Survivor Benefit Plan

Summary Plan Description (SPD)
For Eligible Active Employees

Effective Jan. 1, 2024

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, 2024

LUMEN®

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INTRODUCTION

Lumen Technologies* (hereinafter “Lumen” or “Company”) is pleased to provide you with this Summary Plan Description (“SPD”).

This SPD supersedes and replaces, in its entirety, any other SPD describing Survivor Benefit plan benefits that you currently may possess. In the event of any discrepancy between this SPD and the official *Plan Document*, the *Plan Document* shall govern.

This SPD, together with other plan documents (such as the Summary of Material Modifications (SMMs), and materials you receive at Annual Enrollment,) (hereafter “Plan documents”) briefly describe your Benefits as well as rights and responsibilities, under the Company Welfare Benefits Plan (the “Plan”). These documents make up your official Summary Plan Description for the Survivor benefit options as required by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”).

This SPD is for active, regular, full-time employees on US Payroll, who are not covered by any collective bargaining agreement and whose death occurs on or after July 1, 2016 and such employee leaves behind an eligible surviving spouse or domestic partner and/or dependent children.

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 Eligible Employees, without prior notice to or consultation, subject to applicable laws.

The Plan Administrator, the Company 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 Survivor Benefit Plan benefit —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.

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

The Required Forum for Legal Disputes

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

How to Use This Document

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

Capitalized terms are defined throughout this SPD. All uses of “we,” “us,” and “our” in this document, are references to the Claims Administrator or the Company. References to “you” and “your” are references to people who are Eligible Employees.

You are encouraged to keep all the SPDs and any attachments (summary of material modifications (“SMMs”), amendments, and addendums) for future reference.

GENERAL PLAN INFORMATION

Consequences of Falsification or Misrepresentation

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 under the Plan, the Plan Administrator may without anyone’s consent, terminate coverage, possibly retroactively, depending on the circumstances, and may seek reimbursement for Benefits that should not have been paid out. Additionally, the Claims Administrator may refuse to honor any claim under the Plan.

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

You Must Follow Plan Procedures

Please keep in mind that it is very important for you and/or your dependents 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 your dependents 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 the beneficiaries (called “Qualified Payees” as defined later in this SPD) may be eligible will be paid on a timely basis, or paid at all, and there can be no guarantee that personal health information will remain private and protected.

Plan Number

The Plan Number for the Company Welfare Benefits Plan is 513.

CLAIMS ADMINISTRATOR AND CONTACT INFORMATION

Lumen Health & Life Service Center
P.O. Box 1407
Lincolnshire, IL 60069

833-925-0487

Website Address: **lumen.com/healthandlife**

ELIGIBILITY

You are eligible to participate in the Survivor Benefit Plan described in this summary if you are an active,

regular, full-time Non-Represented Employee. You are referred to as the “Participant.”

This benefit is in addition to already existing benefits. Its purpose is to provide income to your family during the interim period when the eligible family members are waiting for payment from other benefits, such as life insurance.

How the Plan Works

In the event of the death of an Eligible Employee who leaves a Qualified Payee (defined below in subsection A):

- An amount equal to six (6) months of the Participant’s Base Salary will be paid
- An Eligible Employee’s Dependents covered by the Company’s Health Care Plan at the time of death will retain their health coverage fully subsidized (at no charge) for six (6) months (unless the employee was eligible for retirement, in which case, retiree coverage will be available in accordance with the terms of the Company’s Retiree and Inactive Health Plan). COBRA may be elected at the end of the six (6) month subsidy period for 36 months at the full COBRA cost.
- Employee discounts on Company services in place at the time of the employee’s death will be retained for a period of six (6) months for the Surviving Spouse/Domestic Partner.

Who are the Family Members that are Eligible to Receive a Benefit?

Only Qualified Payees as defined by the Plan Document are eligible to receive the Benefit.

I. Qualified Primary Payees are limited to the deceased Employee’s Surviving Spouse or Surviving Domestic Partner, each having their status qualified as such by the Plan Administrator prior to the Employee’s death. If, and only if, there is no Qualified Primary Payee, payment will be made to eligible Qualified Secondary Payee(s).
II. Qualified Secondary Payees are limited to:
    A. Biological or adopted children younger than 19 years old and, if applicable, other minors over whom the deceased Employee had legal guardianship at the time of the Employee’s death who are younger than 19 years old, but excluding foster children,
    B. A biological or adopted child who is an unmarried, full time student, and is younger than 26 years old (as validated under the Company’s Health Care Plan processes), and/or
    C. Biological or adopted children older than 18 years old and, if applicable, others older than 18 years old over whom the deceased Employee had legal guardianship at the time of death and who are determined to be permanently and totally “Disabled” (as defined in accordance with the Company’s Health Care Plan) prior to or at the time of the death of the Employee.

Regardless of the number of Secondary Qualified Payees, the benefit payable to the Secondary Qualified Payees shall, in the aggregate, never exceed the Survivor Benefit amount.

Please Note: If there is neither a Qualified Primary Payee nor Qualified Secondary Payees, there will be no benefit payable.

Any payee receiving payment will be required to provide one of the following proofs of eligibility before payment is disbursed. Dependent verification may be required if your Payee is not currently covered under a Company Health Plan.

I. Primary Payees: Marriage License or proof of qualification as Domestic Partner
II. Secondary Payees
    A. Minor Children and Disabled Children – birth certificate and/or legal guardianship documents.
    B. Children age 19 up to 26 – proof of full-time student status in addition to birth certificate.
    C. If applicable, Court order showing Legal Guardianship

Additional paperwork may be required, this is not an inclusive list.

Tax Considerations

This is a taxable benefit and is includible in income. Notwithstanding any provision of the Plan to the contrary,

neither the Company nor the Plan Administrator makes any commitment or guaranty that any amounts paid to or for the benefit of a Primary Qualified Payee or Secondary Qualified Payee, as applicable, under the Plan shall be excludable from the Qualified Designated Payee's gross income for federal, state or local income tax purposes, or that any other particular federal, state, or local tax treatment shall apply or become available to any Payee as a result of the operation of the Plan.

Payees should speak to their tax professionals regarding potential tax implications. The Company does not provide tax or financial advice and you and your beneficiaries are encouraged to seek professional counseling in this regard.

This benefit will not be extended to any individual who might have been dependent on the employee for income but who does not qualify as an IRS Tax Dependent under Section 152 of the Internal Revenue Code, as amended.

For More Information about Income Taxes

The following are some sources for more information about federal income taxes and how they affect your participation.

- For tax related questions, contact the IRS at the following taxpayer Assistance Lines: 800-829-1040 or 800-829-4059 TDD.

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

CLAIMS AND APPEALS

Claims and Appeals – What to Do First

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

Process to Submit an Appeal

Determinations regarding to whom a Survivor Benefit is paid where there are multiple Secondary Qualified Payees, will be made based on the Employee's family situation at the time of his/her death, in the sole discretion of the Plan Administrator or its delegate(s) and within 30 days of a timely claim being made. Claims must be made no later than 30 days following the death of the Eligible Employee. Claims made later than 30 days after the death of the Employee will not be honored. Your Dependent must send a written request for a benefit to:

Employee Benefits Committee
Attn: Survivor Benefit Plan Claims
214 E. 24th Street
Vancouver, WA 98663

Filing a Second Appeal

There are two levels of appeal. If you are denied a Benefit or are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Claims Administrator within 60 days from receipt of the first level appeal. The Claims Administrator must notify you of the benefit determination within 30 days after receiving the completed appeal.

Note: Upon written request and free of charge, you may request to examine documents relevant to your claim

and/or appeals and submit opinions and comments. There are deadlines to file claims and benefit related actions; please refer to "**Process to Submit an Appeal,**" page 4, in this SPD and for more information about the timing of these deadlines

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 after the last day of the third month following the later of (1) the deadline for filing an appeal under the Plan or (2) the date on which a final adverse benefit determination on appeal was issued with respect to such Plan benefit claim or you lose any rights to bring such an action against the Plan, or the Claims Administrator.

Plan Administrator

Employee Benefits Committee:
214 East 24th Street
Vancouver, Washington 98663

Agent for Legal Service

Associate General Counsel/ERISA:
Lumen
100 CenturyLink Drive
Monroe, LA 71203

Legal process may also be served on:
The Corporation Company (a.k.a. CT Corp)
1675 Broadway, Suite 1200
Denver, Colorado 80202

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.

GENERAL ADMINISTRATIVE PROVISIONS

This section summarizes the legal information about the Plan.

Plan Document

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

Records and Information and Your Obligation to Furnish Information

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

Interpretation of Plan

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

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

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

Right to Amend and Right to Adopt Rules of Administration

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

Clerical Error

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

Conformity with Statutes

Any provision of the Plan which, on its effective date, conflicts with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA, if applicable, (of the jurisdiction in which the Plan is delivered), is hereby amended to conform to the minimum requirements of such statutes and regulations.

Refund of Benefit Overpayment

If the Plan pays Benefits and all or some of the payment we made exceeded the amount of the Benefits under the Plan, we will request a refund.

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 Payee(s) agrees to help the Plan get the refund when requested.

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

GLOSSARY

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning regarding the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Claims Administrator - the organization that provides certain claim administration and other services for the Plan.

COBRA - see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Company - Lumen

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health insurance coverage to certain Employees and their dependents whose group health insurance has been terminated.

Employee - a full-time Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under Eligibility in the Introduction section. An Employee must live and/or work in the United States. The determination of whether an individual who performs services for the Company is an Employee of the Company or an independent contractor and the determination of whether an Employee of the Company was classified as a member of any classification of Employees shall be made in accordance with the classifications used by the Company, in its sole discretion, and not the treatment of the individual for any purposes under the Code, common law, or any other law.

Employee Retirement Income Security Act of 1974 (ERISA) - the federal law that regulates retirement and employee welfare benefit plans maintained by employers.

ERISA - see Employee Retirement Income Security Act of 1974 (ERISA).

Plan - The Welfare Benefits Plan.

Plan Administrator - Employee Benefits Committee and its designees.

Plan Sponsor – Lumen

Qualified Primary Payee - Qualified Primary Payees are limited to the deceased Employee's Surviving Spouse or Surviving Domestic Partner, each having their status qualified as such by the Plan Administrator prior to the Employee's death. If, and only if, there is no Qualified Primary Payee, payment will be made to eligible Qualified Secondary Payee(s).

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