Lumen
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End of Emergency Periods—Impact on your Employee Benefit Plans

This notice contains important information about certain deadlines applicable under the employee benefit plans sponsored by Lumen Technologies, Inc. (collectively, the "Plan"). Please read this notice carefully, as the information described may impact certain rights you have under the Plan and may require your action. You should also share this information with your covered family members because their rights under the Plan also may be impacted. The terms of the Plan govern the benefits, as well as participation in, and eligibility for, Plan benefits. This document is intended to serve as the SMM in accordance with the requirements of Section 104 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), to notify you of certain changes to the Plan, effective as of the Effective Date noted above. Please keep this SMM with your Summary Plan Description for the Plan for future reference.

You can request a copy of official legal documents by contacting the Lumen Health and Life Service Center at 833-925-0487.

End of the Outbreak Period

As required by federal law and guidance from the U.S. Department of Labor and the Internal Revenue Service, certain deadlines otherwise applicable under the Plan (including as described in the Summary Plan Description or "SPD" for each Plan) were extended, beginning on March 1, 2020. Since that date, these deadlines have been subject to a disregarded—or "tolling"—period that ends on the earlier of (i) one year from the date the individual first became eligible for the relief or (ii) 60 days after the announced end of the COVID 19 National Emergency (the end of the so-called COVID-19 "Outbreak Period"). No otherwise applicable Plan deadline is tolled more than one year. When the Outbreak Period ends, the tolling period will end and all usual Plan deadlines will resume.

That extension applies to all of the following Plan deadlines:

For Group Health Plans sponsored by Lumen:

- The 30-day (or 60-day) period to request a mid-year "special enrollment" in the medical coverage of the Plan (for example, the 30-day deadline by which a participant must provide notice of a child born to, adopted by, or placed for adoption with them; or the 60-day deadline by which a participant must notify the Plan of a loss of Medicaid- or CHIP-related coverage or becoming eligible for a Medicaid or CHIP subsidy relating to coverage under the Plan); and

- Certain COBRA continuation coverage-related deadlines, including:
  - the 60-day period during which a qualified beneficiary may elect COBRA coverage;
  - the due dates for making COBRA premium payments; and
  - the date by which an individual must provide notice to the Plan of a COBRA qualifying event or a disability determination by the Social Security Administration.

For All Employee Benefit Plans (if subject to ERISA) that are sponsored by Lumen:

- The following deadlines that apply to claims and appeals and external review (when available) under the Plan, as required by the ERISA:
  - the date by which a claimant must file a claim for Plan benefits;
  - the date by which a claimant must file an appeal of an adverse determination of a claim for benefits; and

- for the medical plan only, the date by which a claimant must file a request for an external review or file information to perfect an incomplete request for external review (when available).

Refer to your SPDs for the usual benefit claim-related deadlines that apply to your coverage(s) and the Plan

For example, assume you received a notice of an adverse benefit determination (a denial of your benefit claim) from the Plan on March 16, 2022. Under the usual Plan terms, you had 60 days to appeal that decision (i.e., until May 15, 2022). However, under the guidance described above, the time period you have to file your appeal with the Plan is tolled for one year, until March 16, 2023 (since the Outbreak Period remains ongoing as of that date), and so the 60-day period you have to appeal that adverse benefit determination now ends on May 15, 2023.

As another example, assume you received a notice of an adverse benefit determination (a denial of your benefit claim) from the Plan on December 15, 2021. Under the usual Plan terms, you had 180 days to appeal that decision (i.e., until June 13, 2022). However, under the extension guidance described above, the time period you have to file your appeal with the Plan is tolled for one year, until December 15, 2022 (since the Outbreak Period remains ongoing as of that date), and so the 180-day period you have to appeal that adverse benefit determination now ends on June 13, 2023.

What is changing — the Outbreak Period is anticipated to end July 10, 2023

The Biden Administration recently announced that the COVID-19 National Emergency will end on May 11, 2023. Unless further guidance is issued to the contrary, **this means that the Outbreak Period, and so any associated tolling periods applicable under the Plan, are anticipated to end on July 10, 2023, and the usual Plan deadlines will resume** (we will notify you if this changes).

For example, assume your child lost Medicaid or CHIP coverage due to a loss of eligibility for that coverage on November 30, 2022, thereby entitling you to a special enrollment right to enroll the child in the medical coverage of the Plan. Under the usual Plan terms, you had 60 days from the date of that loss of coverage to enroll the child in the Plan (i.e., by January 29, 2023). However, under the extension guidance described above, the time period you have to enroll your child in the Plan is tolled, but only until the July 10, 2023 end of the Outbreak Period; and, so, the 60-day period you have in which to enroll the child in the Plan now ends on September 8, 2023.

As another example, assume you received a notice of an adverse benefit determination (a denial of your benefit claim) from the Plan on March 16, 2023. Under the usual Plan terms, you have 60 days to appeal that decision (i.e., until May 15, 2023). However, under the extension guidance described above, the time period you have to file your appeal with the Plan is tolled, but only until the July 10, 2023 end of the Outbreak Period; and, so, the 60-day period you have in which to appeal that adverse benefit determination now ends on September 8, 2023.

As another example, assume you received a notice of an adverse benefit determination (a denial of your benefit claim) from the Plan on March 16, 2023. Under the usual Plan terms, you have 180 days to appeal that decision (i.e., until September 12, 2023). However, under the extension guidance described above, the time period you have to file your appeal with the Plan is tolled, but only until the July 10, 2023 end of the Outbreak Period; and, so, the 180-day period you have in which to appeal that adverse benefit determination now ends January 6, 2024.

Changes to the medical plan as a result of the end of the Public Health Emergency

As a result of the Public Health Emergency, the Plan (other than the PRE91/ERO92 Post-65 retiree plan) offered certain COVID related services to plan participants at no cost to the plan participant. These services include at-home COVID tests, and COVID vaccines and boosters (regardless of whether the booster is received at an in-network or out-of-network provider).

Once the End of the Public Health Emergency expires on May 11, 2023, the requirement that these services are provided at no cost to the participant will no longer exist. (Note – in-network provided COVID vaccines and boosters will still be provided at no cost.)

After May 11, 2023, the following changes will go into effect for your plan:

- In-network Covid-19 tests performed during an office visit or in an eligible urgent care facility will be covered by the CDHP, HDHP, Surest and the Doctor's Plan at 100% of the allowed amount where COVID-19 is the primary diagnosis. All other related services are covered in accordance with the applicable cost share requirements of your Plan.
- COVID vaccines and boosters received at OUT OF NETWORK are no longer covered.
- Important Note: COVID vaccines and boosters received at IN-NETWORK providers (other than under the

PRE91/ERO92 Post-65 retiree plan) will NOT be subject to cost sharing to the extent such vaccines are recommended preventive treatment services as contemplated by the Affordable Care Act. Plan participants (other than participants in the PRE91/ERO92 Post-65 retiree plan) will not be responsible for the costs of these vaccines and boosters.

- Over the counter Covid-19 tests are no longer covered by the Plan.

If you have any questions about an applicable deadline under the Plan, please contact your Plan Administrator.

Material change to the Virtual Healthcare Services under the HDHP and CDHP — effective January 1, 2023

As permitted by the recently enacted Consolidated Appropriations Act, 2023, the Plan (other than the PRE91/ERO92 Post-65 retiree plan) has been amended effective as of January 1, 2023 to permit (1) HDHP members to use the virtual medical care provided by MDLive and UnitedHealthcare Virtual Care Services and Telehealth Services will not be subject to the HDHP deductible and coinsurance for members and (2) CDHP members to use the virtual medical care provide by UnitedHealthcare Virtual Care Services and Telehealth Services will not be subject to the CDHP cost share for members.

Right to amend or terminate the Plan

Lumen and its delegate, the Lumen Plan Design Committee, each has reserved the right in its sole discretion, to change, modify, discontinue or terminate the Plan and/or any of the benefits under the Plan and/or contribution levels, with respect to all participants classes, retired or otherwise, and their beneficiaries at any time without prior notice or consultation, subject to applicable law, specific written agreement and the terms of the Plan document.

Plan Administrator

Lumen has reserved to the Lumen Employee Benefits Committee, as the Plan Administrator, the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan and may adopt, at any time, rules and procedures that it determines to be necessary or desirable with respect to the operation of the Plan.