Lumen Retiree and Inactive Health Care Plan*

Retiree Health Reimbursement Account (HRA)

(Administered by YSA)

Summary Plan Description (SPD) For Eligible Company Retirees

Effective Jan. 1, 2021

This SPD must be read in conjunction with the *Retiree 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, CenturyLink, Inc. is referred to as Lumen Technologies, or simply Lumen. The legal name CenturyLink, Inc. is expected to be formally changed to Lumen Technologies, Inc. upon the completion of all applicable requirements.

Issued Jan. 1, 2021

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I. OVERVIEW SUMMARY

This Summary Plan Description (SPD) provides information regarding the Retiree Health Reimbursement Account (HRA) Benefit offered to only those Medicare-eligible Retirees and their Medicare-eligible Dependents* who are eligible for the Lumen Retiree health care Benefits under the **Lumen Retiree and Inactive Health Plan***. This HRA Benefit option is a part of the umbrella Company Retiree and Inactive Health Plan. See the "IV. WHO IS ELIGIBLE" on page 5 of this SPD for more information. (***Note:** Embarq is the exception with non-Medicare eligible participants allowed to access the SHARE/RRA as noted in the below chart.)

The Benefit provisions vary by the company Retiree group and Benefits are subject to change from time to time and overtime, in accordance with the Company's reserved rights under the Plan. HRA funding is subject to a "Cap" on the Company's contributions (or subsidy) of coverage, and this Cap will not increase for 2020 or in the future. The amount of the Company's Capped subsidy for an eligible retiree's coverage is based on which legacy retiree group you retire from. Therefore, there are several HRA group names established to facilitate the differences in the provisions. The Embarq SHARE/RRA account is also considered one of the HRAs under this Plan. More details and explanations are provided throughout this document and in the Summary Chart below.

COMPANY/ HRA NAME	AMOUNT OF HRA SUBSIDY/ FUNDING FREQUENCY	HOW HRA FUNDING CAN BE USED	HRA YEAR END BALANCE RULE
Embarq (LEQ)/ SHARE RRA	The SHARE/RRA balance at the time you retire as determined by the Company. The amount of the SHRARE/ RRA varies by person/ and can be used by both Medicare and non-Medicare-eligible Retiree/Dependent This has a onetime allocation of funding at your retirement, as agreed to in the collective bargaining agreement, if applicable.	Premiums and out-of- pocket expenses for medical/ prescription, dental and vision (including Medicare Part B premium, but excluding any COBRA premiums).	Balance rolls over from year to year, but once it is depleted there is no more or additional funding.
Qwest Pre1991 HRA/ LQ Pre91 HRA	Annual Company Contribution: $3,800/year single $7,600/year single w/spouse or domestic partner (Additional funds are available for Medicare-eligible child(ren))	Premiums for after-tax medical and prescription drug, dental and vision coverage (no out-of-pocket expenses or Medicare Part B premiums).	Balance at year end, if any, is forfeited each year. There is no rollover.
Qwest ERO'92 HRA/ LQ ERO'92 HRA	Annual Company Contribution: $3,800/year single $7,600/year single w/spouse or domestic partner (Additional funds are available for Medicare-eligible child(ren))	Premiums for after-tax medical and prescription drug, dental and vision coverage (no out-of-pocket expenses or Medicare Part B premiums).	Balance at year end, if any, is forfeited each year. There is no rollover.

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COMPANY/ HRA NAME	AMOUNT OF HRA SUBSIDY/ FUNDING FREQUENCY	HOW HRA FUNDING CAN BE USED	HRA YEAR END BALANCE RULE
Qwest Post- 1990 Occupational/ **LQ HRA**	Annual Company Contribution: $2,570/year single $5,140/year single w/spouse or domestic partner (Additional funds are available for Medicare-eligible child(ren))	Premiums and out-of- pocket expenses for medical/ prescription, dental and vision (including Medicare Part B, but excluding COBRA premiums).	Balance, if any, rolls over from year to year.
Qwest (LQ) Post- 1990 Management/ **CS HRA**	Annual Company Contribution: $1,740/year single $3,480/year single w/spouse or domestic partner (Additional funds are available for Medicare-eligible child(ren))	Premiums only for medical/ prescription, dental and vision (excluding Medicare Part B and COBRA premiums).	Balance at year end, if any, is forfeited each year. There is no rollover.
CenturyTel (LCTL), including Madison River/ **CS HRA**	An amount based on a calculation as determined by the Company. The amount in your HRA varies by person. Annual allocation of funding, each January 1 in accordance with the collective bargaining agreement, if applicable.	Premiums only for medical/ prescription, dental and vision (excluding Medicare Part B and COBRA premiums).	Balance at year end, if any, is forfeited each year. There is no rollover.
Post-1990 Management and certain LCTL Retirees only/ **Dental HRA**	Amount based on Company subsidy and only available when all enrolled family members are Medicare-eligible. Annual allocation of funding, each January 1 in accordance with the collective bargaining agreement, if applicable.	Same as the medical subsidy dollars. Dollars are added to the medical HRA (but are not tracked separately as dental dollars).	Balance at year end, if any, is forfeited each year. There is no rollover.
Those with a group CDHP balance/ **CDHP HRA**	Balance as determined by UHC or Bind when moved from the group CDHP. This has a onetime allocation of funding at the time the funds are moved. These funds can be used after all other HRA funds are depleted, as only one HRA can be accessed at a time.	Expenses only (not premiums) for medical – the balance can be applied for the same types of expenses as under the CDHP group medical plan benefit option.	Balance, if any, continues to roll over at year end until depleted. There is no additional funding.

II. ADMINISTRATOR'S CONTACT LIST

The following list provides toll free numbers for your use should you need to contact any of the administrators below for assistance:

1.	**Lumen Health and Life Service Center:** For any questions about you or your Dependents' eligibility for the HRA/SHARE/ RRA Benefits, or your Medicare/ Non-Medicare medical coverage Press 2, then 1 for Healthcare and continue the prompts to the Heath Reimbursement Account.	**866-935-5011 or 800-729-7526** www.lumen.com/healthbenefits
2.	**Your Spending Account (YSA)** To inquire about your HRA/SHARE Account balances, claims reimbursement, or to set up Recurring reimbursements. Follow the same prompts as above to the Health Reimbursement and Flexible Spending Accounts.	**866-935-5011 or 800-729-7526** www.lumen.com/healthbenefits
3.	**Via Benefits Insurance Services** Enrollment and ongoing advocacy for Retirees who use Via Benefits to enroll in an individual Medicare policy.	**888-825-4252** www.myViaBenefits.com/centurylink
4.	**Aon Retiree Health Exchange** (formerly AonHewitt Navigators) Enrollment and ongoing advocacy for Retirees who used Navigators to enroll in an individual Medicare policy prior to 2014.	**800-505-3575** www.retiree.aon.com

III. INTRODUCTION

Lumen Technologies* (hereinafter "Lumen" or "Company") is pleased to provide you with this Summary Plan Description ("SPD"). This SPD and the other plan documents (such as the Plan Document, the Summary of Material Modifications (SMMs) and materials you receive at Annual Enrollments, if any) (hereafter collectively the "Plan documents") briefly describe your Benefits as well as rights and responsibilities, under the **Lumen Retiree and Inactive Health Plan*** (the "Health Plan") and make up the official Summary Plan Description for this benefit under the Employee Retirement Income Security Act of 1974, as amended, and the regulations thereunder ("ERISA").

The effective date of this Summary Plan Description is January 1, 2021.

As part of the Retiree and Inactive Health Plan (the Plan), this HRA is exempt from the requirements of the Patient Protection and Affordable Care Act ("PPACA").

The Retiree Health Reimbursement Account was established January 1, 2012 and was offered to the Qwest Post-1990 Management and Embarq Retiree legacy groups at that time. The Qwest Post-1990 Occupational

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Retiree group was added May 1, 2014.

The Retiree Health Reimbursement Account (HRA) provides you and each of your Medicare-eligible Dependents subsidy dollars. You can use these HRA/ RRA subsidy dollars to **reimburse** yourself for the cost of the premiums you pay to purchase an **individual** Medicare medical/prescription drug policy outside of the Health Plan (to replace your Lumen group health care coverage). Certain Retiree groups may also use the HRA subsidy for out-of-pocket expenses as noted in the chart at the beginning of this SPD. The company subsidy dollars are self-funded by the Company and are provided based on your fulfillment of the Retiree Health and Welfare eligibility rules. The HRA is a tax-free benefit to you.

When retiree group health care Benefits end (excluding Qwest Pre-1991 and ERO'92 retirees). Your Retiree group health plan medical and prescription drug benefits under the Plan terminate the first of the month in which you become Medicare-eligible and your Retiree HRA is automatically established and available to access for reimbursement of claims, provided you satisfy the Plan eligibility rules and elect Retiree health care benefits. Your Retiree HRA would not be available if you are enrolled in any other Lumen medical plan, including COBRA. If you delay taking your Retiree health care benefits, then your HRA will be delayed.

Note: You are responsible for obtaining your Medicare Part A and Part B benefits upon your Medicare eligibility date (or upon retirement if already Medicare eligible). Your Lumen benefits are cancelled regardless of whether or not you have obtained this coverage. If you do not have your Medicare benefits in place timely, you could have a gap in health care coverage and incur lifetime penalties from Medicare.

The Health Plan* provides Health care coverage under **Plan No. 511. The Bind On-Demand Health Plan No. 514 provides retiree coverage as well**. Each plan may be amended from time to time and over time and is sponsored by the Health Plan. for eligible retired Employees and their eligible Dependents of Lumen and certain Lumen subsidiaries who retired having satisfied certain age and service criteria. "Eligible Dependent" means your Spouse/Domestic Partner or Children who are eligible for the Retiree health care Benefits, and therefore eligible to receive the HRA subsidy upon becoming Medicare-eligible.

Note: While the Plan has processes in place to prevent errors and mistakes, if a clerical error or mistake happens (however occurring) such error or mistake does not create a right to a Benefit or level of contribution rate under the Plan. You have an obligation to correct any errors or omissions that come to your attention by calling the Lumen Health and Life Service Center to correct the error or omission immediately. *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 20 in this SPD and in the Retiree 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 Participant 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

Capitalized terms are defined throughout this document, in the "Retiree General Information" SPD, the Medical Plan SPD and in the Plan Document. All uses of "we," "us," and "our" in this document, are references to the Claims Administrator or, the Plan Administrator which is the Lumen Employee Benefits Committee or Lumen. References to "you" and "your" are references to participants who are eligible and covered under the Plan.

This SPD is provided to explain how the Plan works. It describes your Benefits and rights as well as your obligations under the Plan. It is important for you to understand that because this SPD is only a summary, it cannot cover all the details of the Plan or how the rules will apply to every person in every situation. Specific rules governing the Plan are contained in the official Plan documents. You and your beneficiaries may examine

the official Plan Document and other documents relating to the Plan during regular business hours or by appointment at a mutually convenient time in the office of the Plan Administrator. For additional information, refer to “XXVI. YOUR RIGHTS AS A PLAN PARTICIPANT” on page 26.

You are encouraged to keep this SPD and any attachments and updates (SMM, SARs, Annual Enrollment materials, etc.), if applicable for future reference.

See the *Retiree General Information SPD* for more information as noted in the Retiree General Plan Information section and throughout this SPD.

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, the Company generally takes the position that ERISA preempts such state laws.

IV. WHO IS ELIGIBLE

As a retired Employee **who is eligible for Retiree health care Benefits under the Lumen Retiree Health Plan**, you become eligible for HRA subsidy dollars once you are Medicare-eligible (and for Embarq retirees, who can be either Medicare-eligible or non- Medicare-eligible.) There are different HRAs and Retiree groups based on which Legacy Company’s provisions apply. See the chart below for the name of the HRA associated with each Company/Retiree group.

The HRA also applies to your eligible Dependents **who are eligible for your Retiree health care benefits under the Lumen Retiree Health Plan** and who become Medicare-eligible*. When you or your eligible Dependent become Medicare-eligible, that person’s Company group medical and prescription drug benefits **end the first day of the month in which they become eligible for Medicare**. For example, if you turn 65 on May 8, your Medicare eligible effective date is May 1 and your group medical/prescription drug benefits end effective May 1. See “V. WHEN YOU BECOME MEDICARE-ELIGIBLE” on page 7 for more information.

***Note:** Legacy Embarq Retirees and their eligible Dependents may use the HRA (SHARE/RRA) account, regardless if they are Medicare eligible or non- Medicare-eligible; however, it cannot be used for COBRA premiums.

Certain groups are eligible for the HRA upon becoming Medicare eligible, regardless if they are enrolled in the medical benefits or if they have suspended their coverage prior to becoming Medicare eligible. **Note:** All groups (excluding Legacy Qwest Pre-1991 and Legacy Qwest ERO’92) are not eligible for the HRA if their enrollment status is waived for medical coverage at the time, they become Medicare eligible.

Note: Waiving coverage is different and has different consequences than suspending coverage. For more information, refer to the *Retiree General Information SPD*.

For Legacy Qwest Pre-1991 and ERO’92 only: The Health Reimbursement Account (HRA) benefit option is only available to **Medicare eligible** participants who are enrolled in Medicare Parts A **and** B. This benefit option is offered to you **in lieu** of any medical/prescription drug benefit coverage (also known as the Grandfathered plan) from the Company, Instead, you are electing to use the Company subsidy dollars that will be placed in a Health Reimbursement Account (HRA) which you can access to **reimburse** yourself for medical **premiums** you have paid to a carrier of your choice for an *individual* Medicare policy (such as Medicare Supplemental/gap, Part D or Medicare Advantage). The Company subsidy dollars help to cover the cost you will incur, if any, when you purchase *individual* Medicare medical and prescription drug policies. See “VI. HOW TO ENROLL IN AN INDIVIDUAL MEDICARE POLICY” on page 8 located in this SPD.

To avoid a lapse in health care coverage, you and your Dependents need to take action PRIOR to the Medicare eligible effective date to ensure that other health care coverage (including Medicare Parts A and B) are in place to begin on the correct effective date. Additional information is explained throughout this document. Please read all sections carefully.

ELIGIBLE DEPENDENTS

Your Dependents must be eligible (see below section) for the retiree health care Benefits in order to be eligible to receive the HRA subsidy upon the Dependent becoming Medicare eligible. Call the Lumen Health and Life Service Center if you have questions about your Dependent's eligibility or refer to the *Retiree General Information SPD* for more information.

You Must Declare Your Dependents for Coverage Upon Retirement or they are not eligible to enroll in the future (excluding Qwest Pre-1991 and ERO'92 retirees). There are special rules regarding when you may enroll an individual as an Eligible Dependent. If you do not declare and enroll your dependent in accordance with these rules, that person(s) is not eligible for coverage or HRA Subsidy when they become Medicare eligible. **Note:** You are not allowed to add new or non-declared dependents in the future after your initial retirement election.

The rule restricting the enrollment of Eligible Dependents and the process of timely declaring an Eligible Dependent for enrollment are as follows:

You may not enroll an individual as an Eligible Dependent unless

1. **at the time of your retirement**, or
2. with respect to Qwest Post-1990 Management Retirees, as of Jan. 1, 2012, or
3. with respect to Qwest Post-1990 Occupational Retirees who were current Participants in the Plan during the 2013 Plan Year, the later of the time of your retirement or Dec. 31, 2013, or
4. with respect to Qwest Post-1990 Occupational Retirees who become Participants during the 2014 Plan Year and thereafter, as of Dec. 31, 2013,

you declare and submit information about your dependent to the Plan Administrator as eligible for coverage. To declare an individual as an Eligible Dependent means that you will provide the requested supporting documentation about that person upon your enrollment in the Plan by the deadline, if applicable.

If you have declared someone as an Eligible Dependent and the Plan Administrator validates this status, but you decide at that time to suspend coverage in accordance with the Plan Administrator's suspension of coverage procedures, you may later enroll such declared individual as an Eligible Dependent.

HRA Dual Coverage for Company Couples. Dual HRA Coverage is not allowed. If you and your Spouse or Domestic Partner are both covered as Lumen Retirees (or Employees), each of you can be covered as an individual or one of you may waive coverage and be covered as an eligible Dependent under the other. Once you are eligible for the Retiree HRA, no person is eligible for coverage under both the Company group plan and under an HRA account at the same time. Generally, only one HRA account will be funded at Your Spending Account (YSA) with subsidy for an individual or a family as explained later in this document. See "COMPANY COUPLES HRA ACCOUNT" on page 12 for more information.

NON-MEDICARE PARTICIPANTS (excluding Qwest Pre-1991 and ERO'92 retirees)

If you or an eligible Dependent are not Medicare-eligible, the non- Medicare eligible person remains eligible for the Company group benefit options while the Medicare eligible participant coverage under the Company group benefit option ends and an HRA subsidy account is established. Once the non-Medicare eligible participant

becomes Medicare eligible, that person will be removed from the Company group medical benefit and their HRA dollars will be combined in a joint family account at YSA. There is only one HRA account per family at YSA. See “XII. HOW THE HRA ACCOUNT IS SET UP” on page 14 for more information on how the HRA accounts are established.

REHIRED RETIREES

If you are rehired as an active Employee of Lumen, your subsidy under the HRA will be suspended on the last day of the month in which you return to work for the duration of your employment. Similarly, if you become employed by a supplier or contractor to the Company and work on any assignment or project for the Company, your coverage under this Plan will be suspended on the last day of the month in which you become employed by said supplier or contractor for the duration of your assignment or project for the Company.

If you are employed directly on the Company payroll, you may be eligible for coverage under the Lumen Health Care Plan in effect at that time for active Employees based on your employee classification. If you are employed by a supplier or contractor to the Company, you may be eligible for coverage through the supplier or contractor for the duration of your assignment or project. When you resume retirement and are no longer working either directly for the Company or indirectly through a supplier on assignment for the Company and therefore, **you must** contact the Lumen Health and Life Service Center to resume usage of your HRA benefits under this HRA Retiree Plan. The benefit provisions of your HRA group will determine the status of any fund balances you had in your account upon your return and subsequent termination.

Note: If you are returning to active status and enrolled in an individual Medicare medical policy, you may want to disenroll from that plan as your HRA account will be suspended for you and your Dependents. **You** must notify your carrier directly to disenroll.

V. WHEN YOU BECOME MEDICARE-ELIGIBLE

Medicare: Medicare is a government health insurance plan that you paid into through your payroll taxes while you were working. It covers people age 65 or older, people under 65 with certain disabilities and people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant) or Lou Gehrig’s disease (ALS).

The two main components of Medicare are: Part A (hospital insurance) and Part B (medical insurance, such as doctors and other services). ***However, Medicare does not cover 100% (typically only 80%) of these services and it does not cover most prescription drugs.***

You must have your Medicare Parts A **and** B in place to enroll in any type of individual Medicare Supplement (Medigap) or Medicare Advantage policies. These plans will then use your Medicare to Coordinate Benefits according to their plan provisions. **Note:** This is not new for Medicare-eligible Retirees—as the Company group plans also require you to have your Medicare Part A and B in place as a Medicare-eligible Retiree.

PRIOR to the month in which you become Medicare-eligible, you need to obtain your Medicare Part A **and** Medicare Part B benefits to ensure coverage will be *effective on the first of the month in which you become Medicare-eligible.*

Note: Medicare does not allow any retroactive enrollments and has specific rules for when you can enroll in Medicare and the individual Medicare policies. **Note:** Late enrollment may cause a gap in health care coverage and possible lifetime penalties from Medicare.

You may need to take action. The Social Security Administration (SSA) issues Medicare cards--if you are already drawing Social Security benefits or are applying to start your Social Security benefits at age 65, then

SSA will automatically send your Medicare card approximately 90 days before your birthdate month. Medicare Part A coverage is free as you already paid for it through payroll taxes, but Medicare Part B coverage requires you to pay a monthly premium to Medicare which is typically deducted from your Social Security check. **However, if you are not drawing Social Security benefits at age 65 (or sooner), you must be proactive and apply for your Medicare benefits and arrange for another form for your premium payment.** In some instances, delaying your application for Medicare may cause you to incur lifetime penalties in the future.

If you need to apply for Medicare, follow these helpful tips:

- Apply online at www.socialsecurity.gov/medicare/apply.html or call the SSA at 800-772-1213 or go to your nearest SSA office.
- You can apply as early as the first day of the month that is 3 months before your birthday month. Apply early, because you can't purchase any Medicare-related insurance unless you have your Medicare Part A and Medicare Part B.

In addition to establishing your Medicare Part A and B coverage, you may need to enroll in an individual Medicare Medical/Prescription drug policy to replace your Company group coverage (Qwest Pre-1991 and ERO'92 retirees do not need to enroll in a Medicare policy unless you elect to enroll in the Health Reimbursement Account (HRA) benefit option). You will likely start receiving mailings from many of these insurance carriers in the months prior to becoming Medicare eligible due to age. The plans available to you will depend on where you live and will have a range of benefits and premium rates that you will need to consider.

In most areas, you will have access to Medicare Supplement, Medicare Advantage and Prescription Drug coverage policies. You will need to determine which type of plan or plans work best for your needs.

For additional Medicare information:

Visit www.medicare.gov

1. Call your State Health Insurance Assistance Program. See the outside back cover of your copy of the *Medicare & You* handbook or go to Medicare.gov for the telephone number for personalized help in your state.
2. Call **800-MEDICARE (800-633-4227)**. TTY users should call **1 877-486-2048**.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information , visit SSA online at www.socialsecurity.gov or call **800-772-1213 (TTY 800-325-0778)**.

HOW TO ENROLL IN AN INDIVIDUAL MEDICARE POLICY

Note: Qwest Pre-1991 and ERO'92 enrollment in an HRA is optional; therefore you do not need to enroll in a Medicare policy unless you elect to enroll in the HRA benefit option and you will not receive information from the Lumen Health and Life Service Center or Via Benefits as indicated below.

Medicare Part A and Medicare Part B have deductibles and coinsurance that you will be responsible for. Also, you will be responsible for buying Medicare-approved prescription drug coverage. There are various options for covering these expenses, including a Medicare Advantage Plan, most of which include prescription drug coverage or a Medicare Supplement (Medigap) Plan plus a separate Medicare Part D Prescription Drug Plan. These are all types of individual policies you may choose from.

Approximately 3 months prior to your Medicare effective date, you will receive a reminder letter from the Company that your medical and prescription drug benefits will be ending. The following month you will receive a packet from Towers Watson Via Benefits ("Via Benefits Insurance Services"), a national enrollment vendor that the Company has asked to assist its Retirees in this process of selecting and enrolling in an individual Medicare policy. Their services are free, but you do not have to use them—just kindly advise them when they contact you.

You can enroll in an individual Medicare policy directly with an insurance carrier, through a local insurance broker of your choice, or you may choose to use Via Benefits, as indicated above at no cost. Via Benefits specializes in identifying many of the options in your area and can inform you of the choices available based

on your situation. If you enroll through Via Benefits, they will become your advocate if you need assistance with your carrier or in changing plans during the annual Medicare Open Enrollment periods in the future. You can contact Via Benefits at 888-825-4252.

You will receive information from Via Benefits in advance to allow ample time to research and make a selection. However, you cannot complete the enrollment process until you have Medicare Part A and Medicare Part B in place or prior to 90 days of when you want your coverage to be effective. **Note:** When contacting any enrollment source in advance, be sure you are indicating what effective date applies that will coordinate with when your group benefit coverage ends.

Important: These are **individual** policies that you enroll in, so if you and your Dependent are both Medicare-eligible you must **each** go through the enrollment process as individuals and make a positive enrollment election–you cannot enroll for your Dependent. You may choose to select different carriers or policies for yourself than your Medicare-eligible Dependent selects for him or herself—it is based on your **individual** medical and prescription drug needs for your healthcare. Your HRA is available regardless of which individual Medicare policies you enroll in.

When selecting your carriers/policies, you may also choose one carrier for your medical coverage and a different carrier for your prescription drug coverage. Once you enroll in your individual Medicare polic(ies), you will pay the premium, if any, directly to that carrier. You do not pay any medical/prescription drug premium to the Company or Via Benefits. Determine if you will make your payment directly to the carrier via check, direct debit or credit card. However, you decide to pay your premium, it is important that you make your payment timely and do not miss any payments, as the carrier may cancel your coverage and not reinstate you. If that happens, you will not be able to enroll in another plan until the next annual Medicare open enrollment per the Medicare rules. ***The Health Plan does not have any involvement in your disputes with the individual insurance carriers.***

Lumen Default Coverage. If you are unable to **qualify** for an individual Medicare plan, as verified by **Via Benefits**--the Company will be notified and your circumstances will be reviewed to determine if you can be placed in the Company group Default Plan until such time you can enroll in an individual policy. This is not an option you can choose, but a temporary resolution until you are eligible for and enrolled in a Medicare individual policy. (Examples: You live out of the country; no individual Medicare plans are available in your area or the individual Medicare plans available in your area will not accept early (prior to age 65) Medicare-eligible participants.) Contact **Via Benefits** to assist you in finding an individual Medicare plan and if a plan isn't available, Via Benefits will work with the Company to review your situation and determine if you qualify for the Default Plan. **Note:** This is an exception as you will be required to use Via Benefits services for determining if you qualify for an available plan.

VI. EFFECTIVE DATES OF COVERAGE - DEADLINES YOU MUST BE AWARE OF

As mentioned earlier, you should ensure that your Medicare Parts A **and** B will be effective the *first of the month in which you become Medicare eligible*. Since that is also when your Company group medical benefits end, you should complete the enrollment process for your **individual** Medicare policy coverage **in advance** with an effective date that matches your Medicare effective date. (**Note:** You can go through the enrollment process up to 90 days prior to your effective date of coverage. *Tell the representative you are enrolling with the date you want coverage to be effective)*. Also, Please be aware that Medicare may apply lifetime penalties for *late enrollment* if you miss the enrollment window when you initially become eligible (due to age or disability) for Medicare.

Your HRA account funding will be available on the first of the month in which you become Medicare eligible and your Company group coverage ends, unless you have waived your coverage under the Plan. Your HRA will automatically be set up for you and you will receive a "Welcome Letter" from Your Spending Account (YSA), the HRA administrator, approximately 5-7 days before the account is effective. The letter will advise you that

your account is ready and provide additional information on how to access your account online and the options for submitting claims for reimbursement. **Note:** This letter is only generated for the initial set up (first person) on the account. Additional eligible family members will receive a Confirmation Statement regarding their HRA dollars when they are added to that account upon becoming Medicare eligible.

VII. FUNDING/COST-WHO PAYS FOR COVERAGE

Your responsibility. Once you are Medicare eligible, you are responsible for the cost of all your medical coverage under the individual policy you purchase on your own. For instance, you pay for your Medicare Part B premiums, any medical and prescription drug premiums for Medicare policies you purchase directly from the insurance carriers and all out-of-pocket expenses, if any. **Note:** Medicare and the carrier are responsible for payment of your claims subject to the terms of their policy provisions.

Company Subsidy: Subject to its reserved rights to amend, modify and terminate the Plan, the Company funds the HRA account with a subsidy. HRA funding is subject to each retiree group eligibility and will not increase in the future.

VIII. AMOUNT OF HRA SUBSIDY AND YEAR END BALANCE RULES

The HRA subsidy is funded 100% by the Company and is tax free to you. For those with annual subsidies, the subsidy amount provided will be prorated based on the month in which it becomes available to you. For example, if your Medicare effective date is May 1, you will receive 8 months of subsidy (May-December). Thereafter, the full annual amount will be funded on January 1 of each year. However, for the non-annual subsidized accounts such as SHARE/RRA and the CDHP HRA—those subsidy amounts are provided only one time and can be used until the balance is depleted, then there is no additional funding. **Note:** The CDHP balance, if any, is not transferred until after the runout period of approximately 90-120 days. Refer to the "CDHP HRA" category below.

The amount of your subsidy will be based on the Legacy Company's Retiree provisions that apply to you as shown below. HRA funding is subject to each retiree group eligibility and will not increase in the future. (**Note:** Each Retiree group has a specific HRA name for administration purposes so that the correct provisions can be applied accordingly.)

LEGACY COMPANY/HRA NAME	AMOUNT OF SUBSIDY	YEAR END BALANCE RULE
Legacy Embarq / SHARE RRA	The SHARE/RRA balance at the time you retire as determined by type of retirement and age and/or hire date.	Balance rolls over from year to year, but once it is depleted there is no more funding. This is a onetime only funding.
Legacy Qwest Pre-1991 / LQ Pre91 HRA	$3,800/year single $7,600/year single w/ Spouse/Domestic Partner Additional dollars for Medicare eligible child(ren).	Balance, if any, is forfeited each year. The new annual amount is funded each January 1.

LEGACY COMPANY/HRA NAME	AMOUNT OF SUBSIDY	YEAR END BALANCE RULE
Legacy Qwest ERO'92 / LQ ERO'92 HRA	$3,800/year single $7,600/year single w/ Spouse Additional dollars for Medicare eligible child(ren).	Balance, if any, is forfeited each year. The new annual amount is funded each January 1.
Legacy Qwest Post- 1990 Occupational / LQ HRA	$2,570/year single $5,140/year single w/spouse Additional dollars for Medicare eligible child(ren).	Balance, if any, rolls over from year to year. The new annual amount is funded each January 1.
Legacy Qwest Post- 1990 Management / CS HRA **(Also see the "Dental HRA Subsidy" section below)**	$1,740/year single $3,480/year single w/ spouse Additional dollars for Medicare eligible child(ren).	Balance, if any, is forfeited each year. The new annual amount is funded each January 1.
Legacy CenturyTel (including Madison River) / CS HRA **(Also see the "Dental HRA Subsidy" section below)**	Based on a calculation determined by Lumen using age and service points for CenturyTel. (Madison River is based on years of service only.)	Balance, if any, is forfeited each year. The new annual amount is funded each January 1.
All Retiree Groups -- A Retiree or Participant with a CDHP HRA balance from the Lumen CDHP group coverage option	Balance as determined by UHC after the run-out period has ended (typically 120 days). This is a separate HRA with its own provisions and account rules. These funds can be used after all other HRA funds are depleted, as only one HRA can be accessed at a time.	If there is a CDHP balance from group coverage, the balance rolls over from year to year, but once it is depleted there is no more funding. This is a onetime only funding.

If both you and your spouse/Domestic Partner are Medicare eligible (or there are covered Medicare eligible children), subsidy dollars are also provided for them as shown above. However, there is only one subsidy account per family.

Note: The SHARE/RRA dollars are a one-time allocation of a flat dollar amount for the entire family (who is eligible for Benefits) that can be used until it is depleted—with no additional funding thereafter.

CDHP HRA

If there is a CDHP balance remaining in the group CDHP medical benefit option, it is only available for transfer to the CDHP HRA when all family members are Medicare eligible. There is typically a 90 to 120 day run-out period to make sure all claims have cleared from the group plan before the balance is transferred to the CDHP HRA account, it is not combined with the subsidy HRA account. Once it is transferred to the CDHP HRA, the balance, if any, will roll over from year to year until it is depleted, then no additional funding is provided. **Note:** Any eligible claims during the 90 to 120-day run out period would be held until the funds are moved in to the CDHP HRA, then they would process. Claims are paid from the Retiree HRA first, if applicable, then from the CDHP HRA, as appropriate.

Note: If you have non-Medicare Dependents that are still enrolled in the group CDHP benefit option, the CDHP HRA balance remains with that group plan ***as long as they continue to enroll in a group medical option***. However, if they remain in a group benefit medical option until they become Medicare eligible, the balance, if

any, will transfer after the 90 to 120 day run-out period as described above.

COMPANY COUPLES HRA ACCOUNT

If you are married to another Lumen/Company Retiree who is also eligible for an HRA account, you will each be eligible in your own right (which you will retain in the Company eligibility system) for the HRA subsidy. However, in order to allow you the most beneficial use of the HRA dollars as a Company Couple, the subsidy will be combined into one joint family account at YSA. There are specific rules for determining how the account will be set up at YSA once you and a Dependent are both Medicare eligible, typically as follows:

- One joint account per family*
- The hierarchy for who is Primary on the joint account (whose name will be on the account**) is:
- The Retiree with the "richest" HRA provisions
- The Retiree with the highest subsidy amount
- The Retiree who becomes Medicare eligible first
- The earliest retirement date (if the same status and the exact same date of birth)

***Note:** Separate accounts can be requested, but typically only when subsidy amounts are higher for the spouse/domestic partner of a LQ Occupational Retiree. With individual accounts, you cannot cover each other. Contact the Lumen Health and Life Service Center for more information **866-935-5011** or **800-729-7526**, option 2 option 1.

****Note:** When the second Retiree joins the account, the Primary person whose name is on the account first when they become Medicare eligible, may change if the second person to the account has the richest benefits. Your account may be established in or changed to your spouse's name. Order of richest benefit group for HRA:

1. Post90 Occ
2. Pre91/ERO'92
3. Retiree with the higher funding amount if both Retirees are part of the CS HRA
4. The Retiree who became Medicare eligible first
5. Earliest Retirement Date (if both retirees have the exact same date of birth)

LQ HRA, Pre-91/ERO'92 HRA, CS HRA

For example, a Company Couple where a Legacy Qwest Post-1990 Management Retiree (who is the eldest) is married to a Legacy Qwest Post-1990 Occupational Retiree: The account would first be set up under the LQ Post-1990 Management Retiree's name and provisions—then when the Occupational Retiree joins the account, the name would be changed to the Occupational Retiree's name and provisions for the couple as those are the "richest" benefit provisions. In this same scenario, if the Occupational person was the oldest and has the richest benefits, then there would not be any changes to the account set up when the LQ Post-1990 Management person joins the account.

- **At the time of a death for a Company Couple** in the joint account at YSA, the surviving Retiree will remain in the joint account until the end of that Calendar Year under the richer HRA provisions, if applicable. At the first of the following year, the account would revert back to the surviving Retiree's own HRA account and would fall under their own Retiree subsidy funding and provisions going forward.

See the "COMPANY COUPLES HRA ACCOUNT" on page 12 earlier in this SPD.

Non-Company Couples. The HRA account will be established in the name of the Lumen Retiree, even if the Dependent is Medicare eligible first.

IX. DENTAL HRA SUBSIDY

The Dental subsidy is only available to certain Retiree groups (as shown on the Chart in the "Overview Summary" at the beginning of this SPD) — **only** Legacy Qwest Post-1990 Management and certain Legacy

CTL Retirees.

Since Retirees are eligible to stay in the Retiree group dental plan option (even if Medicare Eligible) or could be covered by an active Lumen group plan option as a Dependent, these dental subsidy dollars are not available or funded in the HRA **until all *eligible* family members** are Medicare eligible. At that time, the dental subsidy amount is added to the medical HRA account. (**Note:** The Dental HRA is not a separate HRA account and the dollars are not tracked or designated specifically for dental expenses. Therefore, you can use the dollars for dental premiums or the same expenses as you would use the medical subsidy dollars once they are moved to that HRA account.) **Note:** The Dental HRA is **not** a separate HRA account and the dollars are not tracked or designated specifically for dental expenses. Therefore, you can use the dollars for dental premiums or the same expenses as you would use the medical subsidy dollars once they are moved to that HRA account.

See examples below for how your Dental premium billing changes once all family members are Medicare eligible and the dental subsidy is added to the HRA account funding.

DENTAL PREMIUMS AND BILLINGS

Example 1: If you are Medicare eligible but your spouse/domestic partner is not—there are no dental HRA dollars provided to your HRA at this time. Both of you continue to be covered by the group dental benefit option (if elected) and the Company subsidy continues to be applied towards the company portion of the cost of the group dental plan premium. You continue to pay your portion of the dental premium as you have in the past. Therefore, your Company subsidy continues under the group plan rather than in your HRA to cover the company portion of the group dental premium. *You are billed only for **your portion** of the dental premium.*

Example 2: If you and all eligible family members are Medicare eligible and you remain enrolled in the Company group dental plan, the Dental HRA subsidy dollars are placed in your medical HRA. At that time, the *company portion* of the cost of the group dental plan premium will **automatically** be *withdrawn* from your medical HRA and you will continue to be responsible for *your portion* of the dental premium as you have in the past. *You are billed only for **your portion** of the dental premium as long as there are available HRA dollars*.

Example 3: If under example2 above, you deplete your HRA account during the year and there are no funds available for the **automatic** withdrawal from your medical HRA for the *company portion* of the group dental premium—then you are responsible for the total dental premium amount (*both the company portion **and** your portion*) for the remainder of the year. *You are then billed for the **total amount** of the dental premium*.

Example 4: If you and all eligible family members are Medicare eligible but you do not remain in the group dental plan (e.g., waived or not eligible) the Dental HRA subsidy is still added to your medical HRA. No funds are automatically withdrawn for dental and you will not be billed for any dental premiums from the Company. You may use the dollars for other dental premiums outside of the Company or for other types of premiums allowed under the Plan.

X. HOW THE HRA SUBSIDY CAN BE USED

The Benefit rules for how you use your HRA subsidy dollars are based on the applicable Retiree Legacy Company you are associated with as shown below.

LEGACY COMPANY	HOW YOU CAN USE YOUR HRA*
Legacy Embarq **(Can be used by both Medicare and non- Medicare-eligible Retirees and Dependents)**	Premiums for after-tax medical, prescription drug, dental and vision coverage--plus any allowable out-of- pocket expenses (including Medicare Part B premiums.)

LEGACY COMPANY	HOW YOU CAN USE YOUR HRA*
Legacy Qwest Pre-1991	Premiums for after-tax medical and prescription drug, dental and vision coverage (no out-of-pocket expenses or Medicare Part B premiums).
Legacy Qwest ERO'92	Premiums for after-tax medical and prescription drug, dental and vision coverage (no out-of-pocket expenses or Medicare Part B premiums).
Legacy Qwest Post-1990 Occupational	Premiums for after-tax medical, prescription drug, dental and vision coverage--plus any allowable out-of- pocket expenses (including Medicare Part B premiums).
Legacy Qwest Post-1990 Management	Premiums for after-tax medical, prescription drug, dental and vision coverage only (no out-of-pocket expenses or Medicare Part B premiums).
Legacy CenturyTel (including Madison River)	Premiums for after-tax medical, prescription drug, dental and vision coverage only (no out-of-pocket expenses or Medicare Part B premiums).

*For those groups who can submit out-of-pocket expenses, the YSA administrator will process eligibility of claims according to the IRS Section 213(d) Eligible Expense list, with some exceptions as noted above and determined by the Plan for those expenses you are allowed to be reimbursed for by the HRA. You can access the Expense list on the YSA website www.lumen.com/healthbenefits **located in the YSA Knowledge Center** or call YSA to inquire about whether certain expenses are eligible for reimbursement as an Eligible Expense at **866-935-5011** or **800-729-7526**, option 2 and option 2.

"Eligible Expenses" means those costs that are reimbursable from the HRA in accordance with Internal Revenue Code Section 213(d) regarding expenses for "medical care", with some exceptions as determined by the Health Plan. Refer to IRS Publication 502 "Medical and Dental Expenses" for more information on what is an Eligible Expense and what is not. However, this is just guidance, as the list is modified for each Retiree group as noted on the Expense List that is posted online at www.lumen.com/healthbenefits. Call YSA if you have questions about specific expenses **866-935-5011** or **800-729-7526**, option 2 and option 1.

XI. HOW THE HRA ACCOUNT IS SET UP

Section XII does not apply to Qwest Pre-1991 and Qwest ERO'92 Retirees.

The HRA is automatically set up at Your Spending Account (YSA), the HRA administrator, a few days prior to your Medicare effective date. The funds are available on your Medicare effective date. YSA will send a "Welcome Letter" 5-7days prior to when the account is first established.

Since there is only one HRA account at YSA *per family*--if you are the second family member to join the HRA account—you will not receive the Welcome Letter but will receive a Confirmation statement. The account is set up as follows:

- If you have Dependents (who are not Lumen Retirees), the account is set up in the name of the Lumen Retiree, regardless of which person is Medicare eligible first.
- If you and your Dependent are both Lumen Retirees (a Company Couple) there are hierarchy rules for determining whose name, the account will be set up under and the benefit provisions that are followed. See the "COMPANY COUPLES HRA ACCOUNT" heading in the "IX. AMOUNT OF HRA SUBSIDY AND YEAR END BALANCE RULES" on page 10 earlier in this document.

DEFER (SUSPEND) HRA ACCOUNT

If you have reason to defer or suspend your HRA, contact the Lumen Health and Life Service Center at **866-935-5011** or **800-729-7526** Option 2 and Option1. The HRA account will be put on "hold" and will not make any reimbursements for any claims and will not be funded during the suspension period. This is typically requested if you have other coverage (such as Tricare or another employer) and would not have any expenses to submit. This process follows the Company's one-time suspension rules for retirees.

Note: Waiving coverage is different and has different consequences than suspending coverage. For more information, refer to the *Retiree General Information SPD*.

If you resume use of the account, the account would be funded prospectively, and claims incurred after that date could be reimbursed. There would be no retroactive activity on the account.

XII. CLAIMING BENEFITS /HOW TO SUBMIT FOR REIMBURSEMENT

Your HRA is a reimbursement account only, and therefore, cannot pay any of your premiums or out-of-pocket expenses, if applicable, directly to the carrier or provider. You must incur the expense and then submit proof for reimbursement. There are several ways to arrange for the reimbursement of premiums as described below. See item #3 for out-of-pocket expense reimbursements. No matter which method you use, retain your receipts and records in case of an audit!

Option #1

Carrier Automatic Reimbursement. This process is for **premiums** only. If you enroll through Via Benefits (or enrolled through AonHewitt Navigators in 2014) with an insurance carrier that allows for "Automatic Reimbursement (AR)", you can **elect** this option and Via Benefits will set the AR up with the insurance carrier that you select for your medical and/or prescription drug policy. This means that the insurance carrier will pass your monthly payment information to YSA and YSA will automatically reimburse you from your HRA via check or automatic deposit — however you choose to set the reimbursement up directly with YSA. However, you must *timely* pay your medical policy premium directly to the insurance carrier in order for the amount to be on the file each month from the carrier to initiate your reimbursement. Late payments could result in delay of reimbursement for at least one month (or longer) due to process timing.

With this Automatic Reimbursement option, if your premium amount changes during the year or at the annual Medicare open enrollment renewal, the change will automatically be passed from the carrier to YSA for a change in your reimbursement amount. **Note:** Please be aware that each year as the carriers process the next year's business transactions, there could be a delay for the amount, or the entire reimbursement to update, or the need for an adjustment to be made for as much as 60-90 days. If you have changed carriers at annual enrollment, then this AR process could also be delayed or require adjustments.

-OR-

Option #2

YSA Auto Recurring Reimbursement. This process is instead of option 1 above and is also for premium reimbursements only. With this process, you set up a "Recurring Reimbursement" directly with YSA rather than having the carrier report your payment amount to YSA. **Note:** You cannot have both Options 1 and 2 set up at the same time. Therefore, you must decline option #1 with Via Benefits in order to do this or cancel option #1 if it has already been set up.

For option #2, you must call YSA and request the "Recurring Auto Pay" form This process works similarly to Option #1, but without waiting for the carrier to report the payment. Once you complete the "Recurring Auto Pay" reimbursement form directly with YSA, you must provide proof of your enrollment and the amount of your premium (just one time for the initial set up). Once established, YSA will automatically reimburse you

approximately the 5th business day of each month without you having to submit any monthly information for the remainder of the year (unless changes occur such as New Year premium amounts).

Auto Recurring changes. With this Recurring Auto Pay option, if the amount of your premium increases or you change carriers, **you** must notify YSA and complete the form again by checking the "change" box and providing the new information. If your premium decreases or you drop your coverage, **you** must simply call YSA with the new change information. Contact YSA for further instructions or questions as processes are sometimes updated throughout the year.

-OR-

Option #3

Standard Reimbursement Form. This process can be used for premiums (if neither Option 1 nor 2 above are being used) and for out-of-pocket expenses, if applicable. Out-of-pocket expenses include such things as copays for office visits and prescription drugs, or coinsurance for hospitalization. If you want to control or vary when you get reimbursed for your premiums (e.g., monthly, quarterly, annually), you can submit a Standard Reimbursement form found online at YSA at <insert website> (or you can call YSA for a paper form <insert phone #>).

Note: Do not share your reimbursement form with anyone, as they are barcoded to **your personal** HRA account.

The HRA claim form or online instructions will provide the information and instructions you need to submit your expenses. You can also contact YSA at **866-935-5011** or **800-729-7526**, option 2 and option 1. If you have questions about what expenses are eligible see your appropriate group's Expense List posted online at www.lumen.com/healthbenefits. The Expense List can be located in the YSA Knowledge Center.

FILING DEADLINES FOR REIMBURSEMENTS

Only eligible expenses incurred during the Plan year are eligible for reimbursement from the annual allocation for that plan year. In order to be eligible for reimbursement, the premium expenses must be submitted and postmarked no later than March 31st of the following Plan year.

XIII. BENEFIT CLAIMS AND APPEAL PROCEDURES

If an initial claim for Plan Benefits is denied, either in whole or in part, you or your Dependents will receive written notification from YSA. This written notification will include:

- The specific reason or reasons for the denial
- Specific reference to pertinent Plan provisions on which the denial is based
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary
- Appropriate information as to the steps to be taken if you, your Dependent or a duly authorized person representing you or your Dependent wish to submit the claim for review.

If a written denial is received by you or your Dependents, the denial date will be the date you receive the denial letter from YSA. However, if you do not hear from YSA within 45 days of your claim submission, you should consider your claim denied as of that date.

In this case, the denial date is 45 days after claim submission.

A claim is defined as any request for a Plan Benefit, in this case, a request for reimbursement from the HRA, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making Benefit claims. The period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances and in compliance with ERISA.

You may call the Claims Administrator (YSA) before requesting a formal appeal. If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

Note: 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 60 days from the receipt of the first level appeal determination.

All claims for reimbursement from the HRA are treated as either a Post-Service Claim or as an Eligibility/ Participation Claim, as applicable. Both processes are outlined below.

POST-SERVICE CLAIM

A Post-Service Claim under the HRA option means any claim for reimbursement from the HRA; in other words, a claim that is a request for payment under the Plan for covered medical/Rx, dental and vision premiums and, if applicable, out-of-pocket expenses for medical/Rx, dental or vision services already received by the claimant.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	**30 days**
You must then provide completed claim information to the Claims Administrator within:	**45 days**
The Claims Administrator must notify you of the benefit determination:	
if the initial claim is complete, within:	**30 days**
after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than (Level 1 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 denial (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision for the HRA reimbursement claim within:	**30 days** after receiving the second level appeal

QUESTIONS, COMPLAINTS, HOW TO APPEAL AN HRA CLAIM

This section provides you with information to help you if any of the following occur:

- You have a question or concern about obtaining reimbursement of your Benefits.
- You are notified that a claim is denied, in whole or in part, because it has been determined that the reimbursement you are seeking is not an Eligible Expense under the Plan which follows the IRS guidelines (as explained in IRS Publication 502 “Medical and Dental Expenses”, with exceptions as determined by the Plan. The covered “Expense List” is posted on the YSA website located in the YSA Knowledge Center or you can call the Lumen Health and Life Service Center to inquire about your specific expense at **866-935-5011** or **800-729-7526** Option 2 and option 1.

To resolve a question, complaint, or appeal, just follow the steps listed.

What to Do First

- Contact the Claims Administrator's at **866-935-5011** or **800-729-7526**, option 2 and option 1. Customer service representatives are available to take your call during regular business hours, Monday through Friday, 7:30 a.m. – 5:30 p.m. Mountain time.

What to Do Next

- If the customer service representative cannot resolve the issue to your satisfaction over the phone, you may submit a written appeal as described in "How Do You Appeal an Adverse Benefit Decision" below.

How Do You Appeal an Adverse Benefit Decision?

If you disagree with a claim determination on your request for reimbursement, you can appeal to the Claims Administrator in writing to formally reconsider your claim. As part of the appeal process, you have the right to submit written comments, documents, and records relating to your appeal. Your appeal **must be submitted** on a "Claim Initiation Form" which you can obtain from the Lumen Health and Life Service Center. If you are not sure whether you have the most current Form, Please reach out to the Lumen Health and Life Service Center. An "old" Form may delay the process.

If the appeal relates to a claim for payment, your request should include:

- Your first and last name as it reflects in the Claims Administrator's system and mailing address
- The reason and detailed description as to why you believe the claim should be paid
- Any new information or records to support your request for claim payment

Please **Note:** Your First Level appeal review request must be submitted in writing to the Claims Administrator **within 180 days** after receiving the initial adverse benefit determination.

The review of the appeal will be conducted by the Claims Administrator and will be made by a person different from the person who made the initial determination. This person will not be the original decision maker's subordinate.

You shall be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim.

The Claims Administrator may consult with, or seek the participation of, experts as part of the resolution process. By initiating the appeal, you consent to this referral and the sharing of pertinent medical claim information.

We have delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

Notice to Claimant of Adverse Benefit Determinations (First Level)

If your First Level appeal is denied, the notification from the Claims Administrator will state:

- the specific reason or reasons for the adverse benefit determination.
- reference to the specific Plan provisions on which the determination was based.
- a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
- a description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures and your rights under federal law.
- if the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination

and a copy will be provided free of charge to the claimant upon request.

Notice of Benefit Determination on Appeal (Second Level appeal)

A notice that your appeal of your claim denial is denied will be in writing and contain the following information:

- The specific reason(s) for the determination on appeal.
- A reference to the specific Plan provision(s) on which the determination is based.
- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge, upon request).
- A statement advising of your right to timely bring a civil suit under federal law.
- A statement that you are entitled to receive, upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination.

Please **Note:** The Claims Administrator's decision is based only on whether your request for the reimbursement of expenses for your premiums or, treatment or procedures, if applicable are "Eligible Expenses" under the HRA. The determination as to whether the health service is necessary or appropriate is between you and your Physician.

- In some cases, you may receive recommendations or be provided written authorization for services by your health care provider(s) that are specifically listed as not Eligible Expenses and therefore not eligible for reimbursement by the Plan. Even if these services are referred or recommended, a written authorization from your Provider does not override any specific Plan exclusions. Please refer to the Eligible Expenses definition and the appropriate YSA "Expense List" for more information at lumen.com/healthbenefits located in the YSA Knowledge Center or you can call the Lumen Health and Life Service Center to inquire about your specific expense at **866-935-5011** or **800-729-7526** Option 2 and option 1.

Also review the "Plan Determinations are not HealthCare Advice" in the "Retiree General Information" section.

ELIGIBILITY/PARTICIPATION CLAIM

An Eligibility/Participation Claim under the HRA option means any claim other than for reimbursement of an eligible expense from the HRA.

Note: 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 and 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**

Eligibility/Participation Claims	
Type of Claim or Appeal	**Timing**
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 an HRA 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 HRA transaction that is later claimed to be erroneous, or
    b. By the last day of the Plan Year of when the HRA error is claimed to have occurred. If the initial claim is not filed by this deadline, it shall be deemed untimely and denied on that basis. Appeals from a claim denial must also be timely filed as described in the Summary Plan Description.

Agent for Service of Legal Process:
Associate General Counsel
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

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

This means that you cannot bring any legal action against the Plan, the Employee Benefits Committee or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action, you must do so no

later than the last day of the 12th month from the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan, or the Claims Administrator.

The Required Forum for Legal Disputes

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

XIV. FALSE OR FRAUDULENT CLAIMS

The Company, the Plan, and its Administrators require complete and correct information with regard to all Benefits claimed under this Plan. False information, intentional misrepresentation of any kind, or any failure to provide accurate information will be cause for denial of the affected Benefits.

XV. RIGHTS OF RECOVERY

If a Benefit is paid - **for any reason** - which is larger than the amount allowed by the Plan, the Claims Administrator has a right to recover the excess amount from you by requesting repayment directly from you or by deducting the excess from any future HRA subsidy, if necessary.

See “REFUND OF BENEFIT OVERPAYMENTS” in “XXVII. GENERAL INFORMATION” on page 28 near the end of this Summary Plan Description for more information regarding the Plan’s rights of recovery.

XVI. CONTINUATION OF MEDICAL COVERAGE - COBRA

Certain of your Dependents have the option of continuing their medical coverage, at their own cost, beyond the date that it would otherwise cease. Below are the COBRA rules that generally apply but may vary depending on the type of HRA.

COBRA and its amendments require continuation of the ability to receive the HRA subsidy in certain situations where coverage would otherwise end. In general, the Company must offer you and certain of your Dependents continued participation in the HRA subsidy they were eligible for at the time of certain “Qualifying Events” (see below).

Lumen and its subsidiaries (hereinafter referred to as Lumen) have retained a vendor to act as COBRA compliance administrator for the Lumen Retiree and Inactive Health Plan and the HRA options”, hereinafter referred to as the Plan. It is important for Plan participants to understand their ongoing rights and obligations under the continuation of coverage provisions of COBRA. This summary of rights should be reviewed by both you and your Spouse/Domestic Partner (if applicable) and referred to in the event that any action is required on your (or your Dependents’) part.

If your Spouse/Domestic Partner or Dependent children should lose Retiree HRA coverage under the Plan due to a “Qualifying Event” listed below, COBRA provides an opportunity to elect temporary continuation of such HRA coverage on a self-pay (after-tax) basis at group rates (“continuation coverage”).

Following is a summary of information concerning COBRA and the procedures which should be followed if or when a Qualifying Event occurs.

If you are the covered Spouse/Domestic Partner of a Lumen Retiree, you have the right to elect continuation coverage for yourself and your covered Dependent children, if you or your covered Dependent children lose HRA Plan coverage for any of the following Qualifying Events:

- the death of your Spouse/Domestic Partner;
- divorce from your Spouse/Domestic Partner;

- the commencement of certain bankruptcy proceedings involving the Company.

If you are the covered Dependent child of a Lumen Retiree who is Medicare- eligible and covered by the Retiree HRA option, you have the right to elect continuation coverage if HRA Plan coverage is lost for any of the following Qualifying Events:

- the death of the Retiree;
- parents' divorce; or
- you cease to be a "Dependent child" under the terms of the Plan. (Example: child is no longer Medicare-eligible, or any other change in status which affects eligibility for coverage).

You also have a right to elect continuation coverage if you are covered under the Plan as a Medicare-eligible Spouse or Dependent child of a Retiree and lose coverage within one year before or after commencement of proceedings under Title 11 (bankruptcy), United States Code.

The covered Retiree, Spouse, or Dependent child has the responsibility to directly inform the Lumen Health and Life Service Center of a divorce or a child losing Dependent status under the Plan, both of which are "Qualifying Events." Notice to the Lumen Health and Life Service Center must be made within 60 days after the later of the date of the Qualifying Event, or the date your Qualified Beneficiaries would lose coverage due to a Qualifying Event. If notice is not received **within 60 days**, rights to continue coverage will terminate.

When the Lumen Health and Life Service Center is notified that a Qualifying Event has occurred, they will subsequently notify the Qualified Beneficiary(ies) losing coverage of the right to elect continuation coverage. A "Qualified Beneficiary" is any Spouse or Dependent child who is covered under the Plan on the day before the Qualifying Event occurs. If they do not elect continuation coverage, their Plan coverage will end in accordance with the provisions outlined in this Summary Plan Description or other applicable Plan documents.

If your Qualified Beneficiary(ies) elect continuation coverage, the Company is required to give them coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated Retirees or family members.

Under the law, the Qualified Beneficiary(ies) losing coverage have 60 days from either the date of loss of coverage or from the date of the notice, whichever is later, to elect continuation coverage retroactive to your qualified beneficiary(ies) ending coverage. They then have 45 days from the date of the initial election to make their first premium payment and any other premium payments that are due during those first 45 days. Subsequent premiums must be paid in full within 31 days of each premium due date. **Please Note:** Some states offer financial aid to help certain individuals pay for COBRA coverage. Contact your appropriate state agency regarding availability and eligibility requirements.

If continuation coverage is elected, the law requires that your Qualified Beneficiaries be afforded the opportunity to maintain continuation coverage for 36 months, measured from the Qualifying Event date. Additional Qualifying Events can occur while continuation coverage is in effect, but coverage will not exceed 36 months from the initial Qualifying Event.

The law provides that your Qualified Beneficiaries' continuation coverage may end sooner for any of the following reasons, as it pertains to Retiree HRAs:

- The Company no longer provides HRA funding for any of its Retirees;
- the premium for their continuation coverage is not paid in a timely manner;
- they first become, after the date of the election, covered under any other pre-tax group health plan which does not contain a preexisting condition exclusion or limitation that would apply to them; or

Your Qualified Beneficiaries will not have to show that they are insurable to choose continuation coverage. However, under the COBRA law, they will have to pay the group COBRA rate premium for their continuation coverage plus an administration fee, if applicable. There is no individual "Coverage Conversion" available at the end of COBRA for an HRA.

Domestic Partner Continuation Coverage

If you are a Domestic Partner of a Retiree, you will have the right to elect continuation coverage for yourself and your covered Dependent children, if you or the covered children lose Plan coverage for either of the following Continuation Events:

- the death of the Retiree; or
- termination of the Domestic Partner relationship between the Eligible Retiree and Domestic Partner.

The covered Retiree or Domestic Partner has the responsibility to notify the Lumen Health and Life Service Center of a termination of relationship between a Retiree and a Domestic Partner. Coverage will end at the end of the month in which the Continuation Event occurs. Notice to the Lumen Health and Life Service Center must be made within 60 days after the later of the date of the Event or the date you would have lost coverage. If notification is not made within 60 days rights to continue coverage will terminate. Participants should call the Lumen Health and Life Service Center at **866-935-5011** or **800-729-7526**, option 2, 1, *0.

When the Lumen Health and Life Service Center is notified of the Event, they will notify the Continuation Beneficiaries losing coverage of the right to elect continuation coverage.

If the Continuation Beneficiary elects continuation coverage, the Company will give them HRA coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated Retirees. The Continuation Beneficiary(ies) losing coverage have 60 days from either the date of loss of coverage or from the date of the notice, whichever is later, to elect continuation coverage. They then have 45 days from the date of the initial election to make their first premium payment and any other premium payments that are due during those first 45 days. Subsequent premiums must be paid in full within 31 days of each premium due date.

If continuation coverage is elected, the Continuation Beneficiary will be given the opportunity to maintain coverage for 36 months, measured from the Continuation Event date.

Continuation coverage may end sooner for any of the following reasons:

- the Company no longer provides HRA funding for any of its employees or Retirees;
- The premium for continuation coverage is not paid in a timely manner;
- They first become, after the date of the election, covered under another group health plan which does not contain a preexisting condition, exclusion or limitation that would apply to them; or

Continuation Beneficiaries will not have to show that they are insurable to choose continuation coverage. They will have to pay the group COBRA rate premium for their continuation coverage plus any administration fee. Children of a Domestic Partner will not be eligible to be a Continuation Beneficiary in their own right. They are only eligible for continuation coverage if the Domestic Partner is a Continuation Beneficiary.

HRA COBRA COVERAGE COST

The cost of COBRA coverage for your Qualified Beneficiaries will be based on the COBRA rules for the applicable type of HRA plus a 2% administration fee. (For example, the SHARE/RRA HRA may be based on the balance of the account while the CS HRA may be based on the Annual Allocation.)

If you have any questions about COBRA, Please contact the Lumen Health and Life Service Center at **866-935-5011** or **800-729-7526**, option 2 and Option 1.

SURVIVING SPOUSE MEDICAL CONTINUATION COVERAGE

Surviving Spouse Benefits and COBRA availability are based on the Legacy Company's Surviving Spouse Benefit rules that the participant Retiree retired under. For details regarding the Survivor Spouse Benefits and to determine if COBRA or HRA funding is applicable, refer to the *Retiree General Information SPD*. You can go online to lumen.com/healthbenefits to obtain an electronic copy or call the Lumen Health and Life Service

Center at **866-935-5011** or **800-729-7526**, option 2 and option 1 to request a paper copy of the *Retiree General Information SPD*.

XVII. PLAN ADMINISTRATOR

The Plan Administrator for the HRA under the Lumen Retiree and Inactive Health Plan is:

Lumen Employees' Benefit Committee
214 E 24th St
Vancouver, WA 98663

Discretionary Authority. The Plan Administrator has the authority, right and discretion to determine all matters of fact or interpretation relative to the administration of the Plan - including questions of eligibility, interpretation of Plan provisions and all other matters.

The decisions of the Plan Administrator, and any other person or group to whom such discretion is delegated, such as the Claims Administrator, shall be conclusive and binding on all persons.

XVIII. CLAIMS ADMINISTRATION

The Plan Document governs the operation of the Plan at all times.

Whenever you have a question or concern regarding your Benefits or a claim, Please call YSA, the Claims Administrator at **866-935-5011** or **800-729-7526**, option 2 and Option 1.

The Claims Administrators shall not be deemed or construed as an "employer" for any purpose with respect to the administration or provision of Benefits under the Plan. The Claims Administrators shall not be responsible for fulfilling any duties or obligations of an "employer" with respect to the Plan.

XIX. PLAN FUNDING AND PAYMENT OF BENEFITS

The Health Reimbursement Accounts are a vehicle for the Company to provide a Retiree healthcare subsidy and the reimbursement from the HRA of Eligible Expense are paid by the Company's general assets or trusts and are subject to "caps" established for a Plan Year by the Company. The Lumen Retiree and Inactive Health Plan, and the benefit options it offers including the HRA and the subsidy levels of the HRA will not increase and are not guaranteed offerings in future years. The Company has reserved its rights to amend, modify, terminate and/or eliminate the Plan, its HRA benefit, and its subsidy levels.

Your Spending Account (YSA), provides claims processing services for the Company and administers the payment or reimbursement of Eligible Expenses under the HRA. All Plan Benefits are paid through the claims processing system established with the

Claims Administrator. The Company may choose to fund a portion of the HRA from one or more trusts established by the Plan sponsor or its affiliates. These trust funds would then be available for payment of your Plan Benefits in lieu of payment directly from the Company's general funds. The Company's contributions, if any, to the trust funds may be in the form of the Company's common stock, in accordance with the requirements of ERISA. If the Plan is terminated, any Plan assets will be applied to the payment of Benefits or administrative expenses incurred in the provision of Benefits, and in no event will trust assets be returned to the Company.

XX. PLAN RECORDS

The Plan and all of its records are kept on a calendar-year basis beginning January 1 and ending December

31 of each year.

XXI. PLAN SPONSOR, EMPLOYER IDENTIFICATION NUMBER OF PLAN SPONSOR AND PLAN NUMBER

The Plan Sponsor is identified by the following numbers under Internal Revenue Service rules:

Plan Sponsor	Employer Identification Number of Plan Sponsor (assigned by the IRS)	Plan Identification Number (assigned by the Company)
Lumen, Inc. 100 Lumen Dr. Monroe, LA 71203-2041	72-0651161	511

The Plan Sponsor is Lumen Technologies. The Plan Sponsor provides certain administrative services in connection with the Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including claims processing services, recovery; and complaint resolution assistance. These external administrators are referred to as the Claims Administrators.

The Lumen Employee Benefits Committee is the Plan Administrator and a named fiduciary for the Plan. The Lumen Employee Benefits Committee has also designated the Claims Administrator under the Plan as the claim fiduciary and delegated to the Claims Administrator the authority and discretion to administer the Health Reimbursement Account.

XXII. PLAN DOCUMENTS

The information included in this Summary Plan Description describes only the highlights of the Health Reimbursement Account. These descriptions do not attempt to cover all details of this benefit option or the Plan. Specific details are contained in the master contracts, the official Plan Documents, and if applicable, the Trust agreement, all of which legally govern the operation of the Plan and govern any questions arising under the Plan. Master contracts exist between the Company and its Claims Administrator. All questions concerning Plan Benefits and any conflicts between this summary and the official Plan Document will be governed by the terms of the official Plan Document.

Company's Reserved Rights

This document summarizes the provisions of the HRA under the Lumen Retiree and Inactive Health Plan that is made available by the Company for eligible Retirees who are Medicare-eligible. If there is any conflict between the terms of the Plan Document and this document, the terms of the Plan Document will govern. The Company reserves the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan. The Plan Administrator has the authority, right and discretion to determine all matters of fact or interpretation relative to the administration of the Plan—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.

The Company, as the Plan Administrator, may adopt, at any time, rules and procedures that it determines to be necessary or desirable with respect to the operation of the Company-sponsored plans, including the Lumen Retiree and Inactive Health Plan. Lumen reserves the right to amend or terminate all of the Plans and the Benefits the Plans provide and the level of Company contribution or subsidy - with respect to all classes of Participants, retired or otherwise - and their beneficiaries, without prior notice to or consultation with any

Participants and beneficiaries subject to, applicable law, collective bargaining if applicable, and the terms of the respective Plan documents.

Note: While the Plan has processes in place to prevent errors and mistakes, if a clerical error or mistake happens (however occurring) such error or mistake does not create a right to a Benefit or level of contribution rate under the Plan. You have an obligation to correct any errors or omissions that come to your attention by calling the Lumen Health and Life Service Center 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 20 in this SPD and in the *Retiree General or Medical 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.

Invalid Provisions

In the event any provisions of the Plan Documents may be held illegal or invalid for any reason, such illegality or invalidity will not affect remaining sections of the Plan and the Plan will be construed and enforced as if said illegal or invalid provisions had never been inserted therein.

Participating Companies

Participants and beneficiaries may obtain, upon written request to the Plan Administrator, information as to whether a particular subsidiary or affiliate of the Company is a participating employer in the Plan.

XXIII. LEGAL SERVICE

Process in legal actions with respect to the provisions of the Plan should be directed to the Plan Administrator--Lumen Associate General Counsel-Litigation, 931 14th Street, 9th Floor, Denver, Colorado 80202 or on the Plan Sponsor's agent for service of legal process — The Corporation Company, 1600 Broadway, Denver, Colorado 80202

XXIV. PLAN TYPE

The Plan is classified under the Employee Retirement Income Security Act of 1974 (ERISA) as a group health plan.

XXV. YOUR RIGHTS AS A PLAN PARTICIPANT

As a Participant in the Lumen Retiree and Inactive Health Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits.

Examine, without charge, at the Plan Administrator's office and at other specified locations, (such as worksites), all documents governing the Plan, and if applicable, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, if applicable, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of the Summary Annual Report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your former employer, or any other person, may discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these cost and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U. S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration,

U. S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

A Word About Your Privacy

The Plan will use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and

health care operations. Please see “HIPAA - NOTICE OF PRIVACY PRACTICES” on page 29 for more information.

XXVI. GENERAL INFORMATION

Annual Enrollment

Once you are Medicare-eligible, you will no longer have an Annual Enrollment period with the Company for your medical/prescription drug benefits. Instead, you will need to follow the rules/guidelines of the Medicare Annual Enrollment, typically October 15 through December 7. This enrollment period is governed by Medicare and has no association with the Company and may change from time to time. The Centers for Medicare and Medicaid Services will notify you of changes. You may, however, continue to receive Lumen Annual Enrollment information if you remain enrolled in the group dental benefit option, group life insurance or have a non-Medicare family member who is still eligible for the company benefits.

Any non-Medicare family members who are eligible for the Company health care benefits may be covered under the group medical plan sponsored by the Company, subject to its terms and conditions, and if so, they will continue to receive Lumen Annual Enrollment information as long as they remain eligible.

Qualified Life Events

The following changes in your family situation are Qualified Life Events and may provide an opportunity for you to modify your benefit choices. All of the following should be reported to the Lumen Health and Life Service Center:

- Death of a Class I Dependent (deaths are reported to the Lumen Health and Life Service Center by selecting the option “To Report a Death”)
- Your divorce

The Plan Administrator also has the discretion to recognize other changes allowed by the Internal Revenue Service (IRS). The Company may require documentation of a Qualified Life Event prior to processing a change in coverage election.

Report Change of Status Due to Qualified Life Event: Gain in Eligibility

To qualify for a change in your benefit option choices, you must contact the Lumen Health and Life Service Center **within 45 days of the Qualified Life Event change**. Changes to your coverage (including obtaining Legal Guardianship) are generally effective on the date of the event. If you are unsuspending a dependent, coverage is added the first of the month following the next month. **Changes to coverage due to a Qualified Life Event received more than 45 days after the Qualified Life Event will not be accepted** and your coverage will remain the same.

Report Change of Status Due to Qualifying Life Event: Loss in Eligibility

Changes in your coverage elections due to a loss of your Dependents’ eligibility, reported timely **within 45 days of the Loss** will be effective as of the first day of the month following the event effective date. However, **Please Note:**

- Coverage will be dropped retroactively for an ineligible Dependent if you contact the Lumen Health and Life Service Center **after 45 days of the Qualified Life Event. You will be responsible for any retroactive repayment of claims incurred and paid by the carrier after your Dependent loses eligibility.**
- COBRA: If you fail to notify the Lumen Health and Life Service Center within 60 days of the change, the Dependent losing eligibility and coverage will no longer be eligible to continue coverage through COBRA. **You will be responsible for any retroactive repayment of claims incurred and paid by the carrier after your Dependent loses eligibility.**

- You must report the death of any covered participant as soon as possible by calling the service center at **866-935-5011** or **800-729-7526**, option 3 and option 1.

Consistency Rule. Any change in your decision for coverage due to a Qualified Life Event must be consistent with the Qualified Life Event. For example, if you have a divorce you may only drop your former Spouse/ Domestic Partner; with respect to coverage for your Children in this situation, you may add your Children if you did not previously cover them under the Plan provided that you provide over half of their support and they reside with you, or you have a QMCSO to add them.

Generally, Qualified Life Events (QLE) that apply for the HRA benefit coverage once you are no longer on the Lumen group benefit options are a divorce or a death, or situations with a Medicare-eligible child. Depending on the reason for your change of status, you can contact the Lumen Health and Life Service Center at **866-935-5011** or **800-729-7526**, option 2 and option 1.

Change in Home Address. It is important to notify the Company of any address or phone number change so that you receive all communications the Company may send to Retirees. Address changes that impact your individual Medicare policies should also be reported to your individual insurance carrier and may impact your eligibility for that policy's service area. Contact the carrier directly for instructions.

To notify the Lumen Health and Life Service Center:

- Log on to lumen.com/healthbenefits and follow these steps:
  1. From the home page, go to Your Profile and click on the Personal Information
  2. On the Personal Information page, under Mailing Addresses, click on Change next to Permanent Address.
  3. You will then be routed to a page that will allow you to update your permanent address.

OR

- Call **866-935-5011** or **800-729-7526**, option 2 and option 1 for the Health and Welfare Benefits. You will also need to update Pension Services by calling **800-729-7526**, option 2 and option 3.

HIPAA - NOTICE OF PRIVACY PRACTICES

The "*Retiree General Information SPD*" contains the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Notice which describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You can obtain an electronic copy online at lumen.com/healthandlife or call the Lumen Health and Life Service Center at **866-935-5011** or **800-729-7526**, option 2 and option 1 to request a paper copy of the *Retiree General Information SPD*.

Privacy Officer Designation/Contact Information.

The Privacy Officer has designated the HIPAA Compliance Committee or its designee to answer any questions regarding this Notice or the subject addressed in it.

Please forward inquires to the:

HIPAA Compliance Committee
Lumen, Inc.
Chief Privacy Office
c/o Lumen Law Department
931 14th Street, 9th Floor
Denver, CO 80202

-or-

E-Mail: askHIPAA@Lumen.com

-or-

Call the Lumen Integrity Line at

800-333-8938 Select Option 1 (Personal Health information or HIPAA issues)

A 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 Retiree 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.*

MISCELLANEOUS INFORMATION

Records and 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. 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. This applies to all Eligible Dependents whether or not they have signed an 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, as we are required by law or regulation.

Interpretation of Plan

The Plan Administrator and the Claims Administrator have sole and exclusive 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 the Claims Administrator may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. Clerical errors include, but are not limited to, providing misinformation on eligibility or Benefit subsidy 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 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 Summary Plan Description and other Plan Documents.

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 Participant wishes to pursue other legal proceedings, the action must be brought in the United States District Court in Denver, Colorado.

Administrative Services

The Plan Administrator or its delegate(s) 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.

Conformity with Statutes

Any provision of the Plan which, on its effective date, is in conflict with the requirements of applicable federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is administered, 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 OVERPAYMENTS

If the Plan pays Benefits or reimburses expenses incurred by an eligible participant, that eligible participant, 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 eligible participant or did not legally have to be paid by the eligible participant
- All or some of the payment we made exceeded the amount of the Benefit subsidy allowable under the Plan (including Medicare Part B premiums if applicable)

If the eligible participant that was paid, does not promptly refund the full amount of the overpayment, we may reduce the amount of any future Benefit reimbursements 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.

TIME LIMITATION ON CIVIL ACTIONS

You cannot bring any legal proceeding or action against the Plan, the Plan Administrator or the Company unless you first complete all the steps in the claims and appeal process described in this SPD.

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.

XXVII. LEGAL NOTICES

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

The Retiree Health Plan complies with all Qualified Medical Child Support Orders ("QMCSO"). Generally, a QMCSO is a court order, under State family or child support laws that mandates that one parent is obligated to provide coverage under an employer's group medical plan to a minor child at the parent's expense. This allows your minor child to be enrolled in a group health plan anytime throughout the year. The child remains enrolled in the plan until a new court order removes the QMCSO or the child becomes ineligible for coverage under the plan's terms (for example, the child reaches age 26 or the parent is no longer eligible). Typically, a custodial parent will obtain a QMSCO or NMSN as part of a child support arrangement. With regard to this HRA benefit option, the QMCSO would apply to allow reimbursements as permitted for an Eligible Dependent.

- If you have a QMCSO, you must send a copy of it to the Lumen Health and Life Service Center.

You may still need to establish that you are the child's parent if the QMCSO does not establish your relationship to the child. Stepchildren are not covered by a QMCSO. This means that if you are a Lumen Retiree and your spouse/domestic partner is required by court order to provide health coverage for his or her children, who are your stepchildren, that court order is not a QMCSO on you, and the Plan is not subject to it. You may validate stepchildren by providing the documents required in the timeframe as outlined above.

If you have questions regarding a QMCSO, where to send your QMCSO or whether you have one on file, contact the Lumen Health and Life Service Center at **866-935-5011** or **800-729-7526**, option 2 and option1.

CIRCUMSTANCES THAT MAY AFFECT YOUR PLAN BENEFITS

Under certain circumstances all or a portion of your Benefits under the Plan may be denied, reduced, suspended, terminated, or otherwise affected. Many of these circumstances have been addressed elsewhere in this summary plan description. Such circumstances, in general, include but are not limited to:

- You are no longer in an eligible class of participants or your Dependents are no longer Eligible Dependents
- The Plan is amended, changed or terminated
- You attain the maximum benefit or limit available under the Plan
- The expense incurred was not an Eligible Expense in accordance with Plan rules and as applicable, IRS Guidelines

and Publication 502.

- There is duplicate premium or Eligible Expense reimbursed
- You misrepresent or falsify any information required under the Plan; you will not be permitted to benefit under the Plan from your own misrepresentation
- You have been overpaid a benefit and the Plan seeks restitution
- Your coverage under the Plan is terminated for one of a variety of reasons, for example, you or a dependent are no longer eligible, a failure to timely pay a COBRA premium, the Plan can't locate you because you haven't kept your address updated, etc.
- You become reemployed, directly or indirectly, by Lumen or any Lumen Company or one of its suppliers or contractors
- You delay bringing a claim for a benefit beyond the time periods permitted by the Plan, which such delay would impact your ability to bring an action or civil suit. Refer to "TIME LIMITATION ON CIVIL ACTIONS" on page 32.

Consequences of Falsification or Misrepresentation

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

Continued coverage of an ineligible person is considered to be a misrepresentation of eligibility and falsification of, or omission to, update information to the Plan. 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/domestic partner is no longer eligible for Plan coverage and this must be timely reported to the Lumen Health and Life Service Center within 45 days, regardless if you have an obligation to provide health insurance coverage to your former spouse/domestic partner through a Court Order. Under the Plan, we do not cover former spouses/domestic partners.

- 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 a former spouse/domestic partner, that is not the responsibility of the Company or the Plan. Therefore, you may not continue coverage for your former spouse/domestic partner.

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

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

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

You Must Follow Plan Procedures

Please keep in mind that it is very important for you to follow the Plan's procedures, as summarized in this Summary Plan Description, 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) to try to get a Benefit claim issue resolved is not following the Plan's procedures. If you do not follow the Plan's procedures for claiming a Benefit or resolving an issue involving Plan Benefits, there is no guarantee that the Plan Benefits for which you may be eligible will be paid to you on a timely basis, or paid at all, and there can be no guarantee that your personal health information will

remain private and protected.

Plan Number

The Plan Number for the Retiree Health Care Plan is 511.