Life and Accidental Death and Dismemberment (AD&D) Insurance Plan

Summary Plan Description (SPD) for active Full-time and active Qwest Union Represented Term Full-time employees

Effective as of Jan. 1, 2025

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Lumen (referred to hereinafter as the Company) is committed to green initiatives. You can help by saving this SPD as a PDF instead of printing. However, if you would like a paper copy and don't have access to a printer, contact the Lumen Health and Life Service Center (referred to hereinafter as the "Service Center") at 833-925-0487 to request one to be mailed to you. Please be advised that mail time is based on the USPS schedule. Lumen and the Service Center are unable to overnight forms, documents, letters, etc. If you are calling to request during Annual Enrollment, we suggest you review the information on InsideLumen, in the **Reference Center** listed on the home page of the Health and Life website, lumen.com/healthandlife or contact the Insurance Company (referred to hereinafter as the "Claims Administrator") directly for a timely response to your comments and questions.

Note: If you are a new hire as of Feb. 1, 2025 or later the effective date of the Plans will be date of hire unless Evidence of Insurability (EOI) is required. For more information, please read this SPD.

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Introduction

Lumen Technologies, Inc. (hereinafter Lumen or Company) is pleased to provide you with this Summary Plan Description (hereinafter SPD). This SPD presents an overview of the general plan provisions, rights and responsibilities under the Company's Life and AD&D Insurance Plan (the Life and/or AD&D Plan) which is a component under the Welfare Benefits Plan. Collectively, this SPD might refer to these plans as Life Insurance Plans, Life Insurance or the Plan.

The effective date of this updated SPD is Jan. 1, 2025. This SPD summarizes Life insurance and AD&D Plans for all active Full-time employees (including active Qwest Union Represented Term Full-time) based on the classification of the employee's status in the Company's payroll system. Otherwise, this SPD, together with other plan documents (such as the Summary of Material Modifications (SMMs) including materials you receive at Annual Enrollment) briefly describe your benefits as well as rights and responsibilities under the Plan. This SPD supersedes and replaces, in its entirety, any other SPD describing its provisions that you currently may possess. This SPD is intended to accurately reflect the provisions of the Group Life plan and AD&D Insurance policies that underwrite the Company's Life and AD&D Insurance Plans.

Since this is only a summary of the policies, it does not cover all details found in the group policies. In the event of any discrepancy between this SPD and the official Plan Document, the group insurance policies along with the Plan Document (collectively The Plans) shall govern.

The Life and AD&D Plans, as described in this SPD, are a part of your total compensation from the Company. You are encouraged to review this information carefully, share it with your dependents & beneficiaries and keep it for future reference.

Questions regarding your Life and AD&D Plans' insurance benefits should be directed to the following: Lumen Health and Life Service Center (Service Center) at 833-925-0487, Mon-Fri, 7 a.m. - 7 p.m. (CST)

Reserved rights

The Company reserves the right to amend, change or terminate the Plans and any of the benefits provided under the Plans – with respect to all classes of covered or eligible Person, retired or otherwise – without prior notice to or consultation with any covered or eligible Person, subject only to applicable law and if applicable, collective bargaining agreements or other written applicable agreements.

The Plan Administrator has the right and discretion to determine all matters of fact or interpretation relative to the administration of the benefit options — including questions of eligibility, interpretations of the Plans' provisions and any other matter. The decisions of the Plan Administrator and any other person or group to whom such discretion has been delegated, including the Claims Administrators, shall be conclusive and binding on all persons. More information about the Plan Administrator and the Claims Administrator can be found in the **Appendix** of this SPD.

With respect to the Company's Union Represented employees who are able to participate in the Plan, the Plan is maintained pursuant to the applicable collective bargaining agreements, if applicable. A copy of the current collective bargaining agreements are available on InsideLumen or by contacting your union directly.

No Company employee (including Human Resource employees) or vendors hired by the Company can be responsible for advising you on the tax effects of your participation in the Plan as described in this SPD. Because tax laws are constantly changing, you should consult a tax advisor if you have questions about how participation in any Company plan will affect your personal tax situation.

How to use this document

This SPD is provided to explain how the Plans work. It describes your benefits and rights as well as your obligations under the Plans. It is important for you to understand that because this SPD is only a summary, it cannot cover all of the details of the Plans or how the rules will apply to every person in every situation. All of the specific rules governing the Plans are contained in the official Plan Documents and underlying group Insurance policies. You, your dependents and your beneficiaries may examine the Plan Documents and Group Insurance policies relating to the Plans during regular business hours or by appointment at a mutually convenient time in the office of the Plan Administrator. For additional information, refer to **Statement of ERISA rights**.

Capitalized terms are defined in the **Glossary of defined terms** section and throughout this SPD. All uses of we, us, and our in this document, are references to the Claims Administrator or Company. References to you and your are references to people who are covered persons as the term is defined in the **Glossary of defined terms**.

You are encouraged to read and keep all SPDs and any attachments (Summary of Material Modifications (SMMs), amendments, and addendums) for future reference.

What is an SPD?

This SPD is designed to provide you with a summary and general description, in non-technical language, of the Life and AD&D insurance benefits and coverages available under the Plans, without describing all the details set forth in all the Plan Documents. Other important details can be found in the Plan Documents. This SPD is not the Plan Document. The legal rights and obligations of any person having any interest in the Plans are determined solely by the provisions of the Plan Documents. If any of the terms of the Plan Documents are in conflict with the contents of the SPD, the Plan Documents and group insurance policies will always govern. The Plan Documents and this SPD supersede any and all prior documents or prior SPDs (excluding the group insurance policies) you may have been provided regarding your benefits under the Plans.

Life and AD&D Insurance Plans

The Life and AD&D Insurance Plans provide a wide range of coverage in the event of death or certain other serious physical losses.

- The **Basic Term Life Insurance Benefit** under the Life Plan pays benefits to your beneficiary(ies) if you die while covered.
- The **Supplemental/Optional Term Life Insurance Benefit** allows you to buy additional coverage under the Life Plan for yourself and, if you want, coverage for your eligible spouse or domestic partner (subject to statutory guidelines where you live) and eligible dependent children. The Supplemental Term Life coverage pays benefits to your beneficiary(ies) if you die while covered. Dependent Supplemental Term Life coverage to your beneficiary(ies) (spouse/domestic partner and/or child(ren)) pays benefits to you if your dependents die while covered.
- The **Personal Basic Accidental Death and Dismemberment (PAD&D) Benefit** under the AD&D Plan pays benefits if you die as a result of a covered accident or pays benefits to you if you have a covered physical loss due to a covered accident.
- The **Supplemental/Voluntary Accidental Death and Dismemberment (VAD&D) Benefit** under the AD&D Plan allows you to buy additional AD&D coverage for yourself, your eligible spouse or domestic partner (subject to statutory guidelines where you live) and/or your eligible dependent children. The Supplemental/Voluntary AD&D coverage pays benefits to your beneficiary(ies) if you die while covered. The Supplemental/Voluntary AD&D coverage pays benefits to you if your depedents die while covered. If you have a covered physical loss due to a covered accident, you will be

the beneficiary.

For assistance in understanding terminology associated with the administration of your benefit Plans, please refer to the **Glossary of defined terms** section in this SPD.

Common features of the Plan

This section provides an overview and common features of the Company's Life and AD&D Plans. Specific and distinct features to each of the Life and AD&D Plans are listed below in separate sections.

Eligibility

(if you are a new hire as of **Feb. 1, 2025** or later, the effective date of the Plans will be date of hire unless Evidence of Insurability (EOI) is required. No eligibility waiting period required, except with EOI).

You are eligible for Life and AD&D coverage described in this summary on the 31st day (changes Feb. 1, 2025 to date of hire) on which you are:

- An active Full-time employee or an active Qwest Union Represented Term Full-time employee (based on the classification of the employee's status in the Company's payroll system); and
- You are employed by the Company or one of our affiliated/subsidiary companies.

You are not eligible for Life and AD&D insurance benefits described in this summary if you are:

- A temporary Full-time or temporary Part-time employee, Qwest Union Represented Incidental employee, Part-time or Qwest Union Represented Term Part-time employee, Qwest Union Represented Seasonal employee or active member of the Armed Forces of any country, a leased employee, an independent contractor, or an individual who is not classified by the Company as an employee, or
- An individual who is carried on the payroll of another Company including but not limited to, a temporary employment service, or whom the Company has classified and/or treated as a vendor or consultant.

Dependent eligibility

You may also cover your eligible dependents when you enroll in the Plans. The Claims Administrator and the Plan Administrator reserves the right to require supporting financial and/or legal documentation to confirm eligibility at any time. Your eligible dependents include:

- Your legal spouse.
- Your domestic partner is defined as a person of the same or opposite sex who:
  - Shares your residence for the past 12 months;
  - Is no less than 18 years of age;
  - Is financially interdependent with you and has proven such interdependence by providing proof of joint ownership;
  - Is not blood-related or any closer than would prohibit legal marriage; and
  - Provides a Certificate of Domestic Partner Declaration if you reside in a state that provides such registration or has signed jointly with you, a notarized affidavit, if you reside in a state that does not provide Domestic Partner Registration.

Note: If you have previously submitted a Domestic Partner Affidavit provided to you by the Company or the Service Center that was validated and coverage is provided accordingly, there is no need to submit a new Domestic Partner Affidavit unless you have had a change in your Domestic Partner status such as a dissolution of relationship or the Company is requiring a Dependent Reverification.

- Your child(ren). Child(ren) coverage is for newborns until the end of the month they attain age 26 and include:
  - Your natural child;
  - Your adopted child (including a child from the date of placement with the adopting parents);
  - Your stepchild;
  - Your domestic partner's child;
  - A child who resides with You, who is supported by You and for whom You are the legally appointed guardian; or
  - Your foster child who resides with You and who is supported by You and for whom You are the legally appointed guardian.

Disabled dependent children: You are responsible for working with the applicable Claims Administrator, Company, Plan Administrator and Service Center to detemine if your child qualifies under the Plan due to your child's disability. This process **must be completed prior** to your child turning age 26, otherwise your child will be terminated under the Life and AD&D Plans due to age and you will not be able to reinstate coverage after the fact. You will be required to complete applications/forms and provide supporting physician documentation to validate the disability of your child based on requests from the medical Claims Administrator. There may be additional requirements set forth by the Claims Administrator and/or a third-party administrator that the Company has requested to view the disability qualifications.

Note: If your child prior to age 26 is deemed disabled by the Claims and Plan Administrator, the child will be able to continue Child Supplemental Term Life coverage unless the employee elects to waive the Child Supplemental Term Life coverage, fails to pay the premiums and/or fails to pay timely through payroll or the Direct Bill process, or if the employee terminates from the Company for any reason and therefore, the disabled child is no longer eligible for the Child Supplemental Term Life coverage under the Plan.

If both you and your Spouse/Domestic Partner work for the Company

If both you and your spouse or domestic partner work for the Company and are eligible for Life and AD&D insurance coverage through the Company, you will each be covered for Basic Term Life and Personal Basic AD&D Insurance and eligible for Employee Supplemental/Voluntary Term Life and Supplemental/Voluntary AD&D Insurance Plans. You cannot be covered for Supplemental Term Life and Supplemental/Voluntary AD&D Insurance coverage as both an employee and a dependent. In addition, both parents cannot cover the same dependent child(ren), regardless if one or both parents are employed by the Company, on a leave of absence or retired from the Company or a subsidiary of the Company through an aquisition. Company couples who wish to have Supplemental Term Life and Supplemental/Voluntary AD&D Plan Insurance coverage for their child(ren) must select which employee will hold the coverage for each child. The same rules apply for Parent/Child relationships where both the parent and the child work for the Company or if one parent works and the other is on a leave of absence or retired from the Company. The child cannot enroll in Employee Supplemental Term Life plan and be enrolled as a dependent under the parent's Child Supplemental Term Life plan. The double coverage rule also applies to the Supplemental/Voluntary AD&D plan. The employee cannot be covered as an employee and as a dependent.

Important: If after enrollment, it is determined that dual coverage was elected, the Plan Administrator will make a correction to the Plan elections removing the employee as a dependent under the Plans. If this occurs, both employees will receive an email sent to their personal email address indicating there is a corrected Benefit Summary available on the Health and Life website for review and for record purposes.

Your primary beneficiary

Your primary beneficiary is the person you choose to receive survivor benefits in the event of your death. You may name any person(s), your estate, almost any organization or a trust as the beneficiary(ies) under your Life and AD&D Insurance Plans. You may name one beneficiary or divide the benefit among multiple beneficiaries. If you name multiple beneficiaries, you must specify the percentage each beneficiary will receive. You also may name different beneficiary(ies) for each Plan.

It is important to enter your beneficiary(ies) information when you enroll. In the event that a beneficiary is named for one coverage but not the others, **the named beneficiary will apply to all Plans.** We encourage you list one or more contingent beneficiaries. If your primary beneficiaries are unable to be located or have predeceased you, the death benefit will go to those listed as your contingent beneficiary(ies).

If you enroll your spouse or domestic partner and your dependent child(ren) in any of the Supplemental Term Life and Supplemental/Voluntary AD&D Plans, you are automatically the beneficiary for their coverage. If you, your spouse or domestic partner and/or child(ren) die at the same time, and your beneficiary(ies) are your spouse or domestic partner and child(ren), the death benefit will be set up with a Total Control Account (TCA) to any remaining benenciary (including contingent beneiciaries, if applicable) you have on file with the Service Center. Please keep this consideration in mind when you are adding beneficiary information.

If no beneficiary is alive on the date of your death, you have not elected a beneficiary or the beneficiary information is incomplete (only lists a name or only lists a name and address and there is no one by that name at the address, etc.), and you have no additional beneficiaries and no contingency beneficiaries the death benefit will be paid based on the following **Facility of Payment:**

1. to your surviving spouse or domestic partner; or
2. if there is no surviving spouse or domestic partner, to your surviving child(ren) in equal shares; or
3. if there is no surviving spouse or domestic partner or child(ren), to your surviving parents in equal shares; or
4. if there is no surviving spouse or domestic partner, child(ren) or parents, to your surviving brothers and sisters in equal shares.

Instead of setting up an account based on the **Facility of Payment**, the Claims Administrator may pay your estate. Any payment made in good faith (based on beneficiary information available on file) will discharge liability to the extent of such payment.

Please confirm that you have primary and contingent beneficiaries for all of your Plans by going to lumen.com/healthandlife or calling the Service Center at 833-925-0487. **The Service Center is the recordkeeper of beneficiary designations and beneficiary information.** Complete all of the beneficiary information fields on the Health and Life website, not only those that indicate it is a required field. This will ensure if a claim is filed, it's processed accurately and timely. When you go online or call the Service Center to add or update your beneficiary informaton make sure to have the following information of your beneficiary readily available:

- First and last name
- Date of birth
- Phone number with area code
- Mailing address
- Social Security Number, if available

If you are listing an Estate or Trust as your beneficiary, please make sure you have the following information readily

available:

- Name of your estate or name of the trust
- Type of trust
- Name of the individual or group of individuals who manages your estate or trust
- Phone numbers with area codes of the individual or group of individuals
- Mailing addresses of the individuals or group of individuals

Minor child(ren) as a beneficiary: If you name your minor child(ren) as yourbeneficiary(ies), please be advised that the Plan will be unable to pay benefits to them until the earlier of:

1. The date your child(ren) reach the age of majority (usually age 18 or 21); or
2. The date a legal guardian of the minors' estate has been appointed by a court. This can be a costly process, and state laws may limit who may be named as guardian of an estate.

Note: The Claims Administrator will not pay proceeds to a minor so in the absence of guardianship papers they will place the death benefit in a Total Control Account (TCA) under the minor's name where it will sit ("blocked") until the minor beneficiary reaches the age of majority. A claim can be paid to a guardian on behalf of the child if the guardian provides approved legal appointed guardianship. If the proceeds are placed into a blocked account for minors, and a guardian is later appointed, he or she can then receive the proceeds by providing proof of the approved legal appointed guardianship.

When coverage begins

Important: See further details within this section about a change to the eligibility waiting period for the Plans as of Feb. 1, 2025

You are automatically enrolled in the Basic Term Life and Personal Basic AD&D Plans within 31 days of becoming eligible and usually coincides with your 31st day of employment. Supplemental Term Life and Supplemental/Voluntary AD&D Insurance coverage, if you enroll within 31 days of becoming eligible, normally coincides with your 31st day of employment. However, if you elect Supplemental Term Life coverage above the guaranteed issue, the amount of coverage above the guaranteed issue will not be effective until Evidence of Insurability (EOI) has been approved by the Claims Administrator. The Plan Administrator will process as soon as administratvely possible if your EOI is approved.

As of Feb. 1, 2025 all newly hired active Full-time employees and Qwest Union Represented Term Full-time employees will be enrolled in Basic Term Life and Personal Basic AD&D Insurance effective on the date of hire. If the employee elects, Supplemental Term Life and Supplemental/Voluntary AD&D, coverage will also be effective as of date of hire. There is no eligibility waiting period unless the employee requests Supplemental Term Life coverage above the guaranteed issue, then there is a waiting period for the additional amount of coverage due to Evidence of Insurability (EOI) requirements. The effective date of the EOI will be based on the Claims Administrator's decision. The guaranteed issue amount will be effective on date of hire.

If you are a rehired employee (not eligible for retirement Health & Life benefits when you initially left the Company) and are rehired within 30 days of your termination date into an active Full-time employee status (including Qwest Union Represented Term Full-time employees), your Basic Term Life, Personal Basic AD&D, Supplemental Term Life (employee, spouse/domestic partner, child(ren)) and Supplemental/Voluntary AD&D coverage will be reinstated on your rehire date based on your rehired compensation: eligible pay amount for Basic Term Life, Personal Basic AD&D and Supplemental/Voluntary AD&D coverage and base pay amount for Supplemental Term Life coverage. Meaning if you had Employee Supplemental Term Life at 3x, you would be reinstated with 3x regardless of your compensation when you left the Company compared to your rehired compensation, if different. If you would like to increase your Supplemental Term Life

coverages, Evidence of Insurability will be required (EOI). If you would like change and increase your amount, you have 14 days from receipt of your Benefit Summary available to you via an email notification to your personal email address on file from the Service Center and available online in your Personal Documents on the home page of the Health and Life website, lumen.com/healthandlife. **Note:** If you are rehired and eligible for both the Basic Term Life of 1x eligible pay and Basic Term Life of $50,000 and you would like to enroll in the opposite of what you are reinstated into, you can do so within the 14 days as indicated in this section.

If you are a rehired employee (not eligible for retiree Health & Life benefits when you initially left the Company) or a rehired retiree and are rehired within 60 days of your **involuntary** termination date into an active Full-time employee status, your Basic Term Life, Personal Basic AD&D, Supplemental Term Life (employee, spouse/domestic partner and child(ren)) and Supplemental/Voluntary AD&D coverage will be reinstated on your rehire date based on your rehired compensation: eligible and base pay amounts. Meaning if you had Employee Term Supplemenetal Life at 3x you would be reinstated with 3x regardless of your compensation initially to your rehired compensation, if different. The multiplier stays the same (1x, 2x, 3x, etc.), the coverage amount may differ due to rehired compensation. If you are reinstated into a Plan that initially requires EOI but you were approved when you were initally working for the Company, you would be excluded from having to complete an Evidence of Insurability (EOI) unless you are requesting a higher multipler. If you are a rehired retiree, you will need to surrender your policy until such time you are re-retired. You cannot have both a Retiree Term Life Plan and an active Employee Term Life Plan. It is **your responsibility** to surrender the policy through the Claims Administrator.

Important: If you are a rehire but do not return to the Company within 30 days or you return within 60 days to the Company and were involuntarily terminated, the guaranteed issue and EOI rules apply and there will be no exceptions if you are a rehire that doesn't fall into the categories mentioned.

If your dependent (spouse or domestic partner) is required to submit Evidence of Insurability (EOI), if EOI is approved, the Plan Administrator will process as soon as administratively possible.

Coverage or increases in coverage will be delayed to a later date under the following circumstances:

- If you are not actively at work on the day coverage is to begin or increase, coverage for you and your eligible dependent(s) will be delayed until you return to an actively at work status and work for at least 20 hours during the seven calendar days preceding the effective date.
- If your dependent is confined at home under a Physician's Care, receiving or applying to receive disability benefits from any source, or hospitalized at the time coverage is to begin or increase, the insurance or change will take effect upon the qualified dependent's final medical release from all such confinement. Hospital confined does not apply to a newborn child. **Important:** It is your responsibility as the employee to notify the Service Center if this applies to your dependent spouse/domestic partner or child.

How to enroll upon initial eligibility

You may enroll either online at lumen.com/healthandlife, or by calling the Service Center at 833-925-0487. At that time, you can make your beneficiary designations for all the Life and AD&D Plans. You must enroll within 31 days of becoming eligible. For rehired retirees, you must enroll within 31 days of your rehire date. If you do not enroll within 31 days, you will only be enrolled in Basic Term Life and Personal Basic AD&D as those are Company-paid plans.

Adding coverage for a new dependent

You have up to 45 days after a dependent first becomes eligible (e.g., newborn, marriage, etc.) to enroll them for Dependent Supplemental Term Life and AD&D Insurance coverage (365 days to add a newborn, adoption or placement for adoption of a dependent child). You do not need to be enrolled in Supplemental Term Life for your new dependent to elect Supplemental Term Life coverage. There are rules around the coverage amount cannot exceed your Basic plus

Supplemental Term Life coverage. If you are only in Basic Term Life, then your new dependent cannot have more than your Basic Term Life amount. Provided you enroll your dependent for coverage within this period, coverage coincides with the date the dependent first became eligible (e.g., newborn's date of birth, marriage date, etc.) (unless dependent Evidence of Insurability (EOI) is required). If dependent Evidence of Insurability (EOI) is required for spouse or domestic partner, the guaranteed issued amount begins on the date the dependent became eligible, the amount of coverage above the guaranteed issued begins as soon as administratively possible if EOI is approved. EOI is not required for Child Supplemental Term Life coverage.

You have up to 45 days after a dependent first becomes eligible (e.g., newborn, marriage, etc.) to enroll them into dependent AD&D coverage. Provided you enroll your dependent in coverage within this period, coverage coincides with the date the dependent first became eligible (e.g., newborn's date of birth, marriage date, etc.). You will need to be enrolled in Supplemental/Voluntary AD&D for your dependents to be enrolled. You can select the Employee only Supplemental/Voluntary AD&D Plan or the Employee + Dependent(s) Supplemental/Voluntary AD&D Plan when enrolling.

Changing your coverage

Annual Enrollment

Each fall, you will have the opportunity to add, change (increase or decrease) or waive your Supplemental Term Life and Supplemental/Voluntary AD&D coverage for yourself and for your dependent(s). This is called the Annual Enrollment period. Any changes you make at that time will become effective the following Jan. 1, subject to Evidence of Insurability (EOI) for the Supplemental Term Life for you and/or your spouse or domestic partner, if applicable. If EOI is required and not approved until after Jan. 1, the amount above the guaranteed issued will be effective as soon as administratively possibly by the Plan Administrator.

Mid-year changes

You may add, change (increase or decrease) or waive your Supplemental Term Life Insurance coverage mid-year without a qualified status change, but may be subject to providing Evidence of Insurability (EOI). Evidence of Insurability is not applicable for decreasing or waiving Supplemental Term Life Insurance coverage. You can make a mid-year change either online through the Health and Life website or calling the Service Center. The effective date will be the first of the month following your election except if EOI is required for approval and/or if your mid-year change is a qualified status change, then it will be the date of the status change; however you only have 45 days from the status change to request to add, change (increase or decrease) or waive coverage.

If you have a dependent child enrolled in the Child(ren) Supplemental Term Life Insurance, the end of the month when they attain age 26, they will be automatically removed from coverage. You **do not** need to notify the Service Center. The Claims Administrator will send paperwork regarding conversion and/or portability options to continue on an individual policy for Term Life Insurance. If you wish to elect coverage for your dependent child(ren), the form must be completed and submitted directly to the Claims Administrator. The individual policy will be with the Claims Administrator and you would pay them directly.

You can't make a mid-year change for Supplemental/Voluntary AD&D Plan unless you have a qualified status change.

Qualified status changes

The Company reserves the right to require supporting legal documentation to confirm the status change at any time. Qualified status changes include the following:

- **Marriage –** Your status has changed from single to married.
- **Domestic Partner Status –** Any event that causes the employee's domestic partner to satisfy or cease to satisfy the requirements for coverage.
- **Addition of dependent –** You gained a new dependent, (e.g., birth, adoption or placement for adoption of a child or legal guardianship).
- **Divorce –** Your divorce is final. **Note:** this does not include a legal separation even if the courts recognize the separation.
- **Death** of spouse/domestic partner or dependent
- Your covered dependent child turns age 26.
- **Change of employment status** – You or your spouse or domestic partner or child change from working Full-time to Part-time or the reverse, or your spouse or domestic partner or child gains or loses employment. In case of a waiting period prior to the eligibility of your spouse's or domestic partner's or child's benefit coverage, you can change your coverage when the waiting period expires, not before because of anticipation of the change. Change of employment status also includes if you or your spouse or domestic partner or child were placed in a layoff status or notified that you will be placed in a layoff status. You can go to the Health and Life website or call the Service Center once you, your spouse/domestic partner and/or child no longer has coverage. The Health and Life website and the Service Center is unable to populate a future dated effective date.
- **Unpaid leave of absence** – You, your spouse or domestic partner or child takes an unpaid leave of absence.

Any other event the Plan Administrator determines what qualifies as a status change under law.

Generally, the affected person must lose or gain eligibility for Life and AD&D Insurance coverage as a result of the qualified status change, and the coverage change you elect must correspond to the gain or loss of eligibility.

What coverage costs

The Company's Basic Term Life and Personal Basic AD&D are insured plans and the Company pays the cost of coverage based on premiums charged by the Claims Administrator.

The Company's Supplemental Term Life Plan is an insured plan based on your age for the Employee Supplemental Term Life Plan (based on your spouse's or domestic partner's age for Dependent Supplemental Term Life Benefit Plan) and the amount/multiplier or flat dollar of coverage you elect for Child(ren) Supplemental Term Life Plan is a flat rate per thousand and covers all eligible dependent children. This plan is paid by the employee and the employee pays one amount bi-weekly through payroll deductions regardless of the number of children covered.

The Company's Supplemental/Voluntary AD&D Plan is an insured plan and the cost of coverage is based on premiums charged by the Claim Administrator for an employee or an employee with one or more dependents, which is paid by the employee based on the amount/multipler of coverage through bi-weekly payroll deductions.

To view the premium rates for the Supplemental Term Life and Supplemental/Voluntary AD&D Plans, you can review the the Rate Sheets available on InsideLumen, in the **Reference Center** on the Health and Life website, through Sofia, your AI generated personal benefits assistant on the website, lumenbenefits.com or you can contact the Service Center. You will need to know your spouse's or domestic partner's date of birth to accurately determine the premium rate of Dependent (Spouse/Domestic Partner) Supplemental Term Life Insurance. You will also see your premium cost when you enroll on the Health and Life website.

Income taxes on the value of your Life Insurance

Company-paid Basic Term Life coverage up to $50,000 is a tax-free benefit to employees. Company-paid Basic Life coverage greater than $50,000 is considered taxable income by the Internal Revenue Service (IRS) and the Company

must report as imputed income; the cost in excess of $50,000 coverage on your W-2. This amount will be reported on your paycheck as Imputed Income.

The cost included in your gross income is not the actual premium paid by the Company for the insurance coverage. Instead, it is an amount computed using a Uniform Premium Table published by the IRS under Publication 15-B.

Note: When your Basic Term Life Plan is more than $50,000, you have the option to reduce your Basic Term Life coverage amount to a flat $50,000. If you elect $50,000 you will not be subject to imputed income calculations.

Important: If you decide to elect the $50,000 and later want to go back to the Basic Term Life (1x eligible pay) to increase your coverage amount, you will be required to complete Evidence of Insurability (EOI). The Claims Administrator will determine if you are approved to increase the amount above $50,000. If approved, you will be subject to imputed income. The Company cannot override the Claims Administrator's decision for EOI approval.

Leaves of absence

You may be eligible to continue your Term Life Insurance coverage in accordance with the Disability and/or Leave policies while you are on an approved leave of absence.

If applicable, you will be required to pay monthly premiums through the Direct Bill process to continue your benefits coverage. The amount you are responsible to pay is the same amount as for active employees except the calculation is not bi-weekly but monthly. Premiums are deducted over 26 pay periods (more than two times per month). Keep that in mind when you are calculating your monthly premium.

Note: If you have a failure to pay your monthly premiums through the Direct Bill, you will be terminated from coverage and will not be able to be reinstated. Because of this, we highly recommend you sign up for auto-pay to automatically have deductions taken out of your checking or savings account on a monthly basis. For more information about the Direct Bill process, contact the Service Center at 833-925-0487.

If you become disabled

If you become disabled and begin receiving monthly benefits under the Company's Long Term Disability Insurance Plan (LTD) or Worker's Compensation, your Basic Term Life Insurance may continue up to 36 months from your date of short term disability. If you are eligible for retiree Basic Life Insurance, at the end of the 36 months from your date of short term disability, you will transition from active Basic Term Life to retiree Basic Term Life Insurance unless (if you are a Bargaining employee) your bargaining agreement indicates otherwise.

Waiver of Premium

If you become totally disabled (as specifically defined by the Plan) prior to age 60, you may be eligible for Waiver of Premium for your Employee and Dependent Supplemental Term Life Insurance (if you are enrolled in this coverage prior to your disability, continually insured for Supplemental Term Life Insurance for 12 months prior to your disability, and this coverage was approved by the Claims Administrator and Plans Administrator). If you are approved by the Claims Administrator for Waiver of Premium, your Employee and Dependent Supplemental Term Life may continue without premium payment required. **Important:** Any outstanding premium owed prior to being approved for Waiver of Premium is required to be paid or your coverage for Waiver of Premium will be removed. This only applies to Supplemental Term Life coverages for Employee, Spouse/Domestic Partner and Child(ren). **This does not mean** you do not need to pay your monthly Direct Bill for the following coverages: medical, dental, vision, Health Care Flexible Spending Account, and any applicable Voluntary Lifestyle Benefits. You will need to continue to pay the monthly premiums, your Supplemental Term Life plans will reflect $0.00.

You must apply for Waiver of Premium no later than 12 months after you cease to be actively at work. Proof of Claim

is required no later than 12 months after you cease to be actively at work. The Plan may require periodic proof of the continuance of total disability (as specifically defined by the Plan) at reasonable intervals, but not more often than once per year.

The Waiver of Premium ceases on the earliest of:

- The date you cease to be totally disabled (as specifically defined by the Plan).
- The date you fail to furnish any required proof that you continue to be totally disabled.
- The date you fail to submit to any required examinations.
- The date you retire, unless you are eligible for Retiree Basic Term Life Insurance at which time the Waiver of Premium will be transferred to your Retiree Basic Term Life Insurance Plan.
- The date you attain age 80, unless you are eligible for Retiree Term Life Insurance and the policies allow you to continue coverage on or after age 80.

If you are not approved for Waiver of Premium, Supplemental Term Life insurance coverage for you and any covered dependents may continue for a certain period of time based on the Disability rules of Continuation of active benefit coverage. For details regarding continuation of coverage, contact the Service Center or go to the **Reference Center** on the home page of the Health and Life website and review the LTD chart for Lumen Health and Life Benefits. At the end of the period you may be allowed to continue coverage, you and/or your covered dependents will be given the opportunity to convert the Supplemental Term Life Insurance coverages to an individual policy through the Claims Administrator.

Personal Basic AD&D and Supplemental/Voluntary AD&D coverage terminates when you begin receiving Long Term Disability or Worker's Compensation benefits. You cannot port but you may be able to convert your Supplemental/ Voluntary AD&D coverage. Please contact the Claims Administrator for more details.

Life Insurance benefits at retirement

If you go from Full-time active to retirement status and eligible for the Company's Retiree benefits, you may be eligible for Company-paid Retiree Basic Term Life Insurance contingent based on your date of hire, age at the time of termination, being a Union Represented employee or a non-union employee and as defined in the Retiree Healthcare & Life Benefits matrix. If you are eligible for Retiree benefits, you will receive a communication from the Service Center explaining your eligibility within 14 business days from your termination date. You will have 45 days from your retirement effective date to enroll in Retiree benefits retroactive to the first of the month following your termination date.

Important: If you are eligible for Retiree Supplemental Term Life coverage (Qwest Protected Participant: **Group 9-1** and Qwest Union Represented: **Group 10** - group definitions can be located in the Retiree Healthcare & Life Benefits matrix on InsideLumen or in the **Reference Center** on the Health and Life website. Qwest employees be **automatically defaulted into the Plan** as the Claims Administrator requires continuous (no gap in) coverage. If you do not want to continue your Supplemental Term Life coverage into retirement, **you must notify** the Service Center no later than the day before your retirement benefits are effective. Your retirement effective date is the first of the month following your termination date. It is not the day after your termination from the Company. If at any point you decide you want to cancel your Retiree Supplemental Term Life coverage, you can contact the Service Center and the effective date will be the first of the month following your notification to the Service Center. The Retiree Supplemental Term Life plan cannot be retroactively terminated due to the Claims Administrator's policy.

The Company reserves the right to change (e.g., decrease or terminate) Retiree Basic Term Life Insurance benefits or to change (e.g., begin to charge or increase) required monthly premiums at any time (including after retirement) for any reason, and may terminate the Basic Term Life plan at any time (including after retirement). For more information, refer to **Plan Amendments** and the **Reserved rights** sections.

With respect to a Dual Retiree, in the event you are a retiree from two legacy Lumen companies and/or a subsidiary of Lumen, for example, if you initially retired from Qwest as a Union Represented employee, then were Rehired and Retired with the same eligibility and benefit rules from another Lumen company, please refer to the applicable **Retiree Life SPD** or **Benefits Resource Guide for Departing Lumen employees** for further information.

How to file a claim

A claim must be filed to receive benefits from any of the Company's Life and AD&D insurance plans.

Claims for Basic or Supplemental Term Life Insurance and Basic or Supplemental Accidental Death & Dismemberment Insurance

When there is a death of an individual enrolled in one or more benefit plans or programs offered by Lumen (e.g., AD&D, dental, life, medical, vision, voluntary lifestyle benefits, etc.) contact WTW, Pension Administrator to report the passing of the individual. WTW will notify all Lumen Claims and Plan Administrators on a daily basis (excluding Saturdays and Sundays) so that those administrators can start the death process. The caller does not need to contact each Lumen vendor or Plan Administrator. For example, the caller doesn't need to call UnitedHealthcare or MetLife to notify of the passing. Contacting WTW will initiate the process to all.

If you are the caller reporting the passing of the individual, you will need to provide the following individual's information to WTW:

- Deceased First and last name
- Deceased date of birth
- Deceased date of death
- Deceased working location - Legacy Company (e.g., CenturyTel, Embarq, Qwest, etc.)
- Deceased mailing address
- Deceased marital status (single, married, divorced, widowed, etc.)

In addition, please provide the following:

- Caller's first and last name
- Caller's phone number with area code
- Caller's relationship to the deceased

For the purpose of this section, the Lumen Health and Life Service Center is the party designated by the policyholder to maintain certain records needed to administer the insurance provided under the Life and AD&D Plans. This notification should be given to WTW as soon as is reasonably possible after the death. WTW will notify the Service Center who will process any Health and/or Life benefits and will notify the Claims Administrator. and the Claims Administrator will mail a claim form to the beneficiary or beneficiaries on file at the Service Center. The beneficiary or beneficiaries must complete the claim form and provide proof of the death (certified death certificate) and if the claim is for AD&D, provide not only a certified death certificate but also the medical examiner's or coroner's report, acciddent/police reports and health records of the deceased to the Claims Administrator as instructed on the claim form. When the Claims Administrator receives the completed claim form(s) and acceptable proof of death, the Claims Administrator will review the claim and, if approved, they will pay benefits subject to the terms and provisions of the Life and AD&D Plan. The death benefit amount may be reduced by the amount of any due and unpaid bi-weekly or monthly (and over time) premiums at the time payment is made. The death benefit amount may be further reduced for any life amounts paid to You under the Accelerated Benefit Option as a result of a terminal illness. The Claims Administrator defaults payment

to a Total Control Account (TCA). The beneficiary/beneficiaries can pull monies from the account at any time. If the beneficiary/beneficiaries would rather receive a lump sum check, they will need to work with the Claims Administrator before the claim is finalized. The beneficiary/beneficiaries can obtain more details about the TCA by contacting the Claims Administrator directly.

Important: If an active employee passes away after termination from the Company (voluntarily or involuntarily) but prior to being set up with Retiree benefits that include Life coverage - if meeting the eligibility rules, the Life Insurance plans will be reviewed by the Claims Administrator as if the former employee was an active employee under the "active" Life plans, not the "retiree" Life plan(s). For example, if the employee terminates on May 19 and is eligible for Retiree benefits that include Life coverage on June 1 and passes away on May 26, the active Life plans will be reviewed to determine if a claim(s) can be paid out by the Claims Administrator.

If an active employee passes away after termination from the Company (voluntarily or involuntarily) and is not eligible for the Company's Retiree benefits, the Claims Administrator will review if the former employee requested and completed the request to port or convert the Life coverage or if the former employee did not request or complete a request to port or convert but at the time of the former employee's passing they were still within their window to have done so, the claim will be reviewed to determine if a claim(s) can be paid out by the Claims Administrator.

If a claim is denied, you or your beneficiary has certain rights of appeal, which are described in the **Important information about the Plans** section.

Recovery of Payments

If your benefit is overpaid for any reason, the Plans have the right to recover the excess amount from the person or organization indicated as your beneficiaries receiving the death benefits. The Plans reserve the rights to recover any amounts due under these provisions by any means and your participation in the Plan means that you, your dependent(s) and beneficiaries understand this right of recovery.

Benefits assignment

You may assign your Life Term Insurance rights and benefits under the Group Life Insurance Policy as a gift or as a viatical assignment. This is usually requested when the individual is terminally ill. Such assignment must be provided to the Claims Administrator on a written form satisfactory to them. The viatical company then becomes the beneficiary. The Claims Administrator does offer an Accelerated Benefit Option (ABO). For more information, please refer to **Accelerated Benefit Option** in this SPD. This assignment provision is not applicable to the AD&D Insurance Plans.

Release of medical or confidential information

By accepting benefits from the Plans, you authorize the Plan and/or Claims Administrator to examine any medical records, medical examiner's or coroner's reports, accident/policy reports and/or health records needed to process Evidence of Insurability, claims or appeals.

Information will be kept confidential whenever possible. Under certain circumstances, this information may be disclosed to other parties with your or your beneficiary's authorization or as required by state or Federal law. Please keep in mind that it is very important for you to follow the Plan's procedures, as summarized in this SPD, in order to obtain Plan benefits and to help keep your personal confidential information private and protected. For example, contacting someone at the Company other than the Claims Administrator or Plan Administrator (or their duly authorized delegates) in order to try to get a death benefit claim issue resolved is not following the Plans procedures. If you or your beneficiary do not follow the Plans procedures for claiming or resolving an issue involving Plan benefits, there is no guarantee that the Plan benefits for which you may be eligible will be paid to you on a timely basis, or paid at all, and there can be no guarantee that your personal confidential information will remain private and protected.

When coverage ends

Your insurance will end on the earliest of:

1. the date the Group Insurance Policies ends; or
2. the date insurance ends for Your class; or
3. the date You cease to be in an eligible class; or
4. the date of the period for which the last premium has been paid and You have a failure to pay because you did not pay for Your current benefits which may include Life and AD&D coverage; or
5. the date Your employment ends and You are not eligible for the Company's Retiree Life Insurance benefits; except as stated in the Section **If you become disabled.**

For Your Dependents (spouse/domestic partner and/or child(ren)), their Life and AD&D insurance will end on the earliest of:

1. the date You die; or
2. the date the Group Insurance Policies ends; or
3. the date Your Employee Basic Term Life and Personal Basic AD&D Insurance under the Group Insurance Policies ends; or
4. the date insurance for Your Dependents ends under the Group Insurance Policies; or
5. the date insurance ends for Your class; or
6. the date You cease to be in an eligible class; or
7. the date insurance for Your Dependents ends for Your class; or
8. the date the person ceases to be a Dependent; or
9. the date Your employment ends and You are not eligible for the Company's Retiree Life Insurance benefits, except as stated in the Section **If you become disabled**; or
10. the date You retire in accordance with the policyholder's retirement plan; or
11. the end of the period for which the last premium has been paid for the Dependent and You have a failure to pay because you did not pay for Your current benefits which may include Life and AD&D coverage.

Converting to individual insurance

If for any reason your Basic Term Life coverage ends, you may request the Claims Administrator to convert your coverage to an individual policy. For You to convert, the Claims Administrator must receive a completed Notice of Group Life Insurance Conversion Privilege form from You within 31 days after the date Your Basic Term Life Insurance Plan ends or is reduced. The notice will be mailed within 10 business days to the mailing address that is on file at the Service Center. Follow the direction on the notice to fax or mail back the completed information and any other information that may be required.

Porting to individual insurance

If for any reason your Personal Basic AD&D, Supplemental/Voluntary AD&D, Employee or Dependent Spouse/Domestic Partner and/or Child(ren) Supplemental Term Life ends, you have the option to continue that insurance under another policy in accordance with the conditions and requirements applicable to **Portability**. The Claims Administrator will mail the conversion form within 10 business days to the mailing address that is on file at the Service Center and you can submit the completed form via fax or mail. For You or Your Dependent to port, the Claims Administrator must receive a completed request form within the request period as described below:

- If written notice of the option to port is given **within 15 days** before or after the date such insurance ends, the request period:
  - begins on the date the insurance ends, and
  - **expires 31 days** after the date.
- If written notice of the option to port is **given more than 15 days after but within 91 days** of the date such insurance ends, the request period:
  - begins on the date the insurance ends, and
  - **expires 45 days** after the date of the notice.
- If written notice of the option to port is not given **within 91 days** of the date such insurance ends, the request period:
  - begins on the date the insurance ends, and
  - **expires at the end of such 91 day period**.

You may choose to Port due to the following events:

- You become retirement eligible under the eligibility rules for Lumen Retiree benefits and therefore You leave the Company; or
- Your employment ends, due to a reason other than retirement; or
- You cease to be in a class that is eligible for such insurance; or
- The Policy is amended to end the Portability Eligible Insurance or Portability Eligible Dependent Insurance, unless such insurance is replaced by similar insurance under another group insurance policy issued to the Company or its successor; or
- The Policy has ended, unless such insurance is replaced by similar insurance under another group policy issued to the Company or its successor.

You may choose to Port the reduced amount of insurance if Your Portability Eligible Insurance is reduced due to:

- An amendment to the Plan which affects the amount of insurance for Your class.

Your former Dependent Spouse or Domestic Partner may choose to Port if their Portability Eligible Dependent Insurance on his or her own life ends because:

- You die; or
- Your marriage ends in divorce or annulment; or
- Your Domestic Partnership, Civil Union (Common-Law Spouse) relationship ends. **Note:** If You and Your spouse are legally separated, the Life and AD&D plans that Your spouse is enrolled in will continue until Your divorce is finalized through the Courts. At that time, Your spouse's coverage will end under the Life and AD&D plans as well as other applicable plans offered by the Company.

Your former Dependent Spouse may also apply for Portability Eligible Dependent Insurance on Your Dependent Child if Your former Dependent Spouse ports insurance on his or her own life. If Your former Dependent Spouse ports insurance on that Dependent Child, that porting will have no effect on the insurance You may have on that Dependent Child.

Your former Dependent Child may apply for Portability Eligible Dependent Insurance on his or her own life if that insurance ends because Your former Dependent Child no longer meets the definition of a Dependent Child according to the Plan eligibility rules.

The individual converted life insurance policy will be issued in a policy format customarily issued by the Claims

Administrator at the time and rate for your class of risk and age of the individual. You must pay the full cost. The cost, terms and benefits of conversion policies differ substantially from those of the Company's Group Life Plans.

If You die within 31 days of the date Portability Eligible Life Insurance ends and an application to port is not received by the Claims Administrator during such period, the Claims Administrator will determine whether Your life insurance qualifies for payment. This determination will be made in accordance with the Claims Administrator's Life Insurance Portability Option for You.

Plan amendments

The Company reserves the right at any time, to terminate, modify or amend, in whole or in part, any or all of the provisions of the Plans.

Interpretation of the Plans

The Employee Benefits Committee and the Plan Administrator, has the discretion and authority to interpret, resolve ambiguities, control and manage the operation and administration of the Plans. The Plan Administrator has delegated to Claims Administrators, the insurance carrier(s) its discretionary authority to make all final determinations regarding claims for benefits under the Plans. This discretionary authority includes, but is not limited to the determination of eligibility for benefits, based upon enrollment information provided by the Plan Administrator, and the amount of any premium/contribution benefits due, and to construe, interpret and resolve ambiguities relative to the terms of the Plans.

Any decision made by the Claims Administrators in the exercise of this delegated discretion and authority, including review of denials of benefit, is conclusive and binding on all parties. Any court reviewing determinations by the Claims Administrators shall uphold such determination unless the claimant proves the determinations are arbitrary and capricious.

Basic Term Life Insurance

Amount of coverage

Your Basic Term Life coverage equals 100% of your annual salary, as described in this SPD, rounded up to the next higher $1,000. The maximum benefit payable by the Basic Term Life Plan is $2,000,000. Any increase in your coverage due to an increase in pay will take effect only if you are actively at work on the date of the increase. If you are not actively at work on that date, your increased coverage will begin on the date you return to active work and work at least 20 hours during the seven calendar days preceding the date of the increase.

To avoid imputed income for those whose annual salary is in escess of $50,000, you may elect the Employee Basic Term Life - $50,000 plan if available when you enroll.

Those in an Executive, Director and Vice President status hired after Dec. 31, 2007, you are eligible for 1x your annual salary unless you elect the Employee Basic Term Life - $50,000.

Annual Salary

The Basic Term Life Plan uses your annual eligible pay which calculates your base pay plus your target incentive (short term incentive pay) if eligible for the Company's Incentive Plan as of your last day of employment before death to determine death benefits for your beneficiaries. Annualized commissions are included, if a sales-related employee, as determined by the Company. Annual salary does not include bonuses, overtime, lump-sum merit awards, shift differentials or any other extra compensation.

Cost of coverage

Except to the extent a collective bargaining agreement provides otherwise, the cost of Basic Term Life coverage for eligible employees is currently paid by the Company.

Coverage

The Basic Life Insurance plan is a Term Life policy. The amount of coverage is payable to your beneficiary(ies) at the time of your death. You cannot cash out this Plan.

Supplemental/Optional Term Life Insurance

You may select Supplemental Term Life Insurance coverage for yourself, as well your spouse or domestic partner and/or your child(ren). **You do not need to elect the Employee Supplemental Term Life plan to elect Supplemental Term Life Insurance for your dependent(s), spouse/domestic partner and/or child(ren).** Electing Supplemental Term Life Insurance is optional. Benefits from this Plan will be in addition to any benefits payable by the Company's other Life Insurance plans.

Employee coverage

The Supplemental Term Life Plan offers a choice of eight supplemental coverage options. You may choose coverage equal to one, two, three, four, five, six, seven, or eight times your annual base pay subject to Evidence of Insurability (EOI) provisions provided herein. Annual base pay for Supplemental Term Life **does not** include your target incentive (short term incentive pay), commissions, overtime, bonuses, lump-sum merit awards, shift differential or any other extra compensation.

Any increase in your coverage due to an increase in pay will take effect only if you are actively at work on the day the increase is to be effective except for Annual Enrollment when the effective date is Jan. 1 if approved prior to Jan. 1. Approval is only needed if you elect a coverage option that requires EOI. If you are not actively at work on that date, your increased coverage will begin on the date you return to active work subject to the EOI provision in the Supplemental Term Life Insurance policy. In addition to having been actively at work on the date the benefit is to take effect, you must also have been actively at work for at least 20 hours during the seven calendar days preceding that date.

Dependent coverage

You may also enroll your eligible dependent(s) in Supplemental Term Life Insurance. Dependents you enroll in the Supplemental Term Life Insurance coverage under the Life Plan will be covered as follows:

- The Life Plan offers a choice of seven supplemental coverage options for your dependent spouse or domestic partner. Your spouse or domestic partner may choose coverage equal to $5,000, $10,000, $25,000, $50,000, $75,000, $100,000 or $200,000 subject to Evidence of Insurability (EOI) provisions provided herein. Coverage for your dependent spouse or domestic partner cannot be more than 100% of your total life insurance amount (combined Employee Basic and Employee Supplemental Term Life) with $200,000 maximum.
  - **Examples:** (1) You have $100,000 of Employee Basic Term Life + $200,000 of Employee Supplemental Term Life $300,000 total; dependent spouse/domestic partner cannot have more than $200,000 of Dependent Spouse/Domestic Partner Supplemental Term Life coverage; (2) You have $100,000 of Employee Basic Life but no Employee Supplemental Term Life therefore, $100,000 is your total; dependent spouse/domestic partner cannot

have more than $100,000 of Dependent Spouse/Domestic Partner Supplemental Term Life coverage.

- The Life Plan offers a choice of four supplemental coverage options for your dependent child. You may choose coverage equal to $3,000, $5,000, $10,000 or $20,000. Evidence of Insurability (EOI) is not required. Coverage for your child(ren) cannot be more than 100% of your total life insurance amount (combined Employee Basic and Employee Supplemental Term Life) with $20,000 maximum.

If both you and your spouse or domestic partner work for the Company, you cannot have Supplemental Term Life coverage as both an employee and as a dependent of an employee. In addition, your dependent child(ren) may be covered only once as your dependent or your spouse's or domestic partner's dependent.

Action Required: Parents must decide which child they will elect to cover under the Child(ren) Supplemental Term Life plan as the same dependent cannot be under each of the parent's records. This would be considered dual coverage, which is not allowed under the Plan. If the parents elect to coverage the same child(ren) under each of their benefits, the Claims Administrator will only pay out the claim based on one of the parent's records, not both.

Please discuss with your spouse/domestic partner who will cover the dependent child(ren) in order for this to not occur, should a claim need to be submitted. If both parents elect the same child, the Plan Administrator will remove the child from the record who most recently enrolled the child that created the dual coverage regardless of the coverage amount the parents elected on each record.

For example: If Employee A enrolled Child on May 19, 2020 at $5,000 and Employee B enrolls same Child on July 4, 2022 at $10,000, after a monthly audit is completed by the Plan Administrator, Employee B will have the Child Supplemental Term Life coverage of $10,000 removed from coverage. Employee A will continue to have the Child coverage at $5,000. If you are a company couple and unsure how to enroll, please contact the Service Center before completing your enrollment.

Important: If You as the employee are not actively at work, any dependent Supplemental Term Life Insurance coverage for spouse/domestic partner and child(ren) will cease until such time that You as the employee return to work and fulfill the Actively at Work rules.

Maximum coverage

The maximum benefit payable for Employee Supplemental Term Life is $2,000,000.

Annual base pay

The Supplemental Term Life Plan uses your annual base pay only. Annual base pay does not include target incentive pay (short term incentive pay), commissions, bonuses, overtime, lump-sum merit awards, shift differentials or any other extra compensation.

Cost of coverage

The Supplemental Term Life coverage under the Life Plan is an insured benefit, which means that the cost of coverage is based on the premium charged by the Claims Administrator. You pay the cost of coverage, which is determined as follows:

- **The cost of your coverage** is based on your age and the coverage option you select.
- **The cost of your spouse's or domestic partner's coverage** is based on your spouse's or domestic partner's age and the flat coverage amount you select for your spouse or domestic partner.
- **The cost of your children's coverage** is a flat amount per thousand, no matter how many eligible dependent children

you have. In addition, you will pay one premium regardless of the number of dependent children you cover.

Note: Your Employee Supplemental Term Life Insurance premium will increase (or decrease) if you experience a change in your base pay. This increase (or decrease) is effective the day of your salary adjustment. In addition, the Employee Supplemental Term Life Insurance premium (as well as the Spouse's/Domestic Partner's Supplemental Term Life Insurance premium, if applicable) will increase on the day of your birthday or your spouse's/domestic partner's birthday if that birthday results in a change from one age bracket to another. The age brackets tiers change at 20, 25, 30, 35, 40, etc. There may be a substantial increase in premium from one age bracket to another; be sure to review the costs for you or your spouse's/domestic partner's current age as well as the age on the next birthdays.

You can view the age brackets and rates on the U.S. Benefit Premium pages available on InsideLumen, lumenbenefits.com, in the **Reference Center** on the Health and Life website or by calling the Service Center.

If your Employee Supplemental Term Life Insurance decreases coverage and premium due to a change in your eligible pay, it may impact your Spouse/Domestic Partner Supplemental Term Life Insurance amount as it cannot be more than 100% of your combined total coverage (Employee Basic Term Life + Employee Supplemental Term Life). For example if your Employee Basic Term Life reduces from $112,000 to $90,000 (example: demotion) and you are not enrolled in Employee Supplemental Term Life Insurance, your Spouse/Domestic Partner can no longer have $100,000 coverage and will be automatically reduced to $75,000 (the flat amount that doesn't exceed 100% of the Employee Basic and Employee Supplemental Term Life coverage). If you have any questions about reductions/decreases refer to your Benefit Summary available on the Health and Life website and well as you paycheck premium deductions. You can also contact the Service Center. **Do not contact** Payroll via HR tickets, chat, email or phone as they cannot assist with benefit premium related questions.

Evidence of Insurability

You are not required to provide Evidence of Insurability when electing coverage as shown below, provided coverage is elected within 31 days of your initial eligibility:

- Coverage for yourself is up to two times annual base pay
- Coverage for your spouse or domestic partner up to $50,000
- Coverage for your child(ren) at any of the four options

The following EOI rules apply during Annual Enrollment for Employee and Spouse/Domestic Partner Supplemental Term Life Insurance:

- You are not enrolled currently and elect any amount;
- You are currently enrolled and increase your coverage more than one times (example – you are currently enrolled for one times Employee Supplemental Term Life coverage and increase to three times Employee Supplemental Term Life coverage); or
- You increase your coverage above the guaranteed amount, two times Employee Supplemental Term Life coverage

Note: If you are already enrolled and your EOI is denied, coverage will revert back to the previous amount before the increase in coverage was requested.

- Your spouse or domestic partner is not enrolled currently and elects any amount;
- Your spouse or domestic partner increases current coverage more than one level (example – your spouse or domestic

partner is currently enrolled for $25,000 and increases to $75,000); or

- Your spouse or domestic partner chooses coverage in excess of the guaranteed issue amount of $50,000.

If your spouse or domestic partner is already enrolled and EOI is denied, coverage will revert back to the previous amount before the increase in coverage was requested.

The following EOI rules apply for newly hired or newly eligible employees (PT to FT status) for Employee and Spouse/Domestic Partner Supplemental Term Life Insurance:

- Needed for those who elect above the guaranteed amount: 3x to 8x annual base pay for Employee Supplemental Term Life coverage
- Needed for those who elect above the guaranteed amount: $75,000, $100,000 and $200,000 for Spouse/Domestic Partner Supplemental Term Life Insurance coverage

The following EOI rules apply for those who experience a qualified status change (marriage, loss of coverage elsewhere, etc.):

- Needed if you are not currently enrolled and elect any annual base pay amount for Employee Supplemental Term Life coverage
- Needed for those who elect more than one times annual base pay for Employee Supplemental Term Life coverage
- Needed for those who elect 3x to 8x annual base pay for Employee Supplemental Term Life coverage
- Needed if you are not currently enrolled and elect any amount for Spouse/Domestic Partner Supplemental Term Life coverage
- Needed for those who elect more than one level for Spouse/Domestic Partner Supplemental Term Life coverage
- Needed for those who elect $75,000, $100,000 or $200,000 for Spouse/Domestic Partner Supplemental Term Life coverage

The following EOI rules apply for those who are in $50,000:

- Needed for those who elect 1x eligible pay for Employee Basic Term Life coverage

You will be asked after you complete your Annual Enrollment elections on the Health and Life website if you would like to go to the Claims Administrator's website to complete the EOI form. Make sure to complete as soon as possible but no later than 90 calendar days. On calendar day 91, your pending EOI requested coverage amount for the Employee and/or Spouse or Domestic Partner Supplemental Term Life plans will be removed and request denied. You will have the same coverage prior to your EOI request.

How the plan pays benefits

Basic and Supplemental Term Life and Basic and Supplemental/Voluntary AD&D Insurance benefits are payable to your beneficiaries on file at the Service Center. Unless otherwise designated by you, if there is more than one surviving beneficiary, all beneficiaries will share equally. If you do not select a beneficiary per plan, benefits for all plans will be paid to the beneficiary you designate.

Benefits paid by the Basic and Supplemental Term Life and Basic and Supplemental/Voluntary AD&D Insurance Plans are set up with a Claims Administrator account called Total Control Account (TCA). TCA allows beneficiaries to take the time to grieve. They do not have to worry about what to do with their life insurance proceeds at the outset. TCA offers easy access to funds and provides competitive interest rates that go into effect from the time your claim is approved so insurance proceeds start earning interest immediately but other methods of payment can be arranged with the Claims

Administrator and must be requested prior to the finalization of the claim. The request must be on a form approved by the Claims Administrator.

Please see **Your Beneficiary** section for further details.

Accelerated Benefit Option

If you have a qualifying medical condition (you are terminally ill, with a life expectancy of 24 months), you may be eligible to receive during your lifetime, a portion of your Life Insurance paid to you as an Accelerated Benefit through a Total Control Account (TCA) unless you or your legal representative selects another payment mode. Applications are available from the Service Center or within the **Reference Center** on the home page of the Health and Life website.

- **Employee Basic and Supplemental Term Life – Class 1** (Executives, Directors and Vice Presidents classified in one of those statuses on Dec. 31, 2007) - you may receive up to 90% of Your Basic Life amount not to exceed $45,000. If You accelerate both Basic Term Life Insurance and Supplemental Term Life Insurance, the maximum amount which can be accelerated under both coverages combined cannot exceed $500,000. **Class 2 -** (all active Full-time non Union employees including all active Full-time Union Represented employees except Executives, Directors and Vice Presidents classified in one of those statuses on Dec. 31, 2007) - you may receive up to 90% of Your Basic Term Life. If You accelerate both Basic Term Life Insurance and Supplemental Term Life Insurance, the maximum amount which can be accelerated under both coverages combined cannot exceed $500,000. The remaining amount of Term Life Insurance payable at death will be reduced by the amount of the approved accelerated benefit previously received and payable to Your beneficiary/beneficiaries.
- **Spouse or Domestic Partner Supplemental Term Life –** The accelerated benefit is an amount up to 90% of your spouse's or domestic partner's Supplemental Term Life coverage. The maximum amount of the accelerated benefit request is $180,000. The remaining amount of Term Life Insurance payable at death will be reduced by the amount of the approved accelerated benefit previously received and payable to You. The Accelerated Benefit Option is paid to your spouse or domestic partner at your request. The accelerated benefit may be elected only once during your spouse's or domestic partner's lifetime.

The Accelerated Benefit Option is not available to Dependent Children.

Notice and proof of claim

A claim must be filed in order to receive benefits from the Life Plans. Please notify WTW by calling 888-324-0689. A Life Insurance Claim packet will be mailed to Your Beneficiary on record or to You if the claim is for one or more of your dependent(s) who has coverage. A notification of death should be filed with WTW as soon as reasonably possible but no later than 30 days after the date of death. Additionally, proof of claim must then be provided no later than 120 days after the date of death even if a certified death certificate is not yet available. For additional details, please see **How to file a claim** section.

Claims appeal procedure

Appealing the initial determination for Life and AD&D Insurance

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by the Claims Administrator. This request for review should be sent in writing to Group Insurance Claims Review at the address of the Claims Administrator's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. You can refer to the **Appendix** section. The Claims Administrator has multiple claims offices. It is imperative you appeal to the address of the office which processed the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believes the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if

applicable, your beneficiary deem appropriate.

The Claims Administrator will re-evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date the Claims Administrator receives your request for review, unless the Claims Administrator notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If the Claims Administrator denies the appeal, the Claims Administrator will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. The policy under which you filed a claim has a provision, which states in part, that no lawsuit or legal action shall be brought to recover on the policy after the expiration of three years from the time proof of loss is required.

Upon written request, the Claims Administrator will provide you free of charge with copies of documents, records and other information relevant to your claim.

Additional services provided by the Claims Administrator

The following services are provided at no additional cost to individuals insured for Supplemental Term Life Insurance coverage as described herein with the exception of residents in the state of Texas.

Will Preparation service

If You elect Supplemental Term Life Insurance coverage, a Will Preparation Service (the Service) will be made available to You, through a Claims Administrator affiliate (the Affiliate), while Your Supplemental Term Life Insurance coverage is in effect. This Service will be made available at no cost to You. It enables You to have a will prepared for You and Your Spouse or Domestic Partner free of charge by attorneys designated by the Affiliate. If You have a will prepared by an attorney not designated by the Affiliate, You must pay for the attorney's services directly. Upon Proof of such payment, You will be reimbursed for the attorney's services in an amount equal to the lesser of the amount You paid for the attorney's services and the amount customarily reimbursed for such services by the Affiliate. This service is offered by MetLife Legal Plan, a MetLife Company in Cleveland, OH. In certain states, legal services benefits are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and Affiliates, Warwick, Rhode Island.

If you would like to speak with a representative from MetLife Legal Plans or get the name of a Plan Attorney that you can speak with about this service, please call MetLife Legal Plan at 800-821-6400.

Probate service

If You become insured for Supplemental Term Life Insurance coverage and You or Your Spouse or Domestic Partner dies while said Supplemental Term Life Insurance coverage is in effect, a probate benefit (the Benefit) will be made available to Your estate in the event of Your death or to Your Spouse's or Domestic Partner's estate in the event of Your Spouse's or Domestic Partner's death. Benefit will be made available through a Claims Administrator affiliate (Affiliate).

The benefit provides for certain probate services to be made available, free of charge by attorneys designated by the Affiliate. If probate services are provided by an attorney not designated by the Affiliate, the estate of the deceased must pay for those attorney's services directly. Upon Proof of such payment, the estate of the deceased will be reimbursed for

the attorney's services in an amount equal to the lesser of the amount such estate paid for the attorney's services and the amount customarily reimbursed for such services by the Affiliate. This benefit will be provided at no cost to You and will end on the date Your Supplemental Term Life Insurance coverage ends. Please call MetLife Legal Plans at 800-821-6400 for more information.

Grief counseling and Funeral assistance services

Your Term Life Insurance coverage through the Company includes grief counseling services, which is provided through **TELUS Health One** for you, your dependents and your beneficiaries at no extra cost. It is valuable, confidential support that can provide the comfort and guidance you need at the most difficult of times, such as death of a loved one, divorce, receiving a serious medical diagnosis, or losing a pet.

TELUS Health One is not an affiliate of MetLife and the services TELUS Health One provides are separate and apart from the insurance. TELUS Health One has a nationwide network of over 30,000 counselors. Counselors have master's or doctoral degrees and are licensed professionals.

Simply call the dedicated 24/7 toll-free number, 888-319-7819, to speak with a professional counselor experienced in helping people who have suffered a loss. You, your dependents, and your beneficiaries can have up to five confidential counseling sessions per event. Sessions can either take place in-person, face-to-face, or by phone if you prefer. The choice is yours.

If further assistance is desired, the counselor will help you access services that are appropriate to your situation, preferences, finances, and health insurance coverage. You can also log on to one.telushealth.com (**username:** metlifeassist; **password:** support) to contact a counselor or access helpful grief-related information and resources.

Funeral assistance services are provided through **Dignity Memorial** for you, your dependents and your beneficiaries at no extra cost. Through private sessions, counselors can help you, your loved ones and your beneficiaries with customizing funeral arrangements. They can provide referrals and provide helpful information, like:

- Nearby Funeral Homes and Cemetery options
- Funeral cost estimates from local providers
- Other service providers, such as florists, caterers and hotels
- Back-up care for children or elderly
- Notifying the Social Security Administration, banks, and utilities
- Local Support Groups

Dignity Memorial is not an affiliate of MetLife and the services Dignity Memorial provides are separate and apart from the insurance. You may prepare your family for life's unexpected outcomes with Dignity Memorial by visiting finalwishesplanning.com or calling 866-853-0954.

Personal Basic Accidental Death & Dismemberment

The Personal Basic Accidental Death & Dismemberment (PAD&D) plan (referred by the Claims Administrator as PAD&D which means Personal Accidental Death and Dismemberment) pays benefits for death or other covered losses, which are the direct result of and occur within 365 days of the covered injury. Benefits are payable for losses that occur on or off the job. To qualify for payment, you must be covered by the Plan at the time of the accident.

Amount of coverage

Your Personal Basic AD&D coverage equals 100% of your annual salary, as described in this SPD, rounded up to the next higher $1,000. The maximum benefit payable by the Personal Basic AD&D Plan depends on the Plan you are in. The amount of your Personal Basic AD&D is considered your Principal Sum. Any increase in your coverage due to an increase in pay will take effect only if you are actively at work on the date of the increase. If you are not actively employed on that date, your increased coverage will begin on the date you return to active work.

PAD&D Plan 1

All Full-time Officers and Subsidiary Officers (classified as Directors, General Managers, and Vice Presidents on Dec. 31, 2007) of the policyholder not included in any other Class - Four times annual salary rounded to the higher $1,000 ($3,000,000 maximum).

PAD&D Plan 2

All active Full-time Directors of the policyholder not included in any other Class - Three times annual salary rounded to the higher $1,000 ($2,000,000 maximum).

PAD&D Plan 3

All active Full-time employees of the policyholder scheduled to work a minimum of 30 hours per week, (must reflect as active Full-time or Qwest Union Represented Term Full-time employees in the Company's payroll system) including all Union Represented employees - One times annual salary rounded to the higher $1,000 ($2,000,000 maximum).

Annual salary

The Personal Basic AD&D Plan uses your annual eligible pay which calculates your base pay plus your target incentive (short term incentive pay) if eligible for the Company's Incentive Plan as of your last day of employment before death to determine benefits for your beneficiaries. Annualized commissions are included, if a sales-related employee, as determined by the Company. Annual salary does not include bonuses, overtime, lump-sum merit awards, shift differentials or any other extra compensation.

Cost of coverage

Except to the extent a collective bargaining agreement provides otherwise, the cost of Personal Basic AD&D coverage for eligible employees is currently paid by the Company.

Supplemental/Voluntary Accidental Death & Dismemberment

You may select Supplemental Accidental Death & Dismemberment coverage (referred to by the Claims Administrator as Voluntary AD&D or VAD&D) for yourself, as well as, your eligible dependent(s). Electing the Supplemental/Voluntary Accident Death & Dismemberment plan is optional. This Plan pays benefits for losses that occur within 365 days of the covered injury on or off the job. To qualify, you must have been covered by the Plan at the time of the accident. Benefits from this Plan may be in addition to any benefits payable by the Company's other Life Plans.

Employee coverage

The Supplemental/Voluntary AD&D Plan offers a choice of eight coverage options. You may choose coverage equal to one, two, three, four, five, six, seven, or eight times your eligible pay (base + target incentive + annualized commissions if a sales-related employee) rounded up to the next higher $1,000, up to a maximum of $2,000,000. The amount you choose will be considered your Principal Sum.

Annual salary

The Supplemental/Voluntary AD&D Plan uses your annual eligible pay including your target incentive (short term incentive pay) if eligible for the Company's Incentive Plan as of your last day of employment before death to determine benefits for your beneficiaries. Annualized commissions are included, if a sales-related employee, as determined by the Company. Annual salary does not include bonuses, overtime, lump-sum merit awards, shift differentials or any other extra compensation.

Spouse or Domestic Partner coverage

If you enroll yourself, you may also cover your spouse/domestic partner. If you enroll your spouse or domestic partner, the spouse or domestic partner is automatically covered for 50% of the Employee Supplemental/Voluntary AD&D amount up to the maximum of $750,000.

Dual coverage is not allowed under the Plan policy. If you, your spouse/domestic partner and/or child work for the Company, you cannot be enrolled as an employee and as a dependent under your spouse/domestic partner's plan as well as your child cannot be enrolled in their own coverage and as a dependent under the parent working for the Company.

Important: If after enrollment, it is determined that **dual coverage** was elected, the Plan Administrator will make a correction to the Plan elections removing the employee as a dependent under the Plans. If this occurs, both employees will receive an email sent to their personal email address indicating there is a corrected Benefit Summary available on the Health and Life website for review and for record purposes.

Child(ren) coverage

If you enroll yourself, you may also cover your child(ren). If you enroll your child(ren), the child or children are automatically covered for 25% of the Employee Supplemental/Voluntary AD&D amount. The maximum AD&D benefit per child is $100,000. Dual coverage is not allowed under the Plan policy.

If you have a dependent child enrolled in the Child(ren) Supplemental/Voluntary AD&D (the Plan is Employee + Dependent Supplemental/Voluntary AD&D), at the end of the month in which they attain age 26, they will be automatically removed from coverage. You do not need to notify the Service Center. The Claims Administrator will send paperwork regarding portability options to continue on an individual policy. If you wish to elect coverage for your

dependent child(ren), the form must be completed and submitted directly to the Claims Administrator. The individual policy will be with the Claims Administrator and you would pay them directly.

Cost of coverage

The Supplemental/Voluntary AD&D coverage under the Life Plan is an insured benefit, which means that the cost of coverage is based on the premiums charged by the Claims Administrator. You pay the cost of coverage which is determined by your annual salary (base pay + anticipated short-term incentive) and the election option you select. Your coverage and premium can change (increase or decrease) if you experience a change in pay (promotion, demotion, etc.). If you experience a change in pay, the effective date is the same day that your salary adjustment is effective. If you have any questions about reductions/decreases refer to your Benefit Summary available on the Health and Life website and well as you paycheck premium deductions. You can also contact the Service Center. Do **not** contact Payroll via HR tickets, chat, email or phone as they cannot assist with benefit premium related questions.

Except to the extent a collective bargaining agreement provides otherwise, you pay the full cost of coverage on a post-tax basis. You can view the rates on the U.S. Benefit Premium pages available on InsideLumen, lumenbenefits.com, in the Reference Center on the Health and Life website or by calling the Service Center.

The following provisions are applicable to Basic and Supplemental/Voluntary AD&D

Payment schedule

The Personal Basic and Supplemental/Voluntary AD&D Insurance Plans will pay a percentage of the Principal Sum (the amount of the coverage) based on your covered loss.

Type of Loss	% of Principal Sum
Life	100%
Both hands, both feet or sight of both eyes	100%
One hand **and** one foot	100%
Speech and hearing	100%
Either hand or foot and sight of one eye	100%
Paralysis of both arms and both legs	150%
Paralysis of three limbs	75%
Paralysis of both legs, or paralysis of the arm and leg on either side of the body	66 2/3%
Paralysis of one arm or leg	50%
Speech **or** hearing	50%
Thumb and index finger of same hand	25%

Loss means with regard to:

- **Foot or Hand –** actual severance through or above wrist or ankle joints.
- **Sight, Speech or Hearing –** total and permanent loss thereof
- **Thumb and index finger –** actual severance through or above the metacarpophalangeal joint of a thumb or index finger
- **Limbs –** (Limbs mean an Arm or Leg) permanent, complete and irreversible paralysis of such limbs

If you die accidentally, the death benefit will be paid to your beneficiary. For any other covered loss, you will receive the benefit. If a covered individual sustains more than one loss due to a single accident, the plan will pay only one benefit, the largest, for the loss.

Hazard limitations:

In case of an air accident injury, benefits are payable only for a loss due to an accident while you are a passenger, (or pilot, operator or crew member of the Company owned or leased aircraft) riding in or on, boarding or getting off:

- any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:
  - medical certificate; and
  - pilot certificate with a proper rating to pilot such aircraft.
- any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

What is not covered

The Personal Basic and Supplemental/Voluntary AD&D Plans do not cover any loss caused or contributed to by any of the following:

1. physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
2. infection, other than infection occurring in an external accidental wound or from food poisoning;
3. suicide or attempted suicide;
4. intentionally self-inflicted injury;
5. service in the Armed Forces of any country or international authority. However, service in Reserve Forces does not constitute service in the Armed Forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the National Guard of any other country;
6. any incident related to:
   - travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger; however this exclusion will not apply to a loss sustained by You as a pilot or a crew member if You were hired by the policyholder as a pilot or crew member and the loss is sustained while You are acting in that capacity;
   - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
   - parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
   - travel in an aircraft or device used:
   - for testing or experimental purposes;
   - by or for any military authority; or
   - for travel or designed for travel beyond the earth's atmosphere;
7. committing or attempting to commit a felony;
8. the voluntary intake or use by any means of:
   - any drug, medication or sedative, unless it is:
   - taken or used as prescribed by a Physician; or
   - an "over the counter" drug, medication or sedative taken as directed;
   - alcohol in combination with any drug, medication, or sedative; or
   - poison, gas, or fumes; or
9. war, whether declared or undeclared; or act of war.

Notice and proof of loss

When there has been a covered loss, notify the Service Center at 833-925-0487. When there has been a death due to an accident, notify WTW at 888-324-0689. For the purpose of this section, **the Service Center is the recordkeeper** and is the party designated by the policyholder to maintain certain records needed to administer the insurance provided under this certificate and the Group Insurance Policy. A notification of death should be filed with the applicable location (Service Center or WTW based on the reason for the claim: covered loss or death) as soon as reasonably possible but no later than 20 days after the date of death. Additionally, proof of claim must then be provided no later than 90 days after the date of death even if a certified death certificate is not yet available. The Service Center will notify the Claims Administrator and a claim form will be sent to You if there has been a covered loss. WTW will notify all Claims and Plan Administrators and your beneficiary(ies) will be sent a claim form(s) if there has been a death due to an accident.

The claim form should be completed and sent along with proof of the covered loss to the Claims Administrator as instructed on the claim form. If You or the beneficiary have not received a claim form within **20** days of giving notice of the claim, proof may be sent using any form sufficient to provide to the Claims Administrator with the required Proof. The claimant **must give us** proof no later than 90 days after the date of the covered loss.

When the Claims Administrator receives the claim form and proof, the Claims Administrator will review the claim and, if we approved it, we will pay benefits subject to the terms and provisions of this certificate and the Group Insurance Policy. The benefit amount may be reduced by the amount of any due and unpaid bi-weekly or monthly (and over time) premiums outstanding at the time payment is made.

Time limit on legal actions: A legal action on a claim may only be brought against the Claims or Plan Administrator during a certain period after the Claims Appeal procedure is followed, if applicable. This period begins 60 days after the date proof is filed and ends three years after the date such proof is required.

Claims appeal procedure

In accordance with the rules and regulations of the Employee Retirement Income Security Act (ERISA), which governs this Plan, you have the right to appeal the **Claims Administrator's decision** to deny the Personal Basic and/or Supplemental/Voluntary Accidental Death & Dismemberment benefit. You have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor Regulations. Your appeal should provide in writing your reason for disagreeing with the Claims Administrator's decision, and should include supplemental documentation that will have a bearing on the Claims Administrator's decision. This appeal must be received by the Claims Administrator within 60 days of the date of the denial letter you receive from the Claims Administrator.

A decision on appeal will be made no later than 60 days after the Claims Administrator receives your written request for review of the initial determination. The review will take into account all new information, whether or not presented or available at the initial determination. If the Claims Administrator determines that special circumstances require an extension of time for a decision on appeal, the review period may be extended by an additional 60 days (120 days in total).

The Claims Administrator will notify you in writing if an additional 60-day extension is needed.

In accordance with Section 502(a) of ERISA, you have the right to bring a civil action following an adverse benefit determination, but you must complete this appeal procedure before filing suit. If the Claims Administrator does not receive your written appeal within 60 days of the date of the denial letter you receive, the Claims Administrator's claim determination will be final. The policy under which you filed a claim has a provision, which states, in part, that no lawsuit or legal action shall be brought to recover on the policy after the expiration of three years from the time proof of loss is required. If the law of the state where You live makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.

Please direct your appeal to:
MetLife Group Life Claims
P. O. Box 6100
Scranton, PA 18505

You have the right to appeal the Life and AD&D Plan **eligibility rules** which is different from appealing the Claims Administrator's decision. If you believe you are eligible for coverage and are not enrolled or if you believe your coverage amount is incorrect, you can submit a Level I Appeal Claims Initiation Form (CIF). The form is available in the **Reference Center** on the Health and Life website. Submit the completed CIF to the Service Center. Make sure you completed the form in its entirety including signing and dating the form. You can submit additional information and/or documentation to support your claim. The Service Center has 30 days to make a decision and will respond in writing via USPS mail. If additional time is needed to review, you may receive an extension letter notifying you of an updated due date because additional time is required.

If the Service Center denies your appeal regarding **eligibility rules**, you do have the right to submit a Level II appeal that will be reviewed by the Lumen Employee Benefits Committee (EBC). They have 60 days from receipt of your second appeal to make a decision and will respond in writing via USPS mail. You would submit a Level II CIF along with any supporting information and/or documentation to the Service Center and they will forward to the EBC. If additional time is needed to review, you may receive an extension letter notifying you of an updated due date because additional time is required.

Additional services provided

Travel Assistance when enrolled in AD&D

You may contact AXA Assistance USA, Inc. (AXA) regarding the Travel Assistance program by calling 800-454-3679 from United States or Canada and collect from anywhere else in the world at 312-935-3783.

Website is metlife.com/travelassist. Reference Policy Number: 148069-1-G.

The following App is available at Apple App Store or Google Play - **Doctor Please!** Call AXA to receive the code needed for user registration.

The Claims Administrator selected AXA to provide a Travel Assistance program. AXA offers medical assistance while traveling, medical evacuation, evacuation due to natural disaster or political unrest, assistance while traveling with your pet, help with lost documents, credit cards or luggage while traveling, replacement prescription medication while traveling and assistance if you are a victim of identity theft while traveling. AXA is an independently owned company and is not associated with or an affiliate of the Claims Administrator. All services must be arranged by AXA. No claims submission for reimbursement will be accepted.

Important information about the Plans

The Life and AD&D Insurance Plans are subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA).

Statement of ERISA rights

The Employee Retirement Income Security Act of 1974 (ERISA) affords you with certain legal protection under the plans the Company provides.

As a participant in the Life and AD&D Insurance Plan component of the Company's Welfare Benefits Plan No. 513, certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and other specified locations, such as work sites, and union halls, all documents governing the plan including insurance contracts, 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 updated Summary Plan Description. The Plan Administrator may make a reasonable charge for copies.
- Receive a summary of the Plan's Annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of this Annual Summary report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who operate your plans, called fiduciaries, have a duty to do so prudently and in the sole interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Welfare benefit or exercising your rights under ERISA.

If your claim for a Welfare benefit is denied or ignored, 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 within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that plan fiduciaries misuse the plans' 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.

If you have any questions about the Plan(s), you should contact the Plan Administrator. If you have any questions

about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20220. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication's hotline of the Employee Benefits Security Administration.

Plan amendments

The Company reserves the right at any time, to terminate, modify or amend, in whole or in part, any or all of the provisions of the plans.

Interpretation of the Plan

The Plan Administrator has authority to control and manage the operation and administration of the Plans. However, the Plan Administrator has delegated to the Claims Administrator its entire discretionary authority to make all final determinations regarding claims for benefits under the benefit Plan insured by these policies. This discretionary authority includes, but is not limited to, the determination of eligibility for benefits, based upon enrollment information provided by the policyholder, and the amount of any benefits due, and to construe the terms of these policies.

Any decision made by the Claims Administrator in the exercise of this authority, including review of denials of benefit, is conclusive and binding on all parties. Any court reviewing Claims Administrator's determinations shall uphold such determination unless the claimant proves the determinations are arbitrary and capricious.

Plan name and type

The names of the Plans in which this SPD summarizes the benefits is outlined below. These Plans are components of the Company's Group Welfare Benefits Plan 513, which is an umbrella Section 125 Cafeteria Plan. Components of this Plan summarized here include the following:

- The Company's Life Insurance Plan which offers the following benefits and coverage:
  - Basic Term Life
  - Supplemental/Optional Term Life for Employee, Spouse/Domestic Partner and Child(ren)
- The Company's Accidental Death and Dismemberment Plan which offers the following benefits and coverage:
  - Personal Basic Accidental Death and Dismemberment (PAD&D)
  - Supplemental/Voluntary Accidental Death and Dismemberment (VAD&D) for Employee or Employee + one or more Dependents

Plan financing and administration

- **Plan Year:** Jan. 1 through Dec. 31.
- **Plan Financing:** The Plans are financed on a fully insured basis. The insurance premiums paid under the Plans may be funded through one or more of the following: employer general assets, employee contributions through payroll deductions or through Direct Deposit monthly payments or, if applicable, a Voluntary Employee Beneficiary Association (VEBA) trust.
- **Administration Type:** The Life and AD&D Plans are administered by a third party claims administrator – insurance carrier operating under the Group Insurance policy.

Plan sponsors (Company)

Lumen
214 East 24th Street
Vancouver, WA 98663

Employer Identification Number: 72-0651161

Agent for legal service

Associate General Counsel | ERISA
Lumen, Room 1NW777
100 CenturyLink Drive
Monroe, LA 71203

Legal process may also be served at:
Lumen Technologies
c/o Employee Benefits Committee (EBC)
214 East 24th Street
Vancouver, WA 98663

Limitation on civil actions

You cannot bring any legal proceeding or action against the Plan, the Plan Administrator, Claims Administrators or the Company unless you first complete all the steps in the claims and appeal process described in this SPD.

After completing that process, you can bring any legal proceedings or action against the Plan Administrator, the Claims Administrator or the Company within 12 months or one year of the date the Claims Administrator notified you of the final decision of your appeal. No person has the right to file a civil action, proceeding or lawsuit against the Plan or any person acting with respect to the Plan, including, but not limited to, the Company, any Participating Company, the Company's Employee Benefits Committee or any other fiduciary, or any third party service provider, after the expiration of three years from the time proof of loss is required.

Clerical error

If a clerical error or other mistake occurs, however occurring, that error does not create a right to benefits. Clerical errors include, but are not limited to, providing misinformation on eligibility or benefit coverages or entitlements or relating to information transmittal and/or communications, perfunctory or ministerial in nature, involving claims processing, and recordkeeping. Although every effort is and will be made to administer the Plan in a fully accurate manner, any inadvertent error, misstatement or omission will be disregarded, and the actual Plan provisions will be controlling. A clerical error will not void coverage to which a participant is entitled under the terms of the Plan, nor will it continue coverage that should have ended under the terms of the Plan. When an error is found, it will be corrected or adjusted appropriately as soon as administratively possible. Interest shall not be payable with respect to a benefit corrected or adjusted. It is your responsibility to confirm the accuracy of statements (Account Statements available online only, Benefit Summary, Pre-Annual Enrollment Statement, etc.) made by the Plans or our designees, including the Claims Administrator, in accordance with the terms of this SPD and the Plan document including the Group Insurance Policy. It is critical for this reason that you are responsible for reviewing your bi-weekly paycheck to confirm the benefit premium deductions for the Life and AD&D plans and to notify the Service Center (not the payroll team) of a possible error. The notification must be provided to the Service Center no later than 180 days or end of year, whichever is the earlier of. Correction in a prior year will not be reviewed or approved.

Records and information and your obligation to furnish information

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

By accepting benefits under the Plan, you authorize and direct any person or institution that has provided services to you, to furnish the Plan or the Claims Administrator with all information or copies of records relating to the services provided to you. The Plan or the Claims Administrator has the right to request this information at any reasonable time. This applies to all covered persons, including enrolled dependents whether or not they were or were not the ones that enrolled. The Plan agrees that such information and records will be considered confidential. The Company, Plan Administrator and the Claims Administrator have the right to release any and all records which are necessary to implement and administer the terms of the Plans, for appropriate medical review or quality assessment, or as we are required by law or regulation.

Circumstances that may affect your Plan benefits

Under certain circumstances all or a portion of your benefits under the Plans may be denied, reduced, suspended, terminated or otherwise affected. Many of these circumstances have been addressed elsewhere in this SPD. Such circumstances, in general, include but are not limited to:

- You are no longer in an eligible class.
- The Plan is amended, changed or terminated.
- You attain the maximum benefit available under the Plans, such as may apply to certain Life and AD&D benefits.
- You misrepresent or falsify any information required under the Plans; you, your dependent(s) or your beneficiaries will not be permitted to benefit under the Plans from your own misrepresentation.
- You have been overpaid a benefit and the Plans seek restitution.
- Your coverage under the Plans is terminated for one of a variety of reasons, for example, failure to pay a supplemental benefit premium or failure to pay it on a timely basis.
- Your coverage is rescinded as permitted by law.

Consequences of falsification or misrepresentation

Coverage for you or your dependent(s) will be terminated if you or your dependent(s) falsify or intentionally omit medical history on the application for coverage, submit fraudulent, altered or duplicate billings for personal gain, allow another party not eligible for coverage to be covered under the Plan or obtain Plan benefits, or allow improper use of your or your dependent's coverage. You and your dependent(s) will not be permitted to benefit under the Plan from your own misrepresentation. If a person is found to have falsified any document in support of a claim for benefits or coverage under the Plan, the Plan Administrator may, without anyone's consent, terminate coverage, possibly retroactively if permitted by law (called recission), and may seek reimbursement for benefits that should not have been paid out. Additionally, the Claims Administrator may refuse to honor any claim under the Plan. You are also advised that suspected incidents of this nature are turned over to Corporate Security to investigate and to address the possible consequences of such actions. You may be periodically asked to submit proof of eligibility to verify claims. All participants are required to cooperate with requests to validate eligibility.

Glossary of defined terms

To understand your Life and AD&D Insurance coverage, you should be familiar with the following terms:

Accelerated Benefit Option (ABO) - You or your spouse/domestic partner have been diagnosed with a terminal illness and have 24 months or less to live. You may be able to accelerate and receive a certain percentage of your Basic and/or Supplemental Term Life Insurance coverage while alive.

Actively at work – Any day you report for work and perform the usual duties of your job at your usual place of employment (or such other places as required by your the Company).

Annual enrollment – Period at the end of each year, during which you make choices about your Supplemental Term Life and AD&D coverage for the coming year (usually held in November). Basic Life - $50,000 may be another plan option if you qualify.

Beneficiary – The person or persons you name to receive a death benefit from your Life and AD&D Insurance Benefit Plan if you die. A beneficiary can also be an estate or trust. You are the beneficiary if the person who dies is your spouse/domestic partner and/or child(ren) and are covered under the Plans..

Converted life insurance policy – An individual policy that you may buy without proof of good health if your Life Insurance Benefit Plan ends or reduces.

Disabled dependent – A dependent who is confined in the hospital.

Domestic partner – A person of the same or opposite sex who shares your residence for the past 12 months (the residence requirement doesn't apply where there is an exception as permitted by the Plan Administrator as required by applicable law); is no less than 18 years of age; is financially interdependent with you and has proven such interdependence by providing proof of joint ownership; is not a blood related or any closer than would prohibit legal marriage; and provides a Certificate of Domestic Partner Registration if you reside in a state that provides such registration OR has signed jointly with you, a notarized affidavit if you reside in a state that does not provide Domestic Partner Registration.

Initial enrollment – The first time you enroll in the Company's plans after you start work as an eligible employee or are newly eligible for the Plans (e.g., Part-time to Full-time change in status).

Plan(s) – Plan pertains to Life and/or AD&D Plans.

Portability – Portability pertains to the Supplemental Term Life Plan whereby an employee or dependent which loses coverage for certain reasons may port their Supplemental Term Life coverage under another group policy. Two sets of rates apply: 1) without Evidence of Insurability and 2) with Evidence of Insurability.

Principal sum – The full coverage amount under the AD&D plans, payable for accidental death and certain other covered losses.

Qualified status change – Significant changes in your family that may allow you to change your coverage. Examples may include marriage, divorce, birth or adoption of a child, death of a spouse, domestic partner or child, or changes in your or your spouse's/domestic partner's or child's employment.

Appendix

Claims Administrator - Life Insurance

Metropolitan Life Insurance Company (MetLife)
200 Park Avenue
New York, New York 10166

800-638-6420

Group Policy #148069-1-G

Claims Administrator - Accidental Death & Dismemberment (AD&D) Insurance

MetLife Insurance Company
Post Office Box 6100
Scranton, PA 18505

800-638-6420

Group Policy #148069-1-G

Pension Administrator for reporting Death Notifications

WTW
888-324-0689, 8 a.m. - 7 p.m. (CST)

Plan Adminisrator

Lumen Health and Life Service Center (aka Service Center or Businessolver)
833-925-0487, Mon-Fri, 7 a.m. - 7 p.m. (CST)

Plan Sponsor - Lumen

214 East 24th Street
Vancouver, WA. 98663