Retiree and Inactive Health Plan General Information

Summary Plan Description (SPD)
For Lumen Retirees and Former Inactive Employees

Effective Jan. 1, 2023

You can go online to obtain an electronic copy or call the Lumen Health and Life Service Center at Businessolver, **833-925-0487** or **317-671-8494** (International callers), to request a paper copy of a Summary Plan Description (SPD).

Issued Jan. 1, 2023

LUMEN®

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INTRODUCTION

Lumen Technologies, Inc. (hereinafter "Lumen" or "Company") is pleased to provide you with this Summary Plan Description ("SPD"). This SPD presents an overview of the general plan provisions and the rights and responsibilities of you and the Company under the Plan. **Detailed descriptions of the benefit options available under the Plan can be found in each of their own specific benefit option SPDs,** including the Health Reimbursement Account (HRA) SPD for Medicare eligible Retirees. There are specific references and sections for Medicare eligible Retirees throughout this SPD.

The effective date of this updated *Retiree General Information* SPD is January 1, 2023. If you are a Covered Person under the Plan on or after January 1, 2023, this *Retiree General Information* SPD supersedes and replaces, in its entirety, any other *Retiree General Information* SPD describing its provisions that you currently may possess. Specific details are contained in the official Plan documents (or Policies for fullyinsured benefits) and/or Trust agreements which legally govern the operation of the Plans. In the event of any discrepancy between this SPD and the official Plan Document or Policy, the Plan Document and Policy, if applicable, shall govern.

This SPD, together with other plan documents (such as the Summary of Material Modifications (SMMs), the plans and benefit options' SPDs (hereafter "plan's summary"), and materials you receive at Annual Enrollment) briefly describe your Benefits as well as rights and responsibilities, under the Lumen Retiree and Inactive Health Plan (the "Health Plan"), the Lumen Disability Plan ("Disability Plan"), and the Lumen Life Insurance Plan ("Life Plan"). These documents make up the official Summary Plan Description for Retiree and Inactive participants as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Where it is appropriate, the Health Plan, the Disability Plan, and the Life Plan are referred to collectively as the "Plan". For the most part, the Health Plan is self-insured; however, the Life Plan and Long- Term Disability Benefits are fully-insured.

This SPD is for all eligible Lumen retired and inactive employees. This does not include Qwest Pre-91 **and Qwest ERO-92 Retirees. These groups should refer to their own applicable Lumen Plan SPDs.**

The Patient Protection and Affordable Care Act Known as the "Affordable Care Act"

As a standalone health care plan, the Lumen Retiree and Inactive Health Plan is exempt from the requirements of the Patient Protection and Affordable Care Act ("PPACA" or "Affordable Care Act"). While Lumen has decided to voluntarily comply with certain provisions of PPACA, this voluntary compliance does not waive the Plan's exempt status. The Company may choose in its sole discretion to no longer apply these provisions at any time.

The Affordable Care Act ("ACA") requires most people to have health care coverage that qualifies as "minimum essential coverage". The Health Plan provides minimum essential coverage. In addition, The ACA establishes a minimum value standard of benefits to a health plan. The minimum value standard is 60% (actuarial value). The coverage under the Health Plan meets the ACA minimum value standard for the benefits it provides.

Company's Reserved Rights

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

The Plan Administrator, the Lumen Employee Benefits Committee, and its delegate(s), have the 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. More information about the Plan Administrator and the Claims Administrator can be found in this SPD.

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

How to Use this Document

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 of the details of the Plan or how the rules will apply to every person in every situation. All of the specific rules governing the Plan are contained in the Plan Document and applicable insurance Policies. You and your beneficiaries may examine the Plan Document and other documents relating to the Plan during regular business hours or by appointment at a mutually convenient time in the office of the Plan Administrator. You may also request to receive copies of the Plan documents and insurance policies by making a request to the Plan Administrator in writing. There is a per page charge for the copying expense. For additional information, refer to the *Your ERISA Rights* section.

Capitalized terms are defined in the *Glossary of Defined Terms* section and throughout this SPD or in the specific benefit option SPD. All uses of "we," "us," and "our" in this document, are references to the Claims Administrator or Lumen. References to "you" and "your" are references to people who are Covered Persons as the term is defined in the *Glossary of Defined Terms*. **Note:** Some terms may be specific to each benefit option—see the applicable benefit option SPD for additional definitions and clarification.

You are encouraged to read and keep all of the SPDs and any attachments (summary of material modifications ("SMMs"), amendments, addendums) for future reference. Please note that your health care Provider does not have a copy of the SPD and is not responsible for knowing or communicating your Benefits.

Exempt Retiree Medical Plan Status Notice

The Lumen Retiree and Inactive Health Plan (the "Plan") meets the requirements of a stand-alone exempt retiree medical plan under the Section 732 of ERISA and therefore is not required to comply with the Patient Protection and Affordable Care Act (PPACA). However, Lumen has decided to voluntarily apply certain provisions of the PPACA to certain benefit options. For example, Lumen is making coverage available to the end of the month in which your adult child(ren) attains the age of 26, provided such individual is not otherwise eligible for coverage under another group plan such as one offered by the child's employer. This means that for all Retiree and Inactive participants, this voluntary application of PPACA may be changed or ended at any time and does not waive the Plan's status as "exempt" from PPACA.

What is an SPD?

This SPD is designed to provide you with a summary and general description, in non-technical language, of the medical, prescription drug, HRA, dental benefit options and general information, all covered under the Health Plan, the life benefits under the Life Plan, and disability benefits under the Disability Plan without describing all the details set forth in all the Plan Documents. Other important details of the plan coverage's can be found in the specific SPD and benefit summaries for each plan and benefit option and the respective Plan Documents, or Policies. This SPD is not the Plan Document. The legal rights and obligations of any person having any Retiree and Inactive Health Plan General Information interest in the Plan are determined solely by the provisions of the Plan Documents and Policies, if applicable. If any of the terms of the Plan Documents conflict with the contents of the SPD, the Plan Documents and Policies, if applicable, will always govern. The Plan Documents, Policies and this SPD supersede any and all prior documents you may have been provided regarding your benefits under the Plan.

Health Care Plan Determinations Are Not Health Care Advice

Please keep in mind that the sole purpose of the Health Plan is to provide for the payment of certain health care expenses and not to guide or direct the course of treatment of any eligible Retiree, Inactive participant or eligible Dependent. Just because your health care Provider recommends a course of treatment does not mean it is payable under the Health Plan. A determination by the Claims Administrator or the Plan Administrator that a course of treatment is not eligible for payment or is not covered under the Health 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 Health Plan coverage and do not constitute health care recommendations or advice.*

You May Not Assign Your Health Care Benefits to Your Provider or any Third Party

Participants and Eligible Dependents may not voluntarily or involuntarily assign to a physician, hospital, pharmacy or other health care provider or any third party (your "Providers") any right you have (or may have) to:

1. receive any benefit under this Health Plan,
2. receive any reimbursement for amounts paid for services rendered by Providers, or
3. request any payment for services rendered by Providers.

The Health Plan prohibits Participants and Eligible Dependents from voluntarily or involuntarily assigning to Providers any right you have (or may have) to submit a claim for benefits to the Health Plan, or to file a lawsuit against the Health Plan, the Company, the Plan Administrator, the Claims Administrator, the appeals administrator or any other Plan fiduciary, administrator, or sponsor with respect to Health Plan benefits or any rights relating to or arising from participation in the Health Plan. If Participants and Eligible Dependents attempt to assign any rights in violation of the Health Plan terms, such attempt will not be effective. It will be void or otherwise treated as invalid and unenforceable.

This Health Plan provision will not interfere with the Health Plan's right to make direct payments to a Provider. However, any direct payment to a Provider is provided as a courtesy to the Provider and does not effectuate an assignment of Participants' and Eligible Dependents' rights to the Provider or waive the Health Plan's rights to enforce the Health Plan's anti-assignment terms. Any such direct payment to a Provider shall be treated as though paid directly to Participants and Eligible Dependents and shall satisfy the Health Plan's obligations under the Health Plan.

Similarly, you may not assign your Disability benefits to your provider or any Third Party.

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

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

Plan Numbers

The Plan Number for the Lumen Retiree and Inactive Health Care Plan is 511.

The Plan Number for the Life Plan and the Disability Plan is 513.

The Plan Number for the Surest Health Plan is 514.

ADMINISTRATORS CONTACT LIST

Throughout the document you will find statements that encourage you to contact the Plan Administrator, the Claims Administrator or another designated entity, for further information. Whenever you have a question or concern regarding your Benefits or a claim, please call the Claims Administrator using the telephone number for Customer Service listed on your ID card (medical benefits only) or from the Contact Information Chart below.

The following Chart lists the Customer Service telephone numbers for the different Plan options:

Claims Administrator or Insurer	Telephone/Web
Lumen Health and Life Service Center (Plan Administrator for Eligibility and Enrollment) **Health Care Advocacy Services)**	**833-925-0487** or **317-671-8494** (International callers) lumen.com/healthbenefits **800-729-7526**
Claims Administrator's Mailing Address	**Medical Claims** ***To file medical claims, mail the claim form to:*** United HealthCare Services, Inc. Attention: Claims P. O. Box 30555 Salt Lake City, UT 84130-0884 Medica Self-Funded – Claims P.O. Box 30992 Salt Lake City, UT 84130-0992 **Requests for Review of Denied Claims and Notice of Complaints:** ***Medical Appeals/Complaints:*** ***Mental Health/Substance Use Disorder Appeals/Complaints:*** For Covered Persons who file a formal written complaint, their advocate will be the appeals coordinator in Member Relations who will thoroughly investigate the matter and bring it to resolution. Resolution on formal complaints is communicated in writing within 30 days. You may submit written complaints to: Optum Behavioral Health Attn: Member Relations Department 425 Market Street, 27th Floor San Francisco, CA 94105-2426 ***Prescription Drug Appeals:*** To file an appeal, mail the appeal to: UnitedHealthcare Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432 ***CDHP HRA Claims and Appeals:*** Health Care Account Services Center P.O. Box 981506 El Paso, TX 79998-1506
COBRA Administration (provided by the Lumen Health and Life Service Center)	**833-925-0487** or **317-671-8494** (International callers) lumen.com/healthbenefits
Mental Health/Substance Use Disorder	To obtain mental health/substance use disorder Prior Authorization – or to contact a care manager (available seven days a week, 24 hours a day), contact Optum Behavioral Health at **800-961-9378** (TDD line Dial 711 for Telecommunications Relay Services).
MetLife Dental	**866-832-5756** metlife.com/mybenefits

Claims Administrator or Insurer	Telephone/Web
ViaBenefits **(For Medicare eligible retirees enrolling in an individual medical/prescription drug policy)**	For assistance in enrolling in an individual Medicare type policy call: **888-825-4252** To contact your individual Medicare policy carrier, refer to the number on the back of your ID card from that carrier. For those who enrolled prior to ViaBenefits, through AonHewitt Navigators (now AonHewitt Retiree Health Exchange) call: **800-505-3575**
Retiree Life Insurance (if applicable)	**833-925-0487** lumen.com/healthbenefits Downloadable App: UPoint mobile app To access Lumen Health & Life Benefits Metropolitan Life Insurance Company 200 Park Avenue, New York, NY 10166 **800-638-6420**
UnitedHealthcare and Medical	**800-842-1219** (UHC and Medical) TDD Dial 711 for Telecommunications Relay Services myuhc.com Downloadable App: UHC app: Health4Me mymedica.com
UnitedHealthcare Pharmacy Management **(OptumRX)**	**800-842-1219** TDD Dial 711 for Telecommunications Relay Services myuhc.com
Surest Health Plan	833-576-6497 Benefits.Surest.com

Participating Providers and Employers

Participants and beneficiaries under the medical plans may obtain Participating Provider Lists, where applicable, upon request to the Claims Administrator(s) and Insurer(s) listed above or upon written request to the Plan Administrator.

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.

A Word About Your Privacy and the Health Plan

The Health 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 Health Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. Please see the *Notice of Privacy* section for more information.

You Must Follow Plan Procedures

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

remain private and protected.

Questions?

If you are a Primary Participant or an eligible Dependent of a Primary Participant who has questions or needs information about your Plan benefits, you first should call the appropriate Plan telephone number on your ID Card (medical benefits only during regular business hours. Alternatively, and for information regarding other Plan benefits, you can call the telephone numbers listed on the Contact Information Chart above. However, if the Claims Administrator is unable to answer your questions, contact the Lumen Health and Life Service Center at **833-925-0487** or **317-671-8494** (International callers) or **800-729-7526**.

ELIGIBILITY

Retiree Coverage

Certain Retirees/Inactive Participants and their Dependents are eligible for Retiree health care coverage under the Lumen Health and Life Retiree and Inactive Health Plan according to the provisions under their associated Retiree Group until Medicare eligible. Once Medicare eligible, medical coverage ends and some Retirees are eligible to receive a Health Reimbursement Account (HRA in lieu of the group benefits--depending on which retiree group you are associated with.

How to determine which Retiree Group, if any, you are in:

There are several resources for you to use:

1. the chart in Appendix 1A of this SPD (Retiree Matrix).
2. the Lumen Retiree Health Care Modeler. This tool also helps you explore your retiree health care and life options, **and helps you determine if you are eligible for coverage** and enables you to compare options and premiums before making important decisions about health care and life insurance plans. You can find this modeling tool on the lumen.com/healthbenefits site. Click on the **Retirement Planning** tile on the home page.
3. the Lumen Health and Life Service Center at lumen.com/healthbenefits — select the "Life Events" tab, select "Other Life Changes" and then select "Retirement" or call **833-925-0487** or **317-671-8494** (International callers) or 800-729-7526.

The costs of the group Benefits and the amount of the HRA vary by Retiree Group as well as the criteria and formulas within the Retiree Group as determined by the Company (see appendix 1A). The costs for the Benefits will be reflected in the Annual Enrollment materials each year.

Vision Benefits. Vision Benefits end at the end of the month in which you retire and can only be continued under COBRA, or you may find individual vision coverage on your own outside of Lumen.

Medicare-Eligible Participants. Medicare-eligible Participants are eligible for retiree dental, the Medicare Advantage PPO + Dental Plan (based on eligible group) or a Health Reimbursement Account as described in Appendix 1A (this does not apply to Pre-1991 and ERO'92 retirees).

Dependent Coverage

In recognition of the wide variety of possible family arrangements, the Company has classified Dependents into a number of categories to determine coverage under the Health Plan and the Life Plan as noted below. However, these Dependents must already be eligible (declared or enrolled) upon retirement in order to be covered under the retiree health care benefit options at retirement or in the future. Note: You must declare (by enrolling or suspending) coverage for all eligible dependents you wish to be covered at the time of retirement or in the future. If you do not, you will not be able to enroll your existing dependents in the future. You are not eligible to add "new" dependents after your initial retirement elections (i.e., if you get married 10 months after

your retirement, you will not be able to add your "new" spouse). See the Suspending Coverage section for more information regarding suspending/unsuspending declared dependents.

As a Retiree or Inactive Participant, as defined above in this section of the SPD, you are considered to be the Primary Participant in the Benefits under the Health Plan and the Life Plan if you are eligible. Your eligible declared Dependents under the Health Plan and Life Plan include:

- **Legal Spouse** - person to whom you are legally married.
- **Common-law Spouse** - provided your relationship began in a state that recognizes such arrangements and you complete a Company-approved affidavit showing that your Spouse meets state requirements for recognition.
- **Domestic Partner** - a same-sex or opposite-sex Domestic Partner is an adult (at least 18 years of age) who lives with the participant in the context of a long-term, committed relationship. Your Domestic Partner can be covered under the Plan provided you certify (by competing a Domestic Partner Affidavit/Certification form) that you and your partner are:
    - Each other's sole Domestic Partner and intend to remain so indefinitely;
    - are not related by blood;
    - are not legally married to any other person;
    - are at least 18 years of age and are mentally competent to consent to the domestic partnership; and
    - are financially interdependent and have resided together continuously for at least 12 months prior to applying for coverage and intend to continue to reside together indefinitely (this does not apply to the State of Washington or except as permitted by the plan administrator on an exception basis as required by applicable law.)
- **Child** - The following qualify under the Health and Life Plan's definition of Child. ***All Children are covered up to the end of the month in which they attain age 26***:
    - Your biological Children
    - Your legally adopted Children including Children who are legally placed for adoption. In the case of a pending adoption, the effective date is the placement date in the home
    - Any child in the process of being adopted by you (if you are responsible for the medical expenses), regardless of residence
    - Your Step-Children
    - Your Foster Children
    - Your Domestic Partner's Children (biological, legally adopted or placed for adoption or foster children)

Note: You are not required to cover your Domestic Partner in order to cover your Domestic Partner's Children

    - Other minors if either you or your Spouse/Domestic Partner is the court appointed legal guardian or permanent legal custody by a court of law, such as grandchildren, nieces or nephews. For this purpose, the term "court-appointed legal guardian" means that there must be a court order specifically granting you "legal guardianship" of the Dependent(s). These terms do not include a court order that simply grants other status such as legal custody, temporary guardianship, foster placement or ward of the state. You must present the Lumen Health and Life Service Center with a copy of the original court order establishing your status as court-appointed legal guardian
    - Your Dependent Children for whom a Qualified Medical Child Support Order (QMCSO) is issued, regardless of whether the Child(ren) currently reside with you. A QMCSO may be issues by a court of law or by a state agency as a National Medical support Notice (NMSN), which is treated as a QMCSO. If a QMCSO is issued, the Child or Children shall become an alternate recipient who is treated as covered under the Plan and subject to the limitations, restrictions, provisions and procedure, same as all other Plan participants. Note: Step-Children and Foster Children are not eligible under a QMCSO. See the *When Health Care Coverage Ends* section for removing a Dependent who is covered under a QMCSO.
- **Unmarried Disabled Children** - Children of any age, who have never been married, qualify if they were disabled and covered as a Child prior to attaining the limiting age (26) and are determined by the Claims Administrator to be indefinitely incapable of self-support and fully dependent upon you for support. Note: Once a disabled Child is removed

from coverage after attaining the limiting age the Child will not be eligible for coverage under the Plan—reinstatement is not permitted

  - If your Child is totally disabled and is older than the age 26 limit when you first become eligible for Lumen's medical coverage, then you must enroll the Child for medical coverage when you are first eligible to enroll. If approved, your Child's medical coverage will start on the date your coverage was first effective. You must complete the application and submit it to the health insurance carrier within 45 days of becoming eligible for Benefits. If your Child is under the normal age 26 limit when you first become eligible for medical coverage, then you must enroll the Child for coverage before the disabled Child reaches the normal age 26 limit.
  - If your Child becomes totally disabled after you first become eligible for Lumen's medical coverage, then you must enroll the Child for Lumen's medical coverage before the normal age 26 limit. If you drop the disabled child's Lumen medical coverage after the normal age 26 limit, then you may not later reenroll the disabled Child for coverage.

- **Child of a Domestic Partner** - Child of a Domestic Partner includes your Domestic Partner's own biological children and legally adopted Children (including those who are in the legal process of adoption if the Domestic Partner has responsibility for medical expenses) regardless of residence. Such term also includes Children who reside a majority of the Calendar Year in the primary participant's household and for whom the Domestic Partner is legally declared guardian. This does not include wards of the state, granting of custody, or foster Children.

No Dual Coverage. No person may be covered both as an Employee/Retiree/Inactive Participant and Dependent, and no person may be covered as a Dependent of more than one Employee/Retiree/Inactive Participant. Only one of two named Employee/Retiree/Inactive participants may cover his or her common eligible Dependents at any one time. *This includes Medicare eligible retirees with a Health Reimbursement Account (HRA).*

Dual Coverage by Plan Participants

Because Lumen benefit plan provisions prohibit you to elect coverage during Annual Enrollment if you are also covered as a dependent on another employee's/retiree/inactive participant's coverage, you will remain in coverage under your own record, but you will be removed as a dependent from the other employee's/retiree/inactive participant's coverage once the enrollment period ends.

Also, two Lumen Employees/Retirees/Inactive Participants cannot enroll the same qualified Dependent in coverage separately.

Covered Dependent Verification

To assure compliance with Plan terms, the Company may periodically conduct audits of covered Dependents to determine their continued eligibility for Benefits under the Plan. Retirees will be required to timely provide supporting documentation to verify the eligibility and relationship (for Spouse, Child and Stepchild, etc.) and financial interdependency (for Spouse/common-law Spouse and Domestic Partner) of their Dependents covered under the Plan. This documentation may include, but is not limited to, birth and marriage certificates, tax returns, court orders and/or proof of residence. To view the eligibility documentation required, log on to the Lumen Health and Life Benefits website at lumen.com/ healthbenefits. Click on the *Health and Insurance* tab. Then Click on *Plan Information* under *Coverage Details*. Scroll down to the ***Dependent Verification Documents Required***.

For declared Dependents being enrolled in a medical, dental, or HRA plan, coverage will become effective based on the Qualifying Life Event. Any individuals who are determined to be ineligible, or for whom proof of coverage is not received timely, will be removed from coverage retroactively to the date they were added and you will be responsible for any health care claims that were incurred during the ineligible period. Premium adjustments, if applicable, will be processed as soon as administratively possible.

See the *When Health and Life Coverage Begins* and *When Health Plan Coverage Ends* sections for adding and dropping Dependents. Also refer to *Changing Your Health Care Coverage—Qualified Life Events*' section for additional information.

RE-HIRED RETIREE HEALTH CARE AND LIFE INSURANCE

If you retire, and subsequently return to work directly for the Company as an active employee, and you were eligible for retiree health care or life insurance from the Company, refer to the applicable section below to see how your retiree benefits may be impacted. Your retiree health care benefits may also be suspended if you work indirectly for the Company on an assignment or project through a Company supplier or vendor. When you suspend/unsuspend or re-enroll in coverage due to a Qualified Life Event (QLE) and outside of Annual Enrollment, your coverage will become effective, first of the following month. For example, if you call in May, your suspend/unsuspend will not be effective until June 1st. First of the following month after you call. Please review the Suspending Coverage section located below for more details on how to suspend.

Note: If you have Retiree VEBA Life Insurance, that coverage will not be impacted.

If you are rehired in a status that is eligible for active benefits, you will be offered the same benefits as other similarly situated Lumen employees based on your employee classification. If you had retiree basic or supplemental life insurance coverage, your retiree basic life insurance will be replaced with the active basic life insurance amount and you will be eligible to elect active supplemental life insurance coverage (if applicable). If there is a loss of supplemental life coverage between what you previously had prior to your rehire date and the amount as an active employee, you may convert the difference with Metropolitan Life Insurance Company. If you continued your retiree supplemental life coverage through Metropolitan Life Insurance Company, you will be required to surrender these policies when you return to retiree status in order to resume your retiree supplemental life insurance coverage, if applicable. In addition, your retiree basic life insurance, if any, would also resume.

If you return to work for a supplier on assignment to the Company, you are not eligible to continue to your retiree health benefits as they must be suspended for the duration of your assignment with the supplier and you are not eligible for active benefits under the Company Plans; however, you will be offered the opportunity to continue your retiree medical and/or dental coverage under COBRA. Your retiree basic and supplemental life coverage, if applicable, will continue under the terms of the Lumen Life Insurance Plan ("the Life Plan").

Once your employment or assignment ends, you may resume your retiree health care, basic and supplemental life insurance coverage, if applicable, in accordance with the terms of the Plan by calling the Lumen Health and Life Service Center at **833-925-0487** or **317-671-8494** (International callers) or **800-729-7526**. If you returned to work for a supplier on assignment to the Company, Lumen will validate that your assignment has ended before you will be allowed to resume your retiree health care coverage.

Note: If you are Medicare eligible and have enrolled in an individual Medicare policy, you may need to complete a disenrollment process to be released by that carrier from the individual plan (which can take up to 60 days). See the Medicare and Retiree Benefit Coverage section for more information.

HEALTH PLAN COVERAGE/ENROLLMENT - NON-MEDICARE ELIGIBLE

As an eligible Retiree (who is non-Medicare eligible), you will continue to receive group medical plan benefit options to choose from for you and your eligible Dependents as described below.

Choosing Your Coverage Level

If you are a non-Medicare eligible Retiree or Inactive Participant, you have the following coverage categories to choose from when enrolling in medical and dental coverage under the Health Plan:

- Retiree only
- Retiree and Spouse/Domestic Partner
- Retiree and Child(ren)
- Retiree and Family (consisting of a Spouse/Domestic Partner and one or more dependent Children)
- Suspend Coverage (temporary coverage status)
- Waived Coverage (see explanation below)

Please Note: Vision coverage can only be continued under COBRA.

Waiving Coverage

You can waive medical/prescription drug and/or dental retiree coverage for you and/or your dependents. If you do, you or your dependents will **NOT** be eligible to enroll in that coverage at any time in the future for any reason. “Waiving’ coverage is a **permanent** election and different from ‘suspending’ coverage.

Suspending/Unsuspending Coverage

You can suspend medical/prescription drug or dental retiree coverage for you and/or your dependents when you first retire (which does not count towards your one-time suspend option) and if you do not make an affirmative election during Annual Enrollment, your coverage will remain in a suspended status. If you later wish to participate in the medical/prescription drug or dental Plan benefit options, you must make an affirmative election during Annual Enrollment, or by unsuspending your medical and/or dental coverage. Coverage will be effective the first of the following month following your call. You can suspend your coverage **one time** and re-enroll at a later date. (This is not the same as permanently waiving coverage—see above.) When you suspend/unsuspend or re-enroll in coverage due to a QLE and outside of Annual Enrollment, your coverage will become effective, first of the following month. For example, if you call in May your suspend/unsuspend will not be effective until 6/1. First of the following month after you call.

If you are unsuspending a dependent, retirees will be required to timely provide supporting documentation to verify the eligibility and relationship (for Spouse, Child and Stepchild, etc.) and financial interdependency (for Spouse/common-law Spouse and Domestic Partner)of their Dependents covered under the Plan.

Note: This one-time rule does not apply with respect to Retiree/Inactive Participants who become re-employed directly with the Company as an active employee or who work for a supplier to the company. See the Rehired Retiree Health Care and Life Insurance section earlier in the SPD for more information.

You can change your coverage level during the year, subject to the limits on when coverage begins (see the *Qualified Life Events* section for more information).

Newly Eligible Retiree/Inactive Participants. Within approximately two weeks after the posting of your termination date in the payroll system, you will receive the following materials at your address on file:

- A Confirmation of Coverage letter indicating that your active health care insurance has ended.
- A retiree worksheet describing retiree health and/or life plan eligibility and premium costs. You can also find helpful information on the health and life benefits website (lumen.com/healthbenefits or lumenbenefits.com)
- Continuation of Coverage packet, COBRA

If you don’t receive the above information within two weeks after termination, contact the Lumen Health and Life Service Center.

Next Steps. As a new retiree, if you are eligible for the Retiree Health Care benefits, after you receive both the COBRA and Company Retiree Health Care information, your next step is to decide if you want to enroll in any eligible Company benefits by:

- Electing your retiree health care benefits. Complete the steps outlined on your Retiree Enrollment Worksheet by the deadline. The benefit options available to you depend on whether or not you (or your Dependents) are eligible for Medicare. See the *Medicare and Retiree Benefit Coverage* section below for more information.

or

- Suspending your group coverage and electing COBRA. While most retirees choose to continue coverage by electing retiree health care benefits, Lumen is required by law to extend COBRA continuation of coverage to all retirees and Inactive Participants. See your COBRA packet for details. ***(Also see the Medicare and Retiree Benefit Coverage section for rules and possible consequences if you become Medicare eligible while on COBRA or if you are already Medicare eligible when electing COBRA)***.

Note: If you elect COBRA coverage, your premium costs will be outlined in the COBRA packet you receive from the Lumen Health and Life Service Center.

Default Status Rules

Upon Retirement

If you fail to enroll yourself and/or your non-Medicare eligible Dependents in coverage elections in a timely manner, your coverage will default to **Suspend - no coverage** for medical and dental coverage, if applicable. Vision coverage terminates at the end of the month upon retirement and can be elected through COBRA.

Medicare Eligible

If you become Medicare eligible, your Lumen group non-medicare medical and prescription drug coverage ends. However, you will need to take action and enroll in your Lumen medicare options. If you fail to timely enroll in your medicare coverage, your Lumen coverage will default to Suspend- no coverage. See the *Medicare and Retiree Benefit Section* for more information.

Annual Enrollment

- To cover previously suspended Dependents during Annual Enrollment, action is required.
    1. To add previously suspended dependents, follow the prompts during your online enrollment or contact the Lumen Health and Life Service Center. A Dependent Verification packet may be sent to you automatically in December. If you are required to validate, follow the instructions outlined in the packet and **respond by the deadline**.
    2. Plan coverage for your previously suspended dependents will become effective January 1 of the benefit year, **EXCEPT**, if validation is required and verification forms are not received by the Lumen Health and Life Service Center by the deadline, your dependents will be removed retroactively from coverage and you will be required to reimburse the Plan for any claims paid while the previously suspended dependents were ineligible under the Plan.
- You may remove dependents from your Plan coverage during Annual Enrollment by following the prompts during your online enrollment or by contacting the Lumen Health and Life Service Center. COBRA will not be offered for dependents removed during Annual Enrollment except for those dependents who reach the maximum age limit.

Enrollment Limitations. See the *Eligibility and Dual Coverage* section earlier in this SPD for more information.

MEDICARE AND RETIREE BENEFIT COVERAGE

Medicare Eligibility

As a Lumen Retiree/Inactive Participant who is eligible for **Retiree** health care coverage, you may elect to receive the retiree group health care benefits (as described above in the Health Plan coverage (Non-Medicare Eligible) section) **until you become Medicare eligible**. Then, your Retiree non-medicare medical (including

prescription drug) coverage ends on the first of the month in which you are Medicare eligible. However, you and your eligible/declared medicare dependents may be eligible for additional medicare benefits offered through Lumen. You will need to review your options and choose to enroll in the Medicare option that best meets your needs. You will need to make your medicare options 30 days prior to your 65th birthday to make sure the coverage you choose is effective the month you turn age 65. For information regarding your options please contact the Lumen Health and Life Service Center at 833-925-0487 or 317-671-8494 (International callers) or 800-729-7526. You may be eligible for the "Lumen Medicare Advantage Prescription Drug (MAPD) PPO + Dental" or the Health Reimbursement Account (HRA) and Lumen Dental plans or No Medical Coverage/Waived in lieu of these benefits as described in the next section of this SPD.

Effective 01/01/2023, Medicare eligible Retirees/Dependents will need to make an election depending on if they want the Retiree HRA plan or the Lumen Group Retiree Medicare Advantage PPO + Dental plan. If at all possible make this election 30-60 days prior to your 65th birthday. Once you become Medicare eligible, if you have not made an election, the default coverage is to suspend coverage until an election is made. You have 30 days to make an election from your 65th birthday. If you do not take action your coverage will be suspended.

Therefore, it is very important that you **take action** to obtain your Medicare **Parts A and Part B** to ensure Medicare coverage will be effective on the first of the month in which you become Medicare eligible. A delay in getting your Medicare in place timely may result in a gap in health care coverage and possible late penalties imposed by Medicare. These penalties are lifetime, not just a one-time charge.

Note: It is recommended that you start this process 60-90 days before your Medicare eligibility date.

The Medicare eligible effective date rule is applied as follows:

- The first of the month in which you turn age 65. For example, if your birthday is on the 10th of the June, your Medicare effective date is June 1.
- The first of the previous month, if your birthday is on the first of a month. For example, if your birthday is June 1, your Medicare effective date is May 1.
- The first of the month following when you are declared Medicare eligible due to disability (if younger than age 65).

When You Need Medicare Part B

You need to obtain Medicare Part B when you are Medicare eligible and in retiree status (even if on COBRA), therefore:

- **Before you retire:** If you become Medicare eligible while still working and not yet retired, you do not need Medicare Part B until you retire.
- **At retirement:** If already Medicare eligible at the time of retirement, you should start the process to obtain Medicare Part B prior to retirement, so that it will be effective on the first of the month after you retiree coincident with when you lose your Lumen coverage. (Note: This also applies if you are electing COBRA).
- **After you retire:** If you are not yet Medicare eligible when you retire, then you should start the Medicare process 60-90 days prior to your Medicare start date to obtain Part B in the future, prior to the month in which you will become Medicare eligible (or sooner if your birthday falls on the first of the month), to be effective coincident with when you lose your Lumen coverage.

Note: It is your responsibility to notify the Service Center if you or your Dependents become Medicare eligible prior to age 65 (for example, due to a disability), as you will no longer be eligible for group health coverage under the Lumen Retiree and Inactive Health Plan once you become Medicare eligible (for any reason).

Important: A delay in obtaining your Medicare Part B when you become Medicare eligible (due to age or disability) may cause a gap in your medical coverage, denied claims and result in a higher lifetime Medicare Part B premium imposed by Medicare.

Cost of Medicare Part A and B

The cost of Medicare Part A (hospital insurance) is free, as you already paid for it by your payroll taxes.

The cost of the Medicare Part B (doctors and other services) premium is your responsibility and typically paid for from your Social Security check, if applicable.

Note/Action: If you are not yet drawing your Social Security payments, **you** will need to contact the Social Security Administration (SSA) **to apply** for Medicare Part B and to arrange for another type of **payment directly** to SSA for your Medicare Part B coverage.

Medicare Benefits

Medicare does not cover 100% of the medical costs and does not typically cover prescription drugs. Therefore, you may need to purchase individual medical and prescription drug coverage to supplement your Medicare benefits as described below.

HEALTH PLAN COVERAGE/ENROLLMENT - MEDICARE ELIGIBLE

Lumen Medicare Medical Benefit Options

The following options are available once you and/or your medicare eligible dependent become Medicare eligible.

Your 2023 Lumen medicare health care options are:

- Lumen Medicare Advantage Prescription Drug (MAPD) PPO + Dental (administered by UHC)
- Health Reimbursement Account (HRA)/SHARE
- Lumen Retiree Dental plans
- Via Benefits (individual Medicare Exchange vendor)
- No Medical Coverage Suspend/Waived

Effective 01/01/2023, Medicare eligible Retirees/Dependents will need to make an election depending on if they want the Retiree HRA plan or the Lumen Group Retiree Medicare Advantage (MAPD) PPO + Dental plan. If at all possible make this election 30 days prior to your 65th birthday. Once you become Medicare eligible, if you have not made an election, the default coverage is to suspend coverage until an election is made. You have 45 days to make an election from your 65th birthday.

Once retired, when you and/or your Dependents become eligible for Medicare, your non-medicare group health coverage under the Lumen Retiree and Inactive Health Plan (medical and prescription drug) coverage ends for that person the first day of the month in which he or she becomes eligible for Medicare, or the first of the month following retirement if already Medicare eligible at that time. See the *Medicare rules* in the section above.

The following options/events take place when you or your Dependents become Medicare eligible. See below:

- The Medicare eligible person loses the Lumen Retiree medical (including prescription drug) benefit options.
- If eligible, the Medicare eligible person receives a Health Care Reimbursement Account (HRA) as described below, in lieu of the medical benefit options.
- Any non-Medicare eligible family members remain on the Retiree health care benefit options and continue to receive Annual Enrollment choices.
- Retiree dental benefits continue to be offered to both the non-Medicare and Medicare eligible persons, if applicable.

Medicare and COBRA Rules (Important!)

Upon retirement, when deciding between the group Retiree health care plan or COBRA, it is important to understand how COBRA can impact your future enrollment in Medicare options and the timing of when you become Medicare eligible in that process:

- If you are non Medicare eligible upon retirement and elect COBRA—and then COBRA ends (voluntarily or involuntarily) and you are still non Medicare eligible. You may enroll in your Retiree health care benefits. You are not eligible to use your Share/HRA dollars to pay or reimburse for Cobra premiums. If you are non Medicare eligible upon retirement, and elect COBRA and then become Medicare eligible **after** you begin COBRA--COBRA will end when you become Medicare eligible and you will need to enroll in an individual Medicare plan (and your HRA will be set up at that time).
- If you are already Medicare eligible at the time of your retirement, and elect COBRA—be aware that if you drop your COBRA at any time before the end of the COBRA period (even if your subsidy ends)—you may not be able to enroll in an individual Medicare plan **until the next Medicare enrollment**. This could result in a gap in coverage. Therefore, you may need to consider staying on COBRA until it ends and pay the full cost without any subsidy until you can obtain an individual policy, and
- Certain Medicare type plans may only be available if you enroll upon retirement and not after dropping COBRA. For instance, Medicare Supplement plans can apply underwriting after the initial enrollment period upon retirement. Guaranteed Issue of coverage under these types of plans do not apply to Annual Enrollment periods—only the initial period after retirement when you first become Medicare eligible.

Reminder: You need Medicare Part A and B when Medicare eligible, even if electing COBRA.

Health Reimbursement Account (HRA) Benefit

Once you are Medicare eligible and no longer covered by the Lumen non-medicare group medical options, you may be eligible (if applicable to your Retiree Group) for a Health Reimbursement Account (HRA) to help cover some of the expenses of purchasing individual health care coverage outside of Lumen.

The eligibility for the HRA, the amount of the HRA and the rules and provisions of using the HRA vary depending on the provisions of which eligible Retiree Group you are associated with. See Appendix 1A to determine eligibility of which Retiree Group you may be eligible for, if any. If you qualify for retiree health care benefits, refer to the *Health Reimbursement Account (HRA) Summary Plan Description* for details on the specific benefits and provisions for each group. If eligible, in order to receive and setup your HRA account you will need to take action and enroll in the HRA plan.

Account Set Up and Administration

If eligible, at the time you become Medicare eligible you (or your eligible dependent) have the option to choose and enroll in the HRA account. The account is administered by a division of Businessolver, called “MyChoice Accounts” (MCA).

There is one account per family that will be set up under the Retiree’s name. However, there are different hierarchy rules that apply if you and your spouse are both Lumen Retirees, which may impact the way the account is set up. See the *Retiree Health Reimbursement Account* (HRA) SPD for more details.

Retiree Health Reimbursement Account (HRA)

As a retiree or dependent that enrolls in an individual Medicare plan, you may be eligible for a Health Reimbursement Account (HRA) to help offset or reimburse your Medicare plan premiums (medical, prescription drug, and vision). This is called the Company Subsidy HRA amount and it is based on which legacy company you were employed by prior to your retirement. Refer to the Healthcare & Life Benefits Eligibility Matrix to see if you qualify for an HRA. As an Active Employee: You can view the matrix on the Company intranet and use the search tool and enter Healthcare Life Retiree Matrix. As a Retiree: You can view the matrix on the Health and Life website or by calling the Lumen Health and Life Service Center at **833-925-0487** or **317-671-8494** (International callers) or **800-729-7526**.

See the *Retiree Health Reimbursement Account* (HRA) Summary Plan Description for more details.

Medicare and Other Health Care Coverage

Once you are retired and Medicare eligible, Medicare will become your Primary coverage and you may need to obtain an individual Medicare health care policy such as a Supplement, Medicare Advantage and/or Prescription Drug Part D plan to replace your Lumen group coverage which has ended. Both Medicare Part A and B are required for enrollment in to any of these types of policies.

You are responsible for choosing, enrolling and paying for other coverage outside of Lumen. As stated above please review your medicare options.

You can enroll in these individual policies directly with a carrier, through a local broker of your choice, or through **ViaBenefits**, the Medicare Exchange enrollment vendor that Lumen has arranged to help its Retirees.

Note: Medicare enrollment is based on single coverage only. Each Medicare eligible person in your family must obtain their own Medicare Part B and enroll in their own Medicare individual type plans for coverage. See the *Retiree Health Reimbursement Account* (HRA) SPD for more details.

Let ViaBenefits Help You Enroll. When retired, approximately 90-120 days prior to the month in which you (or your Dependent) turn 65, ViaBenefits will contact you to see if you need assistance with your Medicare enrollment. You may also contact ViaBenefits directly at 888-825-4252 for assistance within 90 days of your enrollment deadline to enroll in a Medicare policy that best meets your needs. Although you do not have to use ViaBenefits to enroll, there are added benefits such as possible automatic reimbursement of certain health care premiums from your HRA account balance, advocacy issues once enrolled and help with future enrollments or changes.

Note: ViaBenefits does not administer the HRA—and may not have your HRA information by the time you are in contact with them—it is your responsibility to know if you have HRA funds to consider when choosing a policy. They are there to help you enroll.

Other Retiree Benefit Coverage

You are still eligible for enrollment in the Lumen group dental benefit option and some Retirees are still eligible for life insurance, if applicable. See appendix 1A at the end of this SPD.

Upon retirement, Vision coverage may be continued under COBRA. Also, if you are enrolled in the Health Care Flexible Spending Account (FSA) you may also continue participation (on an after-tax basis) to the end of the calendar year in which you retire. *Contact the Lumen Health and Life Service Center for more information.*

Dependent's Coverage

You or your Dependents who are not yet Medicare eligible will remain on the group medical/prescription drug coverage until they become Medicare eligible. If enrolled in the group CDHP benefit option, any CDHP HRA balances will remain with the non-Medicare participants until all family members are Medicare eligible. If any balance remains after that, the balance will transfer to a separate Retiree CDHP HRA to be used separately from the Retiree HRA described above. ***See the Retiree Health Reimbursement Account (HRA) SPD for more details.***

PLAN COST

Health Plan

Benefits, including the Medicare HRA funding, under the Plan are paid from the general assets of the Plan Sponsor. Any required Retiree contributions, as noted below, are used to partially reimburse the Plan Sponsor for Benefits under the Plan.

Life Plans

All life insurance Benefits are insured through Life insurance carriers purchased with premiums paid from Company general assets for Basic Life and from premiums paid by you for Retiree Supplemental Life Insurance, if applicable.

Disability Plan

Cost shall be paid by the Company and the Employees in such proportions as determined by the Company on a periodic basis, subject to provisions in any applicable collective bargaining agreement.

Method of Calculating the Level or Amount of Contributions

The Plan Sponsor may require participant contributions towards the cost of providing coverage under the Plans. A schedule of such required contributions will be available to participants during Annual enrollment each year. The Company reserves the right to change the contribution amounts at any time subject to applicable collective bargaining agreements.

Your Health Plan Contribution Level

The Company may provide you with some amount of subsidy towards your retiree health care (medical and/or dental) coverage premiums. However, you also pay a portion of the cost for these benefits--all health care benefit plan options require participant contributions. The information you receive during Annual Enrollment will include any premium contribution requirements that will apply to the next Plan year, if you are enrolled for coverage.

Payment of Contributions

If you are an Eligible Retiree or Inactive participant, you are responsible for paying your portion of the premium each month that you are receiving covered Benefits. Your payments must be made timely to avoid late or missed payments which can result in termination of coverage.

Payments are due on the first day of each month for the current month’s benefit coverage and your full contribution must be received by the Service Center by the last day of the month. If not, your coverage will be terminated retroactively to the last day of the prior month for which full payment was timely received. If your coverage is terminated due to non-payment or insufficient payment, you will not be allowed to re-enroll. The Service Center will inform you of your right to appeal that determination.

For more information and specific details please refer to and review the Retiree Navigation Guide found in the reference center on the Health and Life Service Center, at Lumen.com/healthbenefits

There are three ways to pay your benefits premiums:

Check or Money Order

You will receive a billing statement each month.

Here's what to do if you do not receive your statement: Call the Service Center at **833-925-0487** or **317-671-8494** (International callers) or **800-729-7526**.

1. Select the **If you are a former employee** option;
2. Select the **medical, dental & life option**; then
3. Press *0 to speak with a representative.

Your premium for each month is due on the first day of the month. Submit your premium payment to the address listed on the statement.

If you submit more than one month of premium payment at a time, your additional payments will be held as a credit in your account.

Deductions from Your Pension Check

This applies only if you are currently receiving a pension check from Lumen and the amount of your check will cover the amount of your benefits premium payment.

To request your benefits premium payment be deducted from your pension check: Call the Lumen Health and Life Service Center at **833-925-0487** or **317-671-8494** (International callers) or **800-729-7526**;

1. Select the **If you are a former employee** option;
2. Select the **medical, dental & life option**; then
3. Press *0 to speak with a representative.

If you elect to pay premiums through your monthly pension check, deductions for premiums are paid for the current month. For example, the January contribution will be deducted from your January pension check. You may change your payment option at any time during the year.

Direct Debit

You can enroll in direct debit by visiting the Lumen Health and Life Benefits website:

1. Go to lumen.com/healthbenefits;
2. From the home page, use your computer mouse to roll over the **Health and Life Benefits** tab at the top of the screen;
3. Under **Take Action**, click on **Billings and Payments**;
4. Under **Current Ongoing Payment Method**, select **Change**; then
5. Select **direct debit** and follow the prompts to enroll.

You can also call the Service Center at **833-925-0487** or **317-671-8494** (International callers) or **800-729-7526** to request a direct debit form. Fill out the form and return it to the address shown on the form.

Direct debit deductions occur on the first of each month or the next business day if the first falls on a weekend or holiday. Payment is for the current month of coverage.

Reimbursement Account, if applicable

Lumen and Qwest Post-1990 Management Retiree's

When you become Medicare eligible and your Non-Medicare Lumen medical options end, one of your medicare options, is Lumen HRA. Lumen will fund an HRA with company subsidy dollars to help pay for your individual Medicare medical policy and dental premiums. Your HRA dollars do not roll over and any remaining balance at the end of the year is forfeited. If you choose this option, you will need to contact the Lumen Health and Life Service to have your HRA set up.

Embarq Retiree's with SHARE Accounts

When you retire from Lumen (if eligible) and your SHARE/HRA (formerly Retirement Reimbursement Account, RRA) will be setup at MCA and can be accessed to help pay for your post-retirement, non-medicare medical and dental coverage and your individual Medicare medical policy once you become medicare eligible. Your SHARE/HRA dollars will roll over each year until funds are depleted.

Qwest Post-1990 Occupational Retiree HRA

When you become Medicare eligible and your Non-Medicare Lumen medical options end, one of your medicare options, is Lumen HRA., Lumen will fund an HRA with company subsidy dollars to help pay for your individual Medicare medical policy and dental premiums. At the end of the year, any remaining HRA dollars (if any) will roll over year over year. If you choose this option, you will need to contact the Lumen Health and Life Service to have your HRA set up.

Company's Funding

Except for contributions you make toward your Plan coverage as described in the Your Contribution Level section above, the Company pays for your Benefits from its general assets. However, the Company may choose to fund a portion of your health care coverage by making contributions to one or more trusts established by the Company or its affiliates. If it so decides, these trust funds would then be available for payment of your Benefits in lieu of payment directly from the Company's general funds.

The Company's contributions to the trust funds, if any, may be in the form of the Company's common stock and up to 50% of the Plan's assets may be invested in Company common stock. If the Plan is terminated, any Plan assets will be applied to the payment of Benefits, insurance premiums, or administrative expenses incurred in the provision of Benefits. In no event will trust assets be returned to the Company.

The Company has contracted with several administrators to process claims under various programs included in this Plan. None of these contracted administrators are responsible for contributing toward payment of your Plan coverage.

HEALTH PLAN COVERAGE (NON-MEDICARE ELIGIBLE)

Your medical and dental benefit options are consolidated into a single Plan – the Health Plan. The detailed benefit coverage information, provisions, defined terms, etc. are described in each benefit option's specific Summary Plan Description.

Medical Benefit Options

Enrollment for health care Benefits will typically take place annually in the Fall. Refer to the below medical benefit options offered within the Plan:

- High Deductible Health Plan (HDHP) with a HSA
- Consumer - Driven Health Plan Option with an HRA
- Surest Health Plan
- Retiree Dental Coverage
- Suspend Coverage (temporary no coverage)
- Waive Coverage (permanent no coverage)*

**If you elect to waive medical coverage, you are also automatically electing to waive prescription drug coverage. Prescription drug coverage is bundled with the medical Plan in which you may enroll. Once you waive coverage, it is permanent and you cannot enroll at any time in the future. See the Health Plan Enrollment (Non-Medicare Eligible) section in this SPD.*

Your Dependents are also eligible, according to the provisions summarized in the Dependent Coverage section. To participate in the Plan, you must submit your coverage elections in accordance with Company directions. If you fail to properly submit your coverage elections in a timely manner, the Company will default your coverage to specific elections (see Default Status Rules in the Health Plan Coverage/Enrollment – Non-Medicare Eligible section).Claims Administrators

Claims Administrators

References to your Claims Administrator will apply to your specific health plan benefit options, such as those listed below. See the full list of Claims Administrators in the Contact Information Chart above and in the Plan Information section below.

- **UnitedHealthcare** (UHC) is the national Claims Administrator for the CDHP and HDHP benefit options
- **Surest Health Plan** (Surest) is the Claims Administrator for the Surest Health Plan
- **OptumRx** administers the retail pharmacy and home delivery pharmacy service for all UHC and Highmark Medical and behavioral beneffit options
- **Optum** administers the Well-Connected Program/Incentives
- **MetLife (Metropolitan Life Insurance Company)** administers the dental program
- **UnitedHealthcare** administers the Health Care and Dependent Day Care FSA's
- **Optum** administers the Employee Assistance Plan (EAP)

Refer to the specific benefit plan option's SPD for more information about the benefits, provisions and details, defined terms, etc.

Other Health Care Plan Benefit Options

Regardless of which medical plan benefit option you are enrolled in, the Health Plan also provides you with access to:

- Employee Assistance Program (EAP)
- Retiree and Inactive Health Plan General Information | Issued Jan. 1, 2023 19
- Well Connected Program/Incentives
- Prescription Drugs
- Dental (Full-time employee only)
- Vision (Full-time employee only)
- Health Care FSAs and Dependent Day Care FSA options (Full-Time Employees)

Life Coverage

Lumen offers limited basic and supplemental life insurance coverage for certain eligible Retiree and Inactive Participants as noted in Appendix 1A.

MetLife is the insurance carrier for Life Insurance. Please refer to the Life Insurance SPD for more details.

WHEN HEALTH AND LIFE COVERAGE BEGINS

Retiree (Non-Medicare eligible)

- Retiree coverage is effective the first of the month following your retirement (if COBRA is not elected). If you make changes during Annual Enrollment, your new coverage will begin on the first day of the new Calendar Year.

- Coverage changes due to Qualified Life Events are generally effective on the date of the event *if the election is made* **within 45 days** *of the event.* (refer to the *Qualified Life Events* section later in this SPD for examples of Qualified Life Events).

Rehired Retiree

Coverage for active Benefits is effective the first of the following month after the re-hire date for retirees.

Medicare Retiree

If you become Medicare eligible, your Health Reimbursement Account, if applicable, will be available the first of the month in which you become Medicare eligible and enroll in an individual Medicare policy outside of Lumen (this coincides with when your group medical/prescription drug coverage ends.) See the Medicare and Retiree Benefit Coverage section for more information.

Dependents

Retirees must have all eligible dependents enrolled or declared upon retirement in order for those dependents to have coverage in the future. Therefore, previously declared dependents may only be added during Annual Enrollment or upon a QLE.

CHANGING YOUR HEALTH CARE COVERAGE—QUALIFIED LIFE EVENTS (QLE)

Generally, your benefit option choices under the Health Plan (medical and dental) and/or life insurance plan will remain in effect for the full Calendar Year and can be changed only during the Annual Enrollment Period. (Medicare eligible Retiree should refer to Medicare and Retiree Benefit Coverage Section for medical enrollment information.

However, you can make limited changes during the year if you experience a Qualified Life Event (QLE). The benefit change you request must be consistent with the type of Qualified Life Event change you experience. Retiree and Inactive Health Plan General Information | Issued Jan. 1, 2023.

If you are making a change to your coverage elections as a result of a Qualified Life Event (as defined by the IRS), coverage for you or your eligible Dependents will generally be effective the first day of the calendar month following your notification to the Lumen Health and Life Service Center, provided notification is given within 45 days of the change.

Qualified Life Event Reminder: If you experience a Qualified Life Event such as rehiring, you must contact the Lumen Health and Life Service Center at lumen.com/healthbenefits or 833-925-0487 or 317-671-8494 (International callers) or 800-729-7526 within 45 days of the event in order to change your coverage elections. If you miss the 45- day window, you will not be able to make changes until the next Annual Enrollment.

Please Note: If you are a Retiree who wishes to provide coverage for your biological Children who are under an issued QMCSO, see QMCSO information above in this SPD.

Effect of Changes in Eligibility Status

You will retain your coverage history relating to Plan limitations whenever you are covered by the Plan in any capacity. For example, if both a husband and wife are covered Retirees or Inactive participants, any expenses

incurred by Dependents who are covered by the husband as a Dependent will be carried over for those Dependents if they are later covered by the wife as her Dependents.

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. Because Dependents must be eligible (enrolled or declared) at the time of retirement, these are the only Qualified Life Events that apply. All of the following should be reported to the Lumen Health and Life Service Center ***(within 45 days of the QLE)***:

- Your divorce;
- Death of a Dependent (deaths are reported to the Lumen Health and Life Service Center by selecting the option "To Report a Death")
- Start or end of your declared Spouse/Domestic Partner's employment impacting your previous coverage or need;
- Significant changes in the health care coverage or cost provided by your declared Spouse/Domestic Partner's employer;
- Loss of Medicare, Medicaid or CHIP coverage;
- Entitlement to Medicare, Medicaid or CHIP coverage;
- Your Dependent no longer qualifies as an eligible Dependent due to exceeding the age limit;
- You or your declared Spouse/Domestic Partner gain or lose eligibility for coverage;

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

If you do not notify the Lumen Health and Life Service Center within 45 days (or 60 days if the event is subject to Children's Health Insurance Program, CHIP) from the date of the qualifying status change, you will not be allowed to make changes until the next Annual Enrollment period. Additionally, if the QLE was a COBRA event, your Dependent will lose the opportunity to elect COBRA if you do not notify the Lumen Health and Life Service Center within 60 days of the QLE. See the Required Notice and Disclosure section of this SPD for more information.

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 are generally effective on the date of the QLE (including Legal Guardianship and QMSCOs on date of order). **Note:** Even if you already have dependent coverage, **you must add** your new dependent to your coverage within 45 days of the QLE. ***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 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 Event
- 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 not be eligible to continue coverage through COBRA. **You will be responsible for any repayment of claims incurred and paid by the carrier after your Dependent retroactively loses eligibility.**
- You must report the death of **any** covered dependent as soon as possible.

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 divorce you may only drop your former Spouse/Domestic Partner; with respect to coverage for your Children in this situation, you may add only your previously declared Children if you did not previously cover them under the Plan or you have a QMCSO to add them.

Health Plan—HIPAA Special Enrollment Provisions

Loss of Other Coverage. Under the Special Enrollment rules under HIPAA, you may enroll yourself and eligible declared dependents in the Health Plan upon the loss of other coverage, referred to as the "other plan," to include the following:

- Termination of employer contribution toward other coverage;
- Moving out of a service area if the other plan does not offer other coverage;
- Ceasing to be a dependent, as defined in the other plan; or
- Loss of coverage to a class of similarly situated individuals under the other plan (e.g., when the other plan does not cover temporary/contractors).

If your declared spouse/domestic partner or other dependents have special enrollment rights, you may enroll and make changes to your enrollment in any health plan benefit option available to you based upon your home ZIP code and plan service areas within 45 days following the qualifying event. For example, if you have Retiree Only coverage in a Lumen benefit option, and your declared spouse/domestic partner loses coverage under his/her employer's plan and has special enrollment rights, both you and your spouse/domestic partner may enroll in any of the Lumen benefit options available to you, provided you verify your spouse's/domestic partner's eligibility for the Plan.

You may not enroll under special enrollment if you lost the other coverage because you failed to pay the premiums or if you lost the other coverage for cause (for example, you misrepresented something on the application form). You may not enroll your declared Dependent unless you already are enrolled or are enrolling yourself along with your Dependent.

WHEN HEALTH AND LIFE INSURANCE PLAN COVERAGE ENDS

Your retiree group health plan coverage ends when you turn age 65 and are no longer eligible. Your active group Health plan coverage ends on the last day of the month you retire. Your life insurance coverage ends on your last day of work. However, there are several other situations that will cause your or your Dependent's Health Plan coverage to end. *Refer to 'Changing Your Health Care Coverage—Qualified Life Events' (QLE) section for additional information.*

In addition, when coverage is lost, you or your Dependents may be eligible to continue coverage at your own expense. For more information, see the *Continuation of Coverage Coverage (Under COBRA and Other Continuation Coverage)* section regarding COBRA.

Ending Coverage for Dependents Who No Longer Meet Eligibility Requirements

If a Dependent covered under the Plan no longer meets the eligibility requirements for coverage, you are responsible for contacting the Lumen Health and Life Service Center within 45 days to terminate his or her coverage. In some cases, you may have the opportunity to continue health care coverage for the formerly eligible Dependent under COBRA (as long as you notify the Lumen Health and Life Service Center **within 60 days** of the change). You also have the option of continuing any supplemental life insurance coverage currently in place for your Dependent by converting to an individual policy. See the Life Insurance SPDs for more information or access the Lumen Health and Life Benefits website at lumen.com/healthbenefits for more details.

Note: Divorce or death of a Spouse/Domestic Partner or death of Child Coverage will retroactively end on the last day of the month from the date of the event, regardless of the notification date. In the event of a divorce, you will be responsible for any claims paid after eligibility ceased. If applicable, there could be a slight delay in receiving a retroactive credit due to administrative processing

Your Health Plan and Life Insurance coverage will end as described below:

Retirees:

- **Upon retirement.** Your active group Health Plan coverage ends on the last day of the month you retire. Your life insurance coverage ends on your last day of work.
- Your **retiree** group Health Plan coverage ends for reasons as stated below:
  - **You are no longer eligible.** Your Health Plan coverage ends on the last day of the month in which you no longer satisfy eligibility requirements of the Health Plan.
  - **Nonpayment of contributions or cancellation.** Coverage ends on the last day of the month during which you stop timely paying any required premium contribution or request cancellation of premium contributions
  - **Loss of LTD Recipient status.** Coverage ends on the last day of the month during which your longterm disability status ends for any reason including reaching the maximum duration age, unless you also qualify for coverage as an active or retired Employee.
  - **Upon becoming Medicare eligible.** Your retiree group medical/prescription drug coverage ends on the first of the month *in which you become Medicare eligible*. See the *Medicare and Retiree Benefit Coverage* section for more information.
- **Medicare eligible with an HRA.** An HRA Participant will cease to be a Participant in this HRA Plan upon the earlier of:
  - the termination of this HRA Plan; or
  - the date the Medicare-eligible Participant dies; or
  - the date the Medicare-eligible Participant makes a Waive Election; or
  - the date on which the Medicare-eligible Participant ceases to be eligible, provided that eligibility may continue beyond such date for purposes of COBRA coverage, as may be permitted by the Administrator on a uniform and consistent basis.
    Reimbursements from the HRA Account after termination of participation will be made pursuant to Section 6.7 in the Plan Document (relating to a run-out period for submitting Medical Care Premium receipts incurred prior to termination and relating to COBRA).
- **Life Insurance for Legacy Qwest Retirees only.** Your basic life insurance coverage will end upon death. If you continued Supplemental Life Insurance, it will end on the last day your eligibility under the Life Insurance Plan ends. Refer to the Life Insurance SPD for additional details.

Dependents:

- **Dependents Who No Longer Meet Eligibility Requirements.** If a Dependent covered under the Plan no longer meets the eligibility requirements for coverage, you are responsible for contacting the Lumen Health and Life Service Center within 45 days to terminate his or her coverage (see box below). In some cases, you may have the opportunity to continue health care coverage for the formerly eligible Dependent under COBRA (as long as you notify the Lumen Health and Life Service Center within 60 days of the change). You could also have the option of continuing any supplemental life insurance coverage currently in place for your Dependent by converting to an individual policy. See the *Life Insurance SPDs* for more information or access the Lumen Health and Life Benefits website at lumen.com/healthbenefits for more details.
- Dependents of a Primary Participant Who Dies. See *surviving spouse matrix*.

Contact the Lumen Health and Life Service Center for more details applicable to your situation.

Coverage Extension

Generally, your health care expenses will no longer be eligible for coverage under the Health Plan after your eligibility ends. However, health care coverage can continue–with approval from the Claims Administrator–in the following situations, as long as your coverage did not end because you failed to pay any required premium:

- If you are receiving care in a covered inpatient facility, facility Benefits can continue for up to 120 days from the date of Admission or until you are discharged, whichever comes first.
- Facility Benefits for inpatient mental or nervous conditions can continue for up to 120 days from the date of Admission or until you are discharged, whichever comes first.
- Facility Benefits for inpatient substance use treatment can continue 120 days or until you are discharged, whichever comes first.
- Home health care, Hospice Care, and Skilled Nursing Facility benefits can continue for up to 120 days from the date of Admission.

Coverage May End or Be Rescinded Retroactively

Generally the Plan will not rescind or revoke coverage on a retroactive basis for a Participant or a Participants' eligible Dependent once the Participant or Dependent is covered. If it is determined that a Participant or a Participant's Dependent is ineligible for coverage or fails to timely pay for coverage, you will be notified that your coverage will terminate prospectively. However, if it is determined that a Participant or a Participant's Dependent has performed an act or practice that constitutes fraud or an intentional misrepresentation of a material fact as prohibited by the terms of the Plan coverage (such as, for example, coverage being continued when the Dependent was ineligible due to divorce or aging out) the Plan's coverage may be rescinded retroactively to the date of the ineligibility. If this is the situation, you will be notified in writing prior to the rescission of the coverage.

HOW TO FILE PLAN CLAIMS

This Section provides you with information about how to file claims for medical and dental services. The claims procedures for the other Benefits (life insurance) are briefly explained below and set forth in more detail in each of those respective benefit option SPDs.

Claims for Medical Services

- If you receive Covered Health Services from a Network Provider, generally the Network Provider will file the claim for you. UnitedHealthcare and the Surest Health Plan pay these Providers directly.
- If you receive Covered Health Services from an Out-of-Network Provider you may be responsible for filing a claim. Subject to written authorization from you, all or a portion of any Eligible Expenses due may be paid directly to the Provider instead of being paid to you. The Claims Administrator will not reimburse third parties who have purchased or been assigned Benefits by Physicians or other Providers

Release of Records. You will be asked to authorize and direct any Provider who has given you health care to release all necessary information to the Claims Administrator. This information is kept confidential. Your failure to authorize or provide such information may result in the denial of your claim for coverage of such health care under the Health Plan.

Claims for Prescription Drugs

For information on submitting claims for home delivery service or retail prescription drugs, refer to the CDHP and HDHP plan benefit option's SPDs which include these Benefits.

Claims for Mental Health and Substance Use Treatment

Claims for mental health care and substance use treatment will usually be filed directly by the mental health/substance use Provider when using In-Network Providers. See your specific health plan option SPD, which includes this Benefit.

Claims for Dental

Typically, if you receive services from a Network provider, they will file the claim for you and MetLife will pay the provider directly. Otherwise, you must submit a claim form to MetLife for the dental services. Refer to the *Dental SPD* for additional information.

Claim Forms and Deadlines

If you are filing claims manually, claim forms may be obtained on www.myuhc.com, or on the Lumen Health and Life Service Center at lumen.com/healthbenefits. To ensure timely processing of your claims, it is important that you include all the information about your Provider, the type of service you received, and the diagnosis. It is also important that you attach an itemized statement with your claim form.

Claims for Life Insurance

You or your beneficiaries are responsible for filing claims for life insurance Benefits under the Life Plan. Refer to the *Retiree Life Insurance SPD* for additional information on the claims and appeals procedures.

The Right to File a Benefit-Related Lawsuit and Deadline. 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.

After you have exhausted or completed the claims and appeal procedures and the process 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.

Note: This means that you cannot bring any legal action against Lumen, 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 against Lumen, the Employee Benefits Committee or the Claims Administrator 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 Lumen or the Claims Administrator.

TIMING OF BENEFIT DETERMINATIONS ON HEALTH CLAIMS AND APPEALS

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- **Urgent Care request for Benefits** - a request for Benefits provided in connection with Urgent Care services, as defined in the Glossary of Defined Terms section;
- **Pre-Service request for Benefits** - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- **Post-Service** - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and the Claims Administrator are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	**24 hours**
You must then provide completed request for Benefits to the Claims Administrator within:	**48 hours** after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	**72 hours**
If the Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	**5 days**
You must then provide completed request for Benefits to the Claims Administrator within:	**15 days**
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	**5 days**
You must then provide completed request for Benefits information to the Claims Administrator within:	**45 days**
The Claims Administrator must notify you of the benefit determination:	
if the initial request for Benefits is complete, within:	**15 days**
after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination (file a first level appeal) no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

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**
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:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Eligibility/Participation Claim

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

Eligibility/Participation Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	**30 days**
You must then provide completed claim information to the Claims Administrator within:	**45 days**
The Claims Administrator must notify you of the benefit determination:	
if the initial claim is complete, within:	**30 days**
after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than (First-Level appeal):	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**180 days** after receiving the first level appeal decision
The Claims 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 Claim and the Time Deadline to File a Benefit-Related Lawsuit

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

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

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

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

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

COORDINATION OF HEALTH CARE BENEFITS

Your Benefits are coordinated with other group plans covering you and your Dependents.

If you, your Spouse/Domestic Partner or an eligible Dependent are covered by any other group medical or health plan – for example, if your Spouse/Domestic Partner has coverage through his or her employer – Benefits from the Health Plan and the other plan will be "coordinated." Coordination of Benefits can be applied in several different ways. This section describes the COB with the Medical benefit options. See COB with the Dental benefit options later in this section.

If you have duplicate coverage, one of the plans will be designated as the primary carrier and the other as the secondary carrier. The primary carrier pays Benefits under its provisions first, and the secondary carrier pays for any remaining expenses under its provisions. This is called Coordination of Benefits ("COB"). Benefits coordination provisions under the medical benefit options, is non-duplicative, meaning that the Benefits you receive from the Health Plan, when combined with Benefits from all other group medical or health plans, will not add up to more than the health care Benefits payable under the Health Plan had it been your only plan coverage.

If the Lumen medical option is primary (the first to pay), Benefits will be paid as if no other plan exists. If the Lumen medical option is the secondary payer, Benefits will be reduced by the Benefits paid by the primary plan. Benefits from your Lumen plan will be paid to the extent that, when Benefits from both plans are added together, the total is not more than what Lumen would have paid if no other plan exists.

Coordination of Benefits is the method used to determine which of your group health care plans (if applicable) has the primary responsibility to provide Benefits, and which group plan pays second. This COB provision generally does not apply to individual policies that are not issued under a group coverage arrangement.

Please Note: The Prescription Drug Program does coordinate with other plans, including Medicare Part D plans.

How Coordination Works

When you have a health care claim, the plan considered primary pays Benefits first, without regard to any other plans. The plan considered secondary then adjusts its Benefits so that the total paid to Providers is not greater than your incurred charges.

The following guidelines are used to determine which plan is primary:

- Any plan that has no COB provisions will be primary
- The plan covering the Retiree or Inactive participant - will be primary—unless the patient is also a Medicare beneficiary. In that event, the plan covering the patient as a dependent will pay first if the following are both true:
  - Medicare is secondary to the plan covering the patient as a Dependent
  - Medicare is primary to the plan covering the patient as other than a Dependent)
- If your Spouse/Domestic Partner has other coverage, that coverage is typically primary for the Spouse/ Domestic Partner and this Plan is secondary
- If a Dependent Child is covered under both parents' plans, the parent whose birthday comes earlier during the Calendar Year will provide the primary coverage. If both parents have the same birthday, the parent who has been covered longer will provide primary coverage
- In the case of a divorce, any court decree establishing financial responsibility for the Child's health care expenses will determine the primary plan. If there is no decree, the plans will pay in this order:
  - The plan of the custodial parent will pay first
  - If the custodial parent has not remarried, the plan of the non-custodial parent will pay second
  - If the custodial parent has remarried, the plan of the stepparent, if any, will pay second and the plan of the non-custodial parent will pay third
  - However, if the court decree states that the parents will share joint custody but does not establish that one of the parents is responsible for the Child's health care expenses, the plans covering the child will pay according to the birthday rule described in this COB section
- If none of the above situations applies, the plan covering the patient as an active Employee (or their Dependent) is considered before the plan that covers the patient as a laid-off or retired Employee (or their Dependent)
- If none of these situations apply, the plan covering the patient the longest will be primary

In order to administer this COB, the Plan Administrator has the right to:

- Provide or receive information needed to determine Benefits
- Recover excess payments, including payments made because of a third party's wrongful act or negligence. For more information on the Plan's right to recovery, refer to the Right to Full Restitution (Subrogation) and Reimbursement section of this SPD

Coordination with Medicare

Since Lumen group health coverage is no longer available to Company retirees who are Medicare eligible, there is no coordination of coverage between Lumen and Medicare. As a retiree, Medicare becomes your primary coverage and you can enroll in other individual policies for additional benefits. Each of those plans will have their own Coordination of Benefit rules.

Note: If you are unable to qualify for a Medicare supplemental plan on the market as verified/confirmed by ViaBenefits (typically when early Medicare eligible), you will remain in a Lumen default plan until you are able to obtain a market Medicare plan as determined by ViaBenefits, but no longer than the first day of the month in which you turn 65. This default plan does coordinate with Medicare therefore you must still obtain both Medicare Parts A and B. Other exceptions may be determined by the Company depending on the circumstances.

Coordination with the Dental Options (if eligible)

The Dental benefit plan option uses the standard COB process, meaning that when the Lumen Plan pays as secondary, it will pay up to the amount it would have paid had it been primary. This can result in the Benefit amount being paid up to 100%, keeping the Participant whole. Contact the Plan Administrator for more information.

CONTINUATION COVERAGE (UNDER COBRA AND OTHER CONTINUATION COVERAGE)

On April 7, 1986, a federal law titled the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (Public Law 99-272, Title X) (known as "COBRA"), was enacted. This law requires most employers sponsoring group health plans to offer covered Employees, their covered Spouses/Domestic Partners and covered Dependent Children (called "Qualified Beneficiaries") the opportunity to purchase a temporary extension of health coverage (called "Continuation Coverage") at group rates (plus a 2% administrative charge) in certain instances where coverage under the plan would otherwise end (called "Qualifying Events"). This notice is intended to inform you, in a summary fashion, of your rights and obligations under the Continuation Coverage provisions of COBRA. You, your Spouse/Domestic Partner and your covered Dependents, if any, should take the time to read this notice carefully.

Continuation Coverage for the Health Plan is administered by Lumen Health and Life Service Center, which is referred to in this section as the COBRA Administrator.

Certain states provide continuing coverage rights in addition to the federal COBRA rights explained in this SPD. Contact the Plan Administrator or its delegate the Claims Administrator, for information regarding the Continuation Coverage offered by your state.

Eligibility, Qualified Beneficiaries and Qualifying Events

Retirees and Inactive participants. If you are covered by the active employee Health Plan (including the medical, dental and vision benefit options and the Health Care FSA), you may have a right to Continuation Coverage under the Health Plan upon retirement if you are suspending your election of your retiree health care benefits. If you elect COBRA first, you can elect to begin your retiree benefits at a later date. Note: If you are Medicare eligible and do not continue COBRA for the entire COBRA period, you may not be able to elect an individual Medicare policy until the next Annual Enrollment, which will result in a gap in coverage.

Spouse or Domestic Partner. If you are the Spouse or Domestic Partner of a Retiree/Inactive Participant and you are covered by the Retiree Health Plan, you have the right to purchase Continuation Coverage under the Plan for yourself if you lose group health coverage for any of the following reasons (with the loss of coverage, known as Qualifying Events):

- The death of your Spouse or Domestic Partner (who is the Retiree/Inactive Participant)
- Divorce from the Retiree/Inactive Participant, your Spouse or termination of your Domestic Partnership

Your covered Spouse is a Qualified Beneficiary for purposes of COBRA. However, while your *Domestic Partner is not a Qualified Beneficiary for purposes of COBRA*, Lumen provides your partner with the opportunity to continue health coverage under terms and conditions similar to COBRA Continuation Coverage as described in this section of the SPD.

Dependents. In the case of a Dependent Child of a Retiree/Inactive Participant who is covered by the Health Plan, such Child has the right to purchase Continuation Coverage under the Health Plan if the Plan coverage is lost for any of the following reasons (with the loss of coverage, known as Qualifying Events):

- The death of a parent who is covered by a Company-sponsored group health plan
- Parents' divorce
- Entitlement to Medicare (Part A, Part B or both) by a parent who is a covered retiree

- The Dependent ceases to be a Dependent Child as defined under the terms of the Company-sponsored group health plan

Your covered Child is a Qualified Beneficiary for purposes of COBRA. *However, while the Children of your Domestic Partner are not Qualified Beneficiaries for purposes of COBRA,* Lumen provides them with the opportunity to continue health coverage under terms and conditions similar to COBRA Continuation Coverage as described in this section of the SPD.

Notification Requirements

Please Note: Under COBRA, you or your family has the responsibility to inform the Plan Administrator of a divorce, termination of a Domestic Partnership or a Child losing dependent status under the Plan within 60 days of the date of the event or the date on which coverage would end under the Plan because of the event, whichever is later. If one of these events occurs, you must notify the Lumen Health and Life Service Center by calling 800-729-7526 or 833-925-0487 or 317-671-8494 (International callers). You may be asked to provide additional information and documentation about the event and the persons involved.

When the COBRA Administrator, the Lumen Health and Life Service Center, is notified that one of these events has happened, each Qualified Beneficiary will in turn be notified of the right to choose Continuation Coverage. Under the law, you have 60 days from the later of (i) the date you ordinarily would have lost coverage because of one of the events described above, or (ii) the date of the notice of your right to elect Continuation Coverage, to inform the COBRA Administrator that you want Continuation Coverage.

Timely Notification Required or Forfeit Continuation Coverage Right. If you or a covered family member does not timely notify the Plan Administrator of a divorce, termination of a Domestic Partnership or a Child's loss of dependent status, you will lose the right to elect Continuation Coverage and your Plan coverage and the Plan coverage of your Dependents will end.

For example, if you and your Spouse/Domestic Partner are divorced effective May 22nd, you must notify the Plan Administrator by calling the Lumen Health and Life Service Center within 60 days (or in this example, by July 21st) to advise that your Spouse/Domestic Partner is no longer eligible.

Electing COBRA and Other Continuation Coverage

To elect Continuation Coverage, you must timely complete your COBRA election. Each Qualified Beneficiary has a separate right to elect Continuation Coverage. For example, the Retiree/Inactive Participant's Spouse/Domestic Partner may elect Continuation Coverage even if the Retiree/Inactive Participant does not. Continuation Coverage may be elected for only one, several or for all Dependent Children who are Qualified Beneficiaries. A parent may elect to continue coverage on behalf of any Dependent Children. The Retiree/Inactive Participant or Retiree/Inactive Participant's Spouse/Domestic Partner can elect Continuation Coverage on behalf of all of the Qualified Beneficiaries.

Things to Consider on COBRA and Other Continuation of Coverage Elections

In considering whether to elect Continuation Coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of and maintenance of Continuation Coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies

that do not impose such pre-existing condition exclusions if you do not get Continuation Coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 45 days after your group health coverage ends because of the Qualifying Event listed above. You will also have the same special enrollment rights at the end of Continuation Coverage if you get Continuation Coverage for the maximum time available to you.

Type of Continuation Coverage Available and Duration (Under COBRA and Continuation Coverage)

When Continuation Coverage Begins. If you timely elect Continuation Coverage, your Continuation Coverage will begin on the date your Plan coverage would have otherwise ended, but for your election to purchase Continuation Coverage.

Type and Duration. If you elect Continuation Coverage, you are entitled to be provided with Continuation Coverage that is identical to the Coverage being provided under the Plan to similarly situated Retiree/Inactive Participants (or their family members).

Up to 18 Months. If you lost medical/prescription drug, dental or vision coverage under the Health Plan because of a termination of employment or due to retirement, COBRA requires that you be afforded the opportunity to maintain Continuation Coverage for up to 18 months. You may also have continued access to the employee assistance services.

If you lost coverage under the Health Care FSA, Continuation Coverage may be provided on an after-tax basis until the end of the year in which the Qualifying Event occurred.

Up to 36 Months. In the case of other Qualifying Events, (death, divorce, Dependent ceases to be a Dependent, Medicare Entitlement), Qualified Beneficiaries will be afforded the opportunity to maintain Continuation Coverage for up to 36 months.

Disability Extension of 18-Month Period of Continuation Coverage. An 18-month period of Continuation Coverage may be extended for up to 11 months (for a total of up to 29 months of Continuation Coverage) if the Qualified Beneficiary is disabled (as defined under the Social Security Act) at any time during the 60 days of the 18-month Continuation Coverage period. The Qualified Beneficiary must notify the COBRA Administrator, within 60 days of the later of:

- The date of the disability determination by Social Security Administration;
- The date on which the Qualifying Event occurs;
- The date on which coverage is lost due to the Qualifying Event; or
- The date the Qualifying Beneficiary receives notice of his responsibility to notify the COBRA Administrator of such determination

(and within the initial 18 month Continuation Coverage period). The disability must last at least until the end of the 18-month period of Continuation Coverage for the Qualified Beneficiary to receive the extension. The 29 month period of Continuation Coverage also is available to a disabled Qualified Beneficiary's non-disabled family members who are entitled to Continuation Coverage.

Notice Required. In the event of such a disability, you must notify the Lumen Health and Life Service Center either by writing or calling the Lumen Health and Life Service Center at 833-925-0487 or 317-671-8494 (International callers) or 800-729-7526. See the section If You Have Questions About Continuation Coverage for the COBRA Administrator's address. You may be asked to provide additional information and documentation about the event and the persons involved. If you or a family member do not timely notify the Plan Administrator of the disability event, you will lose the right to purchase Continuation Coverage for the

longer period.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage. Additional Qualifying Events (including, but not limited to, your death; you become divorced; your Dependent Child is no longer eligible; or you become entitled to Medicare (Part A or Part B or both) Benefits as defined under the Social Security Act) can occur for your Dependents while Continuation Coverage is in effect. Such events may extend an 18 month period of Continuation Coverage to 36 months, but in no event will coverage extend beyond 36 months after the loss of coverage due to the initial Qualifying Event.

Notice Required. If a second Qualifying Event occurs during your Continuation Coverage period, you must notify the Lumen Health and Life Service Center within 60 days of that event either by writing or calling the Lumen Health and Life Service Center at **833-925-0487** or **317-671-8494** (International callers) or **800-729-7526**. You may be asked to provide additional information and documentation about the event and the persons involved. If you or a family member does not timely notify the Lumen Health and Life Service Center of a second qualifying event, you will lose the right to purchase Continuation Coverage for the longer period.

When COBRA and Other Continuation Coverage Ends

If you do not elect to purchase Continuation Coverage within 60 days of the loss of coverage or within 60 days from the date you receive notice from the COBRA Administrator, whichever is later, your coverage or coverages for which you do not elect Continuation Coverage under the Health Plan benefit option(s) in which you participate will end.

Please Note: If you do not timely elect to purchase Continuation Coverage, your Company-sponsored group health coverage under the Health Plan will end as of the date it was scheduled to end due to the Qualifying Event.

Termination of Continuation Coverage. COBRA also provides that your Continuation Coverage may be terminated for any of the following five reasons:

- The Company no longer provides Company-sponsored group health plan coverage to any of its Retiree/ Inactive Participant's
- You do not timely pay the premium for your Continuation Coverage within 30 days of the due date (or within any applicable longer grace period)
- You become covered under another group health plan (as an Employee or otherwise) unless that new plan contains any exclusion or limitation with respect to any preexisting condition of the Qualified Beneficiary. The affected Qualified Beneficiary may continue coverage until the preexisting exclusion or limit would otherwise end. (Pursuant to the Health Insurance Portability and Accountability Act of 1996, there are new restrictions on the use of preexisting condition limitations and exclusions, and group health plans are required to give credit to individuals for prior health coverage in certain circumstances for purposes of reducing a preexisting condition limitation or exclusion period.)
- You become entitled to Medicare (Part A or Part B or both) Benefits except that if the covered Retiree/ Inactive Participant becomes entitled to Medicare, his/her covered family members who are Qualified Beneficiaries may continue coverage for up to a total of 36 months from the date of the Qualifying Event
- Continuation Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled (as defined under the Social Security Act), in which case, coverage will end on the first day of the month that begins more than 30 days after the date of such determination

You do not have to show that you are insurable to purchase Continuation Coverage. However, Continuation Coverage is provided subject to your eligibility for coverage under the Company group health plan. **The Company (and the plan's insurer(s), as may be applicable) reserves the right to terminate your Continuation Coverage retroactively if you or your Dependents are determined to be ineligible.**

Payments Required or Continuation Coverage

Under COBRA, you may have to pay all or part of the premium for your Continuation Coverage. The amount a Qualified Beneficiary may be required to pay may not exceed 102% (or in the case of an extension of Continuation Coverage due to a disability, 150%) of the cost of the group health plan for coverage of a similarly situated plan participant or beneficiary who is not receiving Continuation Coverage. The law also says that, at the end of the 18, 29 or 36 month Continuation Coverage period, you must be allowed to enroll in an individual conversion health plan that is provided under the plan, if one is available.

UnitedHealthcare does not offer conversion to an individual plan.

First Payment for Continuation Coverage. If you elect Continuation Coverage, you must make your first payment for Continuation Coverage no later than 45 days after the date of your election. **The initial payment must include premiums due for all months from the coverage termination date through the date of your payment.** If you do not timely make your first premium payment for Continuation Coverage in full (i.e., through the month prior to the month in which you make payment), your coverage will be cancelled retroactive to your loss of coverage date. You are responsible for making sure that the amount of your first payment is correct and that it is timely received. You may contact the Lumen Customer Service Center by calling **833-925-0487** or **317-671-8494** (International callers) or **800-729-7526** or go online at lumen.com/healthbenefits to elect, pay, or confirm the correct amount of your first payment and to ensure it is timely received.

Your Continuation Coverage will be provided for each month's coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage, your coverage under the Health Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for Benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

You will receive monthly billing statements or you can set your payment plan to electronic fund transfer from your bank.

Please Note: Once your Continuation Coverage terminates for any reason it cannot be reinstated.

If You Have Questions About Continuation Coverage

If you have questions about your rights to Continuation Coverage, you should contact the COBRA Administrator. All questions and correspondence should be directed to the Lumen Health and Life Service Center at **833-925-0487** or **317-671-8494** (International callers) or **800-729-7526**.

You also may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

Keep the Plan Administrator Informed of All Address Changes

In order to protect your family's rights, you should contact the Lumen Health and Life Service Center regarding any and all changes in the addresses of family members.

The information provided above is a summary of the law and, therefore, general in nature. The actual COBRA laws and the terms of the Company's official group Health Plan Documents must be consulted with regard to the application of these provisions in any particular circumstance. If you have any questions about COBRA, please contact the Lumen Health and Life Service Center at **833-925-0487** *or* **317-671-8494** *(International*

callers) or **800-729-7526** *option 1 and option 1. If you have a change such as: marital status, a Child loses Dependent status, you experience a change in address, upon a death or you become entitled to Medicare (Part A or Part B or both), please notify the Plan Administrator as soon as possible, but in no event later than 60 days after the event has occurred. The COBRA Administrator is the Lumen Health and Life Service Center and can be reached at* **833-925-0487** *or* **317-671-8494** *(International callers) or* **800-729-7526**.

ADDITIONAL CONTINUATION OF HEALTH COVERAGE RULES

The Health Coverage Available if you are an LTD Recipient

An LTD Recipient is an individual who is entitled to receive a Long-Term Disability (LTD) benefit under the Lumen Disability Plan. Coverage under the Health Plan is available to LTD Recipients as set forth in the Chart below (subject to continued status as "disabled" under the Lumen Disability Plan):

The below information applies regardless of whether you are a *Protected Participant, disability retiree, or eligible for retiree healthcare/life benefits.

Non LQ LTD Chart 2021

Employment Status	Terminated - LTD
LTD benefit amount	• Basic LTD is 50% of eligible pay which is provided by the Company at no cost; offset provisions apply. • If enrolled in Supplemental LTD, it is 65% of eligible pay, which is purchased by the Participant. Offset provisions apply.
Medical/prescription drug & dental – Participant paid **Note:** If you become Medicare eligible, you must timely enroll in Medicare Part-A and Part-B. Medicare becomes your primary insurance coverage. If you are eligible and elect Retiree medical, you must enroll in an individual Medicare policy. You will receive information regarding retiree coverage from the Service Center.	• At the active rate, which is partially subsidized for up to a total of 3 years from the beginning of STD (2 years and 6 months from LTD date), subject to the terms of the Lumen Retiree and Inactive Health Plan. • Then, offered 18 months of COBRA medical/prescription drug at full COBRA cost. **Note:** If you are eligible for retiree healthcare at the date of LTD, you are defaulted to the LTD continuation benefit at the active rates. However, you can call the Service Center to request retiree medical/prescription drug and retiree dental coverage, if applicable, at any time during the LTD continuation benefit or COBRA period.
Vision – Participant paid	• At the active rate, which is partially subsidized for up to a total of 3 years from the beginning of STD (2 years and 6 months from LTD date), subject to the terms of the Lumen Retiree and Inactive Health Plan. • Then, offered 18 months of COBRA vision at full COBRA cost.
Health Care Flexible Spending Account– Participant paid	Offered COBRA on an after-tax basis through end of calendar year only. Not eligible for re-enrollment.
Basic Life Insurance – Company paid	For up to a total of 3 years from the beginning of STD (2 years and 6 months from LTD date), subject to the terms of the Lumen Group Life Insurance Plan. If you turn age 70, your Basic Life coverage will reduce to 50% of the amount. ** Conversion rules apply. Portability rules do not apply. **Note:** If you are eligible for retiree healthcare at the date of LTD, you are defaulted to the LTD continuation benefit at the active rates. However, you can call the Service Center to request retiree basic life coverage, if applicable, at any time during the LTD continuation benefit or COBRA period.

Supplemental Life Insurance – Participant paid	For up to a total of 3 years from the beginning of STD (2 years and 6 months from LTD date), subject to the terms of the Lumen Group Life Insurance Plan. If you turn age 70, your Supplemental Life coverage will reduce to 50% of the amount.
	Waiver of Premium provisions may apply if < 60 years of age on the date of STD. If you turn age 70, your Supplemental Life coverage will reduce to 50% of the amount. Refer to your SPD for other reduction provisions. ** If not approved for Waiver of Premium with MetLife, Supplemental Life insurance may be continued for a total of 3 years from STD date.
Spouse/domestic partner, Child Life Supplemental Insurance – Participant paid	The rules indicated under the Supplemental Life Insurance row apply. Refer to your SPD for other reduction provisions.
Accidental Death & Dismemberment Insurance (Basic and Supplemental)	Ends on termination date
Business Travel Accident Insurance	Ends on termination date

*A Protected Participant is a Legacy-Qwest Non-Union participant who either had 20 years Term of Employment under the Qwest Pension Plan as of Dec. 31, 2000 and is Service Pension Eligible (SPE) at termination of employment, or was SPE eligible under the Qwest Pension Plan as of Dec. 31, 2003.

** Life Insurance conversion must be requested within 31 days from the day coverage ends; conversion is not automatic. To request Waiver of Premium information, contact MetLife at 877-275-6387. You must apply for Waiver of Premium during the first 12 months of disability. If Waiver of Premium is not approved, you are responsible for any premium contributions. Contact MetLife for other important Policy Information.

MORE LTD INFORMATION - Disability Extension and Other COBRA Information: The 18-month COBRA period described in this section may be extended for 11 additional months to 29 months provided you follow the required procedures and are eligible.

You may also elect to continue dental and vision and Health Care FSA (HCFSA) coverage for you and your covered eligible Dependents for up to 18 months by paying the applicable rate (the HCFSA is available only through the end of the Calendar Year). If you should die before the end of the 18 months of COBRA coverage, your surviving covered eligible Dependents may elect to continue their coverage, at their own expense, for a total of 36 months from the date your COBRA coverage originally began. At the expiration of the 18-month period, medical coverage for you and your eligible covered Dependents may be continued as indicated on the Chart above, but will no longer fall under the provisions of COBRA.

Coverage upon Death. If you should die before the end of the 18 months of COBRA coverage, your surviving covered eligible Dependents may elect to continue their coverage, please contact the Lumen Health and Life Service center for additional details.

If you should die after the 18-month COBRA period but before the end of the 24-month period, medical coverage for your surviving Dependents will end on the last day of the month in which your death occurred. Life Insurance Coverage for LTD Recipients: Refer to the Life and AD&D Insurance SPD for information on when your life insurance Benefits end.

Domestic Partner

If you are a Domestic Partner of an Retiree/Inactive Participant, you will have the right to elect Continuation Coverage for yourself and your covered Dependent Children (“Continuation Beneficiaries”). This Continuation Coverage is administered the same as under COBRA as described above in the Continuation Coverage Under COBRA and Other Continuation section.

The covered Participant or Domestic Partner has the responsibility to notify the Lumen Health and Life Service Center of a termination of relationship between an Participant and a Domestic Partner. Continuation Beneficiaries will not have to show that they are insurable to choose Continuation Coverage. They will have to pay the group rate premium for their Continuation Coverage plus any administration fees. Children of a

Domestic Partner will not be eligible to be a Continuation Beneficiary under their own right. They are only eligible for Continuation Coverage if the Domestic Partner is a Continuation Beneficiary.

PLAN INFORMATION

Plan Sponsor and EIN Number

Lumen Technologies, Inc.
100 Lumen Drive
Monroe, LA 71211
EIN: 72-0651161

Plan	Type of Plan and Administration	Plan Administrator	Send Claims and Appeals to:	Plan #
Lumen Retiree and Inactive Health Care Plan	The Retiree and Inactive Health Plan (including the HRA for Medicare eligible retirees) is a Welfare Plan as defined under ERISA Benefit options are Self-funded with third party contract administrator providing health, prescription, dental.	Lumen Employee Benefits Committee 214 E. 24th Street Vancouver, WA 98663	**For general eligibility appeals:** Lumen Health and Life Service Center Claims and Appeals: P.O. Box 1407 Lincolnshire, IL 60069-1407	511

Note: *Note: Health Care Plan claims, and appeals should be filed with the claims administrators listed in the Health Plan Claims Administrator Information Section below depending on the plan benefit option you elected. Claims and Appeals for the Plans listed in the table directly above should be filed with those claims administrators.*

Health Plan Claims Administrator Information

Whenever you have a question or concern regarding your Benefits or a claim, please call the Claims Administrator for the benefit option using the telephone number for Customer Service listed on your ID card (for medical claims only) or below.

Whenever you have a question or concern regarding your Benefits or a claim, please call the Claims Administrator for the benefit option using the telephone number for Customer Service listed on your ID card (for medical claims only) or below. **Lumen Health and Life Service Center** for Eligibility and Enrollment issues	N/A	**833-925-0487** or **317-671-8494** (International Callers) or **800-729-7526** P.O. Box 1407 Lincolnshire, IL 60069-1407	Send Claims and Appeals To: Lumen Health and Life Service Center Appeals P.O. Box 1407 Lincolnshire, IL 60069-1407

MetLife Dental	74421	**866-832-5756** metlife.com/mybenefits	Send Claims To: MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 Send Appeals To: Appeals/Claim Supervisor P.O. Box 14589 Lexington, KY 45012-4093
MetLife Life Insurance Company	N/A	Lumen Health and Life Service Center **833-925-0487** or **317-671-8494** (International Callers) or **800-729-7526**	Sent Claims and Appeals To: MetLife P.O. Box 6100 Scranton, PA 18505-6100
UnitedHealthcare Claims Administrator for the CDHP and HDHP	Located on ID Card	**800-842-1219** myuhc.com	Claims: UnitedHealthcare Services – Claims P.O. Box 30884 Salt Lake City, UT 84130-0884 Appeals: UnitedHealthcare Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432
Surest Health Plan	Located on ID Card	**833-576-6497** Benefits.Surest.com	Claims: Surest Health Plan Attention: Claims P.O. Box 211758 Eagan, MN 55121 Appeals: Surest Health Plan Attention: Appeals P.O. Box 211758 Eagan, MN 55121
Medicare Medical Plans (For all medical and prescription drug plans elected in the market by Medicare eligible retirees)	Located on ID Card	Contact the individual carrier directly	Contact the individual carrier directly
OptumRX (For prescriptions only Surest and UHC)	192086	**800-842-1219**	Clinical Appeals: ATTN: Clinical Reviews and Appeals: UnitedHealthcare Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432 Administrative Appeals: ATTN: Administrative Reviews UnitedHealthcare Appeals P.O. Box 740816 Atlanta, GA 30374-0816

Note: The Claims Administrator 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 Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan.

Type of Health Care Plan Administration

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 arrangement of access to a Network Provider; claims processing services, including coordination of Benefits and subrogation; care coordination; and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. The Plan Sponsor also has selected a health care Network of Providers established by UnitedHealthcare Insurance Company.

The Employee Benefits Committee is the Plan Administrator and a named fiduciary for the Plan. Lumen Technologies, Inc. is the Plan Sponsor. The Committee has designated the Claims Administrator of each plan benefit option under the Plan as the claim fiduciary.

Agent for Service of Legal Process

Chief Privacy Officer
931 14th Street, 9th Floor
Denver, CO 80202

Legal Process may also be served on:

CT Corporation System (a.k.a. CT Corp)
7700 East Arapahoe Road, Suite 220
Centennial, CO 80112

Source of Contributions under the Retiree and Inactive Health Plan

Benefits under the Plan are paid from the general assets of the Plan Sponsor. Any required Employee contributions are used to partially reimburse the Plan Sponsor for Benefits under the Plan. Also, refer to the *Plan Cost* and *Funding* sections earlier in this SPD.

Plan Year

The Plan Year shall be a twelve-month period ending December 31.

Benefits under the Plan are furnished in accordance with the Plan Document issued by the Lumen Employee Benefits Committee, including this SPD.

Participants' rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA), and the procedures to be followed in regard to denied claims or other complaints relating to the Plan are set forth in the body of this SPD.

Discretionary Authority

The Plan Administrator has the 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 and authority is delegated, such as the Claims Administrators, shall be conclusive and binding on all persons.

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.

RIGHT OF FULL RESTITUTION (SUBROGATION) AND REIMBURSEMENT

The Health Plan does not provide Benefits for any accident, Injury or Sickness for which you or your eligible Dependents have, or may have, any claim for damages or entitlement to recover from another party or parties arising from the acts or omissions of such third party (for example, an auto accident). This includes, but is not limited to, any claim for damages or entitlement to recover from your or another party's:

- Underinsured and uninsured motorist coverage
- No fault and medical payments coverage
- Other medical coverage
- Worker's compensation
- Short term and long term disability coverage
- Personal injury coverage
- Homeowner's coverage
- Other insurance coverage available

No-fault insurance benefits and auto medical payments coverage should always be selected as the primary coverage if given a choice when purchasing automobile insurance coverage as the Benefits available under this Plan are secondary to automobile no-fault and medical payments coverage.

In the event that another party fails or refuses to make prompt payment for the medical expenses incurred by you or your eligible Dependents when expenses arise from an accident, Injury or Sickness, subject to the terms of the Plan, the Plan may conditionally advance the payment of the Benefits. **If the Plan advances payment of Benefits, the terms of this entire subrogation and reimbursement provision shall apply, and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the Covered Individual identifies the medical benefits the Plan advanced. The Plan's right of full reimbursement shall not be reduced or limited in any way by the Covered Individual's actual or alleged comparative fault or contributory negligence in causing the injury(ies) or accident for which the Plan advanced medical benefits.**

See the example below as to how this process might work:

Example: Mr. Jones is a participant in the Health Care Plan and is involved in a motor vehicle accident where another party is at fault. Mr. Jones is admitted to the hospital, using his Lumen Health Care Plan ID card. His claims are paid by his Claims Administrator under the Plan. Once these claims are paid by the Plan, they are electronically sent to HMS, the recovery services administrator. The recovery services administrator contacts Mr. Jones to ask about his treatment at the hospital and is advised of the motor vehicle accident by Mr. Jones, as required by the Plan. The recovery services administrator obtains all the information regarding the accident (auto carrier/attorney/ etc.) and contacts the involved parties putting them on notice of the Plan's interest. The recovery services administrator follows the case until a settlement is made between Mr. Jones and the at fault auto carrier and/or any uninsured/underinsured auto insurance. The Plan is reimbursed for Mr. Jones' hospital claims. This process ensures those claims which are paid by the Plan as the result of a liable third party are captured and returned to the Plan.

Benefits Conditional Upon Cooperation

By participating in the Plan, you and your eligible Dependents acknowledge and agree to the terms of the Plan's equitable or other rights to full restitution, reimbursement or any other available remedy. You will take no action to prejudice the Plan's rights to restitution, reimbursement or any other available remedy. You and your eligible Dependents agree that you are required to cooperate in providing and obtaining all applicable

documents requested by the Plan Administrator or the Company, including the signing of any documents or agreements necessary for the Plan to obtain full restitution, reimbursement or any other available remedy.

Other Party Liability

If you or your Eligible Dependent is injured or becomes ill due to the act or omission of another person (an "other party"), the Plan Administrator shall, with respect to Services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution, reimbursement, subrogation or any other available remedy to recover the amounts the Plan Administrator paid for Services provided to you or your Eligible Dependent from any recovery (defined below) obtained by or on behalf of you or your Eligible Dependent, from or on behalf of the third party responsible for the injury or illness or from your coverage, including but not limited to uninsured/underinsured motorist coverage, other medical coverage, no-fault coverage, workers' compensation, STD and LTD coverage, personal injury coverage, homeowner's coverage and any other insurance coverage available.

The Plan Administrator's right to restitution, reimbursement or any other available remedy, is against any recovery you or your Eligible Dependent receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage or other coverages listed above, related to the illness or injury (the "Recovery"), without regard to whether the you or your Eligible Dependent has been "made whole" by the Recovery and without reduction for any attorney fees and costs paid or owed by or on your behalf by you or your Eligible Dependent. You and your eligible Dependents are responsible for all expenses incurred to obtain payment from any other parties, including attorneys' fees and costs or other lien holders, which amounts will not reduce the amount due to the Plan as restitution, reimbursement or any other available remedy.

You or your Eligible Dependent are required to:

1. Notify the Plan Administrator in writing of any actual or potential claim or legal action which such you or your Eligible Dependent expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,
2. Agree to fully cooperate with the Plan Administrator to execute any forms or documents needed to enable the Plan Administrator to enforce its right to restitution, reimbursement or other available remedies; and,
3. Agree to assign to the Plan the right to subrogate and recover Benefits directly from any third party or other insurer. A Plan representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Plan's equitable (or other) right to obtain full restitution, reimbursement or any other available remedy.
4. Agree, to reimburse the Plan Administrator for Benefits paid by the Plan Administrator from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage or other coverage; and,
5. Provide the Plan Administrator with a lien in the amount of Benefits actually paid. The lien may be filed with the third party, the third party's agent or attorney, or the court; and,
6. Notify HMS Claims Recovery Solutions at 1 888-556-3373 or at resources.hms.com/tpl-questionnaire.com, or fax at 1 402-384-5190 as soon as possible, that the Plan may have a right to obtain restitution, reimbursement or any other available remedy of any and all Benefits paid by the Plan. This also means that if you or your Eligible Dependent goes to the Hospital because of an accident, Sickness or Injury that is the result of the actions of another party, you must inform the hospital staff that the Sickness or Injuries are the result of the actions of another for which that other person may be liable. Generally, the hospital staff notes this information on the report that is submitted to the Plan's Claims Administrator. You will later be contacted by the Plan or its recovery vendor and you must provide the information requested. If you retain legal counsel, your counsel must also contact the Plan or its recovery vendor; and,
7. Inform the Plan in advance of any settlement proposals advanced or agreed to by another party or another insurer; and
8. Provide the Plan Administrator all information requested by the recovery vendor and the Plan Administrator regarding an action against another party, including an insurance carrier; this includes responding to letters from the Plan and its recovery vendor on a timely basis; and
9. Not settle, without the prior written consent of the Plan Administrator, or its designee, any claim that you or your

eligible Dependents may have against another party, including an insurance carrier; and

10. Take all other action as may be necessary to protect the interests of the Plan.

In the event you or your eligible Dependents do not comply with the requirements of this section, the Plan may deny Benefits to you or your eligible Dependents or take such other action as the Plan Administrator deems appropriate.

Note: The Plan (Health, Life, Disability, BTA/ADD) is subject to ERISA. Certain plans - specifically, the Health Plan and Disability Plan - are self-funded, and for those plans you and your Eligible Dependent are also required to do the following:

1. Ensure that any Recovery is kept separate from and not comingled with any other funds or you or your Eligible Dependent's general assets (for example, your household checking account) and agree to hold and retain that the portion of any Recovery required to fully satisfy the lien or other right of Recovery of the Plan in trust for the sole benefit of the Plan until such time it is conveyed to the Plan Administrator; and
2. **Direct any legal counsel retained by you or your Eligible Dependent or any other person acting on behalf of you or your Eligible Dependent to hold 100% of the Plan's payment of benefits or the full extent of any payment from any one or combination of any of the sources listed above in trust and without dissipation except for reimbursement to the Plan or its assignee and to comply with and facilitate the reimbursement to the Plan of the monies owed it.**

Payment Recovery to be Held in Trust

You, your eligible Dependents, your agents (including your attorneys) and/or the legal guardian of a minor or incapacitated person agree by request for and acceptance of the Plan's payment of Benefits, to maintain 100% of the Plan's payment of benefits or the full extent of any payment from any one or combination of any of the sources listed above in trust and without dissipation except for reimbursement to the Plan or its assignee.

Any payment or settlement from another party received by you or your eligible Dependents must be used first to provide restitution, reimbursement or any other available remedy to the Plan to the full extent of the Benefits paid by or payable under the Plan. The balance of any payment by another party must, first, be applied to reduce the amount of Benefits which are paid by the Plan for Benefits after the payment and, second, be retained by you or your eligible Dependents. You and your eligible Dependents are responsible for all expenses incurred to obtain payment from any other parties, including attorneys' fees and costs or other lien holders, which amounts will not reduce the amount due to the Plan as restitution, reimbursement or any other available remedy.

The Plan is entitled to obtain restitution, reimbursement or any other available remedy of any amounts owed to it either from funds received by you or your eligible Dependents from other parties, regardless of whether you or your eligible Dependents have been fully indemnified for losses sustained at the hands of the other party. A Plan representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Plan's equitable (or other) right to obtain full restitution, reimbursement or any other available remedy.

NOTICE OF HIPAA RIGHTS

Important Notice of Your Right to Documentation of Health Coverage

Recent changes in federal law may affect your health coverage under the Health Plan if you are enrolled or become eligible to enroll in health coverage that excludes coverage for pre-existing medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. You are entitled to a certificate that will show evidence of your prior health coverage. If you buy health insurance other than through

an employer group health plan, a certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion. Contact your State insurance department for further information.

You have the right to receive a certificate of your prior health coverage since July 1, 1996. You may need to provide other documentation for earlier periods of health care coverage. Check with your new health plan administrator to see if your new health plan includes coverage for pre-existing conditions and if you need to provide a certificate or other documentation of your previous coverage.

To request a HIPAA certificate contact the Lumen Health and Life Service Center at **833-925-0487** or **317-671-8494** (International callers) or **800-729-7526**. Keep a copy for your records. You may also request HIPAA certificates for any of your eligible Dependents (including your spouse/domestic partner) who were enrolled under your health coverage. The information provided above is a summary of the law and, therefore, general in nature. The actual HIPAA law and the terms of the official Health Plan Documents must be consulted in regard to the application of these rules in any particular circumstance. If you have any questions about HIPAA or your special enrollment rights under HIPAA, please contact the Plan Administrator.

Special Enrollment Rights under HIPAA. You may have special enrollment rights under HIPAA. Please refer to the *Changing Your Health Care Coverage—Qualified Life Events* section above in this SPD for more information.

HIPAA Guaranteed-Issue Requirements

HIPAA requires that all health insurance carriers that offer coverage in the individual market accept any eligible individuals who apply for coverage without imposing a pre-existing condition exclusion. However, you may lose this right to avoid having pre-existing condition exclusion apply to you if you have more than a 63-day gap in health coverage. To take advantage of this HIPAA right, you elect COBRA and maintain it (by timely paying the premium) for the duration of your maximum COBRA coverage period, and then apply for coverage with an individual insurance carrier before you have a 63-day lapse in coverage. Since we do not sponsor this other health coverage, you should contact that insurer directly, your independent insurance specialist or the State insurance commissioner for more information.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. You may also obtain the most recent version of the *Notice of Privacy Practices* on from the Lumen Health and Life Service Center.

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

Please forward inquiries to the:

HIPAA Compliance Committee
Lumen Technologies
931 14th Street
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)

General Information About This Notice. This Notice relates to the use and disclosure of your medical information by the Health Plan.

The term "Plan" as used in this Notice means only the portions of the Health Plan that provide group health Benefits (for example, medical, dental, vision, employee assistance and medical expense reimbursement). HIPAA does not apply to the Disability Plan, the Life Plan or to Worker's Compensation and those Plans therefore are not subject to HIPAA.

The Plan continues its commitment to maintaining the confidentiality of your medical information for the purpose of your Plan coverage. This Notice describes the Plan's legal duties and privacy practices with respect to that information.

This Notice also describes your rights and the Plan's obligations regarding the use and disclosure of your medical information. Your personal doctor or health care provider may have different policies or notices regarding the doctor's or health care provider's use and disclosure of your health information created in the doctor's or health care provider's office or clinic.

This Notice applies to:

- the portions of the Plan listed above that provide group health Benefits;
- any Lumen employee or other individuals acting on behalf of the Plan; and
- third parties performing services for the Plan.

The Plan is required by law to:

- follow the terms of the Notice that are currently in effect;
- provide you with specific information about your rights with respect to your medical information;
- maintain the privacy of your medical information;
- give you this Notice of the Plan's legal duties and privacy practices with respect to medical information about you; and
- Notify you if there is a breach of your unsecured PHI.

Plan Use and Disclosure of Your Medical Information. The Plan is required by law to take reasonable steps to ensure the privacy of your protected health information ("PHI"). PHI is any information held by the Plan that identifies you, such as your name or address, paired with medical information such as:

- your past, present or future physical or mental health or condition;
- the provision of health care to you; or
- the past, present or future payment for the provision of health care.

If the Plan needs to amend this Notice due to changes in their operation, then this Notice will be amended, and an updated privacy Notice will be made available to you.

The Plan needs to use your PHI in certain ways that are described below in more detail.

- **Use or Disclosure for Treatment.** The Plan may use and disclose your PHI to others to facilitate your medical treatment, which includes the provision, coordination, or management of your health care and can include consultation between one or more of your providers. For example, the Plan may disclose information regarding your prior prescriptions to a pharmacist to determine if a pending prescription will conflict with a prior prescription. For these purposes, the Plan may disclose information to business associates of the Plan.
- **Use or Disclosure for Payment.** The Plan may use and disclose your PHI to others so that the Plan can facilitate proper payment for treatment and services provided to you and includes, but is not limited to, making coverage determinations, claims management, subrogation and recovery, reviews for medical necessity and appropriateness of care, utilization and preauthorization reviews. For example, the Plan may use your PHI to determine your Benefit eligibility or coverage level, to pay a health care provider for your medical treatment or to reimburse you for your direct payment to a health care provider. The Plan Retiree and Inactive Health Plan General Information | Issued Jan. 1, 2023 46 may tell a health care provider whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.
- **Use or Disclosure for Health Care Operations.** The Plan may use and disclose your PHI to the extent necessary to administer and maintain the Plan. For example, the Plan may use your PHI in the process of negotiating contracts

with third party carriers, for legal services, for internal audits (including fraud and abuse compliance programs), business planning, or for cost management purposes. For these purposes, the Plan may disclose your PHI to business associates of the Plan.

- **Disclosure to Lumen.** With respect to your Plan coverage, the Plan may use and disclose your PHI to Lumen as permitted or required by the Plan Documents or as required by law. Certain employees of Lumen who perform administrative functions for the Plan may use or disclose your PHI for Plan administration purposes.

  Any PHI disclosure to Lumen by the Plan for other than plan administration purposes will require your written authorization. At no time will PHI be disclosed to Lumen for employment-related actions or decisions, except for drug and alcohol test results under certain circumstances.

- **Disclosures to Family or Close Friends.** Under certain circumstances, as described in the HIPAA Methods and Procedures, the Plan may release your PHI to either a family member or someone who is involved in your health care or payment for your care. The HIPAA Methods and Procedures are available on the Company Intranet or on the Lumen Health and Life website at lumen.com/healthandlife or lumen.com/healthbenefits.

Your Written Authorization. Generally, the Plan must have your written authorization to use or disclose your PHI in circumstances not covered by this Notice or the laws that apply to the Plan. If you provide the Plan with authorization to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization. However, you understand that the Plan is unable to take back any disclosures already made based on your prior authorization.

Special Situations. The following are examples of when the Plan may disclose your PHI without your written authorization (this list is not exhaustive and there may be other situations when it would be necessary to disclose PHI that are not addressed here):

- **Required by Law.** The Plan may disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding, such as a malpractice action.
- **Public Health Risks.** The Plan may use or disclose your PHI for public health reasons. These reasons may include the following:
  - prevention or control of disease, injury or disability;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify individuals of recalls of medications or products they may be using; or
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- **Victims of Abuse, Neglect or Domestic Violence.** As permitted or required by law, the Plan may disclose your PHI to an appropriate government authority if the Plan reasonably believes you are the victim of abuse, neglect or domestic violence. If the conduct does not involve a child, the Plan will make this disclosure only if the victim agrees or when required or authorized by law.
- **To Avert a Serious Threat to Health or Safety.** The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health, safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your PHI in a proceeding regarding the licensure of a Physician.
- **Health Oversight Activities.** As authorized by law, the Plan may disclose your PHI to health oversight agencies. Such disclosure will occur during audits, investigations, inspections, licensure, and other government monitoring and activities related to health care provision or public benefits or services.
- **Judicial Proceedings, Lawsuits and Disputes.** The Plan may disclose your PHI in response to an order of a court or administrative tribunal, provided that the Plan discloses only the PHI expressly authorized by such order.

  If you are involved in a lawsuit or a dispute, the Plan may disclose your PHI when responding to a subpoena, discovery request or other lawful process where there is no court order or administrative tribunal. Under these circumstances, the Plan will require satisfactory assurance from the party seeking your PHI that such party has made reasonable effort either to ensure that you have been given notice of the request or to secure a qualified protective order.
- **Law Enforcement.** In response to a court order, subpoena, warrant, summons or other legal request, or upon a law

enforcement official's request, the Plan may release your PHI to a law enforcement official for certain law enforcement activities. The Plan may also release medical information about you to authorized government officials for purposes of public and national security.

- **National Security and Intelligence Activities.** The Plan may release medical information about you to authorized federal officials for intelligence, counterintelligence and any other national security activities authorized by law.
- **Military and Veterans.** If you are or were a member of the armed forces, the Plan may release your PHI as required by military command authorities. The Plan may also release PHI about foreign military personnel to the appropriate authority.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement officer, the Plan may disclose your PHI to the institution or officer. This may happen, for instance, if the institution needs to provide you with health care, to protect your health or safety or the health and safety of others or to protect the safety and security of the correctional institution.
- **Organ, Eye and Tissue Donation.** The Plan may release your PHI to an organization that handles organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation. This may happen, for instance, if you are an organ donor or are seeking an organ transplant.
- **Coroners, Medical Examiners and Funeral Directors.** Upon your death, the Plan may release your PHI to a coroner or medical examiner for purposes of identifying you or to determine a cause of death, and to funeral directors as necessary to carry out their duties.
- **Workers' Compensation.** The Plan may release your PHI to comply with workers' compensation or similar programs.

Your Rights. You have the following rights regarding your PHI maintained by the Plan:

- **Right to Request a Restriction.** You have the right to request a restriction or limitation on the Plan use or disclosure of your PHI for treatment, payment or health care operations purposes as set forth above. You also have the right to request a limit on the type of PHI the Plan discloses about you to someone who is involved in your care or the payment of your care. For example, you may ask the Plan not to disclose your PHI to a certain family member or you may ask the Plan to limit your PHI provided to a large case manager who is assigned to you. The Plan is not required to agree to your request. If the Plan does agree, the Plan will comply with your request unless the information is needed to provide you with emergency treatment.

  To request restrictions on the use and disclosure of your PHI, you must complete and submit a written request to the HIPAA Compliance Committee or its designee (i.e. a claims administrator such as United Healthcare). Your written request must specify the following:

  - the information you want to limit
  - whether you want the Plan to limit the use, disclosure, or both
  - to whom you want the restrictions to apply
- **Right to Receive Confidential Communications.** You have the right to request that the Plan communicate with you about your PHI in a certain manner or at a certain location. For example, you may request that the Plan contact you only at work and not at home, or the Plan send written correspondence to a post office box.

  To request a specific manner to receive confidential communications, you must complete and submit a written request to HIPAA Compliance Committee or its designee (i.e. a claims administrator such as United Healthcare). The Plan will accommodate all reasonable requests if you clearly state that you are requesting the confidential communication because you feel that disclosure could endanger you. Your request must specify how or where you wish to be contacted.
- **Right to Inspect and Copy Documents Containing PHI.** You have a right to inspect and obtain a copy of your PHI contained in a "Designated Record Set," for as long as the Plan maintains the PHI.

  "Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the Designated Record Set.

  The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

  You or your personal representative will be required to complete a form to request access to the PHI in your

Designated Record Set. Requests for access to PHI should be made in writing to the HIPAA Compliance Committee or its designee (e.g., a claims administrator such as United Healthcare).

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

- **Right to Amend Your PHI.** You have the right to request that the Plan amend your PHI or a record about you in a Designated Record Set for as long as the PHI is maintained in the Designated Record Set.
  - The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.
  - Requests for amendment of PHI in a Designated Record Set should be made to the HIPAA Compliance Committee or its designee (i.e. a claims administrator such as United Healthcare). You or your personal representative will be required to complete a form to request amendment of the PHI in your Designated Record Set and provide the reasons in support of an amendment to your PHI.
- **Right to Receive an Accounting of Disclosures of Your PHI.** You have the right to request a list of the disclosures of your PHI the Plan has made about you, subject to certain exceptions. For example, the accounting need not include PHI disclosures made:
  - to carry out treatment, payment or health care operations;
  - prior to the required compliance date (April 14, 2003);
  - to individuals about their own PHI;
  - based on your own authorization;
  - due to emergency; or
  - disclosures incident to other permissible disclosures.

  In order to receive an accounting of disclosures, you must submit a written request to the HIPAA Compliance Committee. Your request must include the following:
  - the time period for the accounting, which may not be longer than 6 years and may not include dates prior to April 14, 2003; and
  - the form (i.e., electronic, paper, etc.) in which you would like the accounting.

  Your first request within a 12-month period will be free. The Plan may charge you a reasonable, cost-based fee for providing you any additional accounting. The Plan will notify you of the costs involved, and you may choose to withdraw or modify your request before you incur any costs.

  If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual requesting is given a written statement of the reasons(s) for the delay and the date by which the accounting will be provided.
- **Right to Receive a Paper Copy of This Notice.** You have the right to receive a paper copy of this Notice, even if you previously agreed to receive this Notice electronically.

  In order to receive a paper copy, you must submit a written request to the HIPPA Compliance Committee. You may also obtain a copy of the Notice under InsideLink > Benefits > Important Benefits and Documents or on the Lumen Health and Life website at lumen.com/healthbenefits.

Personal Representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action on your behalf. Proof of such authority may take one of the following forms:

- the power of attorney for health care purposes notarized by a Notary Public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to

those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Filing a Complaint Against the Plan. If you believe your rights have been violated, you may file a written complaint with the Plan. The written complaint should contain a brief description of how you believe your rights have been violated. You should attach any documents or evidence that supports your belief, along with the Plan Notice of Privacy Practices provided to you, or the date of such Notice. The Plan takes complaints very seriously. You will not be retaliated against for filing such a complaint. Please call the Lumen Integrity Line at **800-333-8938** and select the HIPAA or Protected Health Information option for additional information. Please send all written complaints to:

HIPAA Compliance Committee
Lumen Technologies, Inc.
Chief Privacy Officer
931 14th Street
Denver, CO 80202

-or-

E-mail: askHIPAA@Lumen.com

You may also file complaints with the United Stated Department of Health and Human Services, which may be contacted at the following address:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019

The Plan will not retaliate against you for filing a complaint.

Additional Information About This Notice.

- **Changes to This Notice.** The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.
- This Notice has been in effect and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to those for whom the Plan still maintains PHI.
- Any revised version of this Notice will be distributed and made available on InsideLink > Benefits > Important Benefits and Documents within 60 days of the effective date of any material change to the uses or disclosures, the individuals rights, the duties of the Plan or other privacy practices stated in this Notice.

No Guarantee of Employment. Nothing contained in this Notice shall be construed as a contract of employment between Lumen and any employee, nor as a right of any employee to be continued in the employment of Lumen nor as a limitation of the right of Lumen to discharge any of its employees, with or without cause.

No Change to Plan. Except for the privacy rights described in this Notice, nothing contained in this Notice shall be construed to change any rights or obligations you may have under the Plan. You should refer to the Plan documents, including your Summary Plan Description and Summaries of Material Modifications, for complete information regarding any rights or obligations you may have under the Plan.

YOUR ERISA RIGHTS

As a participant in the Health Plan, the Life Plan and the Disability Plan, you are entitled to certain rights and protections under ERISA. (**Note:** The Dependent Day Care FSA is not subject to ERISA.) ERISA provides that all Plan participants shall be entitled to:

Receive Information About the 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, including, if applicable, insurance contracts and a copy of the latest annual report (Form 5500) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration
- Obtain, by writing to the Plan Administrator, copies of documents governing the operation of the Plan, including, if applicable, insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated SPD. The Plan Administrator may request a reasonable charge for the copies
- Receive a summary of the Plan's annual financial report

Continue Group Health Plan Coverage

- Continue health care coverage for yourself and your Dependents, if eligible, if there is a loss of medical, dental or vision benefits and Health Care FSA coverage under the Health Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Health Plan for more information on the rules governing Consolidated Omnibus Budget Reconciliation Act of 1986, as amended, ("COBRA") Continuation Coverage rights
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Health Plan, if you have Creditable Coverage from another group health plan. You should be provided a Certificate of Creditable Coverage, free of charge, from the Health Plan or health insurance issuer when you lose coverage under the Health Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage

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 Plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, if applicable or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why, 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 Plan 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 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 the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-EBSA (3272) or by going to its Web site at dol.gov/ebsa.

GENERAL ADMINISTRATIVE PROVISIONS

Plan Document

This Benefits Summary presents an overview of your Benefits. In the event of any discrepancy between this summary and the official Plan Document and Insurance Policies (as applicable), the Plan Document and Policies shall govern.

Our Relationship with Providers

The relationships between us and Network Providers and the Claims Administrator are:

- Solely contractual relationships between independent contractors
- Not that of agents or Employees

Furthermore, the Claims Administrator shall not be deemed or construed as an employer or Plan Administrator for any purpose with respect to the administration or provision of Benefits under the Plan.

The relationship between us and you is that of employer and Employee, Dependent or other classification as defined in the Plan.

Your Relationship with Providers

The relationship between you and any Provider is that of patient and Provider.

- You are responsible for choosing your own Provider
- You must decide if any Provider treating you is right for you. This includes Network Providers you choose and Providers to whom you have been referred
- You must decide with your Provider what care you should receive
- Your Provider is solely responsible for the quality of services provided to you

Records and Information and Your Obligation to Furnish Information

At times, the Plan or the Claims Administrator may need information from you. You agree to furnish the Plan and/or the Claims Administrator with all information and proofs that are reasonably required regarding any matters pertaining to the Plan. 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 Covered Persons, including Enrolled Dependents whether they have signed the enrollment form.

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

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

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

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

During and after the term of the Plan, we and our related entities may use and transfer the information gathered under the Plan, including claim information for research, database creation, and other analytic purposes.

Interpretation of Plan

The Plan Administrator and the Claims Administrators 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 that provide services in regard to the administration of the Plan.

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

Right to Amend and Right to Adopt Rules of Administration

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

Clerical Error

If a clerical error or other mistake occurs, however occurring, that error does not create a right to Benefits.

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

Administrative Services

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

Examination of Covered Persons

In the event of a question or dispute regarding Benefits, the Plan may require that a Network Physician of the Plan's choice examine you at our expense.

Workers' Compensation Not Affected

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

Conformity with Statutes

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

Incentives to You

At various times the Claims Administrator may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not you choose to participate is yours alone, but you should discuss participating in such programs with your Provider. These incentives are not plan benefits and do not alter or affect your Benefits. Contact the Claims Administrator if you have any questions.

Incentives to Providers

The Plan and the Claims Administrator do not provide health care services or supplies, nor does Lumen practice medicine. Rather, the Claims Administrator arranges for Providers to participate in a Network. Network Providers are independent practitioners; they are not Lumen Employees or Employees of the Claims Administrator, nor is there any other relationship with Network Providers such as principal-agent or joint

venture. Each party is an independent contractor.

The Plan arranges payments to Network Providers through various types of contractual arrangements. These arrangements may include financial incentives by the Plan or the Claims Administrator to promote the delivery of health care in a cost efficient and effective manner. Such financial incentives are not intended to impact your access to health care. Examples of financial incentives for Network Providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness
- Capitation is when a group of Network Providers receives a monthly payment for each Covered Person who selects a Network Provider within the group to perform or coordinate certain health services. The Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the health care is less than or more than the payment
- Various payment methods to pay specific Network Providers are used. From time to time, the payment method may change. If you have questions about whether your Network Provider's contract includes any financial incentives, we encourage you to discuss those questions with your Provider. You may also contact the Claims Administrator at the telephone number on your ID card. They can advise whether your Network Provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed

Refund of Benefit Overpayments to You or a Dependent

If the Plan pays Benefits for expenses incurred by a Covered Person, that Covered Person, or any other person or organization that was paid, must refund the overpayment if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person
- All or some of the payment we made exceeded the cost of Benefits under the Plan (including Medicare Part B premiums)

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future Benefits including adding the amount of the overpayment to your W-2 income.

CLAIM FOR PAYROLL ADJUSTMENT AND THE DEADLINES

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

Reminder to Review Your Paycheck Deductions

Review your paycheck along with the Benefits Premiums documents on the intranet or by going online to lumen.com/healthandlife and selecting Benefits Summary.

- Confirm your medical bi-weekly premium deductions based on your medical plan election and how you answered the enrollment questions for the tobacco-free discount and the working spouse/domestic partner surcharge.
- If you are enrolled in the Savings HDHP and contributing to an Health Savings Account, you will want to also confirm your HSA bi-weekly premium deductions. Any questions related to benefit premiums should be directed to the Lumen Health and Life Service Center at 833-925-0487. Do not contact the Lumen Payroll Department as the Payroll staff will be unable to assist you.
- If your benefit premium deductions are not correct or not what you expect you must make a claim to the Plan Administrator in accordance with the claims procedures as soon as possible after the year's payroll deductions begin.
    - **If your claim is denied, be advised that there is a deadline to file an appeal and if you miss the deadline,**

your deductions remain in place for the benefit plan year. The time period to make an appeal is the ***earlier of***:

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

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

The Required Forum for Legal Disputes

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

Administrative Services

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

Examination of Covered Persons

In the event of a question or dispute regarding Benefits, the Plan may require that a Network Physician of the Plan's choice examine you at our expense.

Workers' Compensation Not Affected

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

Conformity with Statutes

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

Additionally, if the Covered Person was determined not to be eligible for any Benefits under the Plan, that individual must refund the amount of the excess Benefit payment.

Deadlines for Lawsuit or Civil Action

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.

After you have exhausted or completed the claims procedures and the process 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 Lumen, 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 against Lumen, the Employee Benefits Committee or the Claims Administrator 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 Lumen or the Claims Administrator.

You Must Follow Plan Procedures

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

REQUIRED NOTICE AND DISCLOSURE

Consequences of Falsification or Misrepresentation

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

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

- You and your Dependent(s) will not be permitted to benefit under the Plan from your own misrepresentation. If a person is found to have falsified any document in support of a claim for Benefits or coverage under the Plan, the Plan Administrator may, without anyone's consent, terminate coverage, possibly retroactively, if permitted by law (called "rescission"), depending on the circumstances, and may seek reimbursement for Benefits that should not have been paid out. Additionally, the Claims Administrator (UHC) may refuse to honor any claim under the Plan or to refund premiums.
- While a court may order that health coverage must be maintained for an ex-spouse/domestic partner, that is not the responsibility of the Company or the Plan.
- You are also advised that by participating in the Plan you agree that suspected incidents of this nature may be turned over to the Plan Administrator and or Corporate Security to investigate and to address the possible consequences of such actions under the Plan. All Covered Persons are periodically asked to submit proof of eligibility and to verify claims.

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

Plan Determinations Are Not Health Care Advice

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

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 SPD. 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 or terminated
- You attain the maximum benefit limit available under the Plan, such as may apply to certain Health Plan, Disability Plan, Life Plan, AD&D and BTA Benefits
- The expense incurred was not Medically Necessary, was Investigational or Experimental, was specifically excluded, or exceeded the reasonable and customary charge
- There is duplicate health care coverage, or you become eligible for Medicare (Part A, Part B or both), and Plan Benefits are coordinated with the Benefits provided under another group health or dental plan or Medicare
- You misrepresent or falsify any information required under the Plan; you will not be permitted to benefit under the Plan from your own misrepresentation; for example, if you misrepresent who your dependents are for purposes of coverage, or Working Spouse status or tobacco-free status, or if you don't update those statuses
- You have been overpaid a benefit and the Plan seeks a refund/restitution
- If you or your Dependents are entitled to receive Benefits from the Plan for injuries caused by a third party, the Plan has the right to obtain restitution, or by other equitable means, to a repayment of the Benefits paid under the Plan from any part of payments received from your insurance carrier or by any other party, including an insurance carrier
- Your coverage under the Plan is terminated for one of a variety of reasons, for example, failure to pay your employee contribution or a COBRA premium
- Your coverage is rescinded as permitted by law

Qualified Medical Child Support Orders (QMCSOs)

The Health Plan complies with all Qualified Medical Child Support Orders ("QMCSO"). A QMCSO is a court order, under State family or child support laws, which may require a parent to enroll his or her children in his or her employer's medical plan. A Child eligible for coverage under the Health Plan pursuant to a QMCSO is a Child of a Primary Participant, including any Child adopted by, or placed for adoption with a Primary Participant. The QMCSO may also require Benefits to be assigned to a Child, to a custodial parent, or to a legal guardian. QMCSOs should be sent to the Plan Administrator (see the *Plan Information* section).

You may receive a free copy of the Health Plan's procedures governing QMCSOs by contacting the Lumen Health and Life Service Center.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**

Website: https://chfs.ky.gov Phone: 800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/publicassistance/index.html Phone: 800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website:https://mn.gov/dhs/people-we-serve/seniors/healthcare/health-care-programs/programs-and-services/other-insurance.jsp Phone: 800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-costhealth-care/program-administration/premium-paymentprogram Phone: 800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
U.S. Department of Health and Human Services
Employee Benefits Security Administration
dol.gov/agencies/ebsa

Toll free: 866-444-EBSA [3272]

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov

Toll free: 877-267-2323, Ext. 61565

Women's Health and Cancer Rights Act Of 1998

This notice is being provided to you in accordance with the requirements of the Federal law entitled the Women's Health and Cancer Rights Act of 1998 (the "Act").

The Lumen Retiree and Inactive Health Care Plan provides medical and surgical Benefits in connection with a mastectomy. In accordance with the requirements of the Act, the Plan also provides Benefits for certain reconstructive surgery.

In particular, the Plan will provide, to an eligible participant who is receiving (or who presents a claim to receive) Benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for the following Benefits:

- reconstruction of the breast on which the mastectomy has been performed
- surgery and reconstruction of the other breast to produce symmetrical appearance
- prosthesis and treatment of physical complications associated with all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient

As with other benefit coverages under the Health Plan, this coverage is subject to the Health Plan's annual deductible (if any), required Coinsurance payments, benefit maximums and Copay provisions that may apply under benefit options of the Health Plan.

You should carefully review the provisions of the Health Plan, the health plan benefit option in which you elect to participate and it's SPD regarding any applicable restrictions. If you have any questions regarding this coverage, please contact your health care Claims Administrator by calling the number listed on your ID card.

The Newborns' and Mothers' Health Protection Act (NMHPA)

Under federal law, the Health Plan generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Health Plan may pay for a shorter stay if the attending Provider (the Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn child earlier than the 48 or 96 hours described above.

Also, under federal law, the Health Plan may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Health Plan may not, under federal law, require that a Physician, or other Provider, obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

GLOSSARY OF DEFINED TERMS

Terms that appear in initial capitalization throughout this SPD (for example, Dependent) are explained within the SPD document or below. This section defines many of the terms used throughout this SPD and is not intended to describe benefits. These definitions are periodically updated and subject to change. If you are uncertain about the meaning of a term, contact the Plan Administrator or the Claims Administrator for further clarification. In the event of any discrepancies or conflicts between these definitions and the Plan Document, the terms of the Plan Document shall govern. Some definitions may be specific to the benefit plan option—see that specific SPD for further details.

Annual Enrollment Period. A period of time that follows the initial enrollment period, as determined by the Plan provisions and the Plan Administrator, during which Primary Participants may enroll themselves, change coverage, and drop coverage and covered Dependents under the Plan according to verification and certification provisions.

Benefits. Your right to payment for Covered Health Services that are available under the Plan, subject to the terms, conditions, limitations, and exclusions of the Plan. The term “Benefits” also means the payments or services provided under the Plans, as applicable, the Lumen Group Life and Business Travel Accident Insurance Plan and the Lumen Disability Plan.

Calendar Year. The period starting on January 1st of each year and ending at midnight December 31st of that year.

CDHP HRA (Health Reimbursement Account). An HRA account funded with Company dollars if you are enrolled in the Consumer Driven Health Plan (CDHP) as a non-Medicare eligible Retiree. See the *CDHP benefit option* SPD for more information.

Child. See the detailed description in the text of this SPD.

Claims Administrator. The entity that has been delegated responsibility for administration of the benefit option to include claims and appeals administration.

Company. Lumen Technologies

Continuous Coverage. The maintenance of continuous and uninterrupted Creditable Coverage by an eligible Employee or Dependent. An eligible Employee or Dependent is considered to have maintained Continuous Coverage if the individual applies for coverage within 63 days of the termination of his or her qualifying coverage.

Covered Person. Either you or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to you and your Dependents throughout this Benefits Summary are references to a Covered Person.

Declared dependents. You must declare eligible dependents who you wish to enroll in coverage at some point in the future. This means if you later gain a new dependent, that new dependent is not eligible for coverage under the Plan. Even if you don’t want to cover a dependent now, all potential dependents must be on file as “eligible” with the Plan Administrator in order to be eligible to be added to coverage with a Qualified Life Event or at Annual Enrollment at some future point.

Dependent. The Employee’s legal Spouse (including a Common-law Spouse in states where it is recognized and where an affidavit is on file with the Plan Administrator), the Employee’s Domestic Partner (where an affidavit

is on file with the Plan Administrator), or certain Dependent Children as discussed earlier in the SPD. Generally, for a Dependent to be eligible for coverage under the Plan, the relationship must be established and, in some circumstances, the financial support. Common-law spouse is not recognized by MetLife for Life Insurance.

Disability or Disabled. With the respect to an Employee, the term is as defined in the Lumen Disability Plan. With respect to a Child, the term is as determined by the Claims Administrator to be indefinitely incapable of self-support and fully dependent on the participant for support.

Enrolled Dependent. A Dependent who is properly enrolled and eligible under the Plan.

Enrollment Date. The first day of coverage.

HRA (Health Reimbursement Account). An HRA is an account funded with Company dollars if you are enrolled in a Consumer Driven Health Plan (CDHP). See the CDHP benefit option SPD for more information.

HSA (Health Savings Account). An HSA is a personal bank account that you fund and own. You are eligible for an HSA if you elect the High Deductible Health Care Plan (HDHP) medical benefit option. See the HDHP benefit option SPD for more information.

Initial Enrollment Period. The first period of time, as we agree with the Claims Administrator, during which the employee may enroll themselves and their Dependents under the Plan.

Long-Term Disability (LTD) Recipient. An LTD recipient is an individual who, after exhausting the maximum payment period of STD benefits, becomes entitled to receive LTD payments under the Disability Plan.

LTD Benefit Payment Schedule. Health care Benefits end when your LTD benefits end or earlier as described in the *"The Health Coverage Available if you are an LTD Recipient"* section in this SPD. LTD benefit payments begin after the expiration of the maximum payment period of STD benefits, if the participant is otherwise eligible and approved for LTD benefits, and such LTD benefits are paid in accordance with the following schedule:

Age at which LTD Benefits Commenced	Maximum Payment Period*
61 or younger	to age 65 or to SSNRA, or 3 years 6 months, whichever is longer
62	to SSNRA, or 3 ½ years, whichever is longer
63	to SSNRA, or 3 years, whichever is longer
64	to SSNRA, or 2 ½ years, whichever is longer
65	2 years
66	1 ¾ years
67	1 ½ years
68	1 ¼ years
69 or older	1 year

***includes 180 or 270 days of STD benefit (depending on collective bargaining agreement).**

Medicare. The federal government's health insurance program under Social Security (Title XVII). Medicare gives health Benefits to people who are age 65 or older, or who are permanently disabled. The program has three parts, Part A, Part B and Part D. Part A generally covers the cost of Hospitals and extended care facilities. Part B generally covers the cost of professional Medicare services. Effective January 1, 2006 Part D covers prescription drugs. All Parts are subject to Medicare deductibles.

Medicare HRA. The Health Reimbursement Account funded by the Company for those Retirees and Dependents who are Medicare eligible and not enrolled in the Company group benefit options.

Plan or Plans. Lumen Health Care Plan; the following are "component plans" of the Lumen Welfare Benefits

Plan: the Lumen Disability Plan, Lumen Life Insurance Plan, and Lumen Business Travel Accident Plan and other plans described in this SPD. While this SPD has referred to coverage for retirees and LTD Recipients, their health care benefits are provided in accordance with the terms of the Lumen Retiree and Inactive Health Plan.

Plan Administrator. The Lumen Employee Benefits Committee or its designee as that term is defined under ERISA.

Plan Document. The insurance contracts, amendments and other documents that describe and govern the Lumen Health Care Plan; the following are "component plans" of the Lumen Welfare Benefits Plan: Lumen Disability Plan, Lumen Life Insurance Plan, Lumen Business Travel Accident Plan and other plans described in this SPD.

Provider. Any person, facility, or other program that provides Covered Services within the scope of the provider's license, certification, registration, or training.

Short-term Disability. As defined under the Lumen Disability Plan.

Subscriber. The Primary Participant (who is not a Dependent) on whose behalf coverage under the Plan is provided.

Term of Employment (TOE). Term of Employment (TOE) is a period of continuous employment, as reflected in the Company's official service records and as defined by the Qwest Pension Plan.

Third Party Administrator. An entity appointed by the Lumen Employee Benefits Committee to administer the Plan.

Total Disability or Totally Disabled. As defined under the Health Plan, a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex. The Disability Plan has its own specific definitions so please refer to the specific Disability Plan SPD.

Waiting Period. The period of time that must pass before you or your Dependents are eligible for coverage under the Plan.

Appendix 1A: Eligibility for Benefits

The following charts outline groups for Legacy Companies: Eligibility for Benefits — Legacy Population Criteria Population Specific Definitions

Issued Jan. 1, 2023

LUMEN®

DEFINITIONS AND ELIGIBILITY PROVISIONS APPLICABLE FOR LEGACY CENTURYTEL AND LEGACY EMBARQ:

Section 1:

The terms and eligibility provisions for Legacy Centurytel and Legacy Embarq Retirees are as set forth below, which matrix, like the Plan, is subject to change from time to time and over time, except where specifically noted. The terms and capitalized definitions with the Plan govern except as set forth below. Notwithstanding the prior sentence or the Matrix below: unless there is a separate written agreement to the contrary (or as set forth in Appendix 8 and 9 of the Plan Document), Eligible Retirees who are eligible for Medicare and their Dependents who are eligible for Medicare (a Medicare-eligible Participant) are only eligible for dental benefits and the Health Reimbursement Account, as described in Appendix 7 of the Plan Document. Eligibility for a life insurance benefit under the Plan, if any, is not affected. Medicare-eligible Participants who are Legacy Qwest Pre-1991 Retirees, Legacy Qwest ERO'92 Retirees or their Dependents, are not subject to this rule. The terms of the CenturyTel Executive Medical Plan are at Appendix 8 of the Plan Document.

Retiree Closed Frozen Groups	
ZA	Retiree – PTI: Pre-99, Waived Dental to age 65 or to SSNRA, or 3 years 6 months, whichever is longer
ZB	Retiree – PTI: Pre 99 with Dental pays full cost
ZC	Retiree – PTI: NW All Medicare eligible
CZ	Retiree – PTI: NW No Pay Medical, Basic Life 1X, (#50251)
ZD	Retiree CTE: Pre '94 Medicare pay full cost, dental. Includes survivor #51731 w/Exec Medical
ZE	Retirees: CTE post '94 to 12/31/2003 & former PTI post '99 to 12/31/2003.
ZG	Retiree CTE: Pre '94 Universal
ZH	Retiree OH Barg retired after 1/1/86 & prior to 1/1/92. All are over 65, No premium
ZI	Retirees: Like ZE – Includes Exec Medical
ZJ	Retiree: Former Exec, w/Exec Medical Plan, Exec Life, (Jim Reppond #51867, Jack Robinson #51872)
ZO	Survivor: OH Barg 4370 Surv of ZH & ZG Groups – Pre 2001. Under 65 – same as active percentage. Over 65 30% of total rate
ZP	Retiree: PTI AK IBEW 1547 Pre '99 employee paid Basic and Supp Life.
ZQ	Retiree: PTI AK IBEW 1547 1/99 – 7/99 employee paid Basic and Supp Life. ZQ medical, dental and vision same as ZE.
ZR	Retiree: 2003 to 3/13/2005 AL CWA 3971, 72,74 Barg (formerly Verizon). Retiree: MO CWA 6301, 6310A, 11A, 12A Barg (formerly Verizon) Eff 1/2003 to 3/2005
ZT	Retiree: Former Exec w/Exec Medical. Receives Exec Life. Cost sheet same as ZJ.
ZU	Retirees: MO CWA 6310, 11, 12,6373 Barg (formerly Spectra) prior to 1/1/2003. Retirees: MO CWA 6301, 6310A, 11A, 12A Barg (formerly Verizon prior to 1/1/2003. Darrell Bender #201527 is the only retiree. Retirees: WI Barg CWA 4671, 72, 74, 75 Prior to February 2005.
ZV	OH LTD/Ret. All move to ZG at age 65. Frozen group of 6.
ZX	Retirees with Life coverage only.
ZY	Retirees AR Barg CWA 6171C to 8/15/2005, 6171NW to 3/12/2005
Z6	Retiree >=01/01/03 to 3/12/2005 MO CWA 6310,11,12,6373 (formerly Spectra) Retiree: Yrs of Service = Points IBEW 257A MO (formerly Verizon – Ret 7/1/03 to 11/22/03.
MZ-M3	Madison River Grandfathered Group 100% company paid. Only Coastal Retirees in this group.
MZ-M6	Madison River – no company subsidy
MZ-M7	Madison River – Retirees with dental only till reach age 65 100% Retiree paid coverage

Retiree Closed Frozen Groups	
E2	EQ 1991 Plan Retirees: Program 200 - 30 years of service receive 100% of “benefit credit”. Benefit credit amount established annually. For less than 30 years of service, retiree pays a percentage of the “benefit credit” plus the difference between total cost and “benefit credit”. Medical - non-Medicare coverage only.
E3	EQ Pre 1991 Plan Retirees (former program 209, 210, 213, 215 – 224) Survivor grandfathered: pays 0% for coverage.
E4	EQ Pre- 1991 Plan Retirees: Medical – non-Medicare coverage only. Program 200 Program 201 – 15% (B3) Program 202, 203, 205, 207 – Group 2 CTT Non- Barg – 10% (B2) Program 208 – 15% (B3) Program 212 Group 1 Texas – 5% (B1) Program 212 Group 2 All Others – 7% (B2) Program 214 – CWA 3680, 3681, 3682 – 10% (B2) Program 215 Program 220 Program 222 – CWA 3685 – 10%
E5	EQ Pre 1991 Plan Retirees Program 209 – Retiree pays 0%, 10% Dep Program 213 – Retiree pays 0%, 15% Dep Medical – non Medicare coverage only

DEFINITIONS AND ELIGIBILITY PROVISIONS APPLICABLE TO LEGACY QWEST: SECTIONS 2 THROUGH SECTION 5

Section 2:

Capitalized Terms are as defined in Plan Section 1.1 except where there is a specific definition below as part of this Appendix 1A:

(a) “Legacy Qwest Access Only Benefit Option” means the limited Benefit option(s) under the Plan that is available to Legacy Qwest Access Only Participants and Legacy Qwest Access Only Executive Level-Officer Participants as determined by the Plan Administrator in its sole discretion, which such Benefit option(s) may include a high deductible health plan (“CDHP”). Under such Benefit options, subject to Plan Section 2.6(b)(ii) as may be applicable, Legacy Qwest Access Only Participants and Legacy Qwest Access Only Executive Level-Officer Participants are not allowed to enroll an individual as an Eligible Dependent who was not enrolled in the Plan as an Eligible Dependent at the time of original commencement of coverage as an Legacy Qwest Access Only Participant or as Legacy Qwest Access Only Executive Level-Officer Participant. With the exception of HMO Benefit options, if offered, the Benefit options available to Legacy Qwest Access Only Participants and Legacy Qwest Access Only Executive Level-Officer Participants will be the same Benefit Options as are available to active Management Employees, including the PPO Benefit option.

(b) “Legacy Qwest Access Only Participant” and “Legacy Qwest Access Only Executive Level-Officer Participant” means respectively as defined herein (i) a management Participant who is not a Protected Employee upon retirement and who (1) has satisfied the “modified Rule of 75” (as defined by the Qwest Pension Plan), (2) has exhausted the full COBRA continuation period, (3) is not eligible for Medicare and (4) pays 100% of the cost of the premium of the Legacy Qwest Access Only Benefit Option. A Legacy Qwest Access Only Participant participates in the Access Only Benefit Option until the last day of the month of the earliest event to occur: the Access Only Participant (A) ceases to timely pay premiums, (B) dies, (C) the Plan is amended to change or eliminate coverage, (D) coverage is waived by the Participant, (E) the Participant attains Medicare eligibility or (F) the Plan is terminated.

(ii) An “Legacy Qwest Access Only Executive Level-Officer Participant” is a Participant who was not a Protected Employee upon an eligible separation from service on the active U.S. payroll with a Participating Company of Legacy Qwest and who: (I) was a member of the Legacy Qwest Executive Level-Officer team of

the Company as determined by the Legacy Qwest Chief Executive Officer prior to April 1, 2011 and included employees that directly reported to the Legacy Qwest Chief Executive Officer, the Chief Operating Officer of the Company or, if on May 27, 2008, an employee had a title that was not Executive Vice President, was a direct report to the Chief Executive Officer, (II) prior to April 1, 2011, had satisfied a "modified Rule of 60" defined as set forth below, (III) exhausts the full COBRA continuation period, and (IV) pays 100% of the cost of the premium of the Legacy Qwest Access Only Benefit Option. Each Legacy Qwest Access Only Executive Level-Officer Participant who separates from the service of a Participating Company in an eligible separation (as determined by the Plan Administrator) and who satisfies the minimum age and service requirements of the "modified rule of 60" shall be entitled to elect Access Only Benefit Option coverage subject to the terms and conditions of the Plan. The "modified rule of 60" for a Legacy Qwest Access Only Executive Level-Officer Participant is defined as any age and Term of Employment combination that equals or exceeds 60 provided the Legacy Qwest Access Only Executive Level-Officer Participant has a minimum Term of Employment of at least five (5) years. A Legacy Qwest Access Only Executive Level-Officer Participant may participate in the Legacy Qwest Access Only Benefit Option coverage until the last day of the month of the earliest event to occur: the Legacy Qwest Access Only Executive Level-Officer Participant (a) ceases to timely pay premiums, (b) dies, (c) coverage is waived by the Participant or (d) the Plan is terminated and no other group health coverage is offered by the Company or its successor. The administrative rules and practices of Legacy Qwest Access Only Benefit Option coverage apply. Effective December 1, 2010, the Company may not amend the Plan (or any successor Plan) to eliminate coverage or Benefits for Legacy Qwest Access Only Executive Level-Officer Participants, except as provided for herein and in the event of the Company's (or its successor's) elimination of any group health plan coverage.

Any change made to the Plan for active Management Employees and their Eligible Dependents automatically applies to the Legacy Qwest Access Only Benefit Option coverage and to the Legacy Qwest Access Only Participants, the Legacy Qwest Access Only Executive Level-Officer Participants and their Eligible Dependents. Neither a Legacy Qwest Access Only Participant nor a Legacy Qwest Access Only Executive Level-Officer Participant is allowed to add an individual as an "Eligible Dependent" if such individual was not enrolled as an Eligible Dependent at the time of the Initial Enrollment Period to commence coverage in a Legacy Qwest Access Only Benefit Option. Neither a Legacy Qwest Access Only Participant nor a Legacy Qwest Access Only Executive Level-Officer Participant is considered a "Retired Employee" for purposes of the Plan.

(c) "Non-Union" or "Management Employee" means under the Active Health Plan, and for purposes of eligibility for this Plan, an Employee whose position is not subject to automatic wage progression and whose pay is at a monthly or annual rate, excluding Employees classified as acting Management Employees (temporarily promoted to salary status). Solely with respect to Legacy Qwest Bargained Employees, for purposes of determining eligibility for health coverage as a retiree, in order to be considered as a Management Employee at the time of retirement, an Employee who was an Occupational Employee and later transfers to or was employed in a management position and retires on or after January 1, 2004, must be employed as a Management Employee for at least three consecutive years (thirty-six consecutive (36) months) immediately prior to retiring, and satisfy all other Plan eligibility requirements, in order to be considered as eligible for coverage under the Plan as a Management Employee at the time of retirement. Prior to January 1, 2004, solely for purposes of determining eligibility for health coverage as a retiree, in order to be considered as an Occupational Employee at the time of retirement, an Employee who was a Management Employee and later transfers to or was employed in an occupational position and retires, must be employed as an Occupational Employee for at least twelve (12) consecutive months immediately prior to retiring, and satisfy all other Plan eligibility requirements, in order to be considered as eligible for coverage under the Plan as an Occupational Employee at the time of retirement.

Notwithstanding the foregoing or any other provision of this Plan, the term "Management Employee" includes an Employee who is represented by a union for collective bargaining purposes and for whom the union and the Company (or a subsidiary thereof) have agreed that the benefits available under the Plan for Management Employees shall be made available rather than the benefits available under the Plan for Occupational Employees, but only for such period of time as specified in the agreement between the union and the Company (or a subsidiary thereof).

(d) Occupational Employee" or "Union Employee" means under the former Legacy Qwest Health Care Plan, and for purposes of eligibility for this Plan, a Bargained Employee or a non-management, nonsalaried Employee, including Employees classified as acting Management Employees (temporarily promoted to salary status). This definition also provides the following eligibility rules solely applicable to Legacy Qwest Occupational Employees: Solely for purposes of determining eligibility for health coverage after Jan. 1, 2004 as a retiree, in order to be considered as an Occupational Employee at the time of retirement, an Employee who is a Legacy Qwest Management Employee and later transfers to or was employed in an occupational position and retires on or after Jan. 1, 2004, must be employed as an Occupational Employee for at least three consecutive years (36 consecutive months) immediately prior to retiring, and satisfy all other Plan eligibility requirements, in order to be considered as eligible for coverage under the Plan as an Occupational Employee at the time of retirement. Prior to Jan. 1, 2004, solely for purposes of determining eligibility for health coverage as a retiree, in order to be considered as an Occupational Employee at the time of retirement, an Employee who is a Legacy Qwest Management Employee and later transfers to or was employed in an occupational position and retires, must be employed as an Occupational Employee for at least twelve (12) consecutive months immediately prior to retiring, and satisfy all other Plan eligibility requirements, in order to be considered as eligible for coverage under the Plan as an Occupational Employee at the time of retirement.

Notwithstanding the foregoing or any other provision of this Plan, the term "Occupational Employee" shall exclude an Employee who is represented by a union for collective bargaining purposes and for whom the union and the Company (or a subsidiary thereof) have agreed that the benefits available under the Plan to Management Employees or Non-Union Employees shall be made available rather the benefits available under the Plan for Occupational Employees, but only for such period of time as specified in the agreement between the union and the Company (or the subsidiary thereof).

Section 3:

3.1 (a) Group 1: Legacy Qwest Post-1990 LTD Participants: Effective Jan. 1, 2019, the below Health and Life Benefits chart is applicable to those employees approved for Long-Term Disability (LTD) or a Disability Pension and who are represented by one of the below Unions:

- Qwest Communications Workers of America, or
- Qwest International Brotherhood of Electrical Workers

The chart provides a brief explanation of what benefits you may be eligible for while approved for LTD or while receiving a Disability Pension benefit. If you have questions regarding your benefits, please contact the Lumen Health and Life Service Center (referred to as the "Service Center") at **833-925-0487** or **317-671-8494** (International callers).

LTD and Disability Pension Participands must continue to meet the definition of disability, as determined by The Standard, to receive the benefits listed below:

Qwest Represented	Long-Term Disability	Disability Pension — Greater than 15 years of service if hired prior to January 1, 2009 or Service Pension Eligible Disability Pension — Not required to meet the Modified Rule of 75 under Lumen's Combined Pension Plan
Employment Status	Terminated - LTD	**Terminated – LTD - Disability Pension or Services Pension / Retired**
LTD Benefit Amount	• Basic LTD is 50% of eligible pay, which is provided by the Company at no cost; offset provisions apply. • If enrolled in Supplemental LTD, it is 65% of eligible pay which is purchased by the Participant. Offset provisions apply. • If you were on Short-Term Disability (STD) prior to Jan. 1, 2018 and never returned to work and subsequently go on LTD, you are subject to the benefits available prior to Jan. 1, 2018 (60% LTD benefit amount).	

<table>
<tr><td>Medical/prescription drug & dental – Participant paid

Note: If you become Medicare eligible, you must timely enroll in Medicare Part-A and Part-B. Medicare becomes your primary insurance coverage.</td><td>Hired, re-hired, or transferred prior to Jan. 1, 2018 and STD date is after Dec. 31, 2018:
At the active rate, which is partially subsidized for up to a total of 3 years from the beginning of STD (2 years and 3 months from LTD date), subject to the terms of the Lumen Retiree and Inactive Health Plan.</td><td>Hired, re-hired, or transferred prior to Jan. 1, 2018 and STD date is after Dec. 31, 2018:
At the active rate, which is partially subsidized for up to a total of 3 years from the beginning of STD (2 years and 3 months from LTD date), subject to the terms of the Lumen Retiree and Inactive Health Plan.</td></tr>
<tr><td>Medical/prescription drug & dental – Participant paid (continued)

If you are eligible and elect Retiree medical, you must enroll in an individual Medicare policy. You will receive information regarding your Health Reimbursement Account (HRA) from the Service Center.</td><td>Hired, re-hired, or transferred on or after Jan. 1, 2018:
At the active rate, which is partially subsidized for up to a total of 3 years from the beginning of STD (2 years and 6 months from LTD date), subject to the terms of the Lumen Retiree and Inactive Health Plan.
Then, offered 18 months of COBRA medical/prescription drug and dental at full COBRA cost.</td><td>Hired, re-hired, or transferred on or after Jan. 1, 2018:
At the active rate which is partially subsidized for up to a total of 3 years from the beginning of STD (2 years and 6 months from LTD date), subject to the terms of the Lumen Retiree and Inactive Health Plan.
Then, offered 18 months of COBRA medical/prescription drug and dental at full COBRA cost. Note: You are defaulted to the LTD continuation benefit at the active rates (refer to the Long-Term Disability column). However, you can call the Service Center to request retiree medical/prescription drug and dental coverage at any time during the LTD continuation benefit or COBRA period.</td></tr>
<tr><td rowspan="2">Vision – Participant paid</td><td colspan="2">Hired, re-hired, or transferred prior to Jan. 1, 2018 and STD date is after Dec. 31, 2018:
At the active rate, which is partially subsidized for up to a total of 3 years from the beginning of STD (2 years and 3 months from LTD date), subject to the terms of the Lumen Retiree and Inactive Health Plan.
Then, offered 18 months of COBRA vision at full COBRA cost.</td></tr>
<tr><td colspan="2">Hired, re-hired, or transferred on or after Jan. 1, 2018:
At the active rate, which is partially subsidized for up to a total of 3 years from the beginning of STD (2 years and 6 months from LTD date), subject to the terms of the Lumen Retiree and Inactive Health Plan.
Then, offered 18 months of COBRA vision at full COBRA cost.</td></tr>
<tr><td>Health Care Flexible Spending Account – Participant paid</td><td colspan="2">Offered COBRA on an after-tax basis through end of calendar year only. Not eligible for re-enrollment.</td></tr>
<tr><td rowspan="2">Basic Life Insurance – Company paid</td><td>Hired, re-hired, or transferred on or after Jan. 1, 2018 and STD date is after Dec. 31, 2018
3 years from the beginning of STD (2 years and 3 months from LTD date), subject to the terms of the Lumen Group Life Insurance Plan. If you turn age 70, your Basic Life coverage will reduce to 50% of the amount.</td><td>Hired, re-hired, or transferred prior to Jan.1, 2018 and STD date is after Dec. 31, 2018:
3 years from the beginning of STD (2 years and 3 months from LTD date), subject to the terms of the Lumen Group Life Insurance Plan. If you turn age 70, your Basic Life coverage will reduce to 50% percent of the amount.</td></tr>
<tr><td>Hired, re-hired, or transferred after Jan. 1, 2018:
3 years from the beginning of STD (2 years and 6 months from LTD date), subject to the terms of the Lumen Group Life Insurance Plan. If you turn age 70, your Basic Life coverage will reduce to 50% of the amount
**Conversion rules apply. Portability rules do not apply.</td><td>Hired, re-hired, or transferred after Jan. 1, 2018:
3 years from the beginning of STD (2 years and 6 months from LTD date), subject to the terms of the Lumen Group Life Insurance Plan. If you turn age 70, your Basic Life coverage will reduce to 50% percent of the amount.
**Conversion rules apply. Portability rules do not apply.

Note: You are defaulted to the LTD continuation benefit at the active rates (refer to the Long-Term Disability column). However, you can call the Service Center to request retiree basic life coverage at any time during the LTD continuation benefit period. Retiree coverage reduces to $10,000, subject to the terms of the Lumen Group Life Insurance Plan.</td></tr>
</table>

Supplemental Life Insurance –Participant paid	Hired, re-hired, or transferred prior to Jan. 1, 2018 and STD date is after Dec. 31, 2018 • At the active rate which is partially subsidized for up to a total of 3 years from the beginning of STD (2 years and 3 months from LTD date), subject to the terms of the Lumen Group Life Insurance Plan.	Hired, re-hired, or transferred prior to Jan.1, 2018 and STD date is after Dec. 31, 2018: • At the active rate which is partially subsidized for up to a total of 3 years from the beginning of STD (2 years and 3 months from LTD date), subject to the terms of the Lumen Group Life Insurance Plan.
	Hired, re-hired, or transferred after Jan. 1, 2018: • At the active rate which is partially subsidized for up to a total of 3 years from the beginning of STD (2 years and 6 months from LTD date), subject to the terms of the Lumen Group Life Insurance Plan.	Hired, re-hired, or transferred after Jan. 1, 2018: • At the active rate which is partially subsidized for up to a total of 3 years from the beginning of STD (2 years and 6 months from LTD date), subject to the terms of the Lumen Group Life Insurance Plan.
	If you turn age 70, your Supplemental Life coverage will reduce to 50% of the amount. Refer to your SPD for other reduction provisions	If you turn age 70, your Supplemental Life coverage will reduce to 50% of the amount. Refer to your SPD for other reduction provisions.
	Waiver of Premium provisions may apply if < 60 years of age on the date of STD. If you turn age 70, your Supplemental Life coverage will reduce to 50% of the amount. Refer to your SPD for other reduction provisions.	Waiver of Premium provisions may apply if < 60 years of age on the date of STD. ** If not approved for Waiver of Premium with MetLife, Supplemental Life insurance may be continued for a total of 3 years from STD date.
	** If not approved for Waiver of Premium with MetLife, Supplemental Life insurance may be continued for a total of 3 years from STD date and you will be billed for the applicable premium..	Retiree coverage may continue coverage up to age 70, provided timely payments are made, through the Service Center, subject to the terms of the Lumen Group Life Insurance Plan. Participant must contact MetLife for information regarding any right to convert to an individual policy.
Spouse/domestic partner, Child Life Supplemental Insurance - Participant paid	The rules indicated under the Supplemental Life Insurance row apply. Refer to your SPD for other reduction provisions.	
Accidental Death & Dismemberment Insurance (Basic and Supplemental)	Ends on termination date	
Business Travel Accident Insurance	Ends on termination date	

*Refer to the Healthcare & Life Insurance Eligibility Matrix, Group 10, for additional detail regarding retiree healthcare eligibility.

**Life Insurance conversion must be requested within 31 days from the day coverage ends, conversion is not automatic. To request Waiver of Premium information, contact MetLife at 877-275-6387. You must apply for Waiver of Premium during the first 12 months of disability. If Waiver of Premium is not approved, you are responsible for any premium contributions. Contact MetLife for other important Policy Information.

3.1 A Legacy Qwest Access Only Participant. The Benefit options available to Legacy Qwest Access Only Participants will be the same Benefit Options as are available to active Non-Union Employees, excluding HMOs, if offered. A Legacy Qwest Access Only Participant may participate in the Access Only Benefit Options until the last day of the month of the earliest event to occur: the Access Only Participant (1) ceases to timely pay premiums, (2) dies, (3) the Plan is amended to change or eliminate coverage, (4) coverage is waived by the Participant, (5) the Participant attains Medicare eligibility or (6) the Plan is terminated.

3.1B Legacy Qwest Access Only Executive Level-Officer Participant. A Legacy Qwest Access Only

Executive Level-Officer Participant shall be eligible to participate in the same Benefit Options as are available to active Non-Union Employees, excluding HMOs if available. A Legacy Qwest Access Only Executive Level-Officer Participant may elect to have Access Only Benefit Option coverage until the last day of the month of the earliest event to occur: the Access Only Executive Level-Officer Participant (1) ceases to timely pay premiums, (2) dies, (3) coverage is waived by the Participant or (4) the Plan is terminated and no other group health coverage is offered by the Company or its successor. Effective December 1, 2010, the Company may not amend the Plan (or any successor Plan) to eliminate coverage or Benefits for Legacy Qwest Access Only Executive Level-Officer Participants, except as provided for herein and in the event of the Company's (or its successor's) elimination of any group health plan coverage.

3.2 Eligible Retiree. Only those Eligible Retirees who are retired from Legacy Qwest in the following classifications shall be eligible for coverage under the Plan:

a. **Legacy Qwest Pre1991 Retirees:**
   I. Retired Employees who were participants in a Predecessor Plan, who were granted a service or disability pension, and who retired prior to January 1, 1991; and
   II. Employees who prior to January 1, 1991 became eligible to receive benefits under one of the Company's long term disability plans and continue to qualify for benefits under those plans.

a. **Legacy Qwest Post90 Retirees: Retired Employees who retire on or after January 1, 1991 and who:**
   I. **Were Occupational Employees and are granted a service pension; or**
   II. **Are receiving a modified disability pension under the Qwest Pension Plan Modified Disability** Pension Program or Qwest Pension Plan immediately prior to attainment of age 65, had at least 15 years of Term of Employment and have attained age 65; or
   III. Are granted a disability pension and have attained age 65;or
   IV. Are former Salaried Employees with the following age and service combinations and who satisfy the definition of a Protected Participant:

Retirement Age	Term of Employment
Any Age	at least 30 years
50-54	at least 25 years
50-59	At least 20 years
60-64	At least 15 years
65 and older	At least 10 years

OR

   V. Are Reemployed Pensioners.

a. **Classified Retirees:** Former Legacy Qwest Employees who are terminated from employment under terms governed by an individualized written agreement or arrangement, which is not a collective bargaining agreement that provides for continued health care coverage, other than COBRA coverage, under the Plan following such termination. Classified Retirees shall be eligible for the same Benefit options available to Post90 Management Retirees, as such options may be amended from time to time in the sole discretion of the Company.

b. **Re-employed Pensioners – Benefits upon Termination of Rehire:** Re-employed Pensioners are not eligible for coverage under the Plan while actively employed by the Company, except as may be required by collective bargaining agreement. A Reemployed Pensioner, if eligible under the terms of the Company-sponsored Active Health Plan, may be covered under the Active Health Plan as an Eligible Employee (as defined by the Active Health Plan) who may receive Benefits available to an Eligible Employee, upon his reemployment. The default coverage of a Re-employed Pensioner who is a Legacy Qwest Eligible Retiree upon becoming an active Eligible Employee under the Active Health Plan, shall be the same default coverage for Eligible Employees as set forth in Active Health Plan Section 2.8 "Default Coverage." Upon the termination of his reemployment, such Reemployed Pensioner shall become an Eligible Retiree in the Plan who shall be eligible for the Benefit options in accordance with the terms of the Plan. Notwithstanding the preceding sentence, with respect to Legacy Qwest Re-employed Pensioners who are Post-1990 Retirees, Pre-1991 Retirees, ERO'92 Retirees, at the termination of his reemployment, such Reemployed Pensioner shall become an Eligible Retiree who shall be eligible for the Benefit options that were available to the classification status of the Re-employed Pensioner at the time of original

retirement (e.g., Post-1990 Occupational Retirees, Post-1990 Management Retirees, Pre-1991 Retirees, ERO'92 Retirees), provided however that such Benefits for each respective classification, subject to the terms of the Plan, may be subsequently amended from time to time and in the sole discretion of the Company.

3.3 Survivor Coverage. At the expiration of the COBRA continuation coverage period, a Surviving Spouse may elect continuation survivor coverage under the Plan in accordance with the plans provisions. Please contact the Lumen Health and Life Service center for additional details. Such coverage shall be available to the Surviving Spouse and his Eligible Dependents who are Surviving Dependents at his/her own expense. Survivor coverage for a Surviving Spouse and any Surviving Dependents shall cease at the end of the Surviving Spouse's life or based on the plan provisions outlined in the survivor matrix, if not changed or amended earlier. Attached Matrix - Surviving Spouse Coverage.