Hospital Indemnity Insurance - Low Plan

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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Fixed Indemnity Notice

This is a Fixed Indemnity Policy, not Health Insurance.

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit HealthCare.gov or call 800-318-2596 (TTY: 855-889-4325) to find comprehensive health coverage.

Questions about this policy?

- For questions or complaints, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under Insurance Departments.
- If you have this policy through your employer, or a family member's job, contact the Benefits Administrator. For Lumen, it is the Lumen Health and Life Service Center or MetLife, as MetLife administers the Hospital Indemnity Insurance Low and High plans.

Introduction

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

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

The effective date of this updated SPD is January 1, 2027. If you are a Covered Person in the Hospital Indemnity Insurance benefit option on or after January 1, 2027, this SPD supersedes and replaces, in its entirety, any other SPD describing the Hospital Indemnity Insurance benefit that you currently may possess. In the event of any discrepancy between this SPD and the official Plan Document, the Plan Document shall govern.

This SPD, together with other plan documents (such as Summary of Material Modifications (SMMs), amendments and Summary of Benefits Coverages (SBCs), and materials you receive at Annual Enrollment) are collectively referred to as, and constitute, the official Plan Document and describe your eligibility, benefits as well as rights and responsibilities under the Plan. The Plan is an insured benefit provided by Metropolitan Life Insurance Company (MetLife). This Welfare Benefits Plan is a 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 Hospital Indemnity 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 Persons, subject to applicable laws and if applicable, collective bargaining agreements.

The Plan Administrator, the Lumen Employee Benefits Committee, and its delegates(s), has the right and discretion to determine all matters of fact or interpretation relative to the administration of the Plan benefit option— including questions of eligibility, interpretations of the Plan provisions and any other matter. The decisions of the Plan

Administrator and any other person or group to whom such discretion has been delegated, including the Claims Administrator, shall be conclusive and binding on all persons. More information about the Plan Administrator and the Claims Administrator can be found in the **Lumen Welfare Benefit Plan General Information SPD**.

Note: While the Plan has processes in place to prevent errors and mistakes, if a clerical error or mistake happens (however occurring) such error or mistake does not create a right to a Benefit or level of contribution rate under the Plan. You have an obligation to correct any errors or omissions that come to your attention by calling the Lumen Health and Life Service Center (referred to the Service Center) to correct the error or omission. There are deadlines to file claims and benefit related actions; please refer to the section titled **Time deadline to file a benefit claim and the time deadline to file a benefit-related lawsuit** in this SPD.

The required forum for legal disputes

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

How to use this document

The SPD is designed to provide you with a general description, in non-technical language of the Benefits currently provided under the Hospital Indemnity 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 L**umen 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 Hospital Indemnity 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. Failure to pay the cost when due will result in the cancellation of your coverage in the Plan. If you have questions regarding your benefits under the Plan or direct billing, please contact the Lumen Health and Life Service Center or MetLife.

Consequences of Falsification or Misrepresentation

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

Continued coverage of an ineligible person is considered to be a misrepresentation of eligibility and falsification of, or omission to, update information to the Plan, which is in violation of the Code of Conduct and may result in disciplinary action, up to and including termination of employment. This misrepresentation/omission is also a violation of the Plan document, Section 8.3 which allows the Plan Administrator to determine how to remedy this situation. For example, if you divorce, your former spouse is no longer eligible for Plan coverage and this must be timely reported to the Service Center within 45 days, regardless if you have an obligation to provide health insurance coverage to your former spouse through a Court Order. Lumen does not allow former spouses or former domestic partners to continue coverage. While a court may order that health coverage must be maintained for a former spouse or former domestic partner, that is not the responsibility of Lumen or the Plan.

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

You and your Dependent(s) will not be permitted to benefit under the Plan from your own misrepresentation. If a person is found to have falsified any document in support of a claim for Benefits or coverage under the Plan, the Plan Administrator may, without anyone's consent, terminate coverage, possibly retroactively, if permitted by law (called rescission), depending on the circumstances, and may seek reimbursement for Benefits that should not have been paid out. Additionally, the Claims Administrator may refuse to honor any claim under the Plan or to refund premiums.

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

Inform the Plan of changes

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

A word about your privacy

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

Health plan coverage is not health care advice

Please keep in mind that the sole purpose of the Plan is to provide payment of certain Hospital Indemnity 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 Plan's procedures for claiming a Benefit or resolving an issue involving Plan Benefits, there is no guarantee that the Plan Benefits for which you may be eligible will be paid to you on a timely basis, or paid at all, and there can be no guarantee that your personal health information will remain private and protected.

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:	Hospital Indemnity Insurance (Low)
Type of Administration:	The Hospital Indemnity 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 Hospital Indemnity 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 unless you first complete all the administrative claims and appeals requirements. Once you have exhausted the administrative remedies, you can bring any legal proceedings or action within 12 months or 1 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

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

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future Benefits including issuing you a Form 1099 for the amount of the overpayment as gross income.

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



METROPOLITAN LIFE INSURANCE COMPANY
NEW YORK, NEW YORK

CERTIFICATE OF HOSPITAL INDEMNITY 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 Persons Specifications page and Eligibility Provisions: Dependent Insurance section for details.

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

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

Important Notice: The insurance evidenced by this Certificate provides limited benefits. The benefit amounts shown on the Schedule are not based on any medical expenses that are incurred. You should have medical coverage in force when You enroll for this insurance.

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

30-Day Right to Examine Certificate. Please read this Certificate carefully. If You are not satisfied for any reason, You may notify Us that You are cancelling Your Certificate within 30 days from the date of delivery by calling us at 1-800-GETMET8. If You notify Us 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.

Florida Residents: The benefits of the policy providing Your coverage are governed primarily by the laws of a state other than Florida.

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 FLORIDA

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

The following provision is added to the When Insurance Ends section of this Certificate if that section does not include an Extension of Benefits provision. If the When Insurance Ends section includes an Extension of Benefits provision, We will only pay benefits under one provision, which will be the one that pays the most.

EXTENSION OF BENEFITS

If a Covered Person is Confined on the date Your insurance ends, and You do not continue insurance under the At Your Option: Continuation with Premium Payment provision, We will pay certain benefits for such Covered Person if the Confinement continues after Your insurance ends, in accordance with, and subject to all of the following:

- No benefits will be available under this Extension of Benefits provision if Your insurance ends due to non-payment of premium.
- The Confinement Benefit will be payable if requirements for payment of that benefit are met while the Covered Person is Confined. No other benefits will be payable.
- Benefits payable under this Extension of Benefits provision will be paid in accordance with and subject to the terms and conditions of this Certificate, except as set forth in this provision.
- Benefits under this Extension of Benefits provision will end on the earlier of:
  - the date the Covered Person is no longer Confined; or
  - the end of the number of days that Confinement Benefits are payable for the Confinement.
- If the Covered Person is again Confined at any time after discharge, no further benefits will be payable.

NOTICE FOR RESIDENTS OF MAINE

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

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

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

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COVERED PERSON SPECIFICATIONS

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

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

SCHEDULE OF INSURANCE

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

HOSPITAL BENEFITS	Benefit / Limit
Admission Benefit	$1,000 for the day of admission We will pay the Admission Benefit no more than: one time per Confinement; and 4 times per Covered Person, per calendar year
ICU Supplemental Admission Benefit	$1,000 for the day of admission
Confinement Benefit	$100 per day We will pay the Confinement Benefit for no more than: 15 days per Covered Person, per calendar year
Confinement Benefit for Newborn Nursery Care	$100 per day We will pay the Confinement Benefit for Newborn Nursery Care for no more than 3 days per newborn baby
ICU Supplemental Confinement Benefit	$200 per day We will pay the ICU Supplemental Confinement Benefit for no more than: 15 days per Covered Person, per calendar year
Inpatient Rehabilitation Benefit	$50 per day We will pay the Inpatient Rehabilitation Benefit for no more than: 15 days per Covered Person, per calendar year

DEFINITIONS

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

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

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

Accidental means happening by Accident.

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

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

Certificate means this Certificate including any riders attached to it.

Complications of Pregnancy means diseases or conditions, the diagnoses of which are distinct from pregnancy and not associated with normal pregnancy or Routine Childbirth, but are adversely affected or caused by pregnancy, such as: acute nephritis; nephrosis; cardiac decompensation; non-elective or emergency Caesarean section; ectopic pregnancy which is terminated; a spontaneous termination of pregnancy when a viable birth is not possible; puerperal infection; eclampsia; hyperemesis gravidarum and pre-eclampsia requiring Confinement; toxemia; missed abortion; or disease of the vascular, hemopoietic, nervous or endocrine systems.

The term Complications of Pregnancy does not include: false labor; occasional spotting; doctor prescribed rest during the period of pregnancy; morning sickness; multiple gestation pregnancy; elective abortion; or conditions of comparable severity associated with management of a difficult pregnancy.

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

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

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

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

DEFINITIONS (Continued)

Dependent Child means the following:

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

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

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

Dependent Child Age Limit means:

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

Dependent Insurance means insurance under this Certificate for Your Dependents.

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.

DEFINITIONS (Continued)

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

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

The term Emergency Room includes short stay observation units or clinical decision units within a Hospital that assess, within a period of less than 20 continuous hours, whether to discharge or admit patients.

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.

Hospice Facility means a facility, unit of a facility, public or private agency, or unit of a public or private agency that:

- is separate from a Hospital or is a separately designated unit within a Hospital; and
- meets federal certification requirements as a hospice, or is comparably licensed under the laws where it is located, to provide care or management of persons who are diagnosed with a Terminal Illness.

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

The term Hospital does not include a separate unit of a Hospital that is licensed as a hospice facility, nursing home, skilled nursing facility, assisted living facility, rehabilitation facility or an outpatient Surgery facility.

Injury means any bodily harm that results directly from an Accident.

DEFINITIONS (Continued)

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

The term Intensive Care Unit includes Hospital units with the following names: intensive care unit; coronary care unit; neonatal intensive care unit; pulmonary care unit; burn unit; or transplant unit.

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

Newborn Nursery Care means routine well baby care provided to a newborn baby while Confined immediately following a Covered Person's childbirth of such baby.

Nurse means a registered professional nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) who is licensed under the laws where the services are performed.

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

DEFINITIONS (Continued)

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

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

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

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

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

Rehabilitation Facility means a facility that:
- provides rehabilitation care services on an inpatient basis;
- is separate from a Hospital or is a separately designated unit within a Hospital; and
- maintains all required licenses and certifications.

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

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

Routine Childbirth means the vaginal delivery of a child or children or the delivery of a child or children by elective Cesarean section.

Routine Pregnancy means a normal pregnancy that does not have Complications of Pregnancy.

DEFINITIONS (Continued)

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

Sickness means:
- a physical illness, physical infirmity or physical disease;
- Complications of Pregnancy; or
- Routine Childbirth.

The term Sickness does not include Routine Pregnancy.

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

Skilled Nursing Facility means a facility that provides nursing care that meets all of the following requirements:
- if licensing or certification is required, maintains all appropriate licensing or certification under the laws where it is located as a skilled or intermediate nursing facility;
- has 24 hour a day care performed by an awake, and trained or certified staff supervised by a Nurse;
- is separate from a Hospital or is a separately designated unit within a Hospital;
- keeps a Written record of services performed for each client;
- has established procedures to obtain emergency medical care; and
- services are not limited to provision of food, shelter, and other residential services such as laundry.

The term Skilled Nursing Facility does not include a Hospice Facility.

Spouse means Your lawful spouse.

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

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 Hospital Indemnity 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.

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. 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 representative.

Other Dependents

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

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

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

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.

HOSPITAL BENEFITS

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

HOSPITAL ADMISSION BENEFITS

Admission Benefit

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

- The admission must occur on or after the date that coverage took effect under this Certificate for such Covered Person.
- The Admission Benefit is not payable for Emergency Room treatment or outpatient treatment.
- We will only pay the Admission Benefit for a Covered Person for one Hospital admission at a time, even if the admission is caused by more than one Injury or Sickness or a combination of Injury and Sickness.
- For Hospital admission for treatment of an Injury, the admission must occur within 180 days after the Accident occurs.
- If a Covered Person is discharged from a Confinement for which We paid an Admission Benefit and, within 90 days is again Confined for the same or related Injury or Sickness, We will treat the subsequent Confinement as a continuation of the previous Confinement (and an additional Admission Benefit will not be payable).
- We will only pay an Admission Benefit for a newborn baby who is born in a Hospital if, due to a Sickness or Injury, the newborn baby is admitted to the Intensive Care Unit.
- If a Covered Person is admitted to a Hospital and is then transferred to another Hospital, We will not pay an additional Admission Benefit.
- We will pay the Admission Benefit no more than the number of times shown on the Schedule.

ICU Supplemental Admission Benefit

We will pay the ICU Supplemental Admission Benefit shown on the Schedule, in addition to the Admission Benefit, if a Covered Person, upon initial admission for Confinement to a Hospital for treatment of an Injury or Sickness, is admitted to an ICU, subject to all of the following:

- The admission must meet the requirements for payment of the Admission Benefit.
- For an ICU admission for treatment of an Injury, the admission must occur within 180 days after the Accident occurs.
- If the Covered Person moves to an ICU after initial admission to a Hospital, We will not pay the ICU Supplemental Admission Benefit.

HOSPITAL CONFINEMENT BENEFITS

Confinement Benefit

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

- The Confinement must begin while coverage is in effect under this Certificate for such Covered Person. For Confinement for treatment of an Injury, the Confinement must begin within 180 days after the Accident occurs.
- If a Covered Person is Confined in a Hospital and is then transferred to another Hospital, We will treat the transfer as a continuation of the prior Confinement.
- We will only pay one Confinement Benefit per Covered Person, per day.
- We will pay the Confinement Benefit for no more than the number of days shown on the Schedule.
- For a newborn baby who is receiving Newborn Nursery Care and is not Confined for treatment of a physical illness, infirmity, disease or Injury, We will pay the Confinement Benefit for Newborn Nursery Care shown on the Schedule for such baby, while Confined, up to the number of days shown on the Schedule. If a newborn baby is Confined for treatment of a physical illness, infirmity, disease or Injury, We will pay the Confinement Benefit instead of the Confinement Benefit for Newborn Nursery Care.

ICU Supplemental Confinement Benefit

We will pay the ICU Supplemental Confinement Benefit shown on the Schedule, in addition to the Confinement Benefit, for each day a Covered Person is Confined in an ICU for treatment of an Injury or Sickness, subject to all of the following:

- The ICU Confinement must meet the requirements for payment of the Confinement Benefit.
- We will only pay the ICU Supplemental Confinement Benefit for a day on which the Confinement Benefit is payable.
- For an ICU Confinement for treatment of an Injury, Confinement in the Intensive Care Unit must begin within 180 days after the Accident occurs.
- We will pay the ICU Supplemental Confinement Benefit for no more than the number of days shown on the Schedule.

INPATIENT REHABILITATION BENEFIT

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

- For treatment of an Injury, the Covered Person’s inpatient stay in the Rehabilitation Facility must start within 365 days after the Accident occurs.
- If the Covered Person is discharged from the Rehabilitation Facility and, within 14 days is again admitted to a Rehabilitation Facility as a resident inpatient for treatment of the same or related Injury or Sickness, We will treat the subsequent Rehabilitation Facility stay as a continuation of the previous stay.
- We will not pay the Inpatient Rehabilitation Benefit for any day for which We paid an Admission Benefit or a Confinement Benefit.
- We will only pay one Inpatient Rehabilitation Benefit per Covered Person, per day.
- We will pay the Inpatient Rehabilitation Benefit for no more than the number of days shown on the Schedule.

EXCLUSIONS

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

- war, whether declared or undeclared; or act of war;
- the Covered Person's active participation in an insurrection, rebellion, riot, or terrorist act;
- the Covered Person's engagement in any activity that constitutes a felony under the laws of the jurisdiction in which the activity occurred;
- dental procedures or Surgery except as the result of an Accident causing Injury to a sound natural tooth;
- cosmetic Surgery, except when such Surgery is performed to:
  - treat an Injury or Sickness;
  - correct a disorder of normal bodily function or structure that was caused by an Injury or Sickness for which coverage is not otherwise excluded under this Certificate; or
  - reconstruct a part of the body which was disfigured or removed as a result of an Injury or Sickness for which coverage is not otherwise excluded under this Certificate; 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 of the following outside of the United States, Canada or Mexico:

- any medical or healthcare treatment, services or transportation; or
- any inpatient admission or stay in any medical or health care facility.

The following additional exclusions apply to payment of benefits for any loss due to an Accident:
We will not pay benefits for any loss due to an Accident for a Covered Person caused or contributed to by:

- the Covered Person's operation, while intoxicated, of a motor vehicle involved in the incident. For purposes of this exclusion:
  - intoxicated means that the Covered Person's blood alcohol level met or exceeded .08%; and
  - motor vehicle means any vehicle that is powered by a motor, including, but not limited to: an automobile; a boat; a motorcycle; a truck; an all-terrain vehicle; or a snow mobile;
- the Covered Person's travel or flight in any aircraft except as a fare-paying passenger on a regularly scheduled charter or commercial flight;
- the Covered Person parachuting or otherwise exiting from a motorized or non-motorized aircraft while such aircraft is in flight, except for self-preservation;
- the Covered Person riding in or driving any motor-driven vehicle in a race, stunt show or speed test;
- the Covered Person participating in any semi-professional or professional competitive athletic activity for which any type of compensation or remuneration is received; or
- the Covered Person bungee jumping, base jumping, hang gliding, para-kiting, sail-gliding, scuba diving deeper than 130 feet; spelunking; or mountaineering including rock climbing using ropes and any other climbing equipment. For the purposes of this exclusion the term mountaineering does not include backpacking, mountain biking, hiking or trail running.

EXCLUSIONS (Continued)

The following additional exclusions applies to payment of benefits for any loss due to a Sickness:
We will not pay benefits under this Certificate for:

- a Dependent Child's Routine Childbirth and any well baby or nursing care provided to the Dependent Child's newborn child
- We will not pay benefits under this Certificate for a Dependent Child's Routine Childbirth and any well baby or nursing care provided to the Dependent Child's newborn child

WHEN INSURANCE ENDS

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

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 Hospital Indemnity Insurance under the Group Policy; and
- the benefits available to Your new class are identical to the benefits available under this Certificate.

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

CONTINUATION OF INSURANCE

AT YOUR OPTION: CONTINUATION WITH PREMIUM PAYMENT

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

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

Requirements for Continued Insurance

Continued Insurance will be available to You if:

- Your Group Billed Insurance ends for any reason other than:
  - non-payment of premium or Contribution; or
  - the end of the Group Policy, provided that Continued Insurance will be available to You if You do not become eligible, within 30 days after the end of the Group Policy, for hospital indemnity 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.

CONTINUATION OF INSURANCE (Continued)

End of Continued Insurance

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

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

FOR INTELLECTUALLY OR PHYSICALLY DISABLED CHILDREN

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

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

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

FOR FAMILY AND MEDICAL LEAVE

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

CLAIMS

NOTICE OF CLAIM

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

CLAIM FORM

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

PROOF OF LOSS

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

PAYMENT OF BENEFITS

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

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

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

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

YOUR BENEFICIARY

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

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

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

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

CLAIMS (Continued)

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

AUTHORIZATIONS

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

EXAMINATIONS

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

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

AUTOPSY

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

TIME LIMIT ON LEGAL ACTIONS

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

REFUND TO US FOR OVERPAYMENT OF BENEFITS

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

- You, or any other person, entity or health care provider to whom We over paid 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 over paid benefits, including offsetting future benefits payable to You or such other person, entity or health care provider by an amount equivalent to the overpayment.

GENERAL PROVISIONS

ENTIRE CONTRACT

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

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

INCONTESTABILITY: STATEMENTS MADE BY YOU

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

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

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

MISSTATEMENTS

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

ASSIGNMENT

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

CONFORMITY WITH LAW

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

STANDARD OF TIME

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

ACCESS TO DISCOUNTS FOR SERVICES

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

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

ERISA INFORMATION

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

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

EMPLOYER IDENTIFICATION NUMBER: 720651161

PLAN NUMBER: 513

COVERAGE: Hospital Indemnity 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 Hospital Indemnity Insurance benefits.

AGENT FOR SERVICE OF LEGAL PROCESS

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

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

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

PLAN TERMINATION OR CHANGES

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

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

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

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

CONTRIBUTIONS

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

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each 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

Hospital Indemnity 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 Hospital Indemnity 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 Hospital Indemnity 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.