heart Attack Covered Condition only if a pathological Diagnosis cannot be made because it would be medically inappropriate or life-threatening under generally accepted medical standards. We will accept a Clinical Diagnosis of Sudden Cardiac Arrest if the sole cause of death shown on a death certificate and medical records indicates cardiovascular collapse, Sudden Cardiac Arrest, or sudden cardiac death.

Such Proof requirements must be documented in a Written report by a Physician.

COVERED CONDITION CATEGORY: INFECTIOUS DISEASE

ADDITIONAL DEFINITIONS THAT APPLY TO THE INFECTIOUS DISEASE COVERED CONDITION CATEGORY

Infectious Disease Covered Condition means each of the following diseases for which a Covered Person was confined in a Hospital as an inpatient for the number of consecutive days as specified below:

- bacterial cerebrospinal meningitis;
- diphtheria;
- encephalitis;
- Legionnaire's disease;
- malaria;
- necrotizing fasciitis;
- osteomyelitis;
- rabies;
- tetanus;
- tuberculosis; or
- COVID-19.

Occurs or **Occurrence**, with respect to an Infectious Disease Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while the coverage is in effect under this Certificate for such Covered Person. An Infectious Disease Covered Condition will be deemed to Occur on the date a Diagnosis of an Infectious Disease Covered Condition is made.

INITIAL BENEFIT FOR AN INFECTIOUS DISEASE COVERED CONDITION

We will pay the applicable Initial Benefit shown on the Schedule for an Infectious Disease Covered Condition, the first time that an Infectious Disease Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

ADDITIONAL PROOF REQUIREMENTS FOR AN INFECTIOUS DISEASE COVERED CONDITION

Proof of an Infectious Disease Covered Condition requires the following additional documentation:

- a Covered Person was confined in a Hospital as an inpatient for 5 consecutive days for treatment of the Infectious Disease Covered Condition; and
- a Clinical Diagnosis:
  - made in Writing by a Physician; and
  - substantiated in the medical records.

COVERED CONDITION CATEGORY: KIDNEY FAILURE

ADDITIONAL DEFINITIONS THAT APPLY TO THE KIDNEY FAILURE COVERED CONDITION CATEGORY

Kidney Failure Covered Condition means the total, end stage, irreversible failure of all functioning kidneys, provided that a Physician has determined that such failure requires either:

- immediate and regular kidney dialysis (no less often than weekly) that is expected by such Physician to continue for at least 6 months; or
- a kidney transplant.

Occurs or **Occurrence**, with respect to a Kidney Failure Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Kidney Failure Covered Condition will be deemed to Occur on the earlier of:

- the date a Covered Person receives the first kidney dialysis treatment; or
- the date a Covered Person is placed on the Transplant List.

INITIAL BENEFIT FOR A KIDNEY FAILURE COVERED CONDITION

We will pay the Initial Benefit for a Kidney Failure Covered Condition shown on the Schedule, the first time that a Kidney Failure Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

ADDITIONAL PROOF REQUIREMENTS FOR A KIDNEY FAILURE COVERED CONDITION

A Clinical Diagnosis of a Kidney Failure Covered Condition must be made in Writing by a Physician and must be substantiated in the medical records.

COVERED CONDITION CATEGORY: MAJOR ORGAN TRANSPLANT

ADDITIONAL DEFINITIONS THAT APPLY TO THE MAJOR ORGAN TRANSPLANT COVERED CONDITION CATEGORY

Bone Marrow means the soft, sponge-like tissue within the bone that produces white blood cells, red blood cells and platelets.

Major Organ Transplant Covered Condition means the following:
- Major Organ Transplant.

Major Organ Transplant means:
- the irreversible failure of a Covered Person's liver for which a Physician has determined that the complete or partial replacement of the liver with a liver, or liver tissue from a human donor, is medically necessary;
- the irreversible failure of a Covered Person's heart, lung, pancreas, or any combination thereof, for which a Physician has determined that the complete replacement of such organ with an entire organ from a human donor is medically necessary;
- the irreversible failure of a Covered Person's Bone Marrow for which a Physician has determined that replacement of the Bone Marrow (stem cells) from a human donor is medically necessary; and
- for all of the above listed transplants, one of the following additional requirements are met:
  - the Covered Person has been placed on the Transplant List; or
  - such Major Organ Transplant Procedure has been performed.

Major Organ Transplant Procedure means a Covered Person undergoes a procedure for any of the transplant types to which the term Major Organ Transplant Covered Condition applies.

Occurs or **Occurrence** means, while the coverage is in effect under this Certificate for a Covered Person:
- with respect to Major Organ Transplant, the earlier of:
  - the date a Covered Person is placed on the Transplant List; or
  - the date a Covered Person undergoes a Major Organ Transplant Procedure.

If a Covered Person is placed on the Transplant List and then subsequently undergoes a Major Organ Transplant Procedure of the same organ for which the Covered Person was on the Transplant List, We will treat this as a single Occurrence of a Major Organ Transplant Covered Condition.

COVERED CONDITION CATEGORY: MAJOR ORGAN TRANSPLANT (Continued)

INITIAL BENEFIT FOR A MAJOR ORGAN TRANSPLANT COVERED CONDITION

We will pay the applicable Initial Benefit for a Major Organ Transplant Covered Condition shown on the Schedule, the first time that a Major Organ Transplant Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

SPECIAL LIMITATIONS APPLICABLE TO A MAJOR ORGAN TRANSPLANT COVERED CONDITION

Payment of benefits for a Major Organ Transplant Covered Condition is subject to the following:

- Two or more organs transplanted on the same day, or during the same Surgery, shall be deemed one Occurrence of a Major Organ Transplant.

ADDITIONAL PROOF REQUIREMENTS FOR A MAJOR ORGAN TRANSPLANT COVERED CONDITION

A Clinical Diagnosis of a Major Organ Transplant Covered Condition must be made in Writing by a Physician. In addition, documentation of the following must be provided:

- for Major Organ Transplant:
  - that the Covered Person has been placed on the Transplant List and the date of such placement; or
  - that the Major Organ Transplant has been performed.

SPECIAL EXCLUSIONS APPLICABLE TO A MAJOR ORGAN TRANSPLANT COVERED CONDITION

We will not pay benefits for a Major Organ Transplant Covered Condition for a Covered Person:

- if prior to the Covered Person's coverage becoming effective under this Certificate, the Covered Person had been placed on a Transplant List for the same organ for which the Major Organ Transplant Procedure is performed;
- for a transplant involving organs received from non-human donors;
- for a transplant involving implantation of mechanical devices or mechanical organs; or
- for a transplant involving islet cell transplants.

COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE

ADDITIONAL DEFINITIONS THAT APPLY TO THE PROGRESSIVE DISEASE COVERED CONDITION CATEGORY

Activities of Daily Living means the following:
- Bathing: washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.
- Dressing: putting on and taking off all items of clothing and any required braces, fasteners, or artificial limbs.
- Transferring: moving into or out of a bed, chair or wheelchair.
- Toileting: getting to and from the toilet, getting on and off the toilet, and performing related personal hygiene.
- Continence: ability to maintain control of bowel and bladder function; or, when not able to maintain control of bowel or bladder function, the ability to perform related personal hygiene (including caring for catheter or colostomy bag).
- Eating: feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously.

Alzheimer's Disease means the development of multiple, progressive Cognitive Disturbances that are manifested by memory impairment (impaired ability to learn new information or to recall previously learned information). Alzheimer's Disease must be confirmed by neuropsychological testing. Results of one of more of the following tests may be provided as confirmation in addition to the neuropsychological testing:
- computed tomography (CT);
- magnetic resonance imaging (MRI); or
- positron emission tomography (PET) documents the presence of abnormal deposits of proteins which have formed amyloid plaques and tau tangles.

Alzheimer's Disease does not include:
- other central nervous system conditions that may cause deficits in memory and cognition (e.g., cerebrovascular disease, Parkinson's Disease, normal-pressure hydrocephalus);
- systemic conditions that are known to cause Cognitive Disturbances (e.g., hypothyroidism, vitamin B12 or folic acid deficiency, niacin deficiency, hypercalcemia, or neurosyphilis);
- substance-induced conditions;
- a form of dementia that is a mental and nervous condition such as schizophrenia or psychoses;
- a form of dementia that is Other Dementia; or
- any form of dementia that is not Clinically Diagnosed as Alzheimer's Disease.

Cognitive Disturbances means the following intellectual impairments:
- aphasia (language disturbance);
- apraxia (impaired ability to carry out motor activities despite intact motor function);
- angosia (failure to recognize or identify objects despite intact sensory function); or
- disturbance in executive functioning (i.e. planning, organizing, sequencing, or abstracting).

Multiple Sclerosis means a progressive neurological condition with evidence of all of the following:
- well-defined neurological abnormalities lasting more than a continuous period of 6 months confirmed by neurological exam;
- presence of demyelination in at least two separate areas of the central nervous system;
- evidence that such demyelination damage took place at different points in time; and
- diagnostic testing results that document the following:
  - magnetic resonance imaging (MRI) that show T2 – weighted lesions;
  - an abnormal response on evoked potential testing; or
  - oligoclonal antibodies or a high immunoglobulin (IgG) index present in cerebrospinal fluid.

Multiple Sclerosis does not include clinically isolated syndrome (CIS).

COVERED CONDITION CATEGORY: PROGRESSIVE DISEASE (Continued)

Occurs or **Occurrence**, with respect to a Progressive Disease Covered Condition, means a Covered Person is Diagnosed with a such Covered Condition while the coverage is in effect under this Certificate for such Covered Person. A Progressive Disease Covered Condition will be deemed to Occur on the date the Diagnosis of a Progressive Disease Covered Condition is made.

Other Dementia means the development of multiple progressive cognitive defects:
- manifested by memory impairment and other Cognitive Disturbances; and
- for which one or more of the following tests document changes to the specific areas of the brain that result in Cognitive Disturbances: electroencephalogram (EEG); or imaging studies, including computed tomography (CT), magnetic resonance imaging (MRI), fluorodeoxyglucose positron emission tomography (FDG Pet Scan) or amyloid positron-emission tomography scan.

Other Dementia includes the following types of neurological conditions:
- dementia with Lewy bodies;
- progressive supranuclear palsy;
- corticobasal degeneration;
- Parkinson's disease dementia;
- frontotemporal dementia;
- primary progressive aphasia;
- normal-pressure hydrocephalus; or
- rapidly progressive dementia as in Creutzfeldt-Jakob disease.

Other Dementia does not include:
- Alzheimer's Disease;
- substance-induced conditions;
- a form of dementia that is a mental and nervous condition, such as schizophrenia or psychoses;
- any form of Parkinson's disease other than Parkinson's disease dementia; or
- reversible dementias such as those cause by thyroid or other hormonal abnormalities, or vitamin deficiencies.

Parkinson's Disease (Advanced) means a chronic, slowly progressive neurological condition affecting the brain's ability to produce dopamine and that is marked by tremor of the muscles, rigidity, slowness of movement, impaired balance, and a shuffling gait which has resulted in a Covered Person's inability to perform at least 2 Activities of Daily Living for a continuous period of 90 days.

Progressive Disease Covered Condition means any of the following:
- Alzheimer's disease;
- amyotrophic lateral sclerosis (referred to as ALS or Lou Gehrig's Disease);
- Multiple Sclerosis;
- muscular dystrophy;
- Parkinson's Disease (Advanced); or
- systemic lupus erythematosus (SLE).

INITIAL BENEFIT FOR A PROGRESSIVE DISEASE COVERED CONDITION

We will pay the applicable Initial Benefit for a Progressive Disease Covered Disease shown on the Schedule, the first time that a Progressive Disease Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

ADDITIONAL PROOF REQUIREMENTS FOR A PROGRESSIVE DISEASE COVERED CONDITION

A Clinical Diagnosis of a Progressive Disease Covered Condition must be made in Writing by a Physician and must be substantiated by the current clinical diagnostic criteria for the condition in the medical records.

COVERED CONDITION CATEGORY: SEVERE BURN

ADDITIONAL DEFINITIONS THAT APPLY TO THE SEVERE BURN COVERED CONDITION CATEGORY

Occurs or **Occurrence**, with respect to a Severe Burn Covered Condition, means that a Covered Person sustains a Severe Burn Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Severe Burn Covered Condition will be deemed to Occur on the date a Covered Person sustains a Severe Burn Covered Condition.

Severe Burn Covered Condition means a Covered Person has sustained a burn that is, at least, a Third-Degree Burn.

Third-Degree Burn means a full-thickness burn caused by acute thermal, chemical, electrical, or radiation exposure that has caused destruction of the skin dermis, epidermis and hypodermis layers.

INITIAL BENEFIT FOR A SEVERE BURN COVERED CONDITION

We will pay the Initial Benefit for a Severe Burn Covered Condition shown on the Schedule the first time that a Severe Burn Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

RECURRENCE BENEFIT FOR A SEVERE BURN COVERED CONDITION

We will pay the Recurrence Benefit for a Severe Burn Covered Condition shown on the Schedule for another Occurrence of a Severe Burn Covered Condition if the subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

ADDITIONAL PROOF REQUIREMENTS FOR A SEVERE BURN COVERED CONDITION

Proof of a Severe Burn Covered Condition requires additional documentation of the following:

- the Severe Burn Covered Condition was treated by a Physician;
- the Severe Burn covers at least 18% of the Covered Person's total body surface area; and
- a Clinical Diagnosis of Severe Burn that:
  - sets forth the date the Severe Burn Occurred;
  - is made in Writing by a Physician using the current clinical diagnostic criteria and burn classification standards; and
  - is substantiated in the medical records.

COVERED CONDITION CATEGORY: STROKE

ADDITIONAL DEFINITIONS THAT APPLY TO THE STROKE COVERED CONDITION CATEGORY

Stroke Covered Condition means the following:
- Stroke.

Stroke means a cerebrovascular accident or incident producing measurable, functional and permanent neurological impairment caused by any of the following which result in an infarction of brain tissue:
- hemorrhage;
- thrombus; or
- embolus from an extra-cranial source.

The term Stroke does not include Transient Ischemic Attacks, or prolonged reversible ischemic attacks).

Occurs or **Occurrence**, with respect to a Stroke Covered Condition, means a Covered Person is Diagnosed with such Covered Condition while coverage is in effect under this Certificate for such Covered Person. A Stroke Covered Condition will be deemed to Occur on the date the Diagnosis of the Stroke Covered Condition is made.

Transient Ischemic Attack (TIA) means a temporary ischemic event (including prolonged reversible ischemic attacks) in which:
- there are measurable, functional neurological impairments that are focal and confined to an area of the brain perfused by a specific artery;
- there is no evidence of cerebral tissue damage on diagnostic imaging; and
- the reversible functional neurological impairments are confirmed by a Clinical Diagnosis.

INITIAL BENEFIT FOR A STROKE COVERED CONDITION

We will pay the applicable Initial Benefit for a Stroke Covered Condition shown on the Schedule, the first time that a Stroke Covered Condition Occurs for a Covered Person. The Initial Benefit Separation Period shown on the Schedule must be satisfied in order for the Initial Benefit to be payable.

RECURRENCE BENEFIT FOR A STROKE COVERED CONDITION

For any Stroke Covered Condition for which the Schedule shows a Recurrence Benefit, We will pay the applicable Recurrence Benefit for another Occurrence of the same Stroke Covered Condition for which We have already paid a benefit if such subsequent Occurrence happens after the Recurrence Benefit Separation Period has been satisfied.

ADDITIONAL PROOF REQUIREMENTS FOR A STROKE COVERED CONDITION

Proof of a Stroke Covered Condition requires the following additional documentation:
- medical records indicating objective evidence of a significant neurological, motor or sensory impairment that is functional and measurable; and
- for a Stroke – a pathological Diagnosis:
  - demonstrated on magnetic resonance imaging (MRI), computerized tomography (CT) or other reliable imaging techniques; and
  - confirmed in Writing by a Physician no earlier than 30 days after the Stroke with such impairments being present and considered permanent on the date that such Written confirmation is made.

Such Proof requirements must be documented in a Written report by a Physician.

COVERED CONDITION CATEGORY: STROKE (Continued)

SPECIAL EXCLUSIONS APPLICABLE TO A STROKE COVERED CONDITION

We will not pay benefits for a Diagnosis of a Stroke Covered Condition for:

- a Transient Ischemic Attack;
- cerebral symptoms due to migraine;
- cerebral injury resulting from trauma or hypoxia; or
- vascular disease affecting the eye or optic nerve or vestibular functions.

SUPPLEMENTAL BENEFITS

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 on the Schedule for the day the measure was taken, subject to all of the following:

- We will pay the Health Screening Benefit amount based on the Schedule that was in effect on the day the Covered Person received the screening measure; and
- We will pay the Health Screening Benefit no more than the number of times shown on the Schedule.

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)
- coronavirus testing
- dental exam
- digital rectal exam (DRE)
- Doppler screening for cancer
- Doppler screening for peripheral vascular disease
- echocardiogram
- electrocardiogram (EKG)
- electroencephalogram (EEG)
- endoscopy
- eye exams
- 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

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 With Premium Payment section of this Certificate. Please see that section for details.

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 Critical Illness 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 WITH PREMIUM PAYMENT

AT YOUR OPTION: PORTABILITY THROUGH 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". 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 critical illness 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 or as soon as reasonably possible from the date of the loss.

CLAIM FORM

When We receive notice of a claim under this Certificate, We will provide You or the claimant 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 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 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 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 a 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 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.

APPEALING A CLAIM DECISION

If We deny Your claim, You may appeal the decision by Writing to Us at the address indicated on the claim form within 180 days of receiving Our decision. Appeals must be in Writing and must include at least the following information:

- name of the Covered Person;
- name of the Group Policyholder;
- claim number;
- Group Policy number; and
- an explanation why You are appealing the decision.

As part of Your appeal, You may submit any Written comments, documents, records, or other information relating to Your claim. After We receive Your Written request appealing the decision, We will conduct a review of Your claim. We will notify You in Writing within 45 days after Our receipt of Your request for an appeal of: (i) Our decision; or (ii) if additional time will be required to complete the review. If additional time is needed, We will notify You of the reason additional time is required.

AUTHORIZATIONS

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

EXAMINATIONS

With respect to a pending claim, at Our expense and as often as is reasonably necessary, in order to substantiate Our Proof requirements:

- We may require a Covered Person to have an independent examination by a Physician of Our choice; and/or
- We may require a Covered Person to have an interview by phone or in person with Our representative.

Failure of a Covered Person to have an independent exam or to be interviewed at Our request as specified in this provision may result in the denial of the claim to which the exam or interview pertains.

AUTOPSY

With respect to a pending claim, at Our expense, in order to substantiate Our Proof requirements, 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.

REFUND TO US FOR OVERPAYMENT OF BENEFITS

If, at any time, We determine that benefits paid under this Certificate were more than the benefits due:

- You, or any other person, entity or health care provider to whom We overpaid benefits have the obligation to reimburse Us for the amount of such overpayment; and
- We have the right to recover the amount of such overpayment from You, or any other person, entity or health care provider to whom We overpaid benefits, including offsetting future benefits payable under this Certificate to You or such other person, entity or health care provider by an amount equal to the overpayment.

GENERAL PROVISIONS

CHANGES IN STANDARDS

This Certificate refers to classification standards for disease that have been developed by independent third parties. If those independent third parties change the classification standards, or if new standards are developed that become generally accepted in the medical community in the United States, We will interpret this Certificate in a manner that recognizes such changed or new standards when We determine it is appropriate to do so.

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 an increase in benefits after the 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.

If Your or Your Dependent's tobacco usage is misstated, the information regarding the correct tobacco usage will be used, as appropriate, to adjust the benefits and/or Contributions.

ASSIGNMENT

The benefits under the Group Policy are not assignable prior to a claim for benefits, 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 LUMEN TECHNOLOGIES CRITICAL ILLNESS 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: Critical Illness 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 Critical Illness 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 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 Critical Illness Insurance. 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 January 1st and ending on the following December 31st.

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

Critical Illness 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 Critical Illness 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 Critical Illness 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.