Lumen Health Care Plan*

Traditional/Limited and Dependent Day Care Flexible Spending Accounts (FSA)

(Administered by UnitedHealthcare)

Summary Plan Description (SPD) For Active Employees

Effective Jan. 1, 2021

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

* The Lumen brand was launched on September 14, 2020. As a result, Lumen, Inc. is referred to as Lumen Technologies, or simply Lumen. The legal name Lumen, Inc. is expected to be formally changed to Lumen Technologies, Inc. upon the completion of all applicable requirements.

Issued Jan. 1, 2021

LUMEN®

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FLEXIBLE SPENDING ACCOUNT BENEFIT OPTION

Notice To Participants and Employees

This Summary Plan Description (SPD) describes the Lumen Flexible Spending Account benefit option under the Lumen Health Care Plan* ("Plan") as of January 1, 2021.

Lumen has entered into an arrangement with UnitedHealthcare Insurance Company, Hartford, CT ("UnitedHealthcare") under which UnitedHealthcare will review and process claims and, upon approval, issue reimbursements, as well as provide certain other administrative services to the Plan.

UnitedHealthcare does not insure the benefits described in this SPD. It is a benefit option that you can elect to participate in as part of the Lumen Health Care Plan, which is a self-funded plan subject to ERISA, as explained in more detail in this Summary Plan Description.

INTRODUCTION

Lumen Technologies (hereinafter "Lumen" or "Company") is pleased to provide you with this Summary Plan Description ("SPD"). This SPD presents an overview of the Benefits available under the Flexible Spending Accounts (FSA) for 1) the Traditional Health Care FSA, 2) the Limited Health Care FSA and 3) the Dependent Day Care FSA benefit options of the **Lumen Health Care Plan* (the "Plan")**.

> **Please Note: This SPD must be read in conjunction with the *General Information SPD* which explains many details of your coverage, ERISA rights, Circumstances which can Affect your Benefits, Administrative Information and provides a listing of the other benefit options under the Plan.**

The effective date of this updated SPD is January 1, 2021. If you are a Covered Person in any of the FSA Plan benefit option(s) of the Plan on or after January 1, 2021, this SPD supersedes and replaces, in its entirety, any other SPD describing FSA plan Benefits that you currently may possess. In the event of any discrepancy between this SPD and the official Plan Document, the Plan Document shall govern.

This SPD, together with other plan documents (such as the Summary of Material Modifications (SMMs), the General Information SPD and Annual Enrollment materials,) (hereafter "Plan documents") briefly describe your Benefits as well as rights and responsibilities, under the Lumen Health Care Plan (the "Plan"). These documents make up your official Summary Plan Description for the Flexible Spending Account Health benefit options as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Dependent Day care Flexible Spending Account is not an ERISA plan or subject to ERISA.

Company's Reserved Rights

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

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

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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 Service Center to correct the error or omission. There are deadlines to file claims and benefit related actions; please refer to "**Time Deadline to File a Benefit Claim and the Time Deadline to File a Benefit-Related Lawsuit**" on page 23 in this SPD and in the General SPD for more information about the timing of these deadlines.*

The Required Forum for Legal Disputes

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

How to Use This Document

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

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

You are encouraged to keep all the SPDs and any attachments (summary of material modifications ("SMMs"), amendments, Summaries of Benefits Coverage, Annual Enrollment Guides and addendums) for future reference. Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.

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.

You can call the Lumen Health and Life Service Center at 866-935-5011 to request a paper copy of **the General Information SPD** or you can go online at lumen.com/healthandlife (if actively working) or lumen.com/healthbenefits to print a copy.

Health Plan Coverage Is Not Health Care Advice

Please keep in mind that the sole purpose of the Plan is to provide for the payment of certain health care expenses and not to guide or direct the course of treatment of any Employee, or eligible Dependent. Just because your health care Provider recommends a course of treatment does not mean it is 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.*

EXCEPTED HEALTH FSA PLAN STATUS NOTICE

For Active Employees

The Health Care Spending Account benefit option under the Plan is an "Excepted" plan option, which means it is not subject to many of the requirements of the Patient Protection and Affordable Care Act (the Affordable Care Act). Being an "excepted health plan" means that the Health FSA benefit plan option does not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, Health FSAs must comply with certain other requirements, such as the limitation on Benefits to $2,750 annually, effective January 1, 2021 (subject to change based on IRS guidance).

Questions regarding which protections apply and which protections do not apply to an excepted Health FSA can be directed to the Lumen Health and Life Service Center at 866-935-5011. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to excepted health plans.

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

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

GENERAL PLAN INFORMATION

The FSA Plan benefit option is just one of the benefit options offered under the Plan. Refer to the ***General Information SPD*** for important and general Plan information including, but not limited to, the following sections:

- Eligibility
- When Coverage Begins
- When Coverage Ends
- Circumstances that May Affect Your Plan Benefits
- The Plan's Right to Restitution
- Coordination of Benefits
- Plan Information (e.g. Plan Sponsor and EIN, administration, contact information, Plan Number, etc.)
- A statement of Your ERISA Rights (applicable to the Health FSAs)
- Your Rights to COBRA and Continuation Coverage (applicable to the Health FSAs)
- General Administrative Provisions
- Required Notice and Disclosure
- Glossary of Defined Terms
- Qualified Medical/prescription drug Child Support Order (QMCSO)

Consequences of Falsification or Misrepresentation

Honesty is the best policy and one that participants in the Plan are required to follow in order to be eligible to participate.

Continued coverage of an ineligible person is considered to be a misrepresentation of eligibility and falsification of, or omission to, update information to the Plan, which is in violation of the Code of Conduct and may result in disciplinary action, up to and including termination of employment. This misrepresentation/omission is also a violation of the Plan document, Section 8.3 which allows the Plan Administrator to determine how to remedy this situation. For example, if you divorce, your former spouse is no longer eligible for Plan coverage and this must be timely reported to the Service Center within 45 days, regardless if you have an obligation to provide health insurance coverage to your ex-spouse through a Court Order.

- You and your Dependent(s) will not be permitted to benefit under the Plan from your own misrepresentation. If a

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

- While a court may order that health coverage must be maintained for an ex-spouse/domestic partner, that is not the responsibility of the Company or the Plan.
- You are also advised that by participating in the Plan you agree that suspected incidents of this nature may be turned over to the Plan Administrator and or Corporate Security to investigate and to address the possible consequences of such actions under the Plan. All Covered Persons are periodically asked to submit proof of eligibility and to verify claims.

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

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

You Must Follow Plan Procedures

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

Plan Number

The Flexible Spending Account Plan is part of the Lumen Health Care Plan*. The Plan Number for the Lumen Health Care Plan* is **512.**

CLAIMS ADMINISTRATOR AND CONTACT INFORMATION

UnitedHealthcare

Flexible Spending Account	877-311-7849
Medical/prescription drug claims	800-842-1219 TTY users: Call 711
Website Address:	myuhc.com
Mailing Address:	UnitedHealthcare PO Box 981506 El Paso, TX 79998-1506 877 311-7849

Lumen

Lumen Health and Life Service Center

P.O. Box 1407 Lincolnshire, IL 60069	866-935-5011
Website Address:	lumen.com/healthandlife

PLAN ADMINISTRATION

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Agent for Service of Legal Process:

Associate General Counsel
931 14th Street, 9th Floor
Denver, CO 80202

Legal process may also be served on:

The Corporation Company (a.k.a. CT Corp)
1675 Broadway, Suite 1200
Denver, Colorado 80202

Plan Name:	Lumen Health Care Plan*
Plan Number:	199383
Employer ID:	72-0651161
Plan Type:	Health Care Plan
Plan year:	January 1 – December 31
Plan Administration:	Self-Funded
Source of Plan Contributions and Funding:	The Plan is funded out of the general assets of the Plan Sponsor based on the salary reduction elections made by participating Employees

FLEXIBLE SPENDING ACCOUNTS

Employees have the opportunity to set aside pre-tax dollars each year in either of the Health Care Flexible Spending Accounts (Traditional or Limited Purpose) and/or the Dependent Day care Flexible Spending Accounts to save money on predictable Eligible Expenses. You do not have to be enrolled in any of the medical/prescription drug, dental or vision plan options offered by Lumen to participate in the FSAs.

Traditional Health Care

Flexible Spending Account (HCFSA) is a type of FSA used for reimbursement of Eligible Health Care Expenses (defined in the Health Care Spending Account section), including certain medical/prescription drug, dental or vision expenses for you, your spouse, your dependent children, and any other dependents you can claim on your federal tax return. Certain Over-the-Counter prescription drugs and medical supplies are covered as approved by the IRS guidelines.

Note: Grace Period dollars are available under the HCFSA, please see "**For Employees Enrolled in both a CDHP and a Health Care FSA**" on page 8 for additional information on how to submit claims manually to access these funds.

Limited Purpose Health Care (if enrolled in the HDHP)

Flexible Spending Account is a type of FSA used for reimbursement of Eligible Dental and Vision Expenses (defined in the Health Care Spending Account section) for you, your spouse, your dependent children, and any other dependents you can claim on your federal tax return. The Limited Purpose Health Care Flexible Spending Account does not reimburse for medical/prescription drug expenses. If you are enrolled in the HDHP medical/prescription drug option and elect a Health Care FSA, you will be automatically enrolled in the Limited

Purpose Health Care FSA even if you elect or do not elect an HSA.

Note: You are not eligible for the Traditional Health Care FSA if you are enrolled in a High Deductible Health Care Plan (HDHP) even if you are not contributing/enrolled in a Health Spending Account (HSA).

Dependent Day Care Flexible Spending Account (DCFSA)

Is a type of FSA used for reimbursement of Eligible Dependent Care Expenses (defined in the Dependent Care Spending Account section), such as day care. Specific rules and timeframes for using a DCSA are set for in more detail in the *General Information SPD*.

Please Note: The DCFSA is not subject to ERISA. Only the HCFSA is subject to **ERISA and the ERISA Rights provisions** described in the **General Information SPD**. You can call the Lumen Health and Life Service Center at 866-935-5011 to request a paper copy of **the General Information SPD** or you can go online at lumen.com/healthandlife (if actively working) or lumen.com/healthbenefits to print copy.

Pre-tax Savings

Each year during annual enrollment, or as a newly eligible Employee, you may elect to make pre-tax contributions into the FSA accounts. Your contributions are not subject to federal income taxes, (e.g., Social Security), or some state employment taxes; you pay taxes only on your income after your spending account contributions have been deducted. During the year, when you have an eligible health care or dependent day care expense, you can be reimbursed from your appropriate account - tax free.

The following example shows how you may decrease your taxes and end up with more spendable income by paying eligible expenses through the spending accounts.

Example: Assume that you are married, filing a joint return, and that your taxable income is $45,000. Assume, too, that you contribute $2,000 to a spending account and have exactly $2,000 in eligible expenses that year. As you can see from the example below, based on 2020 federal income tax rates, you can increase your spendable income by over $650 simply by using the spending account. This is the amount you save in taxes on the $2,000 deposited in your spending account. Additional savings may be realized on reduced state or local income taxes.

Example	Not Using the Plan	Using the Plan
Taxable income before FSA contributions	$45,000	$45,000
Annual contribution to a FSA	$0	$2,000
Taxable income	$45,000	$43,000
Estimated federal income tax	$5,005	$4,765
Estimated Social Security/Medicare tax	$3,443	$3,290
Take-home pay	$36,553	$34,946
Eligible expenses	$2,000	$2,000
Tax-free reimbursement from the account	$0	$2,000
Spendable income (without regard for state or local taxes)	$34,553	$34,946

Effect on Other Benefits

Many Company benefits, such as long-term disability income and life insurance are based on pay. Your spending account contributions do not generally reduce what is considered your “pay” when computing these benefits.

Governmental Benefits

Spending account contributions which are exempt from governmental taxes (e.g., Social Security) are not taken into account when government benefits are calculated. Only the pay that has been taxed (not your spending account contributions) is used to calculate governmental benefits. Thus, contributions to a spending account may slightly reduce your Social Security benefits.

Note: The Company doesn't provide tax advice and you should consult with your own tax advisor regarding your specific situation and circumstances.

Additional Contribution Limits

The IRS has established certain tax qualification rules so that Health Care FSAs do not discriminate in favor of the highly compensated Employees. If you are highly compensated, as annually defined by the IRS, your contributions to the Traditional Health Care FSA or the Dependent Care Savings Account.

Forfeiture of Unused Funds

You should carefully estimate your Eligible Health Care and Dependent Day care Expenses, collectively referred to throughout this booklet as "Eligible Expenses", for the upcoming Plan year because IRS regulations require that you forfeit any unused funds remaining in either account after the reimbursement period ending on April 30 of the following year. Your expenses must be incurred between January 1 and March 15 (of the following year). For example: expenses incurred between January 1,2021 and March 15, 2022, must be submitted for reimbursement by April 30, 2022. All funds remaining after April 30, 2022 will be forfeited ***If you are enrolled in a Consumer Driven Health Plan ("CDHP") benefit option, see below for additional forfeiture information.***

Note: There is an exception to the forfeiture rules if you are called to active Military duty. Under certain circumstances you are allowed to take a withdrawal of your HCFSA balance. Please see the *Required Notice and Disclosure* and the *Military Leave of Absence* sections of the *General Information SPD* for more details.

For Employees Enrolled in both a CDHP medical/prescription drug option and a Health Care FSA (if no Grace Period Dollars are available):

1. Eligible expenses for Medical/prescription drug will be processed from your HRA funds, and eligible expenses for Dental and Vision will be processed out of the current year Health Care FSA.
2. **After the HRA funds have been exhausted:**
   - All eligible expenses for Medical/prescription drug/Dental and Vision will be processed out of the current year Health Care FSA funds

Claims submitted starting in January will process in the following order:

1. Current year HRA funds
2. Current year FSA funds

Example: You receive an annual HRA allocation of $1000 on January 1, 2020 and you elected a contribution goal amount for your Health Care FSA in the amount of $500. When a Medical/prescription drug expense is submitted with a date of service on February 2, 2020 for $1,200 the payment sequence will pay 1) from your 2020 HRA funds up to $1,000, then 2) your 2020 Health Care FSA dollars for the remaining $200.

Note: CDHP HRA will pay first as it is "tied" to your medical/prescription drug plan. Health Care FSA will pay secondary.

For Employees Enrolled in both a CDHP and a Health Care FSA (if Grace Period Dollars are available):

If you are enrolled in one of the CDHP benefit options, you will receive a Company-Funded HRA allocation annually on January 1. HRA dollars are processed first during claims review as they are part of the medical/prescription drug plan; FSA dollars are processed only after HRA funds have exhausted. The exception to this rule is if you have remaining health care FSA dollars from the prior plan year. See additional details:

If you have prior year FSA dollars remaining (also called Grace Period Dollars):

1. Eligible expenses for Medical/prescription drug/Dental and Vision will be processed out of your **prior year FSA dollars first** (if the Dates-of-Service are between January 1st and March 15th of the current year), once these funds are exhausted;
2. Eligible expenses for Medical/prescription drug will be processed from your **HRA funds, and eligible expenses for Dental and Vision will be processed out of the current year Health Care FSA. After the HRA funds have been exhausted:**
    - All eligible expenses for Medical/prescription drug/Dental/Vision will be processed out of the current year Health Care FSA.

Claims submitted between Jan 1 – March 15 will process in the following order:

1. Grace Period Dollars (prior year unused balance – **manual submission required**)
2. Current year HRA funds
3. Current year FSA funds

Example: There is $400 remaining in your 2020 (prior year Health Care FSA, you receive an annual HRA allocation of $1000 on January 1, 2021 and you elected a contribution goal amount for your Health Care FSA in the amount of $500. When a Medical/prescription drug expense is submitted with a date of service on February 2, 2021 for $1,500 the payment sequence will pay 1) from your prior year (grace period) FSA dollars up to $400 (your remaining balance), then 2) from your 2021 HRA funds up to $1,000 and lastly 3) your 2021 Health Care FSA dollars for the remaining $100.

After March 15, Grace Period Dollars will be forfeited, and claims will process in the following order:

1. Current year HRA funds
2. Current year FSA funds

Health Care Spending Cards and Auto-Reimbursement

UnitedHealthcare will provide a Health Care Spending Card (HCSC) to any employee that enrolls in the Traditional Health Care or Dependent Day care flexible spending account. The HCSC is a debit/credit card which can be used to pay for eligible health **and** dependent day care expenses directly from your FSA. (**Note:** *In addition, if you are enrolled in a CDHP benefit option, the HRA balance is also loaded onto the same card, but* ***HRA dollars will be accessed and processed before any FSA dollars when using the HCSC card.***)

If you want expenses paid out of the prior year's (grace period) FSA funds, claims will need to be submitted manually by filling out a manual claim form found on UHCs website at myuhc.com. You also have the option of submitting your claim/s electronically through myuhc.com. If you have allocated your prior year (grace period) FSA funds for specific dental or vision expenses, you can turn off Auto Reimbursement (Auto Rollover) by going to the myuhc.com website under Accounts and Balances.

TIP: You should review each plan year whether you want to turn off Auto Reimbursement/Auto Rollover.

Steps to turn off Auto-Reimbursement (Auto Rollover):

1. Log on to myuhc.com
2. Click on the Claims & Accounts tab
3. Click on the Plan Balances tab
4. When on the Plan Balances screen click the link for "Manage Automatic Payment Settings"

5. The Automatic Payment Options window will appear
6. Click Enroll and the auto rollover/coordinated payment option will be turned off
7. Follow the same steps to dis-enroll

Period of Coverage

Reimbursement available from your spending accounts is limited to qualifying expenses incurred during the annual "period of coverage."

Generally, the "period of coverage" is the calendar year during which you make pre-tax contributions to the spending accounts. However, your "period of coverage," and thus eligible reimbursements, will be affected if you start or change your account election due to a qualified status change as described below. It can also be impacted if you terminate or retire. See the *Qualified Status Changes* section in the *General Information SPD* for more information.

If you are on Short-Term Disability (STD), your Dependent day care will end on the day prior to your STD leave date. See"**When Coverage Ends**" on page 13 for additional information.

What Happens if You Resign, Retire or Experience Termination from Employment? Here is an example how these events would impact your benefits: During the Annual Enrollment period you elected to contribute a total of $1,000 to the Health Care Spending Account. If you terminate or retire from the Company on June 15, your coverage will end June 30. You may request reimbursement for eligible expenses incurred January 1 through June 30.

Optional Continuation Coverage Under Your Health Care Spending Account (COBRA)

This optional continuation coverage only applies if it has been made available by Lumen. Lumen may be required to offer this continuation coverage in certain cases as a result of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. Ask Lumen to find out if and how this continuation coverage and continuation coverage under USERRA described below applies.

In general, COBRA continuation coverage must be offered with respect to a participant's HCSA if the participant has a positive balance in such account at the time of a qualifying event such as termination of employment (other than by reason of gross misconduct) or reduction in work hours. A "positive balance" for this purpose generally means that the contributions made to the account prior to the qualifying event exceed the eligible claims for reimbursement submitted prior to the qualifying event. If this COBRA continuation coverage is available to a participant who experiences a qualifying event and continuation coverage is elected by the participant, such coverage will cease at the end of the Plan year in which the qualifying event occurs and coverage cannot be continued into the next Plan year. Premiums for such continuation coverage (i.e., contributions to the account) will be paid by the participant on an after-tax basis unless otherwise permitted by Lumen on a uniform and consistent basis plus a 2% administrative fee or other cost as permitted by law.

If your coverage under the spending accounts ends because your employment with the Company terminates, including death or disability, or because you are no longer an eligible employee, then:

- Your eligible ***dependent day care*** expenses incurred through the end of the **plan year** (12/31) can continue to be reimbursed to the extent there is a balance existing.
- Your eligible ***health care expenses*** incurred through the end of **month** of termination or loss of eligibility can be reimbursed. (**Note:** Upon leaving the Plan, you have the option of extending your "period of coverage" for the Health Care Flexible Spending Account through the remainder of the Plan year by making monthly payments on an ***after-tax*** basis. See "**COBRA – HEALTH FSA CONTINUATION**" on page 24 in this SPD.

Qualified Status Change example:

- During the Annual Enrollment period you elected to contribute a total of $1,000 to the Health Care Spending Account.
- On July 1, you change your election amount due to a Qualified Status Change to $1,800.
- Those increased contributions are not retroactive to January 1.
- Therefore, you have access to the $1,000 until June 30, with remaining dollars rolling in to your new election.
- You have access to the additional $800 only for expenses incurred on or after July 1.
- So, if you had claims incurred prior to June 30 totaling $600, then on July 1, you would have $1,200 remaining for the year ($400 balance + new $800).
- However, if you had claims incurred prior to July 1 for $1,500—only $1,000 of those claims could be reimbursed against the initial $1,000.
- You would not be able to reimburse the remaining $500 out of the additional $800, as those dollars are for claims incurred only after July 1.

ELIGIBILITY

You are eligible to participate in the Flexible Spending Accounts described in this summary if you are a full-time Employee. Provided you have timely enrolled, your Benefits will begin as described below in the *When Coverage Begins* section. Also see the *General Information SPD* for more eligibility information.

Eligible Dependents

Each spending account looks at eligible Dependents in a different way.

The IRS does not recognize Domestic Partners; therefore, expenses incurred by a Domestic Partner or their Dependent Children do not qualify for reimbursement from these accounts, **unless** they qualify as a tax dependent under Section 152 of the Internal Revenue Code.

Health Care Flexible Spending Account – this account reimburses qualified expenses incurred by you and/or an eligible Dependent, such as your Spouse or any other person who would qualify as a Dependent under federal income tax rules.

Dependent Day Care Flexible Spending Account – this account pays qualified expenses for care while you and your Spouse are at work or school for any of the following:

- Your Dependent Child under age 13;
- Your physically or mentally disabled Spouse; or
- Any other person who qualifies as your Dependent for federal income tax purposes – including a handicapped Child of any age or a dependent parent who is physically or mentally incapable of self-care.

When Coverage Begins

Coverage for regular full-time and regular part-time employees is effective 31 days from your date of hire providing you enroll by the deadline. For example, if you are employed full-time on March 14 and you complete your enrollment within 31 days, you will be covered for Benefits as of April 13. *(***Note:** *See "**Timing Restrictions**" on page 12.)*

If you fail to enroll in your Benefits within 31 days of eligibility, you will be waived from all coverage, including the FSAs. You must wait until the next benefits Annual Enrollment period to enroll with coverage being effective the following January 1, unless you have a Qualified Status Change.

- **Regular Full-time and Regular Part-time employees** - coverage effective date is 31 days from date of hire.
- **Temporary Full-time, Temporary Part-time and Incidental employees** - coverage effective date is 91 days from date of hire.

- **Rehired Employees** – coverage effective date is 31 days from date of rehire. If your rehire date is in the same month you terminated, your coverage effective date will be your rehire date.
- **FSA Enrollment Rules** - An FSA (Dependent Day Care and Health Care) lockdown period will occur from November 1 to December 31. The lockdown period will be in effect based on the effective date of the enrollment event. If you are newly eligible for an FSA in the month of November or December, you cannot enroll for the current plan year; however, you can enroll for the following plan year during Annual Enrollment to become effective January 1. This means that if you are newly hired in November and benefits eligible in December, you can elect to participate in an FSA for the following plan year but not for the month of December. This lockdown applies to electing an FSA, changing your current contribution amount as well as ending your FSA.

How to Enroll

You are required to enroll online when you first become eligible for Benefits, prior to the expiration of the 31 day waiting period. To enroll, log on to the Lumen Health and Life Benefits website at lumen.com/healthbenefits or through the Company intranet, lumen.com/healthandlife and make your benefit selections. *(***Note:** *See* ***"Timing Restrictions"*** *on page 12.)*

Changing Your Coverage

Each year, you will have the opportunity to change your flexible spending account elections, as well as, your health options and/or your Dependent coverage during the Annual Enrollment period. Any changes you make at that time will become effective the following January 1, and will be irrevocable for that calendar year, unless you have a Qualified Status Change as outlined below.

Midyear - Qualified Status Changes to Enrollment

Internal Revenue Service regulations allow you to start or stop participation or to change your contribution midyear if these changes are because of, and consistent with a Qualified Status Change, as described below.

You must report this change within 45 days following the qualifying event to the Lumen Health and Life Service Center, or no change can be made before the next Annual Enrollment period to be effective the following January 1. *(***Note:** *See* ***"Timing Restrictions"*** *on page 12.)*

Special Enrollment Period for Health FSA

An eligible Employee and/or Dependent who did not enroll for coverage when first eligible or during an Annual Enrollment period may enroll for coverage during a special enrollment period.

A special enrollment period is available if the following conditions are met:

a. the eligible Employee and/or Dependent had existing health coverage under another plan when last eligible to enroll in the plan, and

b. coverage under the prior plan was terminated as a result of loss of eligibility (including, without limitation, legal separation, divorce or death), termination of all employer contributions, or in the case of COBRA continuation coverage, the coverage was exhausted.

A special enrollment period is not available if coverage under the prior plan was terminated for cause or as a result of failure to pay premiums on a timely basis. Coverage under this Plan is effective only if the Lumen Health and Life Service Center receives applicable documentation within 45 days of the date coverage under the prior plan terminated.

Special enrollment also is available for an eligible Employee and/or new Dependents following the birth (or adoption or placement for adoption) of a child or marriage. Coverage under this Plan is effective only if the Lumen Health and Life Service Center receives applicable documentation within 45 days of the date of birth, adoption, placement for adoption, or within 45 days for marriage.

Special enrollment is also available for an eligible Employee and/or eligible Dependent if the eligible Employee or eligible Dependent lost coverage under a Medicaid Plan under Title XIX of the Social Security Act or under a State Child Health Insurance Plan under Title XXI of the Social Security Act. Coverage under this Plan is effective only if the Lumen Health and Life Service Center receives applicable documentation within 60 days after the date on which the prior coverage was terminated.

*(**Note:** See "**Timing Restrictions**" on page 12.)*

Special Dependent Day Care Provision

You may start, increase, stop, or decrease your contributions to the Dependent Day Care Flexible Spending Account to correspond to changes in the cost of the dependent day care assistance that you are purchasing from a person other than a relative. For example, if you decide to place your Child in day care, then you may start contributing to your Dependent Day Care FSA. Similarly, you may stop contributing when you remove your Child from day care or if your Child attains age 13 and is no longer eligible to receive tax-favored dependent day care assistance. Likewise, you may increase or decrease your contributions to the Dependent Day Care FSA if your day care costs increase or decrease, either because of a change in the number of hours of day care provided, a fee change by the provider, or a switch to a new provider.

To request a change, you must contact the Lumen Health and Life Service Center at 866-935-5011 .

The effective date of the change is the qualifying event date. If the change is due to special enrollment following birth, adoption, or placement for adoption of a child, the effective date of the change is the date of birth, adoption, or placement for adoption.

Timing Restrictions

For newly eligible Employees or Employees experiencing a Qualified Status Change- Any enrollment or changes to your Healthcare and/or Dependent Day Care the FSA must be on or before November 1 each year in order for timely processing. For example: if you want to elect or increase your FSA on October 15, your election will be processed. However, if you elect or increase your FSA on November 20, your election will not be processed.

Note: *If you are newly eligible for FSA benefits in the month of November or December, you will not be eligible to enroll for the current Plan year; however, you can enroll in a FSA for the following Plan year through your Annual Enrollment election. Please contact the Lumen Health and Life Service Center if you have questions regarding your FSA eligibility and enrollment options.*

Qualified Status Changes

The Company reserves the right to require supporting legal documentation to confirm the status change at any time. Qualified Status Changes include the following:

- **Legal Marital Status** - Any event that changes an Employee's legal marital status, including marriage, divorce, death of a Spouse.
- **Number of Dependents** - Any event that changes the number of an Employee's Dependents, including birth, death, adoption or placement for adoption.
- **Employment Status** - Any event that changes the employment status of an Employee or his or her Spouse or Dependent, including termination, commencement of employment, a strike or lockout, the commencement or return from an unpaid leave of absence, a change in worksite, or any other event that effects an individual's eligibility for coverage under the plan.
- **Dependent Status** - Any event that causes the Employee's Dependent to satisfy or cease to satisfy the requirements for coverage due to reaching the maximum age.
- **Residence** - A change in the place of residence that affects an individual's eligibility for coverage under the plan.

Leaves of Absence

You may be eligible to continue your flexible spending accounts in accordance with the policies and procedures while you are on an approved leave of absence.

You will be responsible for contributions for your coverage during your leave. The amount of the contribution is the same amount as for active Employees, except that your contributions may be made on an after-tax basis while you are on unpaid leave, or retroactively deducted upon your return to work. Contact the Lumen Health and Life Service Center for more detailed information.

Upon your return from approved military leave, if you did not elect to continue coverage during your leave, you still have the right to be reinstated in the Plan, generally without any waiting periods or exclusions except for service-related illnesses or injuries.

When Coverage Ends

Generally, your flexible spending account coverage terminates on the last day of the month during which you cease to be an eligible participant. This occurs:

- when your employment terminates
- when you are no longer a full-time Employee
- you are not actively at work for any reason other than an approved leave of absence
- you fail to make your required contribution or the plans terminate, whichever occurs first.

A deduction will continue through your final paycheck.

Your Dependent Day Care Flexible Spending Account (DCFSA) will end on the day **prior** to your Short-Term Disability (STD) leave date, if you are placed on STD. When you return to active status, **you must contact** the Lumen Health and Life Service Center at 866-935-5011 within **14 calendar days** of your return to work date and elect a new contribution amount. The effective date will be the date you return to work from STD. If you do not contact the Lumen Health and Life Service Center or contact them after the 14-calendar day window, your DCFSA will remain ended with a $0 contribution amount and you will not be able to contribute until the next Annual Enrollment. **Note:** *If you return to active status in November or December, you will not have the option to reinstate your* DCFSA *for the calendar year.*

Coverage under the HCFSA's and DCFSA plan terminates on the day an Employee is not actively at work due to a work stoppage (strike).

Nothing in this summary says or implies that participation in any of the spending plans is a guarantee of continued employment with the Company, nor is it a guarantee that benefit coverage will remain unchanged in future years.

HOW TO FILE A BENEFIT CLAIM

The FSA's are administered by UnitedHealthcare (UHC) FSA.

There are two ways to receive ***reimbursement*** of out-of-pocket expenses from your FSA accounts: 1) automatic reimbursement and 2) manual claim form reimbursement. Please note there are deadlines by which to file a claim for a benefit. Please refer to "**Time Deadline to File a Benefit Claim and the Time Deadline to File a Benefit-Related Lawsuit**" on page 23 of this SPD.

Automatic Reimbursements

As you incur claims during the Plan year, your out-of-pocket health care expenses from Bind Medical Plan, UnitedHealthcare, OptumRx, MetLife Dental and EyeMed Vision benefit options will be reimbursed automatically from your Health Care Flexible Spending Account **unless you specify otherwise**. Dental and

Vision expenses will also be reimbursed automatically from the Limited FSA unless you specify otherwise. Typically, this would be stopped if you have secondary coverage that needs to be coordinated before the FSA amount can be determined. Contact UnitedHealthcare or go to myuhc.com to stop automatic reimbursement. *(***Note:** *If you stop auto payments you must submit a claim form for all Eligible Expenses.)*

If you have not stopped the Automatic Reimbursement feature, when you incur a medical/prescription drug, dental or vision expense to the provider, the claim will be passed to UHC from each carrier and UHC will process a payment to you automatically from your available funds, so you do not have to submit a paper claim for reimbursement from your FSA. Reimbursement payments are made to your last known address unless you arrange for a direct deposit to your bank account.

If you are enrolled in a Consumer Driven Health Plan (CDHP) benefit option with the Health Reimbursement Account (HRA) benefit option, generally, you will not pay anything at the provider's office. When the claim is processed by UHC, they will automatically pay from the HRA account first, and then from the FSA account, after your HRA funds are depleted—even if you have HCFSA dollars remaining from the previous year. *See "**Forfeiture of Unused Funds**" on page 7 and the applicable CDHP benefit option SPD for more detailed information on your FSA and HRA funds.*

Note: *If you are not enrolled in any of the Company sponsored benefit options, other than the FSA, you must file manual claims.*

Manual Reimbursements

When you request reimbursement for eligible expenses from UnitedHealthcare, you must submit a claim form and provide the following information:

- **a.** Your name and address.
- **b.** If the claim is for your Dependent you must provide their name, age and their relationship to you.
- **c.** Your FSA ID number (SSN) and your FSA group number (199383), also found on myuhc.com.

Health Care FSA

- **d.** If expenses were covered by any benefits plan (e.g., medical/prescription drug), attach a copy of the Explanation of Benefits (EOB) along with your FSA claim form. Your insurance carrier (or a spouse's carrier or an individual plan) should pay before you request an FSA reimbursement. If expenses are not covered by any benefit plan, attach a copy of an itemized bill from your provider that includes the date(s) of service, service rendered and total charge.

Dependent Day Care FSA

- **e.** Attach a copy of a receipt that includes the date of service, day care provider's name, address, tax ID and amount paid to the day care provider or attach a copy of a cancelled check from the day care provider.

You will receive your reimbursement from the balance (including pre-funded amount) in your dependent day care spending account. If there's not enough money in your account when you make the claim, you'll receive a partial payment. The remainder will be paid automatically, after you've made more contributions to the account.

Where to submit for manual reimbursement:

Return completed FSA claim forms to:

Health Care Account Service Center
PO Box 981506
El Paso, TX 79998-1506
Fax: 915-231-1709 Toll Free Fax: 866-262-6354

Claim forms are available from the Company intranet or UHC website, **myuhc.com**.

Expenses totaling $25 or more can be reimbursed from your FSA account (amounts under $25 will pend until the $25 is accumulated).

Important Deadline: You have until **April 30th** of the following calendar year to submit eligible expenses **incurred** up to **March 30th** (of the following) Plan year. After that date, any money remaining in your prior year's account is forfeited.

In addition, to help avoid the need for reimbursements, all employees who enroll in either the Traditional or Dependent Day Care FSA(s) (excludes the Limited FSA) will receive a Health Care Spending Card (HCSC) from UnitedHealthcare to use for paying eligible expenses directly from the FSA (or HRA, if enrolled in a CDHP benefit option). *See "**HEALTH CARE SPENDING CARD (HCSC)**" on page 15 for how to use the HCSC for both FSA and HRA expenses*.

HEALTH CARE SPENDING CARD (HCSC)

UnitedHealthcare will provide a Health Care Spending Card (HCSC) to any employee that enrolls in the Traditional Health Care or Dependent Day Care flexible spending account. The HCSC is a debit/credit card which can be used to pay for eligible health **and** dependent day care expenses directly from your FSA. *(***Note:** *In addition, if you are enrolled in a CDHP benefit option, the HRA balance is also loaded on this same card, but **HRA dollars will be accessed before any FSA dollars**.)*

You will need to activate your HCSC as soon as you receive it. Once your card has been activated, you must wait one full business day before you use your card (i.e., if you activate your card on a Monday, you will need to wait until Wednesday to use the card).

Eligible Expenses Paid through the HCSC

If you enrolled in both the Traditional Health Care and the Dependent Day Care FSAs, your HCSC can be used for Eligible Dependent Day Care Expenses **and** Eligible Health Care Expenses (including copayments; and medical/prescription drug, dental and vision copayments, depending on which health care benefit option you selected) at the time you receive the service. **(Note: If your HCSC contains your HRA dollars, the HRA dollars will be accessed before any FSA funds for Medical/prescription drug expenses.)** If you want expenses paid out of the prior year's (grace period) FSA funds, claims will need to be submitted manually by filling out a manual claim form found on myuhc.com. You also have the option of submitting your claim electronically through myuhc.com. If you have allocated your prior year (grace period) FSA funds for specific dental or vision expenses, you can turn off Auto Reimbursement (Auto Rollover) by going into the myuhc.com website under Accounts and Balances. **Turning off Auto Reimbursement (Auto Rollover) should be reviewed every new plan year.**

- **Dependent Day Care FSA** - Money is loaded to the HCSC on a contribution basis (as dollars are deducted from your paycheck). The provider you use must be set up with the MCC code (the MasterCard device code) that indicates child care services in order to use your HCSC for payment. If not, you will need to pay for services out-of-pocket and submit a claim to UHC for a manual reimbursement.
- **Traditional Health Care FSA** - Money is loaded to the HCSC as the total dollar amount you elect for your health care FSA on the effective date of coverage. For example, if during annual enrollment you elect to contribute $500 to your health care FSA for the Plan year, the $500 will be loaded to your HCSC and available for use on January 1. You may use the HCSC for certain over-the-counter prescription drugs and medical supplies as approved by the IRS guidelines.

Substantiation. The IRS has clarified substantiation requirements for debit card transactions and has approved the Inventory Information Approval System (IIAS) as a method for retailers to identify and substantiate eligible expenses. The Inventory Information Approval System (IIAS) enables participants to purchase eligible expenses from a broad range of retailers increasing the use of the card and reducing manual claims processing requirements. A retailer's point of sale system identifies eligible healthcare FSA purchases by comparing the inventory control information (UPC or SKU number) against the list of restricted eligible

medical/prescription drug expenses as described in IRS Section 213(d).

The IRS states merchants need to be able to identify 213(d) eligible items, however, it is not required that merchants break out the eligible items by Prescription and General Healthcare (OTC). While most merchants will break this out, there are some that do not. To determine if a merchant separates prescriptions, look for a "check mark" in the Supporting Prescription Subtotal column of the Merchant List found on **sig-is.org**. Members can visit **sig-is.org** and select the IIAS Merchants List to view a list of participating merchants. The Merchant List is updated every two days. You may use your HCSC at participating merchants that are certified and have a status of "Live" in the Planned Merchant Implementation Date column.

The HCSC can only be used to pay for eligible expenses that are equal to or less than the dollar amount remaining on the HCSC. For example, if you have $200 remaining in your health care FSA but are trying to purchase a prescription for $250 with the HCSC, the card will decline because the amount of the prescription is more than the amount available on the HCSC. You will need to pay for the expense out-of-pocket and submit a claim to UnitedHealthcare to receive reimbursement.

The HCSC cannot be used once your FSA balance has been exhausted. However, do not discard your card. The HCSC is good for 4 years from the issue date and can be used in the next calendar year if you once again enroll in a flexible spending account. Each family will receive two cards.

If you have questions about the use of your UHC or need to order a new card, contact UHC Customer Service at 866-755-2648.

Direct Deposit

You can get your reimbursement faster if you elect direct deposit. UHC will deposit your FSA money directly into your personal checking or savings account at no charge. Log on to myuhc.com and select ***View Account Balance*** to enroll.

Monthly Health Statements and FSA Yearly Statements

Explanation of Benefits (EOBs) will not be issued for card transactions. Instead, you will receive monthly health statements and a FSA yearly statement which will include your card activity. You will also be able to view card transactions on myuhc.com. If you note a discrepancy on the monthly health statement or FSA yearly statement, call the number on the back of your Consumer Accounts Card to resolve the issue. You can also call 866-755-2648 to order additional cards, report a lost or stolen card or get answers concerning Eligible Expenses or your account balances.

Myuhc.com

Online access to account information and card transactions is available via myuhc.com. You can view your current account balance as well as view account transactions that have been processed using your HCSC as well as claims that have been submitted automatically or on a paper claim form.

You have the option to turn off automatic claims submission on the myuhc.com website. You can also set up direct deposit for FSA claims not processed using your HCSC.

If you are not enrolled in a UnitedHealthcare medical/prescription drug plan, but have an FSA, you can still register as a member on myuhc.com. You will need to use group number 743797 and your Social Security Number as your member ID.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT PROVISIONS

How Much You May Contribute

The minimum amount you can contribute is $150 per calendar year and the maximum in 2021 is $2,750 per calendar year. This amount may be periodically adjusted by the IRS.

You will be reimbursed from your Health Care Spending Account for the amount of the eligible expense incurred during the period of coverage during the plan year up to the total amount of your annual election, even if you have not yet contributed that amount for the year.

If you change your contribution mid-year, then reimbursements for expenses incurred before the new contribution election takes effect may be made up to the annual limit elected before the contribution change. Reimbursements will be made for expenses incurred after the new contribution election takes effect up to the new annual limit elected (but reimbursements for expenses incurred before the new contribution election takes effect count against the new annual election).

For example, let's assume you elect to contribute $260 for the year to the Health Care Flexible Spending account. On June 15 you have a baby. As a result, you elect to increase your contribution to $2,750 annually. For expenses incurred before June 1, you may request reimbursement up to the initial $260 limit. For expenses incurred on or after June 1, you may request reimbursement up to the new $2,750 annual limit (but reimbursements for expenses incurred before June 1 will count against the new $2,750 annual election).

Eligible Expenses

Most health care costs incurred by you and your dependents (the IRS does not recognize domestic partners **unless** they qualify as a tax dependent under Section 152 of the Internal Revenue Code; therefore, expenses incurred by a domestic partner or their dependent children do not qualify for reimbursement from this account unless they qualify as tax dependents), which you pay out of your own pocket and are not reimbursable by any other source such as your group medical/prescription drug, dental or vision plan or those of your spouse, are eligible.

Eligible expenses are those which could otherwise count as tax deductions under federal income tax regulations. These may include, but are not limited to:

*(***Note:** *The **Limited** FSA is limited to the reimbursement of dental and vision expenses only. The medical/prescription drug expenses noted below are not eligible for reimbursement if you are enrolled in the Limited FSA.)*

- Charges in excess of reasonable and customary (R&C) charges.
- Deductibles, co-payments and co-insurance for the medical/prescription drug, prescriptions, dental and vision plans.
- Health expenses not normally covered by group health insurance plans, such as:
  - Certain Home improvements specifically to aid disabled residents.
  - Prescription sunglasses.
  - Chiropractic or acupuncture charges in excess of annual limits.
  - Orthodontic charges in excess of the lifetime maximum. **Note:** Only orthodontic expenses for services rendered while participating in the Health Care Flexible Spending Account qualify for reimbursement. No charges actually billed or paid prior to participation or treatment if not during the period of coverage in the Plan will be reimbursed. If you're in a course of treatment that began before your Plan participation, you may be reimbursed for your current expenses if your orthodontist prorates charges and bills you on a periodic basis. For more information, contact MetLife Dental Customer Service.
  - Certain Over-the-Counter prescription drugs and medical supplies are covered as approved by the IRS guidelines.
  - While health club dues generally are not reimbursable, they may be reimbursed if they are prescribed by a physician to prevent, treat, or alleviate symptoms of a disease, such as obesity, high blood pressure, diabetes, etc. You must

provide a letter from your physician identifying the disease that you are seeking to prevent, treat, or alleviate by means of the programs available because of your health club membership. The letter should include information about why the programs available through the health club membership are the physician's recommended means of preventing, treating, or alleviating the diagnosed disease.

- The cost of a weight loss program may be reimbursable in two instances. First, if attendance at a weight loss program is prescribed by a physician to treat a specific illness (e.g., heart disease), the expense is reimbursable. The physician should substantiate the necessity of this treatment. Second, obesity is recognized by the IRS as a disease in its' own right and weight loss programs to treat obesity are reimbursable expenses. Weight loss programs do not need to be prescribed by a physician, but obesity must be diagnosed. You must provide documentation substantiating the diagnosis of obesity. **Note:** *Weight loss program fees are reimbursable, but not special foods purchased as part of the weight loss program.*

Ineligible Expenses

The following expenses are not eligible for reimbursement with the Traditional FSA:

*(***Note:** *The Limited FSA is limited to the reimbursement of dental and vision expenses only.)*

- Health care premiums, including any amounts you pay for your coverage under a Company medical/prescription drug plan. You get a tax-break on your costs of coverage, however, by participating in the separate Pre-tax Premium Payment Plan.
- Expenses payable by another source, such as medical/prescription drug coverage you have through your spouse's employer.
- Premiums you pay for long-term care coverage.
- Services or supplies which are not eligible expenses under federal guidelines. For example: cosmetic surgery (except for certain necessary surgery permitted under the IRS regulations); or mileage to and from health provider visits; weight loss programs, even if your doctor prescribes it (except as stated under Eligible Expenses); health club dues (except as stated under Eligible Expenses); electrolysis; certain health care aids that can be purchased without a prescription.

For a more complete list of eligible and ineligible expenses, see IRS Publication 502 "Medical/prescription drug and Dental Expenses," available from your local IRS office, the IRS website (**irs.gov**), or a shorter summary is on **myuhc.com**.

Automatic Payment of Health Care Expenses

If you are enrolled in a Company medical/prescription drug, dental or vision plan option, the administrators of these plan options automatically submit claims to your health care flexible spending account on a regular basis (weekly or bi-weekly). If you have out-of-pocket costs (not eligible for the HRA), you will be reimbursed automatically if you have health care FSA dollars available. You will not need to submit a paper claim.

Note: *If you are not enrolled in any of the Company sponsored benefit options, other than the FSA, you must file manual claims unless you use the card.*

All employees who elect a healthcare FSA are **enrolled in automatic claims submission** (see the "note" box below). If you don't want to participate (for instance, you have secondary coverage), you will need to log on to myuhc.com and select the "Flexible Spending Account" link. Under the FSA link, you will see a link to "Automatic Payment Options." Select this link and then click on the "Discontinue" button. Once you have discontinued your participation, you will need to submit paper claims to UHC in order to receive reimbursement from your health care FSA. ***You can change the automatic payment election at any time.***

Note: In order for claims to process to the correct plan year during the 3-month grace period, the automatic claims rollover feature needs to be active for the current and prior plan years, otherwise only the current Plan year FSA funds will be utilized.

If You Are Covered by More than One Health Plan

In addition to the Company medical/prescription drug, dental, and vision coverage, you may also be covered by other group health insurance. This is most likely to happen if you have a spouse who works and you are covered under your spouse's employer's plan as well.

In this case, your two health care plans will coordinate to pay their share of covered expenses first, before the FSA plan would know what to pay. Once all plans have paid their portions, then, if there are any remaining eligible expenses, your health care spending account will pay last.

Note: Remember to call UnitedHealthcare Customer Service or go to **myuhc.com** to stop automatic payment from your health care account if you are covered by more than one health plan.

Health Care FSA vs. the Tax Deduction

Instead of using the Health Care Spending Account, you may be able to deduct health care expenses, if itemizing, on your federal income tax return. Most taxpayers don't qualify for this deduction, however, because it applies only to costs that exceed 10.0% of adjusted gross income. See your tax advisor for more information.

DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT PROVISIONS

How Much You Can Contribute

The maximum amount you may contribute to the Dependent Day care Spending Account is the lesser of:

- $5,000 per calendar year ($2,500 if you're married and file separately) for 2021;
- Your annual earned income; or
- Your spouse's annual earned income.

Pre-Funding Available

The pre-funding feature advances seven weeks' worth of your annual election amount to your dependent day care spending account at UnitedHealthcare. This amount, in addition to payroll deductions credited to your account, will be available for immediate claim payment. The maximum reimbursement at any time is current payroll deductions credited to your account plus the seven weeks of pre-funding, not to exceed the total annual amount elected.

Eligible Dependents

If you enroll, you'll be able to use the Dependent Day Care Spending Account to pay for the care of the following, but only if the expenses are incurred to enable both you and your spouse to perform paid work (full-time or part-time) or to actively look for work:

- Your dependent children under age 13 who live with you for at least half the year.
  Note: *If your child turns age 13 during the year, expenses incurred on or after the birthday don't qualify for reimbursement from your Plan.*
- Your spouse or dependent of any age who is physically or mentally incapable of self-care and who lives with the employee for at least half the year.

The definition of physically or mentally incapable of self-care is:

- A dependent who is unable to care for their own hygiene or nutritional needs or;
- A dependent that requires the full-time attention of another for their own safety or the safety of others.

Eligible Day Care Expenses

The Dependent Day Care Flexible Spending Account may be used for reimbursement of most dependent day care costs, including:

- Non-educational care for your children while you work, including pre-school, day care, and babysitting programs for children below the level of kindergarten. However, before and after school care, for kindergarten and above school levels may be eligible.
- General day camps and for computer, soccer and other specialized day camps if used while the employee is working.
- Care in your home for eligible dependent parents, spouses, and children.
- Outside services for an eligible disabled dependent age 13 or older, or a disabled spouse. To qualify, your dependent must reside in your home at least half the year and regularly spend 8 or more hours a day in your household.
- Agency and application fees required to obtain the services of a care provider may be employment related expenses.
- Work related expenses can include the costs for a care provider's room and board as well as employment taxes paid on the provider's behalf.

To pay a provider through the plan, you must supply the provider's tax ID number, name and address on your claim form. For self-employed providers, such as babysitters, that usually means their Social Security numbers. Tax ID numbers are not required for tax-exempt organizations, such as church groups.

Be sure your provider completes an IRS Form W-10 Dependent Day care Identification and Certification for your records. These forms are available from your local Internal Revenue Service office, the IRS website (**irs.gov**) or the public library.

Ineligible Day care Expenses

Expenses not eligible for reimbursement include:

- Overnight camp, educational fees (Kindergarten or higher), most food, clothing, transportation between your house and the care provider or center. Transportation expenses can be reimbursed if they are provided by the care provider.
- Baby-sitting during hours when you and your spouse are not working (e.g., Saturday night baby-sitting).
- Expenses for services provided by a care provider whom you or your spouse can claim a dependent exemption on your federal income tax return, or any child of yours or your spouse who will be under age 19 at the end of the year (December 31). This applies even if you or your spouses do not claim that child as a dependent.
- Expenses for services of a dependent day care center that provides nonresident care for more than 6 individuals, if the center does not comply with all applicable state and local laws.
- Expenses for services provided by anyone who does not have a tax identification or Social Security number.
- Expenses for which you claim a federal income tax credit (see below).
- **IMPORTANT TO NOTE:** Amounts paid for dependent day care while an employee or spouse is off work are not considered employment-related, even if the employee or spouse continues to be paid during the absence. The IRS does allow dependent day care expenses incurred during a short absence, such as a minor illness or vacation, to be considered employment-related if they are paid on a weekly or longer basis.

Tax Considerations

Instead of the dependent day care spending account, the IRS offers alternative ways to get a tax break on eligible expenses:

- The "Child and Dependent Care Tax Credit" is available to most taxpayers. You take this credit at the end of the year when you file your annual federal income tax return. The amount you can use to determine the Tax Credit is reduced one dollar for every dollar you contribute to the Dependent Day Care Flexible Spending Account. That means most

employees will have to choose the Dependent Day care Flexible Spending Account or this Credit.

- The supplemental young child earned income tax credit is available only to individuals who have children under age seventeen and who have household gross annual incomes below a certain level.

You might want to consult a professional tax preparer or the IRS to help determine which approach may work best for you.

Filing Your Federal Income Tax Return

The IRS requires you to complete special Form 2441 Child and Dependent Care Expenses if you use either the Plan or take the Child and Dependent Care Tax Credit.

On the form, you'll show your dependent day care expenses and your provider's tax ID (or Social Security) number. You must attach the completed form to your regular annual income tax return.

For More Information about Income Taxes

The following are some sources for more information about federal income taxes and how they affect your Dependent Day Care Flexible Spending Account participation:

- For questions about your income tax bracket, the Tax Credits, or other tax related questions, contact the IRS at the following taxpayer Assistance Lines: 800-829-1040 or 800-829-4059 TDD
- IRS Publication No. 503 Child and Dependent Day Care Expenses, available from your local IRS office, the IRS website (**irs.gov**) or the public library.

If you need IRS booklets or tax forms, call the IRS Forms Hotline, 800-829-3676. Forms are also available from your local Internal Revenue Service Office, the IRS website (irs.gov) and some public libraries.

CLAIMS AND APPEALS

Questions and Appeals – What to Do First

The Plan Administrator believes that most claim issues, such as a denied claim, can be addressed informally if promptly and objectively raised with the appropriate Claims Administrator, and that the best time to solve a problem or answer a question is when it first arises, not days, weeks or months later. There is a separate claims process if you dispute the deductions from your paycheck for your Plan Benefits. Refer to "**Claim for Payroll Adjustments and the Deadlines**" on page 24.

Participants who have had a claim denied, have questions or complaints, etc., may informally contact the Claims Administrator before requesting a formal appeal. If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in the *How to File a Benefit Claim* section you may appeal it as described below, without first informally contacting the Claims Administrator. If you first informally contact the Claims Administrator and later wish to request a formal appeal in writing you should contact the Claims Administrator and request an appeal. If you request a formal appeal, the Claims Administrator will provide you with the appropriate address to submit your appeal. The address of the Claims Administrator is also provided in the back of this Summary.

The claims administrator's telephone number is shown on your ID card 800-842-1219. Customer Service Representatives are available to take your call during regular business hours, Monday through Friday.

To the extent permitted by law, completion of the claims review procedures described in this summary are a mandatory precondition that must be complied with prior to the commencement of a legal or equitable action by a person claiming rights under the Plan.

How to Appeal a Denied Service Claim

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from your ID card.
- The date(s) of medical/prescription drug service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

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

UnitedHealthcare – Appeals
Attn: Appeals
P.O. Box 981512
El Paso, TX 7998-1512

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

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

Appeals Process

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

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

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

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal. UnitedHealthcare must notify you of the benefit determination within 30 days after receiving the completed appeal.

Note: Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. UnitedHealthcare's decision will be final.

The table below describes the time frames in an easy to read format which you and UnitedHealthcare are required to follow.

Claims Denial and Appeals	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice*

Claims Denial and Appeals	
Type of Claim or Appeal	**Timing**
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	
if the initial claim is complete, within:	**30 days**
after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than (First Level appeal):	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
UnitedHealtcare must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

* UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

How to Appeal a Denied Eligibility/Participation Claim

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

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

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

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

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

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

be timely filed as described in the Summary Plan Description.

Legal Action Deadline: After you have exhausted or completed the claims and appeals procedures as explained above, you may pursue any other legal remedy, such as bringing a lawsuit or civil action in court provided, that you file a civil action, proceeding or lawsuit against the Plan or the Plan Administrator or the Claims Administration no later than the last day of the twelfth month following the later of (1) the deadline for filing an appeal under the Plan or (2) the date on which an adverse benefit determination on appeal was issued to you with respect to your Plan benefit claim.

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

Claim for Payroll Adjustments and the Deadlines

There is a separate claims process if you dispute the deductions from your paycheck for your Plan Benefits.

Reminder to Review Your Paycheck Deductions

- Review your paycheck along with Benefits Premiums documents on the Company intranet or your Confirmation Statement on the Company Intranet to confirm your medical bi-weekly premium deductions based on your medical plan election and how you answered the enrollment questions for the tobacco-free discount and the working spouse/ domestic partner surcharge. If you are enrolled in the Savings HDHP and contributing to an Health Savings Account, you will want to also confirm your HSA bi-weekly premium deductions. Any questions related to benefit premiums should be directed to the Lumen Health and Life Service Center at 866-935-5011. Do not contact the Payroll Department as the Payroll staff will be unable to assist you.
- If your benefit premium deductions are not correct or not what you expect you must make a claim to the Plan Administrator in accordance with the claims procedures as soon as possible after the year's payroll deductions begin.

  ► **If your claim is denied, be advised that there is a deadline to file an appeal and if you miss the deadline, your deductions remain in place for the benefit plan year. The time period to make an appeal is the *earlier* of:**

  1. within 180 days of an adverse 1st level decision by the Plan Administrator, or
  2. the earlier of **(a)** within 180 days of the effective date of an election that is later claimed to be erroneous, or **(b)** by the last day of the plan year of when the election error is claimed to have occurred.

  If the appeal is not filed by this deadline it shall be deemed untimely and denied on that basis.

The Required Forum for Legal Disputes

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

COBRA – HEALTH FSA CONTINUATION

Please note your COBRA rights as described in this section are provided as required by law. If the law changes, your rights will change accordingly. If you have questions about your rights to continue your flexible spending accounts under COBRA, please contact the Lumen Health and Life Service Center. See the *General Information SPD* for more information about Health Care Continuation Coverage, enrollment and when

coverage ends.

If you have funds remaining in your health care account at termination, you may elect to continue participation in the Health Care Spending Account by contributing on a post-tax basis or you may cancel your participation. COBRA continuation coverage may only be elected if the maximum reimbursement available for the rest of the plan year in which coverage is lost would exceed the premiums paid for COBRA continuation. No COBRA continuation is available for the plan years beginning after the COBRA qualifying event. By continuing to participate, you will be eligible to continue to receive reimbursement of funds remaining in your account. This continued coverage is subject to any restrictions that apply to COBRA continuation of coverage.

To apply for COBRA benefits or find out what your monthly costs would be, contact the Lumen Health and Life Service Center at 866-935-5011.

GENERAL ADMINISTRATIVE PROVISIONS

This section summarizes the legal information about the Plan. For more information refer to the ***General Information SPD***. You can call the Lumen Health and Life Service Center at 866-935-5011 to request a paper copy of **the General Information SPD** or you can go online at lumen.com/healthandlife (if actively working) or lumen.com/healthbenefits to obtain a copy.

Plan Document

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

Records and Information and Your Obligation to Furnish Information

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

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

The Plan agrees that such information and records will be considered confidential. We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical/prescription drug review or quality assessment, or as we are required by law or regulation.

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

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

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

During and after the term of the Plan, we and our related entities may use and transfer the information

gathered under the Plan, including claim information for research, database creation, and other analytic purposes.

Interpretation of Plan

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

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

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

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

Right to Amend and Right to Adopt Rules of Administration

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

Clerical Error

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

Administrative Services

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

Workers' Compensation Not Affected

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

Conformity with Statutes

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

Refund of Benefit Overpayment

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 either of the following apply:

- 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

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 adding the amount of the overpayment to your W-2 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.

What Happens to Settlements, Refunds, Rebates, Reversions to the Plan

For purposes of this Plan, any and all reversions, settlements, rebates, dividends, refunds or similar amounts or forms of distribution, of any type whatsoever, paid, provided or in any way attributable to the maintenance of a benefit program under this Plan, including but not limited to any outstanding benefit payments or reimbursements that revert to the Company after remaining uncashed or unclaimed for a period of 12 months, shall be the sole property of the Company, and no portion of these amounts shall constitute "assets" of the Plan, unless and to the extent otherwise required by applicable law.

Frequently Used Terms

Auto-Reimbursement - Medical/prescription drug and Pharmacy claims will automatically roll to your HRA under the CDHP medical/prescription drug option and/or the Health Care FSA after processing through the claims systems.

Grace Period - If you have unused contributions in your account at the end of the current Plan year you can continue to incur expenses during the first 2.5 months immediately following the end of the Plan year and receive reimbursement for these expenses until such unused funds are depleted. All requests for reimbursement will be accepted and processed through March 31. After March 31 funds remaining in your account for the current Plan year will be forfeited. Unused benefits relating to a particular qualified benefit (e.g.

HCSA, DCSA) may only be used to pay expenses incurred with respect to that particular benefit and cannot be transferred to another account.