Short-Term Disability (STD) Benefit

Summary Plan Description (SPD) for Non-Union employees and Qwest Union Represented Retail/Outside Sales

Effective as of Jan. 1, 2025

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).

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Introduction

Lumen Technologies ("Lumen" or the "Company") maintains the Lumen Disability Plan, as restated and effective Jan. 1, 2023 (the "Plan"), except where stated, to provide benefits to eligible employees if they become disabled (as defined by the Plan) and satisfy the requirements described in the Plan. The Plan is a component benefit plan of the Lumen Welfare Benefits Plan and is intended to be an employee welfare benefit plan subject to ERISA.

This "Summary Plan Description" or "SPD" along with the General Information 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 explain all the details of the Plan or how the rules will apply to every person in every situation. This SPD is not 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 document. If any of the terms of the Plan document are in conflict with the contents of the SPD, the Plan document will always govern. The Plan document and this SPD supersede any and all prior documents you may have been provided regarding your STD Benefits under the Plan. The specific rules governing the Plan are contained in the Plan document. You, your beneficiaries and your lawyer (or other legal representative) 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 receive a copy upon sending a written request for the Plan document to the Plan Administrator.

This SPD uses capitalized words and phrases that have specific defined meanings under the Plan. The definitions of these terms can be found in the Glossary located at the end of this SPD. In the event there are any discrepancies or conflicts between these definitions and the Plan document, the terms of the Plan document shall govern. Words in the masculine gender include the feminine gender, and vice versa. Wherever any words are used in the singular form, they shall be construed as if they were also used in the plural form in all cases where the plural form would so apply, and vice versa. Where the definitions include rules regarding the definition, those rules shall apply.

No Company Employee or Third-Party Administrator can be responsible for advising you on the tax effects of your participation in the Plan. Because tax laws are constantly changing, you should consult a tax advisor if you have questions about how participation in any Company plans will affect your personal tax situation.

Who is covered by this Plan and SPD?

The Plan provides Short-Term Disability (STD) and Long-Term Disability (LTD) Benefits for Non-Union employees and Qwest Union Represented Retail/Outside Sales Representatives. Effective Jan. 1, 2022, regular part-time Non-Union Employees were also eligible for participation in STD and LTD Benefits under the Plan. This SPD describes the STD Benefits available under the Plan for Non-Union employees and Qwest Union Represented Retail/Outside Sales Representatives in accordance with the Collective Bargaining Agreement with the union on and after Jan. 1, 2024 except for those employees working in a State where temporary disability laws apply. In the latter case, applicable State temporary disability laws govern. You should consult the SPD for Long-Term Disability Benefits for more information regarding the Plan's LTD Benefits.

Important — Please read regarding 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 STD Benefits and to help keep your personal health information private. For example, contacting someone at the Company other than the Third-Party Administrator, Plan Administrator (or their duly authorized delegates), or those authorized under a collective bargaining agreement in order to try to get an STD Benefit claim issue resolved is not following the Plan's procedures. If you do not follow the Plan's procedures for claiming an STD Benefit or resolving an issue involving Plan Benefits, there is no guarantee that the STD 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.

Questions?

If you have any questions about the Plan, you should contact the Plan Administrator or the Third-Party Administrator, Sedgwick Claims Management Service, Inc. (known as "Sedgwick"). The name, address and telephone number of the Plan Administrator and Sedgwick, and other important information about the Plan and its administration, are shown in the **"Plan administration"** section of this SPD.

Sedgwick, Lumen's Disability Claims Administrator, may share limited information regarding your leave of absence with other Lumen Health and Disability vendors. A member from one of these vendors may reach out to you to discuss additional benefits and services available to you. This will provide you with more personalized and enhanced services.

Special Provisions for employees in states with Temporary Disability Insurance Policies.

If you are employed by the Company in a state with a temporary disability insurance policy (e.g. CA, HI, MA, NJ, NY, RI, WA, WA D.C.), there are special disability benefits rules mandated by laws that are applicable to you. Please check dol.gov/agencies/whd/state/contacts to access your state labor office to determine if your state has a temporary disability insurance policy, as the list of state examples noted above is not exhaustive and changes over time. Refer to **"STD Benefits and State Disability leave laws"**, in this SPD, for a more detailed explanation of the special provisions.

Plan determinations are not health care advice

Please keep in mind that the sole purpose of the Disability Plan is to provide for some income replacement Benefits when you are disabled and not to guide or direct the course of treatment. Just because your health care provider recommends a course of treatment does not mean it will be a recommended treatment plan under the Plan. A determination by the Plan Administrator or Third-Party Administrator that a particular course of treatment is not eligible to continue your status for STD Benefits under the Plan does not mean that the recommended course of treatments, services or procedures should not be provided to you or that they should not be provided in the setting or facility proposed. **Only you and your healthcare provider can decide what the right health care decision is for you.** Decisions by the Plan Administrator or Third-Party Administrator are solely decisions with respect to Plan coverage and do not

constitute health care recommendations or advice.

This document summarizes certain provisions of the the Company's Disability Plan as restated and effective Jan. 1, 2023, except where stated. If there is any conflict between the terms of the Plan document and this document, the terms of the Plan document will govern. The Plan Administrator has the right to determine eligibility, has the authority and discretion to interpret the Plan and other documents, shall decide questions and disputes, has the right to supply omissions, to establish Plan rules and procedures, and resolve inconsistencies and ambiguities in the Plan or any document relating to the Plan. Benefits are determined by the Company and do not create a contract of employment. The Company has reserved the right to change, modify, discontinue or terminate the Plan and the Benefits under the Plan at any time without prior notice subject to applicable collective bargaining.

Plan administration

Name of Plan:	Lumen Disability Plan which is a component program under the Lumen Welfare Benefit Plan
Type of Benefits:	Short-Term Disability Benefits
Administration of the Plan:	The Plan is self-funded by the Company, which means Benefits are paid by the Company out of general assets except for those temporary disability insurance policies for employees working in states with temporary disability insurance policies, where premiums are paid by the Company and remitted to the applicable insurance company/ies. The Third-Party Administrator reviews claims and determines qualification for Benefits under the Plan. The Disability Plan is a Welfare Benefit Plan for purposes of ERISA.
Plan Number:	513
Plan Sponsor:	Lumen Technologies 214 East 24th Street Vancouver, WA 98663
Employer Identification Number:	72-0651161
Participating Companies:	The list of participating companies is subject to change at any time without advance notice. You may contact the Plan Administrator or the Human Resources Department to confirm whether it is up-to-date.
Plan Year:	Jan. 1 to Dec. 31

Plan Administrator:	Lumen Employee Benefits Committee 214 East 24th Street Vancouver, WA 98663 833-925-0487
Third-Party Administrator:	Sedgwick Claims Management Service, Inc. (Sedgwick) Post Office Box 14426 Lexington, KY 40512 844-223-7153
Agent for Service of Legal Process:	Associate General Counsel/ERISA Lumen Technologies, Inc 931 N. 14th Street Denver, CO 80202
Legal process may also be served on:	Lumen Employee Benefits Committee 214 East 24th Street Vancouver, WA 98663

Important to note: Legal remedy and deadline by which to bring a legal action.

You must complete the claims and appeals process with regard to any benefit claim which is denied and that process is explained within this SPD. This means that before you can seek any legal proceeding outside of the Plan, you must submit your claim and if denied, then submit an appeal to the Claim administrator as explained in this Summary Plan Description. If after the final appeal is exhausted and you receive a final adverse benefit determination on appeal, you may have the right to timely bring a civil suit under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, any suit or legal proceeding must be brought no later than the last day of the twelfth (12th) 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 (a denial) on appeal was issued with respect to such Plan Benefit claim. This means that you must first exhaust all Plan claims and appeal procedures. For more information, refer to **"Claims and appeals procedures"**, in this SPD.

Short-Term Disability Benefits (STD)

Short-Term Disability Benefits provide financial support in cases of Disability lasting longer than seven (7) consecutive full or partial days, but not more than 26 weeks (6 months), which excludes the seven (7)-day wait period, except for unrelated disabilities within the Return-to-Work Period, as defined in "Successive periods of Disability", in this SPD.

Provided you meet all of the requirements described in this section, you will be eligible for STD Benefits after a waiting period of one (1) year of continuous employment with the Company or any Affiliated Entities and the waiting period of seven (7) consecutive calendar days (full or partial days) of Disability. The Company adopted the tw telecom's Sick Bank Policy for those former Level 3 employees who were eligible on or before Dec. 31, 1999. The Company will allow eligible employees to use these hours in lieu of Short-Term Disability, but only if STD is approved.

Note: Time off work for Bereavement Leave can be used to satisfy the seven (7) consecutive calendar day (full or partial

days) waiting period for Disability.

The Benefit amount you receive shall be 70% of Base Pay subject to your tax election, pre or post-tax, as described in the **"Benefit amount"** section in this SPD.

Plan participation

You're eligible for participation under the Plan if you are:

- A Non-Union Employee or Qwest Union Represented Retail/Outside Sales Representative, as defined in **"Glossary"**, in this SPD, of a Participating Company (see "Non-Union Employee");
- A Non-Union Employee or Qwest Union Represented Retail/Outside Sales Representative who is regular full-time or part-time;
- Have completed the service requirement, which is:
  - One (1) year, and
  - Satisfy all other Plan eligibility requirements within the **"Eligibility to receive Benefits"** section.

If an Eligible Employee is rehired within 12 months from the date of termination due to a voluntary or involuntary Reduction in Force (RIF), upon rehire, the Eligible Employee is eligible for Benefits based on the date of hire prior to the RIF. This term is also meant to allow such rehired Eligible Employee to use Service prior to the RIF, towards the required one (1)-year of Service eligibility.

Ineligibility

You're not covered by the Disability Plan while you're on a non-paid Leave of Absence (LOA) or otherwise not receiving Base Pay. You are not eligible if you are a temporary or Project-Based Employee.

Service

For purposes of determining your eligibility for Disability Benefits, the Plan considers the length of employment you earned with the Company (or any of its Affiliated Entities from hire date pursuant to its Service Bridging and Greater Length of Service policies) as part of your Service. These policies may be updated from time to time and over time. Service in an ineligible category shall be considered in accordance with the Company's Service Bridging Policy and count towards your eligibility.

Disability definition

The Plan defines "Disability" to mean, for purposes of STD Benefits, when you provide Objective Medical Documentation supporting that, due to a medical condition and related limitation(s), you are unable to perform the normal job duties of your regular job or any other job to which you could be assigned (with or without modification of those duties) or is medically quarantined, supported by documentation from a State or Governmental entity. The Objective Medical Documentation must support both the medical condition and any actual limitation(s) caused by the medical condition as determined by the Plan.

Eligibility to receive Benefits

If you are unable to work due to a Disability that lasts longer than seven (7) consecutive calendar days (full or partial days), the STD or Supplemental Workers' Compensation Payment (SWCP) Benefit period starts on the eighth (8th) consecutive calendar day of your Disability, subject to first having completed one (1) year of continuous service with the Company or any Affiliated Entities. The SWCP benefit has the same criteria as is used for STD benefits, including, but not limited to: Eligibility Period, maximum benefit period, return to work period, waiting period, etc.

Reporting a Disability

To receive STD or SWCP Benefits, you must file a claim by reporting any Disability that keeps you from coming to work for more than seven (7) consecutive calendar days.

Follow this process in order to report a Disability:

- Contact your supervisor on the first (1st) day of absence to report your Disability; follow your reporting-in requirements established for your work unit.
- Contact the Third-Party Administrator, Sedgwick, who administers the Disability Plan, at 844-223-7153 or online at lumen.com/disability, on or before the fourth (4th) calendar day of your absence - or on the first (1st) day of a Relapse as described in the **"Successive periods of Disability"** section. Your supervisor or a representative can report your Disability if you're unable to do so. If your absence is due to an On-Job Injury or Illness, immediately contact both Sedgwick and UNICALL. Contact UNICALL at 1-866-UNI-CALL (864-2255).

Note: Failure to report your absence to the Third-Party Administrator may result in the denial of STD Benefits for the period of time such Benefits would otherwise be payable until the date the absence is reported, unless such failure is shown to have been unavoidable.

Documenting a Disability

"Objective Medical Documentation" is written documentation of observable, measurable and reproducible findings from examination and supporting laboratory or diagnostic tests, assessment or diagnostic formulations, such as, but not limited to, x-ray reports, elevated blood pressure readings, lab test results, functionality assessments, psychological testing, etc. Objective Medical Documentation supports both the medical condition and any actual limitations(s) caused by the medical condition. Other examples of objective findings that may or may not support the presence of a disabling condition include temperature (or fever), lab test results, functionality assessments, psychological testing, etc. You may also provide "subjective" information as it relates to the Objective Medical Documentation. Subjective information is documentation of non-observable or non-measurable symptoms. Subjective symptoms relate to how a person feels. Examples are: "My throat hurts," or "I'm tired all the time," or "I am in pain."

Benefit payment requirements

Sedgwick, as Third-Party Administrator, has been delegated the authority and discretion to determine eligibility for STD Benefits. If you receive STD Benefits and are subsequently determined not eligible for STD Benefits for a period of time you were paid such benefits, you must reimburse the Plan for any overpayment. Refer to **"Benefit adjustments, recovery of overpayments"**, in this SPD.

To receive STD Benefits, if you are eligible, you must:

- Report the Disability, as explained in the **"Reporting a Disability"** section in this SPD, and stay in contact with Sedgwick.
- Place yourself under an Approved Provider's care and follow the recommended treatment of your provider as defined by Sedgwick (refer to **"Approved Providers"**, in this SPD, for the definition of an Approved Provider). Normally, you should seek treatment by an Approved Provider if your condition causes an absence lasting four (4) or more consecutive days.

- Furnish Objective Medical Documentation of your Disability to Sedgwick as soon as possible but no later than 21 days from your first (1st) day of absence, and cooperate with requests for additional information, such as, but not limited to, timely completion of requested forms (including repayment agreements) and providing appropriate updates as requested.
- **The following documents are required from all employees in order for STD Benefits to be approved:**
  - Attending Physician's Statement.
  - Copy of State Disability Benefits application and award notices, as applicable.
- Report for medical or psychological examinations at the request of Sedgwick.
- Obtain permission to travel from Sedgwick prior to traveling if you need to recuperate away from your home or leave your community for any reason at any time during your Disability (for example, traveling to visit family).
- Obtain written permission from Sedgwick prior to attending or continuing in school during your Disability.
- Obtain written permission from Sedgwick prior to engaging in work outside the Company during your Disability period, including, but not limited to volunteer work, military service, pre-existing work - such as real estate, teaching piano lessons, etc., in accordance with the Lumen Conflicts of Interest Policy.
- Apply for Social Security Disability Insurance Benefits (SSDIB) when eligible or at Sedgwick's request, and meet the additional requirements outlined in**"Social Security Disability Insurance Benefit (SSDIB) requirements"**, in this SPD. Exhaust all permissible appeals under SSDIB.
- Apply for any and all Temporary Disability Benefits for which you may be eligible under applicable State Law and advise the Third-Party Administrator so that Benefits under the Plan may be coordinated (offset). The combined Benefit may not be greater than your Benefit under the applicable Benefit Payment Schedule as set forth in the Plan; and
- Report any other source of disability income and reimburse the Company for any overpayment of STD/SWCP Benefits that occurs for any reason, including, but not limited to, a Social Security Disability Insurance Benefit (SSDIB) award, State Disability insurance, Workers' Compensation, etc., as defined in **"The Plan's right to recovery, repayment and right of full restitution"**, in this SPD, received for a period during which you also received STD Benefits from the Company.

If you fail to comply with any of these above requirements, your STD Benefits may be denied, reduced, or discontinued. If your claim is denied, in whole or in part, you're entitled to request a review of that denial through the claims review process. The review/appeals procedure is outlined in **"Dispute resolution"**, in this SPD. All disputes under the Plan are resolved through the claims review procedure and not through grievance procedures outlined in collective bargaining agreements.

Accurate and complete information required timely: The Company requires complete and accurate information with regard to all Disability Benefits. Intentional misrepresentation of any kind will be cause for denial of Disability Benefits. **Note:** Falsifying any employee benefit information or claim is a violation of Lumen's Code of Conduct and may result in discipline up to and including discharge. Your participation in the Plan is your acceptance of the Plan terms and conditions, including repayment of any benefit you were paid and subsequently denied for such benefit.

Under care by Approved Provider required

Benefits won't be payable during any period of Disability in which you're not under the care of an Approved Provider. Your provider must provide the Objective Medical Documentation supporting both the medical condition and any actual limitation(s) caused by your medical condition and timely submit this information to Sedgwick.

Approved Providers

This term is defined to mean the following legally licensed persons who provide services within the scope of their license, and the full range of proper treatment for the Disability-causing condition that falls within the scope of the provider's license and practice:

- Physician - a doctor of medicine or osteopathy licensed to prescribe and administer all drugs and perform surgery
- Physician's Assistant
- Nurse midwife/ practitioner
- Dentist
- Podiatrist
- Optometrist
- Chiropractor
- Psychologist
- Psychiatrist
- Social Worker

Note: The Plan excludes Approved Providers who are related to you or your spouse.

It's important to follow your Approved Provider's recommended treatment plan. However, Sedgwick will review the treatment plan and length of Disability (including total Disability or partial Disability that may qualify for Rehabilitation Benefits) for payment of STD Benefits under the Plan based on Objective Medical Documentation, for your medical condition, illness or injury. A determination by the Plan Administrator that you are not eligible for continued STD Benefits under the Plan during a specific course of treatment does not mean that the recommended course of treatment should not be followed.

Only you and your healthcare provider can decide what the right health care decision is for you. Decisions by the Plan Administrator or Claims Administrator are solely decisions with respect to Plan coverage and do not constitute health care recommendations or advice, refer to**"Plan determinations are not health care advice"**, in this SPD. In order to be eligible to receive STD Benefits under the Plan, your medical condition, injury or illness must also continue to satisfy the definition of Disability, as defined by the Plan.

When Benefits may be suspended or terminated

Your STD Benefits may be suspended or terminated, including, but not limited to, if:

- You or your provider fail to cooperate with requests by Sedgwick for Objective Medical Documentation;
- You fail to undergo an independent medical evaluation (IME) or other review of your disability status;
- You do not comply with the Plan provisions in any part;
- Your employment ends;
- You die;
- Your disability ends;
- You are on an unpaid leave of absence;
- You are incarcerated;
- You do not obtain pre-approval for travel, school or other work as required by the Plan; or
- Your work duties are restricted on account of loss of a required license other than for those cases that are supported by Objective Medical Documentation.

Benefit amount

The STD Benefit payments you may be eligible to receive depend on the following factors as they apply after you've met the applicable waiting period (seven (7) consecutive full or partial calendar days) of Disability:

- For Non-Union Employees, 70% of Base Pay subject to coordination with other sources of disability income (refer to **"Payments offset by other benefits"** in this SPD) unless the Temporary Disability State Law indicates otherwise.
  - For Non-Union Employees, if you choose for your STD Premium to be Pre-tax, you may be eligible to supplement your STD Benefit payment with any accrued PTO or FTO, if applicable. You must notify Sedgwick at the time your claim is open if you wish to supplement your STD Benefit.
- For Qwest Union Represented Retail/Outside Sales Representatives, in accordance with the collective bargaining agreement with the union, STD Benefits shall be 70% of Base Pay subject to coordination with other sources of disability income (refer to **"Payments offset by other benefits"** in this SPD) or as provided for under the applicable Temporary Disability State Law.

If applicable, the Company provides you the option to choose the way you want your STD benefit payment with two tax options:

- **Pre-tax* –** Elect to receive your disability benefit payment on a pre-tax basis; then, the benefit payment is taxable income. You will not see a line item on your paycheck identifying this election; or
- **Post-tax –** Elect to receive your disability benefit payment on a post-tax basis; then, the benefit payment is NOT taxable income. Imputed income** is added to your taxable pay so that you will not have to pay taxes on benefits you receive from the Plan. Note: The Post-tax option is the default option for all employees.

*For the pre-tax option only, you may elect to supplement your STD Benefit payment with accrued PTO/FTO.

**Imputed income is the term the IRS applies to the value of any benefit or service that should be considered income for the purposes of calculating your

federal, state and local taxes. On your paycheck, the amount for the STD Benefit in the "Imputed Income" section is the taxable amount that reflects the value of the STD Benefit.

If you are enrolled in the STD Post-Tax option, follow the steps below to calculate your imputed income per pay period:

- Take your weekly base pay (annual amount divided by 52) and multiple by $0.204.
- Then divide by 10.
- Then multiply by 12.
- Then divide by 26 (# of pay periods).

Base Pay	$60,000
Divide by 52	$1,154
Multiply by $0.204	$235.42
Divide by 10 (monthly amount of imputed income)	$23.54
Multiply by 12 (annual amount of imputed income)	$282.46
Divide by 26 (amount of imputed income per pay period)	$10.86

Note: The Imputed Income amount is located underneath the Earnings section on your paycheck.

On-job Injury or Illness

Under the Plan, On-Job Injury or Illness means an injury or illness that arises out of and in the course or scope of employment with the Company and has been accepted by a Claims Manager as a compensable Workers' Compensation claim under the Workers' Compensation program of the respective state. Also refer to **"Workers' Compensation and your Supplemental Workers' Compensation Payment (SWCP) Benefits"** in this SPD.

Maximum Benefit period

Short-Term Disability Benefits can last up to 26 weeks (6 months) under the Plan and as defined below under the **"Successive periods of Disability"**; this maximum benefit period may vary under Temporary Disability State Law, if applicable. The maximum benefit period for Supplemental Workers' Compensation Payment (SWCP) Benefits, which is a benefit payment to supplement approved Workers Compensation claims, may be up to 26 weeks (6 months). The STD and SWCP maximum benefit periods are concurrent, not consecutive. If you are eligible for SWCP Benefits, you are not eligible for STD.

The Plan applies the same wait period and maximum benefit period requirement for cases that may also be covered under a Workers' Compensation claim. These requirements may differ from the Workers' Compensation law requirements in your state. In no circumstance will the total of your STD and/or SWCP Benefit payments exceed 70% of your base pay as outlined in the **"Workers' Compensation and your Supplemental Workers' Compensation Payment (SWCP) Benefits"** section.

Base Pay rate

Base Pay rate will be used to calculate STD Benefits for Participants not receiving non-taxable Workers' Compensation pay.

Except as specified below, your Base Pay rate means your regular wages or salary rate. Overtime, bonuses, commissions, sales incentives, "at-risk" pay and differentials are not included as part of your Base Pay Rate.

Pay increases/decreases during Disability

Your Disability Benefits will be increased or decreased if your Base Pay rate is changed while you are receiving STD Benefits. Bonuses under the Short-Term Incentive (STI) Plan can be prorated for time away from work. Please refer to the STI Plan Document to determine any impact to you.

Continuing Course of Treatment

If you would otherwise be eligible for full calendar days of STD Benefits, you may substitute your full-time absence with intermittent or reduced work schedules if all of the following criteria are met:

- You are in a Continuing Course of Treatment;
- The intermittent or reduced work schedule can be accommodated by the business unit for which you work; and
- The need for the intermittent or reduced work schedule can be medically supported by Sedgwick.

While receiving STD Benefits under this provision, you will continue to be subject to all other Plan provisions, including but not limited to eligibility, waiting periods, relapse provisions and payment schedules. The maximum STD Benefit period for this provision is up to 26 weeks (6 months) unless stated otherwise under Temporary Disability State Law, subject to all Plan provisions regarding return to work. This maximum benefit period is calculated based upon the days that would otherwise have been eligible for full calendar days of STD Benefits. This provision is separate from any Benefits or limitations under the **"Rehabilitation Benefits (RB)"** section.

If you are scheduled for work hours under a Continuing Course of Treatment, but are unable to work those hours, contact Sedgwick immediately.

Rehabilitation Benefits (RB)

Rehabilitation Benefits are Benefit payments to help make up for pay lost during a partial Disability period. **RB shall not be paid for periods beyond your maximum benefit period.** A part time work schedule may be necessary depending on your individual condition to "rehabilitate" you towards your pre-disability schedule or a full time return to work with or without reasonable accommodations. Sedgwick may approve Rehabilitation Benefits for a limited time if you're unable to work your regularly scheduled hours and your medical condition is such that a gradual re-entry into the work force or a temporary reduction in your work hours will assist in your recovery. To receive Rehabilitation Benefits, you must actually work the hours as outlined by Sedgwick on that day. Failure to work the hours required may result in the denial of Rehabilitation Benefits. If you want to take PTO/FTO on a day you are receiving RB, you need to obtain approval from your supervisor and the day will be coded RB and PTO/FTO (e.g. if you are scheduled to work four (4) hours RB, the day will be coded four (4) hours RB, four (4) hours PTO/vacation, if you work an eight (8) hour schedule). If you request a week or more of PTO/FTO during your RB, you need to obtain approval from your supervisor and this time will be coded PTO/FTO. After your PTO/ FTO, your RB may or may not continue based on Sedgwick's determination of your claim.

Rehabilitation Benefits are considered part of your STD Benefit and are paid according to the Benefit Payment Schedule listed in the **"Benefit amount"** section. Payments will continue according to the appropriate schedule when you return to work on a part-time basis.

Rehabilitation Benefits are determined on a case-by-case basis to assist you in achieving restoration of normal form or function following your illness or injury and must be approved by Sedgwick. If you are covered by a collective bargaining agreement, the continuation of RB is subject to the provisions of the collective bargaining agreement covering medically-restricted employees.

The following guidelines apply:

- Generally, you shouldn't need to work on a part-time basis for more than three (3) weeks. If longer periods are needed and appropriate, Sedgwick will review your situation periodically (at least every 30 days). RB Benefits will not be paid if the duration of the part-time schedule is expected to last longer than the maximum benefit period.
- Part-time days will generally not be used for intermittent absences, such as doctor's appointments, therapy, medical treatments, etc.
- Rehabilitation Benefits are generally not used following a normal recovery period (for example, after a four (4) week recovery period for abdominal surgery that calls for a total recovery period of six (6) weeks, RB could be approved for two (2) weeks, taking the recovery period to a total of six (6) weeks).
- Rehabilitation Benefits may not be used in place of a leave of absence in a case of anticipated Disability (for example, preoperative appointments, or non-disabling discomforts of pregnancy).

How Rehabilitation Benefit days are counted

When you're receiving Rehabilitation Benefits, you're considered to be "on Benefits," and Rehabilitation Benefits are applied against the maximum period allowed for STD Benefits. In addition, you don't accumulate days toward your Return-to-Work Period while you are receiving Rehabilitation Benefits (refer to **"Return-to-Work period/Benefit reset period"**, in this SPD).

The following chart shows how Rehabilitation Benefit days are counted as part of your maximum STD Benefit period:

If you're regularly scheduled to work eight (8) hours per day...		
And you actually work...	**Your Rehabilitation Benefits (hours not worked) are...**	**The days counted against your maximum STD Benefit period are...**
2 hours	6 hours	**1 day**
4 hours	4 hours	**½ day**
6 hours	2 hours	**½ day**

Circumstances that affect your STD Benefit

You can receive STD Benefits for as long as Sedgwick determines you're "Disabled," up to the maximum period allowed by the Plan. Refer to **"Successive periods of Disability"**, and **"Rehabilitation Benefits (RB)"**, **"When Benefits may be suspended or terminated"**, **"Circumstances that affect your STD Benefit"**, in this SPD.

Your STD Benefits end on the earliest of the following situations to occur:

- You recover from your Disability sufficiently to perform your job or modified job duties (with or without accommodations);
- You exhaust the maximum STD benefit period applicable to your condition; **Please Note:** At the time your STD Benefits are exhausted, the Company will consider requests for an additional, unpaid medical leave of absence beyond the length of your Short Term Disability benefits if:
  - Such a leave request is for an additional, reasonable period to allow you to recover sufficiently to return to work to

do the essential functions of your job and,

- Additional leave is required under federal, state or local disability laws. Please tell your Supervisor if you want to be considered for such additional, unpaid leave. While out on Disability or Leave and not having benefit premium deductions taken through Lumen payroll, or if at any time you miss having benefit premiums deducted via Lumen payroll for two or more pay periods, you are responsible to pay your portion of premiums to continue your Lumen Health and Life benefits (including Health Care Flexible Spending Account). You will be set up on Direct Bill and notified monthly of the amount you owe. If premiums are not paid by the 1st of each month, your benefit coverages **will be terminated retroactive to your last paid through date**. Any healthcare claims incurred by you and/or your eligible dependents after the termination date will be your responsibility. If you return to work and receive pay via Lumen payroll, you are eligible for active benefits but may have a "gap" in coverage if billed premiums are not paid while you are out on Disability or Leave. Please contact the Lumen Health and Life Service Center at Businessolver for more information, 833-925-0487, Mon-Fri, 7 a.m. to 7 p.m. (CST).

- If you are unable to return to work after you exhaust the Maximum STD benefit period, you will be terminated from the payroll, unless you are transferred or reassigned to another position and/or an unpaid leave is authorized as an accommodation.
  - You will be eligible to apply for Long-Term Disability (LTD) benefits under the Plan, with benefits to be effective based on the eligibility criteria of Lumen's LTD Third Party Administrator.
  - If you are terminated from payroll, you may contact Lumen's LTD Third Party Administrator for up to 12 consecutive months after the expiration of STD benefits to apply for LTD benefits and submit an application packet.
  - For additional information about LTD, please refer to the LTD Summary Plan Description (SPD).
- Documentation doesn't support total Disability (however, in some cases, Rehabilitation Benefits may continue for a brief period of time);
- Documentation doesn't support the medical need for Rehabilitation Benefits;
- There is work for you that you are able to perform, even if you can't perform your normal job duties;
- You fail to meet any of the Benefit payment requirements listed in the **"Benefit payment requirements"** and **"Eligibility to receive Benefits"** sections in this SPD;
- Your other sources of Disability income exceed your maximum STD Benefit amount – no further STD Benefit payment is made, however, you are considered on STD, or you are receiving Workers' Compensation; or
- Your Provider's treatment is not based on current industry standards for your medical condition, illness or injury.

For additional information about exclusions under the Plan, please refer to **"Other Benefit exclusions"**, in this SPD. These exclusions are not exhaustive and are subject to change.

Workers' Compensation and your Supplemental Workers' Compensation Payment (SWCP) Benefits

If you're receiving non-taxable Workers' Compensation pay, you are eligible for an SWCP Benefit, but not an STD Benefit. Your SWCP Benefits will be the difference between your Workers' Compensation benefits plus any other benefits you receive (such as Social Security disability benefits) and 70% of your Base Pay. Your SWCP Benefit begins after your wait period, 7 consecutive calendar days. In no event shall you be entitled to receive an SWCP Benefit that when combined with Workers' Compensation is greater than your Base Pay. This SWCP benefit has the same Eligibility Period, maximum benefit period, and return to work period as STD Benefits, which is 26 weeks (6 months) for Non-Union Participants.

Payments offset by other benefits

Your STD and SWCP Benefits are reduced dollar-for-dollar for any "offsetting benefits" you may receive. "Offsetting benefits" are disability benefits you receive from other sources.

The most common "offsetting benefits" include, but are not limited to:

- Workers' Compensation or similar payments (for On-Job Injury or Illness);
- Social Security Disability Insurance Benefit (SSDIB) payments (see **"Social Security Disability Insurance Benefit (SSDIB) requirements"** in this SPD);
- State temporary disability insurance or state paid family leave benefits; and
- Similar payments provided by any present or future law.

Effect of SSDIB on Disability Benefits

Only your initial monthly SSDIB, and not any benefits paid to your family, is considered when calculating how much to reduce your Disability Benefits. Your Disability Benefits won't be further reduced for any future SSDIB cost-of-living increases.

Effective Jan. 1, 2024, if any present or future law - such as state disability and/or paid family medical leave laws should provide for payment of disability or paid family leave benefits, your STD Benefit will be reduced, or offset, at the maximum weekly amount you are eligible for under the applicable state law, regardless of whether or not you apply for the state disability and/or paid family leave benefit, provided, however, that the amount of the weekly state disability/ paid family leave offset will not exceed the amount of your weekly STD Benefit. The offset will be reduced or eliminated, and reimbursements made to you, as necessary, if, prior to the end of the STD maximum benefit period for your STD leave, you:

1. Sign an attestation form indicating you are in a state where you can voluntarily apply for state disability and/or paid family leave benefits and that you will not be filing for those state benefits, or
2. Submit documentation verifying that you applied for state benefits but you were not awarded any benefits, or
3. Submit documentation verifying that you were approved for an amount that is less than the maximum weekly offset amount.

It is possible that a state disability insurance policy may pay you STD first, and in that case, this Plan will have the right to recover any duplicative STD Benefits paid to you. Your STD Benefit will not be reduced by benefits paid for military service (such as Veterans' Benefits) or privately purchased disability insurance you choose to obtain.

Note: It is possible that your offsetting benefits could exceed the Benefit amounts payable under the Plan. In that event, no STD Benefits would be paid to you under this Plan.

Benefit adjustments, recovery of overpayments

If you receive an overpayment of STD or SWCP Benefits or you receive a retroactive disability payment from another source after your STD or SWCP Benefit has been paid to you:

- You must notify Sedgwick immediately;
- You'll be notified of the overpayment amount that you received from the Plan; and
- You'll be notified of the time period in which the overpayment amount must be paid back to Lumen.

The Company reserves the right to deduct overpayments from future Plan Benefit payments and/or to recover the overpaid amount through payroll deduction.

Your participation is your agreement to these terms: By your participation in the Plan, you agree to the deduction from your wages of an overpayment of benefits and specifically agree to cooperate in the signing of any documents as necessary, including documents necessary to meet any legal requirements for wage deduction.

Note the Plan's right to deduct repayment of Benefit Overpayments: In the event you receive an overpayment of Benefits from the Company's Disability Plan, by your participation in the Plan and subject to your collective bargaining agreement, **you authorize the Company and the Plan to obtain recovery of such overpayment from you by regular deductions from your paycheck**, in addition to any other legal or other authorized deductions already in place, until such Benefit overpayment is repaid in full. **You may be asked to memorialize this in writing as well.** If you are terminated for any reason whatsoever before you have repaid the Company/Plan in full, then you authorize the Company to deduct the entire remaining balance due from any salary, wages, commissions, bonuses, expense reimbursements or other sums due to you. You acknowledge that the prior overpayment constitutes an advance payment of wages to you and, thus, the Company may, to the full extent permitted by applicable laws, offset and withhold all amounts otherwise due to you. The Company's rights to withhold the repayment of Benefits overpayment amount from wages and other monies due to you does not limit its right to collect the debt through other legally permissible means. If you terminate from the Company, and your overpayment has not been repaid in full, the Company will seek reimbursement.

Retroactive Awards on SSDIB

In some cases, the Social Security Administration may take a while to determine whether you're eligible for SSDIB payments. At the time Social Security makes a favorable determination and Plan Benefits have been paid for the same period, you will be required to reimburse the Plan for all or a portion of your Company-paid Benefit (refer to **"Benefit adjustments, recovery of overpayments"** in this SPD, for information on repaying this overpayment).

Social Security Disability Insurance Benefit (SSDIB) requirements

If your Disability lasts longer than five (5) months, you must apply for Social Security Disability Insurance.

To ensure that you receive your maximum Disability Benefits, you are required to:

- Apply for Social Security Disability Insurance Benefits (SSDIB) by the end of your sixth (6th) month of Disability or as directed by Sedgwick;
- Sign the following forms that you will receive from Sedgwick and Allsup, who can assist you in filing for SSDIB, and return them within 30 days of receipt:
  - SSDIB Reimbursement Agreement form indicating you agree to reimburse the Company for any overpayment of STD Benefits due to a SSDIB award (return to Sedgwick);
  - Authorization to Secure Award or Disallowance Information form, which authorizes the Social Security Administration to give the Plan and its delegates information related to your SSDIB claim (return to Allsup);
- Notify the Plan of all SSDIB determinations and provide a copy of the SSDIB Award or Disallowance immediately, but no later than 30 days of receipt;
- Appeal (within Social Security guidelines) any unfavorable determination made by the Social Security Administration, as there are significant financial advantages;
- Reimburse the Plan for any overpayment of STD Benefits within the timeframe communicated to you by the Plan Administrator.

If you fail to meet the SSDIB requirements, as stated above, STD Benefits will be reduced by at least 50%. If the Plan is collecting an overpayment of an STD Benefit, your prospective Benefit, if any, may be reduced by more than 50%. Benefits may be reinstated retroactively once you fulfill your SSDIB requirements.

SSDIB claim assistance

Sedgwick will assist you in the SSDIB claim process through one (1) of the following options:

- The Plan contracts with and pays a vendor to provide SSDIB assistance for you and notifies them of your disability that has lasted for at least five (5) months; OR
- If you elect to hire an attorney not under contract with the Company the fee allowance used to offset any overpayment balance shall be equivalent to the maximum amount the Company would have paid a contracted vendor but no more than $9,200 (or the maximum the Social Security Administration is allowed to withhold by law). Reasonable attorney's fees will be used to reduce any outstanding overpayment balance only.

Note: At no time will the Company provide direct reimbursement of attorney fees or issue an amount that exceeds the overpayment of STD Benefits resulting from the receipt of SSDIB Benefits.

Returning to work

One of the goals of the Plan is to ensure that you're able to get the care you need so that you can return to work as soon as you're able. To support your efforts to return to work, Sedgwick will work with you, your Approved Provider and/or your department to obtain suitable restrictions or accommodations if you're unable to perform your current job duties or any other job to which you could be assigned with or without accommodation of those duties. These accommodations may include Rehabilitation Benefits.

Sedgwick, may, in its capacity as Third-Party Administrator, impose return to work requirements on a case-bycase basis. **If you are in a safety-sensitive position, you may be required to submit a medical release from your doctor prior to your return to work.**

Return-to-Work period/Benefit reset period

You'll be considered to have "returned to work" when you're working full-time or when the hours you're working are the same as your regular pre-Disability schedule.

Your Return-to-Work Period will determine how STD Benefits are paid if you're absent again due to a Disability. The Return-to-Work Period is 91 work days long and begins with the first full day you're back to work at your Regular Hours. Only Regular Hours, scheduled days off* (such as Saturday and Sunday), and Company designated holidays* count toward your Return-to-Work Period. You must satisfy your Return-to-Work Period in order to be eligible for a new 26-week (6 months) period of benefits.

In some cases, days counted toward your Return-to-Work Period are counted in half-day increments. This can occur when you work only a portion of your regularly scheduled work day and have a portion of the day as vacation, personal time or other absence. The portion of the day you work is included in your Return-to-Work Period - the remaining portion is excluded as described in the next section.

*Scheduled days off and Company-scheduled holidays are not counted toward the Return-to- Work Period if they're preceded by a day that's excluded from the Return-to-Work Period. Scheduled days off and Company-designated holidays are counted in half-day increments if they're preceded by a day that's counted as a half day toward the Return-to-Work Period.

If you do not return to work at the end of your approved or denied STD period, any subsequent time off does not count

toward your Return-to-Work Period.

Rehabilitation Benefits don't count toward the Return-to-Work Period

If you're receiving Rehabilitation Benefits, you're still "on Benefits," and your Return-to-Work Period won't begin until you're able to return to work at your pre-Disability scheduled hours. Therefore, any day on which you work a portion of a day - and receive Rehabilitation Benefits for the other portion - won't count toward your Return-to-Work Period. However, as explained in **"How Rehabilitation Benefit days are counted"**" section Rehabilitation Benefits are counted towards your maximum Benefit period.

Disability Absences and Your Return-to-Work Period

Your Return-to-Work Period will restart after each STD period. For example, if you had 10 weeks credited toward your Return-to-Work Period, and then missed 12 days of work because of a Disability, you would need to satisfy a new 91-day Return-to-Work Period before you would be eligible for a new maximum benefit period of Benefits.

Return-to-Work Period exclusions

The following is a list of examples of days (or partial days) that aren't counted toward the 91-day Return-to-Work Period. This list doesn't cover all exclusions, so if you have a question about whether a particular type of absence will count toward your Return-to-Work Period, contact Sedgwick.

The following do not count toward your Return-to-Work Period:

- PTO /FTO or personal days (or portion thereof).
- Scheduled days off or holidays that are preceded by any day or partial day that is excluded from the Return-to-Work Period.
- Absences for illness or injury.
- Excused time off (paid or unpaid).
- Unexcused time off (paid or unpaid).
- A relapse or unrelated Benefit absence.
- Absences related to denied STD Benefits.
- Any period you're not receiving pay (such as a Leave of Absence or suspension).

The following table shows some examples of how days are counted toward - or excluded from - the Return-to-Work Period:

If you're regularly scheduled to work eight (8) hours per day...		
And you actually work...	**If the hours excluded for one or more of the reasons listed above are...**	**The days counted toward your Return-to-Work Period are...**
0 hours	8 hours	**0 days**
2 hours	6 hours	**½ day**
4 hours	4 hours	**½ day**
6 hours	2 hours	**1 day**

Successive periods of Disability

If you have a Relapse

A "Relapse" means a successive period of Disability which occurs within the Return-to-Work Period that is related to a previous Disability. If you have a Relapse during your 91-day Return-to-Work Period, the Relapse would be considered to be a continuation of your original Disability case. Your available Benefits for the Relapse would be the difference between the original maximum benefit period for which you were eligible and the Benefits already used.

For example, if you were eligible for a maximum benefit period of 26 weeks (6 months) and you were out for two (2) months of STD Benefits, and then returned to work, and, if you then went back out on Benefits before returning to work for 91 days, you would have four (4) months of Benefits still available for use for the Relapse. Additionally, if the STD Benefits had been denied at the end of the STD case, any Relapse would also remain denied until supported by the Plan. This is true even if some prior portion of the STD case was approved.

Anticipated Extended Course of Treatment

The Relapse Wait Period above shall not apply to those who, during their initial commencement of an STD claim under the Plan:

- Have a treatment plan for their Disability including an anticipated short-term recovery and return to work;
- Have a subsequent Disabling medical condition(s) requiring an Extended Course of Treatment over time, provided that the Extended Course of Treatment is supported by Objective Medical Documentation.

For example, only one Wait Period would apply in the treatment of Breast Cancer which occurs over an extended period of time during which the Participant has periods of short-term recovery, returning to work, and subsequent Disabling treatment plans.

If you have a new, unrelated Disability within the Return-to-Work period

An "unrelated" absence or Disability is one that occurs during your Return-to-Work Period and is of a different nature or cause than your previous Disability. Upon receipt of your claim, Sedgwick will determine whether the Disability is related to a previous Disability based on the objective medical documentation submitted.

Generally, an unrelated Disability that extends beyond seven (7) consecutive calendar days (full or partial days) will be subject to a waiting period of seven (7) consecutive calendar days of Disability and will be eligible for up to your maximum benefit period of STD, subject to Temporary Disability State Law. STD Benefits for all STD cases involving an original Disability Case and one or more unrelated absences that are determined to be new Disability Cases shall be limited to a maximum of 39 weeks (9 months) in any consecutive 365 day (12-month) period, regardless of the number, but not to exceed the STD Maximum Benefit for any one claim. This is illustrated by the following example:

Example: You never had a prior STD claim before you were out on an STD claim for four (4) months (back problem) and returned to work for two (2) months. You experience a second unrelated claim, (broken hand). The maximum total time off you can have for this unrelated second claim is five (5) months. You cannot exceed a maximum of nine (9) months in any consecutive 12-month period or the Maximum Benefit Period of 26 weeks (6 months) for any one STD claim.

Employees won't be eligible for additional "unrelated Disability" STD Benefits unless they have returned to work on a normal basis and started their Return-to-Work Period. If an employee has not yet begun the Return-to-Work Period and has another illness or injury unrelated to the original Disability, the entire absence is considered one (1) Disability case,

regardless of whether or not the additional illness or injury may be considered unrelated.

STD Benefit payments for unrelated Disabilities begin on the eighth (8th) consecutive calendar day (full or partial days) of Disability.

Relapse Benefits

STD Benefits for a Relapse, will be paid as follows:

- When the Disability occurs between one (1) and 14 calendar days after the end of the preceding Disability, STD Benefits begin immediately (on the first day of the relapse).
- When the Disability occurs after the 14th calendar day after the end of the preceding Disability - and before the end of the 91-day Return-to-Work Period – STD Benefits will begin following another waiting period of seven (7) consecutive calendar days (full or partial days) with the exception of relapses as identified under the Anticipated Extended Course of Treatment section.

Once the Return-to-Work period is satisfied

Any Disability that occurs after the end of the 91-day Return-to-Work Period is considered a new Disability whether it's related to a previous Disability case or not.

Circumstances that may affect your Plan Benefits

Under certain circumstances all or a portion of your STD Benefits under the Plan may be denied, reduced, suspended, terminated or otherwise affected, such as by a repayment obligation. Many of these circumstances are addressed elsewhere in the SPD. Such circumstances, in general, include, but are not limited to:

- You are not or no longer an Eligible Employee;
- The Plan is amended or terminated;
- You elect to take a Leave of Absence, if any available, under the Company's Leave of Absence policies;
- You accept a voluntary termination and severance benefits in lieu of Disability Benefits;
- You are not receiving Base Pay to be replaced by STD Benefits, at the time of your application for STD Benefits, meaning, for example, you are on an unpaid leave of absence (refer to **"Other Benefit exclusions"** in this SPD);
- Your Disability is caused or contributed to by your attempt or commission of a felony which is prosecuted;
- Your Disability is caused or contributed by an intentionally self-inflicted injury (however, if the Participant's Disability is a result of a mental health condition, the Participant may be eligible for STD Benefits related to the Disability caused by the injury);
- Your Disability is caused or contributed to war or any act of war (declared or undeclared) where you are eligible to receive military benefits;

- Your Disability occurs while you are on active military service;
- Your Disability is caused or contributed to active participation in a riot, insurrection, rebellion or other civil commotion;
- Your Provider's treatment plan is not based on current industry standards for your medical condition, illness or injury;
- You misrepresent or falsify any information required under the Plan;
- You are found to have violated the Lumen Code of Conduct; or
- You have been overpaid a Benefit and the Plan seeks to recover the overpayment from you;
- You obtain a recovery with regard to your Disability and the Plan has a right of repayment or restitution of your STD Benefits based on such court determination, award or settlement (Refer to **"The Plan's right to recovery, repayment and right of full restitution"** in this SPD).

Other Benefit exclusions

If you are not receiving Base Pay to be replaced by STD Benefits, at the time of your application for Benefits, you are not eligible for STD Benefits under the Plan. For example, STD Benefits are not payable, including, but not limited to:

- During any period in which you may be suspended without pay;
- You are receiving benefits under Surplus Transitional Leave of Absence;
- You are on active military service;
- You are on an unpaid Leave of Absence, except for an unpaid Leave of Absence under the Family Medical Leave Act of 1993, that is not related to the Disability.
- You are incarcerated; or
- Your work duties are restricted on account of loss of a required license other than for those cases that are supported by Objective Medical Documentation as defined by the Plan.

STD Benefits and the Family and Medical Leave Act of 1993

The Family and Medical Leave Act of 1993 (FMLA) guarantees that a position will be held in the Company for you during a qualifying absence of up to 12 weeks of unpaid leave in a rolling 12-month period. An FMLA leave can be granted if you become seriously ill, if you need to care for a newborn, adopted or foster child, or if you need to care for a seriously ill child, spouse, or parent.

Conditions related to your own serious health condition, certified by your physician, may be paid by STD Benefits or Workers' Compensation, where applicable. In the event you receive paid leave pursuant to these programs, such paid leave will be substituted for and count against any unpaid medical leave entitlement under the FMLA.

Additionally, the National Defense and Authorization Act (NDAA) allows eligible employee FMLA leave for leave to care for a covered Service-member ("Service-member Family Leave") or Leave Due to Active Duty of a Family Member ("Qualifying Exigency Leave") if they are eligible for Family and Medical Leave (FMLA) (see the eligibility criteria

for FMLA under the Company Policy summarized above or found on the Company intranet) and have met the other eligibility criteria for leave as described below. FMLA is an employment policy, specifically a leave of absence policy. It is not an employee benefit plan.

To be eligible for an FMLA leave, you must have at least 12 months of service (need not be consecutive) and have worked a minimum of 1,250 hours in the 12 months prior to the first day of the leave. If you're eligible under FMLA, any time you're absent from work and receiving STD Benefits will be applied toward the 12 weeks of FMLA or Qualifying Exigency leave (or the 26 weeks of Service-member Family Leave). If you have a period of personal illness for which you have been denied STD Benefits, Sedgwick will review your absence for coverage under the FMLA. State leaves where applicable run concurrent with FMLA. Contact Sedgwick for questions about state leaves of absence.

Service member Family Leave

Eligible employees are entitled to take up to a total of twenty-six (26) workweeks of leave, inclusive of any/all other FMLA time, during a single one-time 12-month period to care for a covered Service member who has incurred an injury or illness in the line of duty while on active duty in the Armed Forces.

Leave due to active Military Duty of a family member ("Qualifying Exigency Leave")

Eligible employees are entitled to take up to 12 workweeks of leave, inclusive of any and all other FMLA time, due to active duty of a family member because of any "qualifying exigency" arising out of the fact that the employee's spouse, child, or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

STD Benefits and State Disability leave laws

Under the terms of the Plan but subject to state law requirements, you must apply for any and all Temporary Disability Benefits for which you may be eligible under applicable State Law. You must also advise the Third-Party Administrator of the income you are receiving from these benefits in the form of an award letter. STD Plan Benefits will be reduced by state disability benefits you receive or are eligible to receive whether such benefits are applied for or not. The combined state and STD Benefit may not be greater than your STD Benefit under the applicable Benefit Payment Schedule as set forth in the Plan.

Other important information

The information listed below may affect your STD Benefits and the ways you use your STD Benefits.

Cost of the program and funding

The entire cost of providing and administering STD and SWCP Benefits under the Disability Plan is currently paid for by the Company.

Discretionary authority

The Plan Administrator of the Disability Plan, and its delegates, have the sole authority and discretion regarding the Plan and its administration as set forth in the Plan, including but not limited to, the right and discretion to determine all matters of fact or interpretation relating to the administration of the Plan including questions of eligibility, interpretation of Plan provisions, and all other matters. Additionally, the Plan Administrator has the sole authority and discretion to interpret the Plan and other documents, to decide questions and disputes, to supply omissions, and to resolve inconsistencies and ambiguities arising under the Plan and other documents, which interpretations and decisions shall be final and binding for purposes of the Plan. The Plan Administrator shall obtain from Participants and others, such information as shall be necessary for the proper administration of the Plan, such as proof of other coverage, receipt of benefit payment(s) or reimbursement, etc., and to require such information as a condition of receipt of Benefits under the terms of the Plan.

The Plan states that the Employee Benefit Committee, as Plan Administrator, may delegate its duties, including but not limited to, its sole authority and discretion to determine all matters of fact or interpretation, questions of eligibility, status and rights under the Plan, to review and grant or deny claims (as defined by the Plan), to review appeals for purposes of making all Disability determinations and determining all other claims and appeals under the Plan. The decisions of the Plan Administrator and any other person or group to whom such discretion is delegated shall be conclusive and binding on all persons, subject only to the right to submit an appeal as described in this summary plan description.

The Plan's right to recovery, repayment and right of full restitution

A third-party, such as an insurance company, may be responsible for paying your STD, Temporary Disability Benefits or SWCP Benefits. For example, if you were in a car accident that was not your fault, the car insurance company of the person at fault may be responsible for paying your claim, which may include the income replacement you receive under the STD or SWCP Benefit. The Plan generally will not pay STD or SWCP Benefits that can be paid by a third party.

However, collecting reimbursement for the STD or SWCP Benefits from the responsible third-party or insurer may take a long time. In such cases or in other circumstances, the Plan may pay an STD or SWCP Benefit to you. If the Plan pays Benefits to you, the Plan has the right of recovery, a right to seek repayment (often called "subrogation") from the responsible party or insurer or from you, if you receive payments from the responsible third-party or insurer.

STD Benefits conditional upon cooperation

The Plan's payment of STD or SWCP Benefits is conditional upon:

- The cooperation of you or your respective agent(s) (including your attorneys) working on your behalf to recover damages from another party. You may be asked to complete, sign, and return a questionnaire and possibly a restitution agreement. But regardless of whether you sign such agreement, the Plan must be repaid the amount of your STD or SWCP Benefit.

If you or your agent(s) are asked to sign an agreement, and you refuse to sign and return a restitution agreement, or to cooperate with the Plan or its assignee, such refusal and non-cooperation may be grounds to deny payment of any STD or SWCP Benefits. By participating in the Plan, you acknowledge and agree to the terms of the Plan's equitable lien or

other rights to full restitution. You will take no action to prejudice the Plan's rights to an equitable lien for full restitution. By participating in the Plan, you 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 and all documents or agreements necessary for the Plan to obtain full restitution and to enforce its equitable lien against proceeds received from a third party, if any.

You are obligated to cooperate with the Plan and the Third-Party Administrator in order to protect the Plan's right of recovery and you agree to do nothing to impair the Plan's rights. Such cooperation includes, but is not limited to:

- Providing any relevant information;
- Signing and delivering such documents as the Plan or Third-Party Administrator reasonably requests to secure the Plan's right of recovery claim; and
- Obtaining the Plan's consent before releasing any party from liability for any payments.

You are also required to do all of the following:

- Inform the Plan Administrator in advance of any settlement proposals advanced or agreed to by another party or another party's insurer.
- Provide the Plan Administrator all information requested by the Plan Administrator regarding any action against another party, including an insurance carrier; this includes responding to letters from the Plan Administrator on a timely basis.
- Not settle, without the prior written consent of the Plan Administrator, or its designee, any claim that you may have against another party, including an insurance carrier.
- Take all other action as may be necessary to protect the interests of the Plan.

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

Note: Your refusal or failure to help with the right of recovery process will not limit the Plan's rights, and it can be grounds for denial of your STD Benefit claims. You must reimburse the Plan to the extent of payments made by the Plan, from the proceeds of any settlement, judgment or payments made by any individual, organization or other entity to you.

The Plan has an equitable lien against both STD or SWCP Benefits and overpayments and the right to obtain full restitution of the Benefits paid by the Plan from:

- Any full or partial payment which an insurance carrier makes (or is obligated or liable to make) to you;
- You, if any full or partial payments are made to you by any party, including an insurance carrier, in connection with, but not limited to, your or another party's:
  - Uninsured motorist coverage
  - Under-insured motorist coverage
  - Other medical coverage
  - No fault coverage
  - Workers' Compensation coverage
  - Personal injury coverage paid by medical
  - Homeowner's coverage
- Any other insurance coverage except for private disability insurance and amounts received under SSDIB.

This means that, with respect to STD or SWCP Benefits which the Plan pays in connection with a sickness, injury or

accident, the Plan has the right to full restitution from any judgment, payment, settlement or recovery received by you from any other party or source, regardless of whether the judgment, payment, recovery or settlement terms state that there is a separate allocation of an amount for the restitution or reimbursement of STD or SWCP Benefits under the Plan.

Payment recovery to be held in trust for the Plan

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

Any amounts that you recover in connection with an injury, disease, sickness or condition with respect to which the Plan makes payments shall be apportioned as follows:

1. The Plan shall receive the first dollars for any recovery to the extent of the Plan's payments.
2. The remaining balance of any recovery shall be apportioned to you and any other Plan or insurer providing benefits to you.

Note: If you receive any monies as the result of injury, sickness, accident or condition, and the Plan is entitled to such monies and is not reimbursed the full amount it has paid for such injury, sickness, accident or condition, the Plan shall have the right to reduce future Disability Benefit payments (LTD, SWCP and STD, as applicable) due to you by the amount of Benefits overpaid by the Plan. This right of offset shall not, however, limit the rights of the Plan to recover such monies in any other manner.

Plan's right to offset future Future Benefits. Failure to make an appropriate refund or to cooperate in the recovery or restitution of any amount subject to the provisions of this Section shall result in a reduction or offset of future Benefits, to the extent of such refund or amount. If a Participant's counsel or representative initiates a direct action against the Plan to recover attorney's fees and costs incurred in pursuing recovery against any third party as a result of such illness or injury, the Plan reserves the right to offset any amounts, costs or expenses incurred by the Plan as a result of such direct action against future Plan benefits that may become payable on a Participant's behalf. In addition, the Plan shall exercise such other rights and remedies as it has available with regard to such refunds, and Participating Companies shall have the right, subject to applicable law and collective bargaining arrangements, to withhold amounts subject to recovery from any Employee's paycheck if the Employee is responsible for repayment as a Participant.

The Plan Administrator or any representative of the Plan may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Plan's right of equitable restitution or right of full reimbursement.

What happens to settlements, refunds, rebates, reversions to the Plan

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

A participant may not assign Benefits or rights

A Participant may not voluntarily or involuntarily assign any right he may have or has to:

1. Receive any benefit under this Plan,
2. Receive any reimbursement for amounts paid for services rendered by Providers or any third party, or
3. Request any payment for services rendered by Providers or any third party.

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

Right to amend, eliminate Benefits or terminate the Plan

Although at this time the Company intends to continue the Plan, the Company reserves the right to amend the Plan, eliminate Benefits or terminate the Plan at any time, and each participating company reserves the right to terminate its participation or amend the terms of the Plan for its employees, subject to applicable limitations of law and any applicable collective bargaining agreement.

The Company's decision to amend the Plan may be due to changes in the law governing welfare plans, in the provisions of a contract or policy with an insurance company, or in the cost of maintaining current levels of coverage, or for any other reason. Changing eligibility, coverage levels or employee contribution requirements are examples of how the Company might amend the Plan.

If the Plan is amended, Benefits eliminated, or terminated, or if there is a transfer of Plan assets and liabilities, or a Plan split-up, you won't have any other rights other than a right to benefit payments to which you have previously become eligible before such termination or change. If the Plan terminates, any remaining assets of the Plan, if any, may be used either to purchase or to provide disability or other permissible employee benefits as the Company shall determine in its discretion, subject to the terms of any applicable trusts.

Benefits are not Vested. If the Disability Plan is terminated or changed, you won't be vested in any Plan Benefits or have any other rights other than a right to Benefit payments to which you may have previously become eligible before such termination or change. If the Disability Plan terminates, remaining assets of the Plan, if any, may be used either to purchase or to provide Disability or other permissible employee Benefits as the Company shall determine in its sole discretion.

Alienation

Except as specifically permitted by the Plan (such as offsets or restitution to the Plan), or as otherwise required by applicable law, STD Benefits aren't subject to sale, assignment, anticipation, alienation, garnishment, levy, execution, or any other form of transfer.

Your other Benefits while on Disability

You may be eligible for other benefits while you are receiving your Disability Benefits. For more information, see the applicable pension, health care and life insurance Summary Plan Descriptions. If you participate in the Lumen 401(k) Plan and you have an outstanding loan at the time you go on Disability Benefits, there are very specific rules that govern what happens to your 401(k) Plan loan repayment obligations. Please contact the Plan Administrator for the 401(k) Plan by calling 800-547-7754 and choosing the appropriate option, as soon as possible.

Dispute resolution

All disputes regarding the Plan are resolved through the Plan's claims and appeals review procedure.

Claims and appeals procedures

Filing a claim

A claimant, who is a Plan Participant, or any person duly authorized by the claimant, may file a claim for Benefits under the Plan or for review of any other appropriate matter related to the Plan by following the procedures outlined here.

To file a claim please contact Sedgwick by calling 844-223-7153 or online at lumen.com/disability. You must report your initial claim to Sedgwick by the 4th calendar day of your absence or if your absence is due to a Relapse, you must contact Sedgwick on the first day of absence. Failure to report your claim timely may result in forfeiture of your Benefits. If your absence is due to an On-Job Injury or Illness, you must contact both Sedgwick and UNI-CALL. You may reach UNI-CALL at 1-866-UNI-CALL (864-2255).

Upon reporting your claim, you will be assigned a case manager. Your case manager will attempt to work with your Approved Provider to obtain the necessary medical information to process your claim. However, it is ultimately your responsibility to ensure that your Approved Provider furnishes your case manager with the information necessary to process your claim.

On your initial claim, you have 21 days from the first day of absence, to submit Objective Medical Documentation that supports both your Disability and any limitation(s) i.e., Medical Restriction. Depending on the duration of your Return-To-Work, if you are reporting a Relapse, or you did not make a timely claim, you may only have one (1) week to provide Objective Medical Documentation to support your Disability or limitation(s).

For those claims that continue beyond the STD Benefit approval date, you may only have one (1) week to provide Objective Medical Documentation to support your continuing Disability and any related limitation(s).

If sufficient medical information supporting Disability is not received by the deadline(s), your STD Benefits may be denied. If new medical is received after the deadline(s), this information will not be reviewed unless you submit a request for an appeal.

Your case manager will also work with you, your Provider, and your supervisor to identify opportunities to return you back to work. If your case manager identifies a reasonable opportunity to return you to work, no further STD Benefits will be paid to you.

Your case manager will also monitor your treatment plan to assure that it complies with normal medical protocols. If your treatment does not comply with medical protocols or support your claim under the Plan, your STD Benefits may be denied. In order to continue receiving Benefits under this Plan you must comply with your case manager's request.

Important: It is your responsibility to assure that your claim is reported. Reporting a Disability claim to Sedgwick does not relieve you of your responsibility to report your absence to your supervisor in accordance with Company policy. If your absence is due to an On-Job Injury or Illness, you must contact both Sedgwick and UNI-CALL.

After your approved STD Benefits end under the Plan, and any approved FMLA or state leaves expire, you are expected to return to work. (Refer to **"STD Benefits and the Family and Medical Leave Act of 1993"** in this SPD.) If you choose not to return to the workplace, you must obtain authorization for continued absence from your supervisor, otherwise your absence will be considered unexcused and possibly job abandonment, eligible for termination from employment.

What if your claim is denied?

If sufficient Objective Medical Documentation is not received within the prescribed timeframes as set forth, your claim will be denied. If your claim is denied, Sedgwick shall provide you written notification setting forth:

1. The specific reason(s) for the denied claim;
2. Specific reference(s) to pertinent Plan provisions on which the denied claim is based;
3. A description of any additional material or information necessary for you to perfect the claim;
4. If an internal rule, guideline, protocol or other similar criterion was relied upon, a statement that such rule etc. was relied upon and either a copy of such rule or a statement that such a rule was relied upon and a copy will be provided free of charge;
5. An explanation of how the underlying scientific or clinical judgment applies to your situation; and
6. An explanation of the procedure to appeal a denied claim, the time limits applicable to such procedure and your right, at no charge, to have reasonable access to and to obtain copies of all relevant documents upon request therefore, and a statement that you may have the right to timely bring a civil action under Section 502(c) of ERISA following receipt of a final denied claim.

In accordance with the terms of the Plan, Sedgwick, as Third-Party Administrator, has full authority and discretion to deny or grant any claim in whole or in part.

How to request an appeal

In the event of a denied claim, you may request an appeal for review of the denial of your claim by contacting Sedgwick (in writing) but you must do it within 180 days of notification of your claim denial.

Note: State Disability Insurance Claims and Appeals Procedures. For those claims filed under a State Temporary Disability insurance policy, all claims and appeals timeframes are governed by the State law.

Appeals or complaints should be directed to the appropriate state.

You have the right, at no charge, to reasonable access to and to obtain copies of all relevant documents upon request. You also have the right to submit in writing, in support of your appeal, issues and comments, including, without limitation, appropriate evidence or testimony of an expert.

Decision on an appeal

1. The Sedgwick Appeals Specialist shall make a decision within a reasonable period of time, but within 45 days following the completion of your request for appeal unless, however, special circumstances require an extension of time for processing. In that event, Sedgwick may extend the time in which it will review the appeal provided that any such extension shall not exceed 45 days and further provided that you are notified in writing prior to the expiration of the initial 45 days of the special circumstances necessitating the extension(s) and of the date by which a determination is anticipated. If notice of the decision on the appeal is not timely furnished, the appeal shall be deemed to have been denied and you may have the right to exercise your right to legal remedy.
2. Sedgwick shall perform a review of the claim denial (also known as an "adverse benefit determination") on appeal, taking into account all comments, documents, records and other information submitted by you relating to the claim regardless of whether the information was previously considered on initial review of the claim.
3. You will be provided with a copy of the Independent Physician Advisor report, completed by a 3rd-party vendor who

reviews your claim file during the appeal process, which will be taken into consideration in making the determination on your appeal.
Sedgwick will suspend their review for 21 days to allow you to respond, if you choose. This can be in the form of comment, additional medical records, documentation or other relevant information. Information may include but is not limited to job description, chart notes, diagnostic tests, and hospital summaries.
If you choose to submit additional information Sedgwick will have 14 days to review the information provided. If you have not contacted Sedgwick or provided additional information within 14 days, Sedgwick will continue to review your appeal based on the information contained in your file.

4. You shall be notified in writing of the decision on appeal. In the event of a denial on appeal, the notice of the appeal denial shall state:
   - The specific reason(s) for the denial;
   - The specific reference(s) to the pertinent Plan provisions on which the denial is based;
   - If an internal rule, guideline, protocol or other similar criterion was relied upon, a statement that such rule etc. was relied upon and either a copy of such rule or a statement that such a rule was relied upon and a copy will be provided free of charge;
   - An explanation of how the underlying scientific or clinical judgment applies to your situation;
   - An explanation of the procedure to appeal a denied claim, the time limits applicable to such procedure and your right, at no charge, to have reasonable access to and to obtain copies of all relevant documents upon request therefore, and a statement that you may have the right to timely bring a civil action under Section 502(c) of ERISA following receipt of a final denied claim.

Legal remedy and deadline by which to bring a legal action

You must complete the claims and appeals process before you can seek any legal proceeding outside of the Plan. If, after the final appeal is exhausted and you receive a final adverse Benefit determination on appeal, you may have the right to timely bring a civil suit under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, any suit or legal proceeding must be brought no later than the last day of the 12th 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 (a denial) on appeal was issued with respect to such Plan Benefit claim. This means that you must first exhaust all Plan claims and appeal procedures.

Statement of ERISA rights

As a Plan Participant in the Company's Disability Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to:

Receive information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Obtain, upon written request to the Third-Party Administrator, copies of your claim file and other relevant notices. The Third-Party Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report.

Prudent actions by Plan fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the 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, your union 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 an STD 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. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these cost and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20220. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at dol.gov/ebsa.

General Administrative Provisions

Plan document

This SPD presents an overview of your STD Benefits. In the event of any discrepancy between this summary and the official Plan document, the Plan document shall govern.

Your relationship with Approved Providers

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

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

Records and information

At times, the Plan or the Third-Party Administrator may need information from you. You agree to furnish the Plan and/or the Third-Party Administrator with all information and proofs that are 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 STD Benefits under the Plan, you authorize and direct any person or institution that has provided services to you, to furnish the Plan or the Third-Party Administrator with all information or copies of records relating to the services provided to you. The Plan or the Third-Party Administrator has the right to request this information at any reasonable time from you and/or your Provider. The Plan agrees that such information and records will be considered confidential. The Plan Administrator and the Third-Party Claims Administrator have the right to release any and all records 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.

In some cases, we and the Third-Party 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, the Plan Administrator, the Company and its related entities may use and transfer the information gathered under the Plan, including claim information for research, database creation, and other analytic purposes.

Right to amend, eliminate Benefits or terminate the Plan

The Plan Administrator may adopt, at any time, rules and procedures that it determines to be necessary or desirable with respect to the operation of the Plan. The Company, in its separate roles as the Plan Sponsor and Plan Administrator, retains 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 Plans at all, to require contributions or not, and/or to terminate the Plans, subject to all applicable laws.

Clerical error

If a clerical error or other mistake occurs, that error does not create a right to STD Benefits. Clerical errors include, but are not limited to, providing misinformation on eligibility or Benefits or entitlements. It is your responsibility to confirm the accuracy of statements made by the Plan or its designees, including the Third-Party Administrator, in accordance with the terms of the Plan document.

Administrative services

The Plan Administrator may, in its sole discretion, arrange for various persons or entities to provide administrative services with regard to the Plan, such as claims processing and utilization management services. The identity of such providers and the nature of the services they provide may change from time to time in the Plan Administrator's 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 STD Benefits, including, but not limited to medical restrictions, the Plan may require that a physician of the Plan's choice examine you at our expense.

List of Participating Companies

The list of Participating Companies is subject to change at any time without advance notice. You may contact the Plan Administrator or the Human Resources Department to confirm whether it is up-to-date.

- **Participating Companies:** Subject to the exceptions, if any, described below, Lumen and its U.S. domestic Subsidiaries and affiliates as of Jan. 1, 2024 (including subsidiaries and affiliates of Embarq Corporation and Qwest Communications International, Inc.).
- **Participating Companies, with limited participation:** Level 3 Communications, Inc. and its affiliated or subsidiary companies became Participating Companies under the Plan upon Close, Oct. 31, 2017.
- **Non-Participating Companies:** Non-U.S. Subsidiaries.

The Vice President, Human Resources, Benefits & Policy, is authorized to change and modify Appendices from time to time, for conformity with State insurance law (except as subject to collective bargaining).

Glossary

Terms that appear in initial capital letters throughout this SPD are defined below. This list is not exhaustive; the Plan document has other defined terms, and this list may be amended and revised from time to time. If you are uncertain about the meaning of a term, contact Sedgwick, the Third-Party 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.

"Anticipated Extended Course of Treatment" means treatment plan for an employee's Disability, which has an anticipated short-term recovery, and return to work, but subsequent Disabling medical condition(s) which are or may be anticipated to require an Extended Course of Treatment, provided that the Extended Course of Treatment is supported by Objective Medical Documentation.

"Approved Provider" means the following licensed persons who provide services within the scope of their license and the full range of proper treatment for the Disability-causing condition that falls within the scope of the provider's license and practice: (a) physician (a doctor of medicine or osteopathy licensed to prescribe and administer all drugs and perform surgery); (b) dentist; (c) podiatrist; (d) optometrist; (e) chiropractor; (f) psychologist; (g) ophthalmologist; (h) psychiatrist; (i) social worker; (j) nurse midwife/practitioner; (k) medical professional - diagnosing and treatment of individuals within the scope of the license; and (l) physician's assistants.

"Base Pay" With respect to Non-Union Employees, except as set forth in Section 1.5 of the Disability Plan document, Base Pay means an Employee's regular wage or salary rate. The term "Base Pay" shall not include overtime, bonuses, commissions, sales incentives, "at risk" pay, or differentials.

"Continuing Course of Treatment" means the payment of STD Benefits when an Employee is on a reduced work schedule for the purpose of receiving medical treatment. The Plan shall pay the difference in hours between the Employee's Regular Hours and the actual hours worked according to the approved intermittent or reduced work schedule.

"Disabled" or **"Disability"** means:

- **STD Benefits –** For purposes of STD Benefits, when a Participant provides Objective Medical Documentation supporting that due to a medical condition and related limitation(s) he is unable to perform the normal job duties of his regular job or any other job to which he could be assigned (with or without modification of those duties). The Objective Medical Documentation must support both the medical condition and any actual limitation(s) caused by the medical condition.
- **LTD Benefits –** Months one (1)-24. During the first 24 months a Participant receives LTD Benefits, Disability means the Participant is unable to perform his last Company-assigned job, which inability is supported by Objective Medical Documentation, and you suffer a loss of at least 20% in your Pre-Disability Earnings when working in our Own Occupation.
- **LTD Benefits –** Greater than 24 Months. After a Participant has received LTD Benefits for 24 months, Disability means the Participant is unable to engage in any occupation or employment, which inability is supported by Objective Medical Documentation, or may reasonably become qualified for by training, education or experience, and in which you can be expected to earn at least 80% of your Pre-Disability Earnings.

"Maximum Benefit Period" means the maximum benefits you are eligible to receive (182 days/6 months) and as defined in the "Successive Periods of Disability" section.

"Medical Restriction" means the Employee's specific functional limitations due to an illness or injury and may be of a temporary or permanent nature and which are supported by Objective Medical Documentation.

"Non-Union Employee" means an Employee whose position is not subject to automatic wage progression or whose pay is at a monthly or annual rate, including a non-salaried Employee promoted to salaried status for more than 12 consecutive months. In addition, notwithstanding the foregoing or any other provision of the Plan, the term "Non-Union 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 Plan benefits available to such Employee shall be made available under the Plan for Non-Union Employees rather the benefits available under the Plan for Occupational Employees, but only for such a period of time as specified in the agreement between the union and the Company (including but not limited to, Retail Sales Associate, Retail Sales and Services Associate, Retail Senior Sales Associates and Outside Sales Representatives). Further, the term "Non-Union Employee" will include an Employee who is hired pursuant to an "overseas assignment letter" and participation in the Plan by such Non-Union Employee will be pursuant to his or her "overseas assignment letter."

"Objective Medical Documentation" means written documentation of observable, measurable and reproducible findings from examination and supporting laboratory or diagnostic tests, assessment or diagnostic formulation, such as, but not limited to, x-ray reports, elevated blood pressure readings, lab test results, functionality assessments, psychological testing, etc.

"On-Job Injury or Illness" means an injury or illness that arises out of and in the course or scope of employment with the Company and has been accepted by a Claims Manager as a compensable Workers' Compensation claim under the Workers' Compensation program of the respective state.

"Plan" means the Disability Plan, as amended from time to time.

"Plan Administrator" means the Employee Benefits Committee.

"Plan Participant" means an Employee who has satisfied the applicable requirements set forth under the Plan.

"Regular Hours" means the hours that an Employee is present and working scheduled hours for the Company. "Regular

Hours" shall not include overtime hours, whether or not such overtime hours have been scheduled.

"Relapse" means a successive period of Disability which occurs within the Return-to-Work Period and is determined by the Third-Party Administrator to be related to the previous Disability Case.

"Return-to-Work/Benefit Reset Period" means the period that begins on the date an Employee returns to work on a full-time basis or current scheduled hours (if the Employee is classified as other than full-time), and which ends when the Employee has worked Regular Hours for 91 days, in accordance with the provisions set forth in the Plan.

"Supplemental Workers' Compensation Payment (SWCP) Benefits" means the payment of Benefits when you are also receiving non-taxable Workers' Compensation pay. The Plan shall pay the difference between your Workers' Compensation benefits, plus any other benefits you receive (such as Social Security disability benefits), and 70% of your Base Pay.

"Third-Party Administrator" means one or more of the individuals or entities appointed by the EBC by entering in to a contract to administer STD Benefits and/or LTD Benefits under the Plan and to whom the EBC or its designee may have delegated certain fiduciary duties under the Plan.