Lumen Welfare Benefits Plan General Information

Summary Plan Description (SPD) for active employees

Effective 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, Inc. ("Company" or "Lumen") has established the Lumen Welfare Benefits Plan ("Plan"). The Plan is maintained by the Company to provide certain health and welfare benefits ("Benefit Options") exclusively to Eligible Employees and their Eligible Dependents. **The specific Benefit Options offered through this Plan are identified in Appendix A to this Summary Plan Description. Each Benefit Option is maintained pursuant to a separate document referred to herein as a Benefit Option Document. You will also find a list of Claims Administrators for each Benefit Option in Appendix A.**

In addition, the EAP and Cor Medical Onsite Clinic benefits are described in Appendix G and H of this SPD.

The purpose of this document is to summarize important features of the Plan. This summary, together with Benefit Option Documents, are intended to serve collectively as the Summary Plan Description ("SPD") for the Plan, as required by the Employee Retirement Income Security Act of 1974 ("ERISA"). If there is a conflict between a provision in this SPD and a provision in the Benefit Option Documents, the Benefit Option Documents control except as expressly stated otherwise in this SPD.

The Plan is also maintained pursuant to a plan document. If there is a conflict between a provision in this SPD and a provision in the plan document, this SPD will control. Likewise, if there is a conflict between a provision in any of the Benefit Option Documents and a provision in the plan document, the Benefit Option Documents will control.

Some of the Benefit Options are also offered through a "Cafeteria Plan" established by the Company in accordance with Internal Revenue Code ("Code") Section 125. The Cafeteria Plan allows You to pay for Benefits offered through the Cafeteria Plan ("Cafeteria Plan Benefits") with pre-tax salary reductions. This document also represents the written plan required by Code Section 125.

Definitions

In order to better understand Your rights and obligations under this Plan, You will need to be familiar with the Plan's defined terms. Defined terms are capitalized throughout to highlight them for You. Most of the Plan's defined terms are provided below; however, the meaning of a capitalized term may be provided in the text of this SPD. All other terms that are not identified below or defined within this SPD will be defined as expressly set forth in the plan document. If a term is not defined in either this SPD or the plan document, then the term will be defined in accordance with its general use:

"Adopting Employers" means Affiliates of Lumen Technologies, Inc. identified in plan document that participate in the Plan.

"Affiliates" means any corporation that is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Company; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Company; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Company; and any other entity required to be aggregated with the Company pursuant to Treasury regulations under Code Section 414(o).

"Benefits" means the actual coverage provided by a Benefit Option in accordance with the Benefit Option Documents.

"Benefit Option Documents" means any of the following with respect to a Benefit Option:

- A separate "Summary Plan Description" or booklet furnished to You by the Company; and/or
- Insurance Documents.

The Benefit Option Documents are incorporated into and made a part of this SPD by reference. If there is a conflict between this SPD and a Benefit Option Document, the Benefit Option Document will control.

"Benefit Options" means the specific welfare benefits offered this Plan, as described in Appendix A to this SPD.

"Cafeteria Plan" means the plan established by the Company in accordance with Code Section 125.

"Cafeteria Plan Benefits" means those Benefit Options identified in Appendix B that are offered through the Cafeteria Plan.

"Child" means Your natural or adopted child, a child placed with You or Your current Spouse for adoption, Your Step-children, or Your foster children. A foster child is any child who has been placed with You by an authorized placement agency, or by judgement, decree, or court order.

"Claims Administrator" means the third party identified in Appendix A that administers claims for Benefits and appeals for Adverse Benefit Determinations (as applicable).

"Code" means the Internal Revenue Code of 1986, as amended from time to time.

"Company" means Lumen Technology, Inc. and its successors.

"Covered Dependent" means an Eligible Dependent who is properly enrolled with a Participant in a Benefit Option in accordance with the terms of the Plan except that a Covered Dependent may be enrolled without the Participants as expressly permitted by the Benefit Option Documents.

"Covered Persons" collectively means the Participant and the Covered Dependent.

"Domestic Partner" means a same-sex or opposite-sex individual to the extent You and Your Domestic Partner meet the following requirements:

- Each other's sole Domestic Partner and intend to remain so indefinitely;
- are not related by blood;
- are not legally married to any other person;
- are mentally competent to consent to the domestic partnership; and
- are financially interdependent and have resided together continuously for at least 12 months prior to applying for coverage and intend to continue to reside together indefinitely (this does not apply to the State of Washington or except as permitted by the Plan Administrator on an exception basis as required by applicable law).

"Eligible Dependent" means an individual who satisfies the eligibility requirements of the Plan for dependents of Participants.

"Eligible Employee" means an Employee who satisfies the eligibility requirements of the Plan. See the Eligibility section of this SPD for details regarding the eligibility requirements of the Plan.

"Employee" means an individual defined as an "Employee" in the plan document.

"Employer" collectively means the Company and Adopting Employers.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

"Full-time Employee" means a common law employee who is classified by the Employer as a "Full-time Employee" and is regularly scheduled to work 30 or more hours per week.

"Insurance Documents" means a certificate of coverage, booklet and/or insurance contract prepared by the Insurer of an Insured Benefit.

"Insured Benefit" means a Benefit identified in Appendix A that is provided solely pursuant to an insurance policy issued to the Company by the Insurer. In the case of an Insured Benefit, the Insurer bears all risk with respect to the Benefit.

"Insurer" means any insurance company or HMO licensed to do business in a state in accordance with applicable state law with which the Company has entered into an insurance policy or contract to provide Insured Benefits.

"Part-time Seasonal" means any Employee who is subject to a collective bargaining agreement who is designated by the Company as "Part-time Seasonal". A Part-time Seasonal employee is typically employed for at least 1,150 hours a year and only works during certain months of the year as determined by the Company.

"Participant" means an Eligible Employee that has properly enrolled in a Benefit Option in accordance with the terms of the Plan and has satisfied any applicable Waiting Period.

"Plan Administrator" is the entity identified in the Plan Information Appendix that is generally responsible for the administration and operation of the Plan.

"Plan Year" means the 12-month period on which the Plan generally operates. Nothing prohibits the Benefit Options from operating a different Plan Year. The Plan Year is identified in the Plan Information Appendix of this SPD.

"Regular Full-time Employee" means an Employee that is regularly scheduled to work 30 hours or more per week.

"Regular Part-time Employee" means an Employee that is regularly scheduled to work at least 20 hours per week but not more than 29 hours per week.

"Required Contributions" means the share of the cost of a Benefit Option required to be paid by the Participant. See the Required Contributions section of this SPD for more details.

"Self-funded Benefits" means Benefits for which the Company has agreed to provide the Benefits under the Plan. In the case of Self-funded Benefits, no Insurer has agreed to provide benefits in accordance with an insurance contract or policy issued to the Company.

"Spouse" means any individual to whom You are legally married. This term also includes a common-law Spouse provided Your relationship began in a state that recognizes such arrangements and You complete a Company-approved affidavit showing that Your Spouse meets state requirements for recognition.

"Step-Children" or **"Step-Child"** means a Child of Your current Spouse. It also includes the natural or legally adopted child of (or child for adoption with) Your Domestic Partner. Such term also includes Children who reside a majority of the

Calendar Year in the primary Participant's household and for whom the Domestic Partner is legally declared guardian. This does not include wards of the state, granting of custody, or foster Children.

"Temporary Employee" means an Employee that has been classified by the Employer as a Temporary Employee.

"Term Employee" means an employee subject to a collectively bargained agreement who is employed for a specific project, as determined by the Company. The Term Employee may be either a Full-time or Part-time Employee.

"You" or **"Your"** means the Eligible Employee or Participant, as applicable.

"Waiting Period" means the period that must pass before an Eligible Employee becomes a Participant.

Eligibility

Employee eligibility

You are eligible to participate in one or more of the Benefit Options as described below:

- Regular Full-time Employee
- Regular Part-time Employee
- Temporary Employee

The above Employees are eligible for the various Benefit Options as follows:

Eligible Employee	Benefit Options
Regular Full-time Employee (including a Term Full-time Employee)	Medical/Prescription Drug, Dental, Vision, Health FSA, Dependent Care FSA Employee Life Insurance, AD&D, Business Travel Accident
	STD and Basic LTD
	Supplemental LTD
Regular Part-time Employee (including a Term Part-time Employee)	Medical/Prescription Drug, Dental, Vision, Health FSA, Dependent Care FSA
	STD and Basic LTD
Part-time Seasonal	Medical, Dental, Vision, Health FSA, Dependent Care FSA
	STD and Basic LTD (only available to Part-time Seasonal Qwest Union Represented employees if hired before Jan. 1, 2018 and Parttime Non-Union Employees)
Temporary Employee	Medical/Prescription Drug

The following individuals are not eligible under any circumstance:

- An individual who is or is otherwise classified by the Employer as an independent contractor, even if later determined to by a court or administrative agency to be a common law employee.
- An individual who is a "leased employee" as defined in Internal Revenue Code Section 414(n) or who is otherwise classified by the Employer as a "leased employee".
- Any individual performing services for the Employer pursuant to an agreement with a temporary or staffing agency or that is otherwise classified by the Employer as "temporary".
- Individuals classified by the Employer as interns or co-ops.

- Individuals subject to a collective bargaining agreement between the Employer and one or more employee representatives unless the collective bargaining specifically requires the Employer to offer one or more of the Benefit Options to the individual.
- Any other individual that is expressly excluded from eligibility as set forth in the plan document or the Benefit Plan Documents.

Just because You are an Eligible Employee does not necessarily mean that You will receive Benefits from a Benefit Option. You must be a Participant to receive Benefits. You can only become a Participant if You are enrolled in accordance with this SPD and You have satisfied any applicable Waiting Period. See the Enrollment and Effective Date section of this SPD for more details regarding the Plan's enrollment requirements and the date You become a Participant. See the Leaves of Absence section for details regarding the impact paid and unpaid leaves have on Your status as an Eligible Employee or a Participant.

Rehired Retirees

Note: If You had CTT Life insurance (VEBA) Insurance, that coverage will not be impacted.

If You are a retiree of an Employer and You are rehired as an Eligible Employee, You will be offered the same benefits as other similarly situated Eligible Employees based on Your employee classification. You will no longer be eligible for retiree benefits until You once again retire and become an Eligible Retiree. If there is a loss of supplemental life coverage between what You previously maintained as a Retiree and the amount You may elect as an active employee, You may convert the difference with the Insurance Carrier. If You convert Your retiree supplemental life coverage after Your are rehired, You will be required to surrender these policies when You return to retiree status in order to resume Your retiree supplemental life insurance coverage, if applicable. In addition, Your retiree medical and retiree basic life insurance, if any, would also resume (assuming You make any necessary elections).

If You return to work for a supplier on assignment to the Company, You are not eligible to continue to Your retiree health benefits as they must be suspended for the duration of Your assignment with the supplier even though You are not eligible for active benefits under the Company Plans; however, You will be offered the opportunity.

Dependent eligibility

If You enroll Yourself, You may also enroll Your Eligible Dependents. The definition of Eligible Dependents may vary among the Benefit Options. Except as otherwise set forth in the Benefit Plan Documents, an individual qualifies as an Eligible Dependent if they meet the following requirements:

- Legal Spouse;
- Domestic Partner;
- Child who has not turned age 26;
- Unmarried Disabled Children age 26 or older - Children age 26 or older, who have never been married, were covered as a Child prior to attaining the limiting age (26) and are determined by the Claims Administrator to be indefinitely incapable of self-support and fully dependent upon You for support. Note: Once a disabled Child is removed from coverage after attaining the limiting age the Child will not be eligible for coverage under the Plan—reinstatement is not permitted.
- If Your Child is totally disabled and is older than the age 26 limit when You first become eligible for the Company's medical coverage, then You must enroll the Child for medical coverage when You are first eligible to enroll. If approved, Your Child's medical coverage will start on the date Your coverage was first effective. You must complete the application and submit it to the health insurance carrier within 45 days of becoming eligible for Benefits. If Your Child is under the normal age 26 limit when You first become eligible for medical coverage, then You must enroll the Child for coverage before the disabled Child reaches the age 26 limit.

- If Your Child becomes totally disabled after You first become eligible for Lumen's medical coverage, then You must enroll the Child for Lumen's medical coverage before the age 26 limit. If You drop the disabled child's Lumen medical coverage after the age 26 limit, then You may not later reenroll the disabled Child for coverage.

Dependent Verification process

The Company, Plan Administrator or Claims Administrator may request at any time documentation that the dependent You have enrolled is an Eligible Dependent. A dependent's enrollment in the Plan is conditional upon You providing any such requested documentation. Your dependent's coverage is suspended until You provide the required supporting documentation. If You provide appropriate documentation, Your dependent's coverage will be retroactively reinstated to the applicable effective date. If You do not timely provide appropriate documentation, Your enrollment request will be denied. If You are asked to provide documentation after coverage has begun, and You fail to provide the documentation as requested, coverage for Your dependents will end for failing to meet the plan's enrollment requirements. Your coverage and Your dependent's coverage may be retroactively cancelled if the Plan Administrator determines that You engaged in fraud or You materially and willfully misrepresented information related to Your dependent's eligibility.

Qualified Medical Child Support Order (QMSCO)

A QMCSO is a judgment, decree, or order that is made pursuant to a State domestic relations law (including a community property law) or certain other State laws relating to medical child support and provides for health benefit coverage for a child of a Participant under a group health plan and relates to benefits under the plan.

In accordance with ERISA section 609 and the Plan Administrator's policies and procedures, we will provide group health coverage pursuant to a medical child support order that we have received and determined to be a QMCSO. Our determination may be conditioned on receipt of additional information that we deem reasonably necessary to make the determination. You and the "alternate recipient" (the child, the child's legal guardian and/or the state agency, as applicable) will receive a notice that we have received the order along with any request for additional information that we need. Once we have made our determination as to whether the order is a QMCSO, the Plan Administrator will send a notice of its determination. Except as specifically provided for in the QMCSO, coverage will be prospectively provided as of the date we make our determination that the order is a QMCSO. You may obtain a copy of the Plan's procedures for handling QMCSOs upon request without charge from the Plan Administrator. Nothing in a QMCSO may require the Plan to provide coverage that it otherwise doesn't cover, and coverage is not obligated to be provided for a child beyond the limiting age set forth in the plan.

The Program does not recognize orders, judgments, decrees, settlements or agreements that require coverage for a former Spouse of a Covered Employee. NOTE: if a QMCSO expires while the alternate recipient is still an Eligible Dependent, the expiration of the QMCSO will not result in a termination of coverage.

Eligibility appeals

If the Company or the Plan Administrator determines that You are not an Eligible Employee or that a dependent is not an Eligible Dependent and You disagree with that determination, You may file an appeal with the Plan Administrator in accordance with Appendix D to this SPD.

Enrollment and effective date of coverage

Enrollment requirements generally

You will not become a Participant until You are properly enrolled in accordance with the Plan's enrollment requirements

(or You have been enrolled into a default benefit) and You have satisfied any applicable Waiting Period. Likewise, Your Eligible Dependents will not become Covered Dependents until they are enrolled in accordance with the Plan's enrollment requirements, and You have satisfied any applicable Waiting Period. The Plan's enrollment requirements vary for the following types of Benefit Options:

Employer Provided: You are automatically enrolled by the Company in Employer Provided Benefit Options when You become an Eligible Employee. An Employer Provided Benefit Option is one that is paid for entirely by the Employer. You do not have to enroll in these programs. You become a Participant in an Employer Provided Benefit Option on the date that You become an Eligible Employee or the day after You satisfy any applicable Waiting Period. The enrollment materials furnished to You by the Company will identify which Benefit Options are Employer Provided Benefit Options.

Voluntary: You generally need to make an election to enroll in a Voluntary Benefit Option by following the enrollment procedures described in the enrollment materials provided to You by the Company. A Voluntary Benefit Option is one for which You will have Required Contributions. If You do not elect to enroll in a Voluntary Benefit Option during one of the applicable enrollment periods, You will not become a Participant in that Benefit Option during that Plan Year unless You subsequently have another enrollment opportunity during the Plan Year.

Default: There are situations in which You are deemed to have elected to enroll in a Voluntary Benefit Option, even if You do not actually affirmatively elect to enroll in the Voluntary Benefit Option, if the Voluntary Benefit Option is a Default Benefit and You fail to affirmatively elect another similar Benefit Option or You fail to affirmatively elect to waive the Default Benefit. The enrollment materials will identify the Default Benefits and describe when You are deemed to have elected to enroll in a Default Benefit.

There are three different enrollment periods during which You have the opportunity to elect to enroll Yourself or Your Eligible Dependents in one or more of the Voluntary Benefit Options, and/or to change Your prior Benefit Option elections. Each of these enrollment periods are described below.

Enrollment Periods

Initial Enrollment Period

Beginning Feb. 1, 2025, most Benefit Options will be effective upon date of hire. Prior to Feb. 1, 2025, you will have a 30-day opportunity to elect one or more of the Voluntary Benefit Options ("Initial Enrollment Period") for Yourself or for Yourself and Your Eligible Dependents beginning on the date You become an Eligible Employee. Coverage may be subject to a Waiting Period after which it will become effective (assuming You remain an Eligible Employee throughout the Waiting Period and You satisfy any applicable enrollment requirements). If there is a Waiting Period, coverage will be effective on the first day following the waiting period (if You timely and properly enroll). **Note:** Temporary employees will continue to have a 90-day waiting period.

Eligible Employee	Benefit Options	Waiting Period
Full-time or Term Full-time employees	Medical, Dental, Vision, Health Care FSA, HSA when enrolled in the HDHP with optimal HSA Dependent Day Care FSA, Employee Life Insurance, AD&D, BTA and EAP	*30 Days *Beginning 2/1/2025, coverage is effective upon date of hire.
	STD and Basic LTD	365 days
	Supplemental LTD	Through the end of the Plan Year following the year in which You were hired (365 days +)
Part-time, Term Part-time employees	Medical, Dental, Vision, Health Care FSA, HSA when enrolled in the HDHP with optional HSA, Dependent FSA, and EAP	*30 Days *Beginning 2/1/2025, coverage is effective upon date of hire.

Eligible Employee	Benefit Options	Waiting Period
	STD and Basic LTD	365 Days
Temporary Full-time and Temporary Part-time employees	Medical, HSA if enrolled in the HDHP with optional HSA, EAP	90 days

At the end of Your enrollment, print Your Benefit Summary (formerly referred to as Confirmation Statement) from the Health and Life website that identifies the specific Benefit Option elections (and/or deemed elections for default benefits) You made during the initial Enrollment Period, according to the applicable enrollment system. If You don't have access to print Your Benefit Summary and want a copy mailed to you, contact the Health and Life Service Center at 833-925-0487 to request a copy by mail. **Once the confirmation and correction period ends, You will not be permitted to make any changes to Your elections, or make new elections, for the remainder of the Plan Year unless You experience an event that gives rise to a Mid-Year Enrollment Period (described below).**

Rehired Employee

If You were an Eligible Employee enrolled in the Plan at the time You terminate employment with the Company or You cease to be eligible, and You once again become an Eligible Employee during the same Plan Year and within 30 days of ceasing to be eligible, You will automatically be re-enrolled in the Benefit Programs in which You were enrolled prior to Your termination.

If You are rehired more than 30 days after Your termination date or You are rehired in a subsequent Plan Year, You may make new elections if You are rehired and once again become an Eligible Employee.

If You are a Rehired retiree, Your coverage will be effective on the first of the month following Your rehire date if You are rehired as an Eligible Employee and You make timely elections.

Annual Enrollment Period

Each year, the Company conducts an Annual Enrollment Period (usually in November but that is subject change from time to time) during which You have the opportunity to make various Benefit Option elections during the upcoming Plan Year. For example, You can elect to enroll for the first time, change Your current Benefit Option elections or elect to waive enrollment in a Benefit Option. Your Benefit Option elections that You make during the Annual Enrollment Period (or that Your deemed elections for default benefits) are effective the first day of the following Plan Year (to the extent that You are still an Eligible Employee on that date) and they cannot be changed during the Plan unless You experience an event that gives rise to a Mid-Year Enrollment Period and You make a timely election change (see Mid-Year Enrollment Period below for more information regarding midyear election changes).

The Company may conduct an Active Annual Enrollment Period or a Passive Annual Enrollment Period. The Company will inform You during the Annual Enrollment Period whether it is Active or Passive.

If the Annual Enrollment Period is Active. If You do not affirmatively make elections during an Active Annual Enrollment period to keep Your current Benefit Options, change Your elections or waive enrollment in the Benefit Options, You will be deemed to have elected no Benefits for the up and coming Plan Year other than Default Benefits.

If the Annual Enrollment Period is Passive. If You do not affirmatively make elections during a Passive Annual Enrollment Period to change Your Benefit Option elections or waive enrollment in the Benefit Options, then Your Benefit Option elections in effect on the last day of the Plan Year will continue during the next Plan Year, subject to any adjustments in the Required Contributions. With the exception of FSAs and or HSA. You must enroll in these accounts each year as current elections and goal amounts **do not** roll over.

Mid-Year Enrollment Period

As noted above, You generally cannot change Your Benefit Option elections during the Plan Year unless You experience an event that gives rise to a Mid-Year Enrollment Period. The events that give rise to a Mid-Year Enrollment period, the scope of changes that You are permitted to make during that period and the time period for making changes are described in Appendix C to this SPD.

Consent provided at Enrollment

When You enroll in the plan during an applicable enrollment period, You may be consenting to certain activities. For example, the medical plan Claims Administrators conduct outreach to members or share data with other medical plan vendors. **Also,** Lumen's Disability Claims Administrator, may share limited information regarding Your leave of absence with other Lumen medical and disability plan Third Party Administrators. Someone from one of these Administrators may reach out to You to discuss additional benefits and services available to You. This will provide You with more personalized and enhanced services. You may occasionally receive printed material from Lumen and/or the various third-party Administrators to keep You informed about Lumen's healthcare and wellness programs, including health support programs, services, and tools. These home mailers are an effective way to let You know important information about Your benefits, how to access them and where You can get assistance. However, if You do not wish to receive home mailers, You can opt out by contacting the claims Administrators directly.

MyEvive

MyEvive is a tool designed to promote better health and wellness of all active U.S. Employees and their Spouses/ Domestic Partners and dependents (ages 18-26). Evive's services are paid by the Plan; there are no separate or direct costs billed to You for this service.

As an active U.S. Employee or Eligible Dependent of an active Employee in the Plan, an account (your "Evive Account") has been established and is maintained for You (unless You have elected otherwise as described below).Your Evive Account is designed to increase and improve Your engagement and use of the benefits provided by Lumen by using Participant data and principles of predictive analytics and behavioral economics to help You be aware of and thus access these benefits with the goal of better health for our Employees and their Eligible Dependents.

To do this, health information from the Plan ("Your Information") is shared with Evive (as permitted under the Plan and HIPAA) and held by Evive in Your Evive Account. Evive is required to take reasonable steps to ensure the privacy and protection from unauthorized disclosure of Your protected health information ("PHI") and personally identifiable information ("PII"). As a general matter, Evive will store and maintain Your Information in accordance with the requirements agreed to by Evive and the Plan. Evive will retain Your Information: (1) for as long as Your Evive Account is active; (2) as needed to provide You services; and/or (3) as necessary to comply with Evive's and the Plan's legal obligation, resolve disputes, and enforce the agreements between Evive and the Plan. If You do not want to have an Evive Account — You may opt out.

Enrollment appeals

If the Plan Administrator rejects Your election to enroll, change Your Benefit Option elections, or waive enrollment, You may file an appeal with the Plan Administrator in accordance with Appendix D to this SPD.

Dual Coverage

Company couples and parent/child relationships who are eligible for their own benefits because they are/were employed by the Company, or a subsidiary of the Company are prohibited from being enrolled in more than one Company medical, dental or vision Plan benefit option, if applicable (except as noted below).

Company couples or parent/child relationships who are employed, on leave or retired from Lumen or a subsidiary of

Lumen, will need to contact the Service Center to reflect current relationship status (married or divorced company couple, parent/child relationship where one was recently hired). It is important to provide this information to the Service Center (outside of the Dependent Verification process) which ensures the Service Center offers the correct benefit plan and program options to each individual based on Plan rules and provisions.

- If you elect coverage and are also enrolled as a dependent on another employee's/retiree's benefits, you will remain enrolled under your own record. You will be automatically removed as a dependent from the other employees/ retiree's benefits during monthly audit processes. If your record is administratively corrected based on Plan rules and provisions, you will receive a Benefits Summary notification reflecting you have a change in your benefits, based on your Contact Preference (email or mail).
- If you or your spouse/domestic partner are employed/retired and you have both elected coverage for the same dependent child, the **birthday rule** will apply, and your record will be updated to drop coverage from one of the parents.
  - The **birthday rule** follows the month/day of birth only and not the year. Your dependent child will be removed from the other employees/ retiree's benefits during monthly audit processes.
- If you are enrolled as a dependent under a Qwest Pre-1991 retiree's benefits, you will be allowed to remain enrolled as both a dependent and as an employee or retiree, and you may also cover the Qwest Pre-1991 retiree as your dependent under your benefits.
  - **Note:** Qwest Pre-1991 retirees must be enrolled in the Company Guarantee Plan; otherwise, dual coverage is not allowed and does not apply.

If your record is administratively corrected based on Plan rules and provisions, you will receive a Benefits Summary notification reflecting you have a change in your benefits, based on your Contact Preference (email or mail).

Use of Social Security numbers

The Company retains the right to use Your Social Security number for benefit administration purposes, including tax reporting.

Required Contributions

General

The enrollment materials furnished by the Company will identify the Required Contributions for each Benefit Option, if any. The Company will determine the Required Contributions for the Benefit Options for similarly situated Participants on a uniform and nondiscriminatory basis. The Company reserves the right to change those Required Contributions at any time.

If You elect to enroll in a Benefit Option with Required Contributions, and You are actively employed, a pro-rata share of the Required Contributions will be withheld from each paycheck that You receive. If the Benefit Option is a Cafeteria Plan Benefit, the Required Contributions will be withheld from Your pay prior to any applicable federal and most state taxes being withheld. If You are deemed to have elected to enroll in a Default Benefit, the Required Contributions will be withheld from Your paycheck as described above.

If You are on an unpaid leave of absence and You are permitted to continue Your coverage under a Benefit Option, You must make the Required Contributions in accordance with the Leave of Absence section of this SPD.

If You dispute the Required Contributions that are withheld from Your paycheck, You can appeal in accordance with Appendix D.

Tax implications of Domestic Partner/Domestic Partner child coverage

If You wish to enroll Your Domestic Partner in medical benefits, there are federal and possibly state tax implications. The federal Internal Revenue Code considers the fair market value of this health care coverage to be imputed income to you, which means You will be taxed according to state and federal laws. The Company will report the annual amount of this imputed income on Your W-2 Form at the end of each year. Before enrolling Your Domestic Partner, You should talk with Your tax advisor about the tax implications for You.

Working Spouse/Domestic Partner Surcharge

If Your Spouse/Domestic Partner is eligible for health insurance/coverage from Your Spouse's/Domestic Partner's employer and waives that insurance/coverage, a Working Spouse/Domestic Partner Surcharge of $100 per pay period is added to Your medical premium if You enroll Your Spouse/Domestic Partner in the medical coverage provided by the Plan.

The surcharge does not apply in the following situations:

- My Spouse/Domestic Partner is enrolled in Medicaid, Medicare or another plan that is not defined as an "Employer group medical plan".
- My Spouse/Domestic Partner's annual enrollment has already passed (see below for additional details).
- Your annual base salary is less than $30,000, and
- Your annual base salary is less than $100,000 AND Your Spouse/Domestic Partner works for an employer with less than 50 employees.

You have a Continuing Obligation to Update the Plan If Your Spouse or Domestic Partner Becomes Eligible for Coverage. If the enrollment period has passed for a Spouse/Domestic Partner who could have enrolled in his or her employer's medical plan and did not, and if his or her employer does not recognize Your benefits Annual Enrollment period as a qualifying event for Your Spouse/Domestic Partner to enroll, You may elect to cover Your Spouse/Domestic Partner for a period of time under Plan without paying the Working Spouse/Domestic Partner Surcharge. The surcharge will be suspended but only until Your Spouse/Domestic Partner has the opportunity to enroll for coverage with his or her employer. **Important Note:** Once Your Spouse/Domestic Partner has the opportunity to sign up for his or her employer's coverage, it is Your responsibility to notify the Lumen Health and Life Service Center within 45 days of Your effective date of Your Spouse's/Domestic Partner's enrollment period, to either:

- Remove Your Spouse/Domestic Partner from coverage under the Lumen Health Care Plan; or
- Keep Your Spouse/Domestic Partner covered under the Lumen Health Care Plan and begin paying the Working Spouse/Domestic Partner Surcharge because Your Spouse/Domestic Partner chose to waive his/her employer's group medical plan.

Note: The Working Spouse/Domestic Partner Surcharge does not apply to any benefits but medical benefits.

Tobacco Surcharge

If you and/or your dependent(s) use tobacco products and are not enrolled in a Company-recognized tobacco cessation program, you will be subject to an $80 bi-weekly surcharge which will be added to your medical premium. If you and/or your dependent(s) are non tobacco users, the surcharge doesn't apply.

Note: The Tobacco Surcharge does not apply to Temporary Full-time, Temporary Part-time or Incidental employees. If You are enrolled in the Hawaii Medical Services Association (HMSA) Plan the non-tobacco user premium and $80 per bi-weekly surcharge will not apply.

Leave of Absence

Leaves other than Military Leave

Except as otherwise set forth in the Benefit Option Documents, You may continue coverage under the Benefit Options You elected while You are on an approved, paid leave of absence, including a leave covered by the federal Family and Medical Leave Act and You make Required Contributions the same as You would if You were not on a leave of absence. Except as otherwise set forth in the Benefit Option Documents, You may also continue Your coverage under the Benefit Options You elected while You are on an approved, unpaid leave of absence provided that You timely make the Required Contributions in the manner agreed to by the Company (You are typically direct billed). Your eligibility for coverage ends when You fail to make the Required Contributions, Your employment with the Company is terminated or Your leave is no longer approved.

If You return to an eligible position, You will become eligible for benefits again on the first day of the month following Your return provided You make Your election within 31 days of Your return to active employment through the Lumen Health and Life Service Center and make the Required Contributions. Your coverage election is not required to be the same coverage election You made prior to Your leave of absence.

Military Leave

Health Care Benefits. Employees who are called to military duty will continue to receive health care coverage up to 12 months while in the military at active Employee rates, and up to 12 additional months at the full Company rate, if still in military service. Although You will be covered under the Company health care benefits during this 24-month period as if You were an active Employee, if premiums are paid timely (and unless You elect otherwise), this is considered a COBRA Qualifying Event and 18 months of the 24 months will count towards the COBRA 18-month continuation coverage period. However, You will not be charged the full COBRA rates. This means that at the end of the 24 months of benefit coverage, if You are still on military leave, health care coverage under the Company's Health Care Plan (including COBRA) is no longer available. You must make timely monthly payments during your leave to avoid cancellation of COBRA coverage. While You are on military leave, the military benefits for which You are eligible will be primary. However, if Your Dependents participate under the Plan while You are on military leave, the Plan coverage is primary; any military coverage for them will be secondary to the Plan.

If You are entitled to reinstatement following Your military service and You return to active employment, Your health coverage and Your Dependent's coverage under the Health Plan will be reinstated effective the first day following the end of the military leave period if You and Your Dependents were covered under the Health Plan on the day before Your absence from employment due to military service (whether or not You elected to continue coverage). If You return to active employment with the Company during the same Plan Year in which You left, eligible charges You had accumulated towards satisfying Annual Deductibles and Out-Of-Pocket Maximums will be taken into account in determining Your Benefits for the Plan Year. If You would like to reinstate the dependent day care flexible spending account or make a change/revision to the health care flexible spending account contribution, You must contact the Lumen Health and Life Service Center. Changes or corrections to elections can be made by contacting the Lumen Health and Life Service Center within 45 days of the qualifying life event or returning from a Military Leave.

Term Life Insurance. Employees who are called to military duty will have the following Life Insurance provisions apply:

- Basic and Supplemental Term Life Insurance for the Employee, Spouse/Domestic Partner and Child(ren) will be terminated beginning with the first day of the military LOA period. Upon return from military LOA, Basic and Supplemental Life Insurance will be reinstated effective with the first day following the end of the military LOA period even if the employee's return date is in a new Plan year. Employees may convert their Basic and Term Supplemental Life Insurance to an individual policy during the LOA period. Employees must contact MetLife within 31 days following the leave effective date.

- Employees will then be asked to complete the conversion application and if MetLife approves the request, the applicable individual's (employee, spouse/domestic partner and/or child(ren)) will be enrolled in an individual policy/ies. **Important:** If the employee returns to work as a Full-time employee, they will need to surrender the individual policy at MetLife. The Lumen Health and Life Service Center will not be able to request the individual policy to be surrendered. It is up to the employee to surrender the policy. If the employee and/or any of their dependents pass away and there is an active individual policy and an active group Lumen policy, only one policy will be paid out and MetLife will make the decision as to which policy will be paid out.
- Basic Accidental Death & Dismemberment (AD&D), Voluntary AD&D, Business Travel Accident will be reinstated effective with the first day following the end of the military Leave period even if the employee's return date is in a new Plan year. Employees may not convert Basic AD&D or Voluntary AD&D benefits.

Disability. Eligibility for Disability benefits will be reinstated effective with the first day following the end of the leave effective date. Please refer to the specific SPD for Disability benefits and applicable Waiting Periods and benefit coverage.

Termination of Coverage

Termination Events

You cease to be a Participant in a Benefit Option on the earliest of the following to occur:

- You cease to be an Eligible Employee (e.g. You terminate employment or You remain employed but You cease to be a Full-time Employee). If You cease to be an Eligible Employee, the specific date that You cease to be a Participant varies depending on the Benefit Options. See the Benefit Options for more information.
- You choose not to enroll in a Benefit Option (other than a Default Benefit) in which You are currently enrolled during an Annual Enrollment Period. In this situation, You will cease to be a Participant in that Benefit Option on the last day of the current Plan Year.
- You permissibly revoke Your election to enroll in the Benefit Option during a Mid-Year Enrollment Period. If You revoke Your election during the Mid-Year Enrollment period, You cease to be a Participant in the Benefit Option on the last day of the month in which You submit Your election change.
- You fail to properly make the Required Contributions (or You do not have sufficient pay to make the required Employee Contributions). If You fail to make the Required Contributions, Your participation in the Benefit Option will end on the last day of the last month for which You timely made the Required Contributions.
- The date the Company terminates the Benefit Option (or the Plan).

A Dependent ceases to be a Covered Dependent in a Benefit Option on the earliest of the following to occur:

- The date that You cease to be a Participant in that Benefit Option.
- When the Covered Dependent ceases to be an Eligible Dependent (even if the Plan learns of the ineligibility at a later date). If the Child remains is covered upon turning age 26, coverage will generally end at the end of the month in which the Child turns age 26 (except as otherwise set forth herein).
- The last day of the month in which You permissibly submit Your election to revoke the Covered Dependent's enrollment.
- If You choose not to enroll a Covered Dependent during the Annual Enrollment Period, the Covered Dependent's coverage will end on the last day of the current Plan Year or when a terminating event occurs, if earlier.

You are obligated to notify the Plan Administrator immediately after a dependent ceases to be eligible so that the formerly Eligible Dependent does not incur claims after the date the dependent ceased to be eligible. You may still have COBRA rights if You delay providing notice (not more than 60 days) but that does not affect Your obligation to repay the Plan for ineligible claims incurred because You delayed providing notice.

Cobra Continuation of Coverage

If a Covered Person loses coverage under a Benefit Option that is a "group health plan" as defined in Code Section 5000, the Covered Persons may be eligible for continuation coverage required to be offered by a federal law called "COBRA". See Appendix E to this SPD for more information regarding COBRA continuation coverage and the Benefit Options subject to COBRA continuation coverage. In addition, Covered Persons may be eligible for conversion or portability with respect to any fully Insured Benefit Options that provide benefits in the event of death. See the Benefit Option Documents for more information regarding conversion and portability of coverage.

Continuation of Coverage during a Leave of Absence

You have special continuation rights if You take an approved leave of absence. See the "Leaves of Absence" section in this SPD for more information.

Continuation during LTD

You also have special continuation rights if You are receiving LTD benefits. See Appendix F for more information.

Continuation following death of employee

In some instances, if the covered employee was eligible for retiree health benefits offered by Lumen at the time of his or her death, the Surviving Spouse may be eligible to enroll in the retiree health benefits in which the covered employee could have enrolled. See the General Information for Retiree Health Plans for for more information.

Claims for benefits and appeals of Adverse Benefit Determinations

You have certain rights and obligations with respect to claims for Benefits from the Benefit Plans. The details surrounding those rights and obligations, including but not limited to the time period for filing claims, where to file claims, the time period for appealing any Adverse Benefit Determinations, are generally set forth in the Benefit Option Documents. However, we have identified below the fundamental rights and obligations of both the Plan and You with respect to claims and appeals, as prescribed by ERISA.

For purposes of this SPD, an "Adverse Benefit Determination" has the same meaning of adverse benefit determination as set forth in 29 CFR 2560.503-1 and 29 CFR 2590.715-2719 (as applicable).

All Benefit Option claims and appeals

- You have the right to have an authorized representative file a claim for Benefits on Your behalf. Whether a representative is authorized to act on Your behalf will be determined in accordance with the Plan's or the Insurer's reasonable procedures.

- The Plan may establish reasonable procedures for filing claims for Benefits. The specific claim filing procedures for a Benefit Plan will be described in the applicable Benefit Plan Documents.
- If You receive an Adverse Benefit Determination, You will receive a notice of the Adverse Benefit Determination that contains the following information:
  - Reference to the specific plan provisions on which the denial is based;
  - Description of information necessary to perfect Your claim;
  - A description of the Plan's procedures for filing an appeal of the Adverse Benefit Determination;
  - A statement of Your right to file suit under ERISA 502 (provided You exhaust the Plan's claims and appeal procedures).
- You have the right during any appeal of an Adverse Benefit Determination to submit written comments, documents, records, and other information related to the claim.
- You have the right to receive, upon request and free of charge, reasonable access to and copies of all documents and records that are "Relevant" to Your claim for benefits (as defined by ERISA).
- You generally may not file suit until You have exhausted the Plan's internal claims and appeals process.

Group Health and Disability claims and appeals only

In addition to the above rights and obligations, the following requirements apply to any Group Health Plan and Disability Plan claims and appeals of Adverse Benefit Determinations:

- A determination on appeal will be made by person(s) that are different from and not subordinate to the person(s) who made the initial Adverse Benefit Determination.
- If an appeal of Adverse Benefit Determination involves medical judgment, experimental or investigative, or a similar exclusion or limit, the Plan will consult with an independent health care professional with appropriate training and experience in the field involving the medical judgment. You also have the right to the identity of such health care professional, even if the Plan did not rely on the professional's advice.
- If the Adverse Benefit Determination is based on medical necessity, experimental or investigative, or similar exclusion or limit, the Plan will either provide an explanation of the scientific or clinical judgment for the determination or a provide a statement that such explanation will be provided free of charge upon request.

Group Health Plan claims and appeals only

In addition to the above rights and obligations, the following requirements apply to Group Health Plan claims and appeals of Adverse Benefit Determinations:

- The Plan can establish no more than two internal levels of appeals of Adverse Benefit Determination that must be exhausted before You can take legal action.If the Plan has an additional voluntary level of appeal, You are entitled to receive certain information upon request regarding Your rights and obligations with respect to the voluntary level of appeal.
- A Plan's determination regarding a Pre-Service Claim may be oral unless written notice is requested. A Pre-service Claim is a request for benefits for which prior authorization is required as a condition to receiving the full benefit under the Benefit Plan.
- If a Group Health Plan claim or appeal involves Urgent Care, the following applies:
  - Notice of an Adverse Benefit Determination may be oral so long as a written notice is subsequently provided;
  - A notice of an Adverse Benefit Determination will describe the expedited appeals process.

  A claim involves "Urgent Care" if application of the time periods for making a determination under ERISA would seriously jeopardize the life or health of the claimant or, in the opinion of a physician with knowledge of the claimant's medical condition could subject the claimant to severe pain that cannot be adequately managed without the services

or treatments at issue.

- If an internal, rule, guideline or protocol was relied upon in making the Adverse Benefit Determination, the Plan will either provide the specific rule, guideline or protocol or provide a statement that a copy will be provided free of charge upon request.

Disability claims and appeals only

In addition to the above rights and obligations, the following requirements apply to disability plan claims and appeals of Adverse Benefit Determinations:

- If applicable, the Notice will explain the reason for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration.
- If an Adverse Benefit Determination on appeal is based on new or additional rationale, the Plan will provide to You and You will have a reasonable opportunity to review and to respond to any new or additional evidence considered before the Adverse Benefit Determination is required to be issued by the Plan.
- If an internal, rule, guideline or protocol was relied upon in making the Adverse Benefit Determination, the Plan will provide the specific rule, guideline or protocol.
- The notice of the Plan's Adverse Benefit Determination will identify the applicable contractual limitations period that applies to Your right to bring an action under ERISA and the calendar date on which the contractual limitations period expires.
- Notices will be provided in a culturally and linguistically appropriate manner (consistent with ERISA).

Authorized Representatives

You have the right to have an authorized representative file a claim for benefits on Your behalf. Whether a representative is authorized to act on Your behalf will be determined in accordance with the Claims Administrator's or Insurer's reasonable procedures. For example, You will be required to use a form approved by the Claims Administrator and the form must be executed after any services are provided by the provider You should contact Your Claims Administrator or Insurer regarding that Claims Administrator's or Insurer's specific requirements to designate a third party as an authorized representative. An assignment of benefits with a provider is not a valid designation of the provider as Your or Your Covered Dependents.

Plan Administration

Fiduciary Authority and Discretion

The Plan Administrator will make determinations that may be required from time to time in the administration of the Plan. The Plan Administrator will have the sole authority, discretion and responsibility to interpret and apply the terms of the Plan and to determine all factual and legal questions under the Plan except as otherwise specifically delegated to a third party, such as an Claims Administrator in the Benefit Option Documents or as otherwise set forth in writing by the Plan Administrator. The Plan Administrator or its designee may adopt such rules as it deems necessary, desirable, or appropriate. All determinations, interpretations, rules, and decisions of the Plan Administrator or its designee shall be made in its sole discretion and shall be conclusive and binding upon all persons having or claiming to have any interest or right under the Plan.

If a Benefit Option is fully insured, the Claims Administrator will have the sole authority and discretion to interpret and construe the Benefit Option and to determine all factual and legal questions with respect to that Benefit Plan as

necessary to determine whether Benefits are payable in accordance with the terms of the applicable Benefit Option Documents. All determinations, interpretations, rules, and decisions of the Claims Administrator of a Fully Insured Plan shall be made in its sole discretion and shall be conclusive and binding upon all persons having or claiming to have any interest or right to Benefits under that Benefit Option.

Amendment or termination of the Plan

The Lumen Plan Design Committee, may amend, modify, or terminate this Plan at any time in any manner or with respect to any individual, including but not limited to employees, Eligible Dependents, and disabled individuals, in its sole discretion. Any amendment adopted will be in writing and executed by the Lumen Plan Design Committee. Coverage upon Plan termination will be governed by the terms of each Benefit Option. Nothing in this document, the Benefit Option Booklets, or the Plan shall be construed to provide vested, non-forfeitable, non-terminable, or nonchangeable benefits or rights thereto.

Plan not a contract of employment

Your participation in the Plan does not guarantee Your continued employment with the Company. All Employees of an Employer remain subject to discharge, discipline, or layoff to the same extent as if the Plan was not established. The Benefits offered under the Benefit Options are in no way vested or guaranteed.

Adopting Employers

United States Affiliates of the Company may adopt the Plan, subject to the Company's consent. Any Affiliate that becomes an Adopting Employer cannot amend or terminate the Plan itself, but it may, acting through its Board of Directors or designated representative, and subject to the consent of the Company, terminate its participation in the Plan or any of the Plan's Benefit Options. The Affiliates and subsidiaries of the Company that have adopted the Plan are listed in the Plan Information Appendix.

An Adopting Employer's participation in this Plan will automatically cease on the date that the Adopting Employer ceases to be a member of the same controlled group (regardless of the reason) except as otherwise approved in writing by the Company.

Right of Reimbursement/Subrogation

If, for any reason, any benefit under a Benefit Option is erroneously paid or exceeds the amount appropriately payable under the Benefit Option to a Covered Person, the Covered Person will be responsible for refunding the overpayment to the Plan. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other recipient of the Benefit (e.g. a provider). **Note:** The remaining portion of this Right to Reimbursement/Subrogation section applies only to the extent not specifically addressed in the applicable Benefit Option Documents. For purposes of this section of the SPD, a "Covered Person" means any Covered Person at the time the Benefit under the Plan was provided without regard to whether the individual is a Covered Person at the time the Plan seeks to exercise its right to reimbursement or subrogation.

In addition, the Plan has a right to seek reimbursement of expenses that are paid by the Plan on behalf of Covered Persons if those expenses are related to the acts of a third party (for example, if You are involved in an automobile accident). The Plan may seek reimbursement of these expenses from any recovery You may receive from the third party or another source, including from any insurance proceeds, settlement amounts or amounts recovered in a lawsuit. The terms of the Plan's reimbursement rights are described below. If a Covered Person incurs expenses covered by the Plan as a result of the act of a third party (person or entity) You may receive Benefits pursuant to the terms of the applicable Benefit Option Documents. However, the Covered Person will be required to refund to the Plan all benefits paid if the Covered Person receives any recovery from any other party (such as proceeds from a settlement, judgment, lawsuit or otherwise as a result of the act). The Plan's right to recover Benefits will apply to the entire proceeds of any recovery by the Covered Person. This includes any recovery by judgment, settlement, arbitration award or otherwise. The Plan's right

to recover will not be limited by application of any statutory or common law "make whole" doctrine (in other words, the Plan has a right of first reimbursement out of any recovery, even if the Covered Person is not fully compensated), or the characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained. The Plan will have a lien against the proceeds of any recovery by the Covered Person and against future Benefits due under the Plan in the amount of any claims paid.

The lien will attach as soon as any person or entity agrees to pay any money to or on behalf of any Covered Person that could be subject to the Plan's right of recovery if and when received by the Covered Person. If the Covered Person fails to repay the Plan from the proceeds of any recovery, the Plan Administrator may satisfy the lien by deducting the amount from future claims otherwise payable under the Plan.

The Covered Person will cooperate fully with the Plan in asserting claims against a responsible third party and such cooperation shall include, where requested, the filing of suit by the Covered Person against a responsible third party and the giving of testimony in any action filed by the Plan. If a Covered Person fails or refuses to cooperate in connection with the assertion of claims against a responsible third party, the Plan Administrator may deny payment of claims and treat prior claims paid as overpayments recoverable by offset against future Plan benefits.

Errors

An error in Plan administration cannot result in a Benefit to You or Your Eligible Dependent solely as a result of the error to the extent that a Benefit would not otherwise be payable under the applicable Benefit Option.

Fraud

Knowingly and willfully engaging in fraudulent behavior, including executing, or attempting to execute, a scheme to defraud the Plan, or to obtain by means of false or fraudulent pretenses, any of the money or property owned by or under the control of the Plan or the Claims Administrator, by Your or Your Eligible Dependents, may result in immediate termination from coverage under the Plan. The Plan Administrator reserves the right to retroactively terminate coverage under the Plan in the event of fraud or intentional misrepresentation by You or a dependent. The Plan Administrator has the right to seek full recovery of any losses from, and to pursue criminal and civil prosecution against any individuals committing fraudulent behavior.

Anti-assignment and alienation

No right, benefit, cause of action arising after the denial of benefits, or any other interest under this Plan shall be subject to alienation, sale, transfer, assignment, pledge, or encumbrance or charge, voluntary or involuntary, by operation of law or otherwise, and any attempt at such transaction(s) shall be void except as otherwise expressly permitted in the Benefit Option Documents. Any attempt to assign any right, payment, benefit, or cause of action under the Plan will be null and void and will not be recognized or given effect. Only Eligible Participants have benefit rights under the Plan. In no event will an assignment of benefits constitute a designation of the purported assignee as the covered person's authorized representative. However, benefits under the Plan may be subject to a Qualified Medical Child Support Order (QMCSO). The Claims Administrator or Insurer may, in its discretion, pay a provider directly for services rendered to You or Your Covered Dependent(s). The payment of benefits directly to a provider, if any, will be done at a convenience to You and Your Covered Dependent(s) and will.

Plan assets and Plan administration expenses

Benefits provided by Self-funded Benefit Options will be paid first with any available plan assets. If Benefits payable exceed plan assets, the Company may, in its sole discretion, contribute the difference. The Plan is generally responsible for payment of all plan administration expenses unless and to the extent responsibility for such expenses is shifted to the Covered Individuals. The Company may choose to pay any administrative expenses. If the Company pays a plan administration expense, the Plan will reimburse the Company upon request.

Statute of Limitations

Except as otherwise specifically set forth in the Benefit Option Documents, no suit for Benefits may be brought against the Company, an Employer Company, the Plan, the Claims Administrator, or an Insurer (collectively, "Plan Entities") with respect to any claim arising more than one year after the date the final determination that is part of the internal claims and appeals process has been made by the applicable claims fiduciary or is deemed to have been made in accordance with federal law. Likewise, no other claims or actions may be brought against Plan Entities for any other reason more than one year after the date the act or omission giving rise to the claim or action occurred. Any claim or action must be filed in federal court in Denver, CO.

Requesting Documents

A covered person is entitled under ERISA Section 104(b)(4) to request certain documents or instruments that govern the terms of the plan (such as this SPD, and insurance certificate, etc.), a copy of the most recent Form 5500 and a copy of the most recent Summary Annual Report. All such requests must be submitted in writing to the Plan Administrator identified in this SPD. You may also authorize a third party to request these documents by completing the Plan Administrator's approved form. Contact the Plan Administrator for a copy of the approved authorization form.

Statement of ERISA rights

As a Participant in the 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 insurance contracts and 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 Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan coverage

Continue health care coverage for Yourself or Your Covered Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or Your Covered Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing Your COBRA Continuation Coverage rights.

Prudent actions by Plan fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the persons who are responsible for the operation of this Plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and the other Plan Participants and beneficiaries. No one, including Your Company, Your union, or any other person, may fire You or otherwise discriminate against You to prevent You from obtaining a welfare benefit or exercising Your rights under ERISA.

Enforce Your Rights

If Your Claim for a welfare benefit is denied, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan and do not receive them in 30 days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If You have a Claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or federal court. In addition, if You disagree with the Plan's decision or lack of a decision concerning a medical child support order, You may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs 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 Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 800.998.7542.

Plan Information Appendix

Plan Name	Lumen Welfare Benefits Plan
Plan Sponsor	Lumen Technologies, Inc 214 East 24th Street Vancouver, WA 98663
Plan Sponsor's EIN	72-0651161
Plan Administrator	Lumen Employee Benefits Committee 214 E. 24th Street Vancouver, WA 98663
Agent for Service of Process	Lumen Technologies, Inc. Associate General Counsel/ERISA 931 N. 14th Street Denver, CO 80202 Legal process may also be served on: Lumen Technologies, Inc. 214 East 24th Street Vancouver, WA 98663
Plan Number	513
Type of Plan/Administration	Welfare Plan
Plan Year	Jan. through Dec. 31

Plan Name	Lumen Welfare Benefits Plan
Adopting Employers	See Plan Document

Appendix A: Benefit Options

Benefit Options	Fully Insured or Self Insured	Group Health Plan for COBRA purposes?
Medical • HDHP with Optional HSA (UHC) • Surest Health PPO • Surest Select Health PPO • Prescription Drug (Optum Rx)	Self Insured	Yes
Dental (MetLife)	Self Insured	Yes
Vision (EyeMed)	Self Insured	Yes
Health Care FSA (UHC)	Self Insured	Yes
Dependent Care FSA (UHC)	Self Insured	No
EAP (Optum)		Yes
Group Term Life Insurance (MetLife)	Fully Insured	No
Dependent Term Life Insurance (MetLife)	Fully Insured	No
Supplemental Term Life Insurance (MetLife)	Fully Insured	No
Accident Death and Dismemberment (MetLife)	Fully Insured	No
Business Travel Insurance (AIG)	Fully Insured	No
Short-Term Disability (Sedgwick)	Self Insured	No
Long-Term Disability (MetLife)	Fully Insured	No

Claims Administrators and Contact Information

Claims Administrator or Insurer	Telephone/Web
Sedgwick (Short-Term Disability)	844-223-7153 lumen.com/disability
MetLife (Long-Term Disability)	833-622-0135 tampa@metlife.com
UNIcall (Workers' Compensation)	866-UNI-CALL
Lumen Health and Life Service Center (Plan Administrator for Eligibility and Enrollment)	833-925-0487 lumen.com/healthandlife
Health Care Advocacy Services	lumen.com/healthandlife
COBRA Administration (provided by the Lumen Health and Life Service Center)	833-925-0487 lumen.com/healthandlife
Employee Assistance Program Optum Emotional Wellbeing Solutions	866-374-6061 lumen.com/eap
MDLIVE	888-910-8622 lumen.com/mdlive

Claims Administrator or Insurer	Telephone/Web
MetLife Dental	888-356-4191 metlife.com/mybenefits
UnitedHealthcare Flexible Spending Accounts (FSAs)	800-311-7849 myuhc.com
UnitedHealthcare	800-842-1219 TDD Dial 711 for Telecommunications Relay Services myuhc.com
UnitedHealthcare Pharmacy Management (OptumRX)	800-842-1219 TDD Dial 711 for Telecommunications Relay Services myuhc.com
Surest	800 531-6329 benefits.surest.com
EyeMed	855-874-4744 lumen.com/eyemed

Appendix B: Cafeteria Plan Benefits

The following Benefit Options are also offered through the Cafeteria Plan maintained by the Company:

- Medical
- Dental
- Vision
- Health Care Flexible Spending Account
- Health Savings Account contributions
- Dependent Day Care Flexible Spending Account

Appendix C: Mid-year Enrollment Events

Change in Status

If You experience a qualified change in status during a Plan Year, You may be eligible to complete a new election for some of the Benefit Coverages offered under the Program as specified by the Plan Administrator. Even if You experience a change in status event, no election change is permitted unless You satisfy the IRS' consistency rule (see below for more details). Such new elections will apply only to the balance of the Plan Year. If a change identified below expressly prohibited by a Benefit Option Document, no election change is permitted with respect to that Benefit Option. If a Benefit Option Document permits a change that is not permitted below, then the election change is not permitted.

These changes are administered according to the rules and regulations under Code Section 125, even if the benefit is not otherwise offered through the Program's Cafeteria Plan component. Events that constitute a qualified change in status are:

- **Legal marital status –** events that change Your marital status, including marriage, death of a Spouse, divorce, or annulment;

- **Number of Dependents –** events that change the number of dependents You have, including birth, adoption, placement for adoption, legal guardianship, death of a dependent, or judgment, decree or order due to divorce, annulment, or change in legal custody;
- **Employment Status –** a termination or commencement of employment by You or Your dependent;
- **Work Schedule –** a reduction or increase in Your or Your dependent's employment hours, including a switch between part-time and full-time employment, a strike or lockout, or the commencement of, or return from, a leave of absence;
- **Dependent Status –** an event that causes Your dependent to satisfy or cease to satisfy the requirements for coverage due to age, marital status, student status, or any similar circumstances as defined by the Program;
- **Residence or Worksite –** a change in Your or Your dependent's place of residence or work that results in a change in eligibility.

The Plan Administrator will specify the changes that You may make to Your benefit elections as a result of each allowable change in status, subject to the requirements imposed by Code Section 125 rules and regulations. When You report a change in status, You will receive information about the changes You may make to Your benefit elections. You are obligated to provide satisfactory substantiation (as determined in the sole discretion of the Plan Administrator) regarding the event and/or whether or not the election change is consistent with the event as described below, as well as the eligibility of any dependent added to coverage.

Consistency Rule for change in status events

Even though You may have experienced a change in status event, no election change is permissible unless the election change satisfies the Consistency Rule prescribed in the IRS Code Section 125. Under the Consistency Rule, a change in status will only permit an election change if the change in status event affects Your or Your dependent's eligibility for medical coverage under this or another employer's plan. A change in status also affects eligibility for medical and dental coverage if it results in an increase or decrease in the number of Eligible Dependents who may benefit under plan. In addition, You must satisfy the following special rules:

- **Loss of Dependent Eligibility.** If the event is divorce, annulment, death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements, and You are enrolled in medical coverage, You may only cancel the coverage for the Spouse or Dependent who loses eligibility for coverage. Coverage may not be cancelled for You or any other Covered Dependent, unless some other permitted election change applies.

  Example: Pat is unmarried, has one married child, and is enrolled in employee plus child medical coverage. Pat's child turns 26 and therefore loses eligibility for medical coverage. Pat's coverage will automatically change to single coverage. Pat cannot, however, cancel coverage for herself.
- **Gaining Eligibility under another Employer Plan.** If You or Your Spouse or Dependent gains eligibility for coverage under another employer's plan as a result of a change in marital status or a change in Your Spouse's or Dependent's employment status, an election to cease or decrease coverage for that individual under the plan would be consistent with the change in status event only if medical coverage for that individual becomes effective or is increased under the other employer's group medical plan.

  Example: Employee Chris elects employee only medical coverage. Chris marries. Chris's wife elected employee only medical coverage from her employer's group medical plan prior to their marriage. Chris may either cancel medical coverage if he certifies (or is deemed to certify by waiving coverage) that he and his wife will be covered under her employer's plan, or Chris's wife may cancel coverage under her plan and become covered under the Program.
- **Group Term Life Insurance, Disability Income, or Dismemberment Benefits** (if offered under the Plan). See the list of Benefit Options offered under the Plan. For Group Term Life Insurance, Disability Income and Accidental Death and Dismemberment benefits, an election to either increase or decrease coverage is permitted; however, evidence of insurability requirements may apply, as set forth in the applicable Benefit Option Documents.

Cost or Coverage Changes

You may also make changes due to cost or coverage changes in accordance with applicable IRS rules. **Note:** None of the following cost or coverage changes apply to Your Health Care Spending Account elections. The following is a summary of those rules:

- **Change in Cost of Coverage.** If Your share of the contributions for coverage You elected significantly increases, You may choose either to make an increase in contribution, revoke the election and receive coverage under another benefit option maintained by the Company or another employer that provides similar coverage, or drop coverage altogether if no similar coverage exists. The Plan Administrator will have final authority to determine whether the requirements of this section are met.
- **Entitlement to or Loss of Entitlement to Medicare or Medicaid.** You or Your Eligible Dependent becomes entitled to or loses entitlement to Medicare or Medicaid.
- **Governmental Plan Coverage change.** You or Your Eligible Dependent loses coverage under a group medical plan sponsored by a governmental or educational institution.
- **New Benefit Option added.** You are eligible for a new or improved Benefit Option.
- **Court Ordered Coverage.** You are an Eligible Employee and You are required by a Qualified Medical Child Support Order ("QMCSO") to provide medical coverage for Your Eligible Dependent child; or Your Spouse, former Spouse or another individual is required by a QMCSO to provide coverage to a Dependent child You have enrolled the child in the medical plan.
- **Reductions in Coverage.** If coverage under an option is significantly curtailed, You may elect to revoke Your election and elect coverage under another option that provides similar coverage, if available. If the significant curtailment amounts to a complete loss of coverage, You may also drop coverage if no other similar coverage is available. The Plan Administrator will have final discretion to determine whether the requirements of this section are met.
- **Change under another Employer Plan.** You may make an election change that is on account of and corresponds with a change made under another employer plan so long as: (a) the other employer plan permits its Participants to make an election change permitted under Code Section 125; or (b) the Plan Year for the Plan is different from the Plan Year of the other employer plan. The Plan Administrator will have final discretion to determine whether the requirements of this section are met.
- **Enrollment in a Qualified Health Plan.** A Participant may prospectively revoke his or her group health plan election (other than a Health Care FSA or Dependent Day Care FSA election) if: (1) the Participant and/or related individuals are eligible for a special enrollment period to enroll in a qualified health plan through an Exchange (QHP) pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant or one or more already-covered related individuals seeks to enroll in a QHP during the QHP's annual open enrollment period; and (2) the revocation of coverage under the group health plan corresponds to the enrollment or intended enrollment of the Participant and/or related individual(s) in a QHP for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked. An election may not be revoked for the Participant and any other already covered related individuals who are not enrolled in the QHP as set forth herein.

You must report the change in status or cost or coverage change and complete the new election within 45 days of the event. Your new election will generally be effective on the date You report the status change (if the request is approved by the Plan Administrator). When You report the change and make Your election change, You will be certifying that the event occurred and that all the requirements described above for making the requested election change have been satisfied.

Special Enrollment Period for Medical Benefit Plan

There are three categories of "special enrollment" events under the Health Insurance Portability and Accountability Act

("HIPAA") that will allow a mid-year election change under the Medical Benefit Options.

First, when an Eligible Employee marries, has a child, adopts a child or a child is placed with the Eligible Employee for adoption, the Medical Expense Plan must allow the eligible employee to enroll himself. The Eligible Employee may also enroll his Eligible Spouse, and/or the newly born/adopted child if enrollment is timely requested. You have 31 days from the event to request enrollment. If You timely and properly request enrollment coverage will be effective on the date of the event.

Second, if an Eligible Employee initially refused coverage on behalf of the Eligible, his Eligible Spouse, or his

Eligible Dependent children because of other major medical health coverage and such individual experiences a "loss of eligibility" for that other major medical health coverage, then the Eligible Employee will be able to enroll himself, his Eligible Spouse or Eligible Dependent Children who loses eligibility in the other employer's group health plan if enrollment is timely requested. You have 45 days from the event to request enrollment. If You timely and properly request enrollment coverage will be effective on the date of the event.

A "loss of eligibility" results if any of the following occurs:

- Loss of eligibility for reasons other than failure to pay premiums or fraud.
- Cessation of all Employer contributions.
- Moving out of an HMO service area if the other plan does not offer other coverage.
- Ceasing to be a "dependent," as defined in the other plan.
- Loss of coverage to a class of similarly situated individuals under the other plan (e.g., Part-time Employees).

Third, You may enroll Yourself and/or an Eligible Dependent child in the Medical Benefit Options if either of the following conditions is satisfied:

- You or Your Eligible Dependent child loses eligibility for Medicaid or a state child health plan; or,
- You or Your Eligible Dependent child is determined to be eligible for group health plan premium assistance under a Medicaid plan or a state child health plan.

You have 60 days from the event to request a special enrollment. If You timely and properly request enrollment coverage will be effective on the first day of the month following the month in which You request the special enrollment except for a special enrollment request due to birth, adoption, or placement for adoption, which will be retroactively effective to the date of the event.

Appendix D: Eligibility and Election Appeals

If Your request to participate in the Plan or to make an election change is denied, You have the right to submit a written appeal to the Plan Administrator. Your appeal should be submitted to the Plan Administrator within 60 days of the date that You are notified that You are not eligible (or are no longer eligible) or that You are not permitted to change

Your prior election. You should submit with Your appeal any information that You believe supports Your assertion that You are eligible under the terms of the Plan or that Your election change request should be granted. Upon receipt of the written appeal, the Plan Administrator will review Your appeal and make a determination within 60 days. The Plan Administrator will base its determination on all of the applicable facts and circumstances and the terms of the Plan. The Plan Administrator's determination on appeal is final and binding on all of the parties. While You have the right under ERISA to file suit following the final determination, You may not file suit until You have exhausted this appeal process.

Appendix E: COBRA Continuation Coverage

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to You when You would otherwise lose Your group health coverage. It can also become available to other members of Your family who are covered under the Plan when they would otherwise lose their group health coverage.

Appendix A identifies the Benefit Options that are group health plans subject to COBRA continuation coverage.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage by a Qualified Beneficiary when coverage would otherwise end because of a Qualifying Event. The specific Qualifying Events are listed below. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay the applicable premium otherwise required for COBRA continuation coverage.

If You are a Participant (i.e. a covered Employee), You will become a Qualified Beneficiary if You lose Your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced.
- Your employment ends for any reason other than Your gross misconduct.

Note: if You take an FMLA qualifying leave of absence and You choose not to continue coverage, You have not experienced a qualifying event by virtue of the leave. However, if You fail to return from leave as required by FMLA, then Your qualifying event date will be the date the FMLA period ends.

If You are the Covered Spouse of a Participant, You will become a Qualified Beneficiary if You lose Your coverage under the Plan because any of the following Qualifying Events occur:

- The Participant dies;
- The Participant's hours of employment are reduced;
- The Participant's employment ends for any reason other than his or her gross misconduct; or
- You become divorced from Your Spouse.

If You are the Covered Dependent child of a Participant You will become Qualified Beneficiary if You lose coverage under the Plan because any of the following Qualifying Events occur:

- The Participant dies;
- The Participant's hours of employment are reduced;
- The Participant's employment ends for any reason other than his or her gross misconduct;
- The Participant becomes entitled to Medicare benefits (Part A, Part B, or both);
- Your parents become divorced; or
- You cease to be eligible for coverage under the Plan as a "Dependent child".

When is COBRA coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator identified in the Plan Information section of this Booklet has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment, or death of the Participant, the Employer must notify the COBRA Administrator of the Qualifying Event.

You must give notice of some Qualifying Events

For the other Qualifying Events (divorce of the Participant and Covered Spouse or a Covered Dependent child's losing eligibility for coverage as a Dependent child), You must notify the COBRA Administrator within 60 days after the qualifying event occurs.

How is COBRA coverage provided?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Participants may elect COBRA continuation coverage on behalf of their Covered Spouses, and parents may elect COBRA continuation coverage on behalf of the Covered Children who reside with them.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the Associate, Your divorce, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the Qualifying Event is the end of employment or reduction of the Associate's hours of employment, and the Associate became entitled to Medicare benefits less than 18 months before the Qualifying Event that is a termination of employment or reduction in hours of employment, COBRA continuation coverage for qualified beneficiaries other than the Participant lasts until 36 months after the date of Medicare entitlement. For example, if a Participant becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the Qualifying is the end of employment or reduction of the Associate's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

Disability extension of 18-month period of continuation coverage

If a Qualified Beneficiary is determined by the Social Security Administration to be disabled and You notify the COBRA Administrator in a timely fashion, each covered Qualified Beneficiary may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify the COBRA Administrator before the expiration of the 60-day notice period or the 18 month period, whichever ends first. The 60 day notice period begins on the latest of the following to occur: (i) the qualifying event (ii) the date coverage is lost as a result of the qualifying event and (iii) the date You receive notice from the Social Security Administration indicating that You are determined to be disabled.

Second qualifying event during 18 or 29-month period of continuation coverage

If a Qualified Beneficiary other than the Participant experiences another qualifying event during the 18 (or, if applicable, the 29) month COBRA continuation coverage period, the qualified beneficiary (other than the Participant) can get up to 36 months of COBRA continuation coverage measured from the date of the original Qualifying Event, if notice of the second Qualifying Event is properly given to the Plan. This extension may be available to a Qualified Beneficiary Spouse and/or any Qualified Beneficiary Dependent children receiving continuation coverage if the Associate or former Associate dies, or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You have questions

For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). If You have other questions about Your rights under COBRA, contact the COBRA Administrator identified in the Plan Information section.

Keep Your Plan informed of address changes

In order to protect Your family's rights, You should keep the Plan Administrator and the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send.

Failure to provide written documentation of any of the above events, within the required 60 days will result in loss of continuation rights.

If You do not choose continuation coverage, Your group health insurance coverage will end.

If You choose continuation coverage, coverage will be provided which is identical to the coverage provided under the Plan to similarly situated Associates or family members.

The law also provides that Your continuation coverage may be cut short for any of the following reasons:

- The Group no longer provides group health coverage to any of its Associates;
- The premium for Your continuation coverage is not paid in a timely fashion;
- You become covered by another employer's group health plan;
- You become entitled to Medicare;
- You extended coverage due to Your disability and there has been a final determination that You are no longer disabled.

Note: If You become covered by another group health plan and that plan contains a Pre-Existing Condition limitation that affects You, Your COBRA continuation coverage cannot be terminated. However, if the other plan's Pre-Existing Condition rule does not apply to You by reason of credit for prior coverage, Your group health coverage may be terminated.

A child that is born or placed for adoption with the Participant during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with terms of the Plan and the requirements of Federal Law, these Qualified Beneficiaries can be added to COBRA coverage upon proper notification to the COBRA Administrator within 31 days of the birth or adoption.

You do not have to show that You are insurable to choose continuation coverage. However, under the law, You will have to pay all or a part of the premium for Your continuation coverage. You will have a grace period of 45 days to pay any retroactive premium for the period from the date continuation coverage starts until the date You choose continuation coverage. You will have a grace period of 30 days to pay any subsequent premiums.

Other coverage options may cost less. If You choose to elect continuation coverage, You don't have to send any payment with the Election Form. Additional information about payment will be provided to You after the election form is received by the Plan. Important information about paying Your premium can be found at the end of this notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, You could be eligible for a new kind of tax credit that lowers Your monthly premiums and cost-sharing reductions (amounts that lower Your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and You can see what Your premium, deductibles, and out-of-pocket costs will be before You make a decision to enroll. Through the Marketplace you'll also learn if You qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for Your state at healthcare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit Your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time You lose Your job-based coverage to enroll in the Marketplace. That is because losing Your job-based health coverage is a "special enrollment" event. **After 60 days Your special enrollment period will end and You may not be able to enroll, so You should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what You need to know about qualifying events and special enrollment periods, visit healthcare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If You sign up for COBRA continuation coverage, You can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end Your COBRA continuation coverage early and switch to a Marketplace plan if You have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if You terminate Your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted Your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If You sign up for Marketplace coverage instead of COBRA continuation coverage, You cannot switch to COBRA continuation coverage once Your election period ends.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if You request enrollment within 30 days of the loss of coverage.

If You or Your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing Your COBRA continuation coverage.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if You don't enroll in Medicare Part A or B when You are first eligible because You are still employed, after the initial enrollment period for Medicare Part A or B, You have an 8-month special enrollment period to sign up, beginning on the earlier of:

- The month after Your employment ends; or
- The month after group health plan coverage based on current employment ends.

If You don't enroll in Medicare Part B and elect COBRA continuation coverage instead, You may have to pay a Part B late enrollment penalty and You may have a gap in coverage if You decide You want Part B later. If You elect COBRA continuation coverage and then enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate Your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if You enroll in the other part of Medicare after the date of the election of COBRA coverage. If you are Medicare eligible and enroll in COBRA, COBRA coverage will pay secondary regardless if you enroll in Medicare.

Additional information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator. The Plan Administrator is identified in the Plan Information Section below.

Appendix F: Continuation of Benefits during LTD

The below Health and Life Benefits chart is applicable to those employees approved for Long-Term Disability (LTD) beginning on or after Jan. 1, 2025, and who are in the below classifications or Union groups.

- Non-Union, CenturyTel (CTL) Union Represented, Embarq (EQ) Union Represented, Former Level 3, and Qwest Union Represented Retail/Outside Sales Associates
- Qwest Communications Workers of America, or
- Qwest International Brotherhood of Electrical Workers

The chart provides a brief explanation of what benefits you may be eligible for when approved for LTD.

Note: You will be direct billed for the premium payments for these continued benefits while on LTD. If you have questions regarding your benefits or direct billing, please contact the Lumen Health and Life Service Center (referred to as the "Service Center") at 833-925-0487. For any questions related to pension benefits while on LTD, please contact the Lumen Pension Service Center at 888-324-0689.

LTD Participants must continue to meet the definition of disability, as determined by the LTD Claims Administrator, MetLife, to receive the benefits listed below:

Benefits available when terminated and approved for LTD	
Benefit/Status	**Benefit/Status details**
Employment status	Terminated to LTD • If you are a non-Qwest Union Represented employee and unsure of your Disability Pension or Service Pension/Retiree eligibility contact the Lumen Pension Service Center at 888-324-0689. • For Qwest Union Represented employees, Disability Pension is defined as greater than 15 years of service (Term of Employment (TOE)) if hired prior to Jan.1, 2009 or Service Pension Eligible. Employees are not required to meet the Modified Rule of 75 under Lumen's Combined Pension Plan.
Retiree benefits	If eligible for Retiree health care and/or life benefits upon termination to LTD: • You are defaulted to LTD continuation benefit at the active rates. • You will receive enrollment information from the Service Center.

	However, you can call the Service Center to request retiree healthcare and/or life coverage if applicable, at any time during the LTD continuation benefit or COBRA period.
LTD benefit amount	• Basic LTD is 50% of eligible pay which is provided by the Company at no cost. • Supplemental LTD is 65% of eligible pay, which is purchased by the Participant. LTD benefit payments will be reduced by the amount of all other income you may receive while on LTD, e.g. SSDI, Worker's Compensation, etc.
Medical/prescription drug, dental and vision – participant paid	You are defaulted to the LTD continuation benefit at the active rates. • At the active rate, which is partially subsidized (active employee rate, however direct billed on a monthly basis) for up to a total of three years from the beginning of STD, subject to the terms of the Lumen Retiree and Inactive Health Plan. • Then, offered 18 months of COBRA medical/prescription drug and dental at full COBRA cost. **Important:** If you or your covered dependents become Medicare eligible, you must timely enroll in Medicare Part-A and Part-B. Medicare becomes your primary insurance coverage.
Health Care Flexible Spending Account – participant paid	Offered COBRA on an after-tax basis through end of calendar year only. Not eligible for re-enrollment.
Basic Term Life Insurance – Company paid	• For up to a total of three years from the beginning of STD, subject to the terms of the Lumen Group Life Insurance Plan. * Conversion rules apply. Portability rules do not apply.
Supplemental Term Life Insurance – participant paid	• At the active rate which is partially subsidized (active employee rate, however direct billed on a monthly basis) for up to a total of three years from the beginning of STD, subject to the terms of the Lumen Group Life Insurance. *Waiver of Premium provisions may apply if < 60 years of age on the date of STD. Refer to your SPD for other reduction provisions.

	• *If not approved for Waiver of Premium with MetLife, Supplemental Life insurance may be continued for a total of three years from STD date, and you will be billed for the applicable premium.
Spouse/domestic partner, Child Supplemental Term Life Insurance – participant paid	• At the active rate which is partially subsidized (active employee rate, however direct billed on a monthly basis) for up to a total of three years from the beginning of STD, subject to the terms of the Lumen Group Life Insurance. *Waiver of Premium provisions may apply if < 60 years of age on the date of STD. Refer to your SPD for other reduction provisions. *If not approved for Waiver of Premium with MetLife, Supplemental Life insurance may be continued for a total of three years from STD date, and you will be billed for the applicable premium. • Refer to your SPD for other reduction provisions.
Accidental Death & Dismemberment Insurance (Basic and Supplemental)	Ends on termination date
Business Travel Accident Insurance	Ends on termination date.

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

Important: In the event that there is any conflict between the terms of the Plan documents which govern the particular Lumen benefits Plans and/or the insurance policies as described in this chart the terms of the official plan documents/policies govern. The Company reserves the right to change, modify or terminate benefits and/or the Plan/Policies, in its discretion at any time subject to the Collective Bargaining Agreement.

Appendix G: Your Employee Assistance Program

The Employee Assistance Program (EAP), offered by Lumen under the Lumen Health Care Plan (the 'Plan") through Optum Emotional Wellbeing Solutions, is designed to help You balance Your responsibilities at work and in Your personal life. The EAP is available to all Lumen employees whether they elect a medical plan option under the plan or not. It is provided at no cost to employees and household members. Household members are defined as those residing in Your household and Eligible Dependents away at school.

How it works

The EAP offers free and confidential assistance with many of the work-life challenges You face each day. Your EAP benefit, administered by Optum, provides practical solutions, information, resources, and support for a wide range of work-life issues including, but not limited to, anxiety, depression, child or senior care, relationship or marital issues, alcohol or substance abuse, finding colleges, bereavement, financial or legal concerns, and parenting challenges. Your EAP can help You handle problems that affect Your physical and mental well-being, as well as Your relationships.

Life is full of ups and downs. The EAP helps to resolve personal problems before they negatively affect Your health, relationship with others or job performance. Personal counselors will help You decide which counseling options fits Your needs. The EAP provides up to 8 Counseling Sessions per problem per year, by either Face-to-Face, Telephonically, or Video Counseling.

You can contact the EAP 24 hours a day, 365 days a year, by any of the following:

- 866-270-0033
- Visit lumen.com/eap

Optum EAP offers many resources including pre-recorded webinars on lumen.com/eap.

- Alcohol and drug abuse
- Depression and anxiety
- Grief and loss issues
- Legal and Financial Services
- Marital and family problems
- Natural disasters
- Personal growth and development
- Work-related concerns, career transition issues

The Lumen EAP offers many resources and free monthly webinars. Please keep in mind, early registration is recommended. Space availability is on a first come, first serve basis.

Optum

Focuses on 5 multi-dimensional facets of employee wellbeing:

- Emotional
- Physical

- Financial
- Community
- Resilience

Optum allows members:

- To choose how You want support—by video, phone, or in person.
- Allow members to choose and schedule online appointments.
- Access to Highly trained professional counselors—24/7 coverage.
- On-demand access to clinicians for immediate clinical needs.
- Integration with behavior health and other member benefits.

At lumen.com/eap, You can find the tools You need to face everything life may hand You. It's available around the clock, from the convenience of Your desk or the comfort of Your home. You'll find confidential access to professional care, self-help programs and information. Explore how You can:

- Get personalized assistance for the big events in Your life.
- Request information, resources or referrals to help balance work and personal needs.
- Get answers to questions about stress, anxiety and other conditions.
- Find childcare resources, eldercare services and much more.

Easy online clinicial search and special databases

Whether you're seeking a therapist, daycare provider or divorce lawyer, lumen.com/eap has the search tools to assist You. The Clinician Search offers a searchable list of clinicians and clinician groups. Narrow Your selection by clinician name, location, specialty, medical group, ethnicity, language, gender, or area of expertise. You can also search by condition and service types and get cost estimates as well.

If You have a Smartphone download the new myLiveandworkwell app today! Search for a clinician or connect to a real person dedicated to making Your life easier.

Accessing Services

You can reach the EAP by phone at 866-270-0033, 24 hours a day, seven days a week or at lumen.com/eap.

What is covered

Depending on Your situation, the EAP counselor may assist by:

- Linking You to available resources.
- Offering You EAP support over the telephone.
- Referring You to a licensed network EAP provider in Your community.

Additionally, if the counselor determines the situation requires it, You may be referred for additional assistance through the mental health or substance abuse coverage offered through Your medical plan.

Any information about Your call or treatment is confidential and may only be disclosed as permitted or required by law.

Work/Life Services

Work, children, friends, family — it all adds up to lack of time, and stress. Let us do Your legwork. We can provide You and Your loved ones with information and referrals for many of Your personal needs. Just call. We'll do the research and provide a list of service options in Your area, or wherever You need them. Look to us for information on a variety of services, including:

- Adult/Elder Support Services. For people who are caring for adult and elder dependents, including caregiving, housing, transportation, meal services.
- Child/Parenting Support Services. Answers to parenting questions, resources for daycare, summer camps, adoption, sick-child care.
- Household Services. Plumbers who work evenings, housekeepers, carpenters, dry cleaners, auto repair shops, electricians, landscapers.
- Shopping. Clothing, antiques, sporting goods, specialty stores, shopping services for the elderly or disabled.
- Chronic Condition Support. Non-medical support and resources for conditions like diabetes, arthritis or asthma.
- Health and Wellness. Fitness centers, urgent care clinics, all-night pharmacies.
- Personal Services. Apartment brokers, caterers, tailors, translators, dog walkers.
- Entertainment. Theater tickets, golf, travel arrangements, kid-friendly restaurants, nightclubs, horseback riding, concerts, skydiving lessons.

Our referrals are reliable

Our Resource specialists conduct searches using our extensive database and make phone calls to find options that meet Your needs. You'll get up-to-date details — including what services are offered, how much they cost, professional credentials and contact information — by telephone, fax or email. What might have taken You hours takes just one call!

Legal/Financial

Legal matters are tricky and managing finances can be overwhelming. Access to financial counseling services, legal advice, including help drafting a will or assistance with a complicated legal matter should not be out of anyone's reach. You don't need to figure it out all alone — get free confidential access to experts.

Find support to help You increase Your savings, lower debts and improve credit — so You can dial down financial stress. Included at no additional cost to You.

- Online financial stress assessment;
- Self-directed online learning modules on credit, debt, and budgeting;
- Financial calculator to assess Your current situation;
- Tax consultation and preparation;
- 25% discount for preparation of all personal income tax documents;
- Two calls with a money coach – 100% confidential.

Legal assistance services that give You free and discounted confidential access to local attorneys to answer legal questions, prepare legal documents and help You resolve legal issues. Access to legal assistance services includes access to licensed state-state specific attorneys, one 30-minute telephonic or face-to-face consultation per issue per year at no cost to You* and ongoing representation by an attorney at a 25% discounted rate.

Help is available for a variety of issues including:

- Consumer issues
- Living wills
- Power of attorney
- Probate
- Separation and divorce
- State-specific will
- Trusts

*Some exceptions apply. Cannot be used for issues with an employer, health insurer or health care provider.

Reimbursement of claims

You do not have to file EAP claims. There re no copays, coinsurance, or deductibles. You should not make any payment to a provider for EAP services. However, You will be responsible for services that You obtain without receiving prior authorization for an EAP case with a EAP counselor.

2nd.MD

Employees, and enrolled dependents (e.g. Spouses, Domestic Partners and Dependents) have access to 2nd.MD consultations with board-certified, expert doctors for a voluntary expert second opinion via phone or video all within a matter of days and at no cost to You.

2nd.MD grants You and Your enrolled dependents direct access to top U.S. medical experts for second opinions and expert advice 2nd.MD works with leading physicians across the country from top institutions like Cleveland Clinic and Harvard. You connect with these doctors virtually and 2nd.MD does all the heavy lifting — eliminating the wait, travel and hassle of traditional doctor's appointments.

Use 2nd.MD when You or Your enrolled dependent has questions about a:

- A Chronic condition
- New or existing diagnosis
- Possible surgery

What kind of conditions can 2nd.MD help with?

- Treatment plan
- Medications

2nd.MD experts are industry leaders across hundreds of subspecialties and thousands of conditions, such as but not limited to:

- Cancer
- Digestive problem
- Heart disease & stroke
- Knee, hip, ankle surgery
- Immunological disorders (type 1 diabetes, rheumatoid arthritis)

- Infertility
- Mental health issues

2nd.MD services are free for employees and dependents enrolled in a Lumen UnitedHealthcare (UHC) or Surest medical plan. But costs related to services or procedures that 2nd.MD consultants may recommend are subject to the UHC or Surest Plans benefits and coverage. Review your plan documents for specific coverage and benefit details or call the number on the back of your medical ID card.

Lumen requests that if You are a Participant in the a Surest Health Plan, You seek a second opinion through 2nd.MD prior to receiving hip, knee, shoulder, or spine surgery (on a non-emergency basis). It's Your choice to use or decline the second opinion service for these four procedures. However, if You do not seek a second opinion for these procedures You will be responsible for an additional $500 in out-of-pocket costs for the procedure, whether or not You've met Your annual deductible.

This requirement does not currently apply to enrolled dependents or COBRA Participants enrolled in these plans.

The Administrator is available for second medical opinions about more than just these four procedures, but it's only the knee, hip, back, shoulder, and spine surgery procedures that will affect Your out-of-pocket costs for the procedure at this time.

Second opinion medical consultations are conducted by phone or through a video conference on your computer, at a time that's convenient for You. You don't have to travel or go to an office for this advice.

Am I required to follow the advice of the second opinion?

It's always Your decision whether to follow the second opinion or stay the course on Your original treatment plan. Lumen is simply asking that You seek an expert second opinion through 2nd.MD to help You make informed decisions about Your care before Your hip, knee, shoulder or spine surgery (on a non-emergency basis).

How long does it take to receive a second opinion?

The intention is to make getting this second opinion as easy as possible. On average, the time between when the Administrator receives Your completed form and when You are speaking with a leading specialist regarding Your second opinion is three business days.

What's considered an emergency?

Your procedure is considered an emergency if Your doctor recommends the surgery be scheduled in seven days or less. You are still encouraged to use the 2nd.MD service, but it will not affect the outcome of Your out-of-pocket costs for the procedure.

Request a consult with 2nd.MD

Lumen extends 2nd.MD's services at no cost to employees and their dependents enrolled in a Lumen sponsored medical plan. To activate Your account and request a consult:

- Visit lumen.com/2ndmd
- Call Lumen Well Connected at 866-842-1151

Specialist Management Solutions Program

Specialist Management Solutions (SMS) is a UHC program that provides guidance and options for both conservative and

surgical care as well as access to networks of ambulatory surgery centers and designated providers to help support a positive journey and better health outcomes. Whether scheduling a routine colonoscopy, orthopedic surgery, or other specialty care procedure, SMS connects members to a local Ambulatory Surgery Center (ASC) or Center of Excellence (COE). SMS offers unmatched access to high quality, localized, and cost-effective clinical care to provide better experiences and improved health outcomes. An SMS Care Advocate or nurse will help find a specialist for Your condition, schedule an appointment, and discuss options for a localized site of care.

Note: Engagement in the Specialist Management Solutions (SMS) program is required for employees enrolled in the HDHP with Optional HSA medical plan to access benefit coverage for inpatient and outpatient hip, knee, shoulder or spine surgery. If You do not engage with SMS, the prior authorization will be denied, and You could be responsible for the full cost of the surgery.

If You think You may be eligible to participate or would like additional information regarding the program, please call 833-344-1640 or the number on Your ID card.

Appendix H: Your Cor Medical Program

The on-site clinic is designed to ensure employees and retirees can easily manage their health during business hours. Lumen recognizes that a healthy, engaged, and high-performing workforce is the Company's competitive advantage.

Cor Medical, an independent company, which manages the on-site clinic located at the Company's Monroe, LA offices and provides high-quality medical care to Company employees while keeping them connected with their regular area providers.

Who is eligible?

ALL U.S. Lumen employees enrolled in one of our medical plans are eligible to use the on-site clinic. (**Note:** that You do not have to work at the Monroe, LA location to use the clinic. Traveling employees covered under Lumen medical plans are eligible to use the Monroe clinic).

Spouses, Domestic Partners and Dependents (age 18 and older) who are enrolled in a Lumen medical plan are also eligible to use the clinic.

What services are offered?

The onsite clinic will focus on wellness and prevention; all participation is voluntary. Some services include:

- Wellness Visits;
- Acute illnesses such as respiratory infections or seasonal allergies;
- Chronic conditions such as high blood pressure, diabetes, asthma;
- Vaccinations;
- Referrals to specialists as needed;
- Regular lab work;
- Same day or next morning pharmacy delivery (Through a local pharmacy partnership, Your prescriptions can be delivered to Lumen's medical clinic);
- Prescriptions can also be sent electronically to any pharmacy of Your choosing.

Why is the on-site clinic important?

Consumer service-based programs like the on-site health clinic contribute positively to the Lumen work environment. Hosting common consumer services at work makes it easier for employees to easily address personal issues that can ultimately impact long-term well-being and productivity. Clinic participation is optional, and it is not intended to replace Your current medical provider.

Cost information: You share in the cost of the clinic is as follows:

- If enrolled in the Surest Health PPO or Surest Select Health PPO: $0 copay/visit.
- If enrolled in the HDHP with Optional HSA: Full payment is required at time of service until deductible is met.

Payment options include: cash, personal credit card, personal debit card, HRA/FSA United Healthcare account card, or HSA account card.

To obtain treatment, please present Your Lumen badge and United Healthcare or Surest Health Plan medical ID card at the clinic and pay Your copay.

Please note that the information You provide will remain completely anonymous. Cor Medical will never share a patient's personal health information with Lumen.

Clinic hours: Mon-Fri, 8 a.m. – 5 p.m. (CST) - closed 12 p.m. - 1 p.m (CST) for lunch.

Appendix I: Tobacco Cessation Programs and Surcharge

Tobacco Surcharge (applicable to Full-time and Part-time Employees only)

If you and/or your dependent(s) use tobacco products and are not enrolled in a Company-recognized tobacco cessation program, you will be subject to an $80 bi-weekly surcharge which will be added to your medical premium. If you and/or your dependent(s) are non tobacco users, the surcharge doesn't apply.

Newly Eligible: When You initially enroll in a Company-sponsored medical plan option, You will be asked to attest whether You or Your enrolled dependent(s) uses tobacco products. If You attest "yes" and you are not enrolled in a Cessation Program (as defined below), You will be subject to an $80 bi-weekly surcharge. If during the enrollment period Your tobacco use status changes because You or Your Covered Dependent(s) (1) stop using tobacco products or (2) enrolls in a Cessation Program, then the $80 bi-weekly surcharge will not apply, provided You update your status on the Health and Life Service website (lumen.com/healthandlife) or by calling the Lumen Health and Life Service Center at 833-925-0487 before the end of the enrollment period.

Qualified Life Event (QLE): If you are paying the $80 bi-weekly surcharge at enrollment but after the end of the enrollment period You or Your Covered Dependent(s) become tobacco free or enroll in a Cessation Program and notify the Lumen Health and Life Service Center of your status change, then the $80 bi-weekly surcharge will discontinue for the remainder of the year as provided in the following examples:

- **QLE Example 1:** If during the Plan Year You or Your dependents enrolled in a Lumen medical plan become tobacco

free or enroll in a Cessation Program, You will be required to attest You are tobacco-free or enrolled in a Cessation Program in order to discontinue the $80 bi-weekly surcharge as a result of the QLE. The tobacco surcharge will be discontinued the first of the month following Your notification to the Lumen Health and Life Service Center and You update Your tobacco product use attestation.

- **QLE Example 2:** If You are enrolled in a Lumen medical plan and Your tobacco products use status changes after you process a QLE, for example, you get married and You were a tobacco user and 15 days later you enroll in a Cessation Program or quit using tobacco products, You must call the Lumen Health and Life Service Center within 30 days of the initial QLE to update Your status. Your update would be retroactive to Your initial QLE date.

Annual Enrollment: If You or Your dependent(s) become tobacco free or enroll in a Cessation Program by Jan. 1 following Annual Enrollment, the tobacco surcharge will discontinue for the entire Plan Year, provided You update your status on the Health and Life Service website (lumen.com/healthandlife) or by calling the Lumen Health and Life Service Center at 833-925-0487 before Jan. 1. If You or Your Covered Dependent(s) become tobacco free or enroll in a Cessation Program after Jan. 1, the tobacco surcharge will be discontinued for the remainder of the plan year and the first of the month following Your notification to the Lumen Health and Life Service Center and You update Your tobacco product use attestation.

Cessation Programs: Pelago and Quit For Life are Company-sponsored tobacco cessation coaching programs. Quit For Life is offered through Optum available to You and enrolled dependent(s) over the age of 18 at no cost. You can find more information related to the Quit For Life and Pelago Programs at lumen.com/wellconnected. Pelago is available to You and your dependent(s) ages 15 or older and who are enrolled in a Lumen medical plan. Pelago is a Wellness Coaching Program that supports reaching health goals by cutting back, quitting, or managing any tobacco, alcohol, cannabis, opioid or tobacco use. In addition to Quit For Life and Pelago, a complete list of other Company-recognized and approved Cessation Programs can be found on the Tobacco Cessation page on InsideLumen. If You are unable to satisfy the requirements of any Company-approved program, the Plan will accommodate the recommendation of an individual's personal doctor, if needed, and the doctorrecommended program will be considered a Plan approved Cessation Program.

Tobacco Products: Tobacco products include but are not limited to the following: chewing tobacco, cigarettes, cigars, e-cigarettes, hookahs, nicotine gels/dissolvables, pipe tobacco, tobacco snuff, vapors and other products associated with tobacco.

Important: If You are unsure how to answer the tobacco products use question or if You have a medical condition that does not allow You to stop using tobacco products and/or does not allow You to enroll in a Cessation Program, please contact the Lumen Health and Life Service Center at 833-925-0487.