2020 **Annual Enrollment guide**

Annual Enrollment begins Nov. 4, 2019 and ends Nov. 22, 2019

Qwest Post-1990 Occupational Retirees
Including: Inactive and COBRA Participants

What's inside

Welcome to Annual Enrollment for 2020

It's time to enroll for your 2020 benefits under the **CenturyLink Retiree and Inactive Health Plan ("the Plan")**. We encourage you to review this guide and your Annual Enrollment Worksheet (EWS) as it contains important benefit information and plan changes that could impact you. If you are not making any changes or updates to your coverage, no action is required.

This guide pertains to BOTH non-Medicare eligible and Medicare eligible participants and their dependents. However, page 12 is ONLY specific to Medicare-eligible participants.

NOTE: For more information, refer to the Health and Life website at **centurylinkhealthandlife.com** or contact the CenturyLink Service Center (referred to hereafter as the Service Center). Refer to the Helpful Resources page in this guide or your Summary Plan Description (SPD) for further details. If you need a copy of your SPD, contact the Service Center at **866-935-5011** or **800-729-7526**, Option 2 and then Option 1.

What's new for 2020
Page 3

Enrollment reminders
Page 8

Medical and prescription drug - HDHP
Page 9

Medical and prescription drug - CDHP
Page 10

Medical and Prescription Drug overview
Page 11

Medical and prescription drug overview - Bind On-Demand
Page 12

Newly eligible for Medicare
Page 14

Dental overview
Page 15

Retiree Life Insurance
Page 16

Paying for your coverage
Page 17

Enroll
Page 18

Helpful resources
Page 19

Important coverage rules
Page 20

Legal and important required notices
Page 21

What's new for 2020

This section serves as a Summary of Material Modifications (SMM), pursuant to the requirements of Section 104 of the Employee Retirement Income Security Act of 1974, as amended (ERISA). This SMM notifies you of certain changes to the CenturyLink sponsored Plans (collectively, the "Plan"). For further details, refer to your Summary Plan Descriptions (SPD's) and the Legal and Important Required Notices section of this Guide.

Please keep this SMM with your SPD for future reference. This SMM summarizes only certain provisions of the Plan. If there is any conflict between the terms of the Plan documents and this SMM, the terms of the Plan documents will govern. The company has reserved to the Plan Administrator the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan.

As a Qwest Post-1990 Occupational Retiree previously represented by either the Qwest/CWA or Qwest/IBEW Local 206 collective bargaining agreement, you and your eligible dependent(s) are impacted by the recently negotiated Collective Bargaining Agreement reached with CWA D7 and IBEW 206. With the ratification of the Collective Bargaining Agreement, these changes are effective Jan. 1, 2020.

The information listed below is not meant to be a complete list of all changes to your benefits. Refer to the applicable SPD's for additional detail.

Service Center phone number

You can contact the Service Center for Health and Welfare benefits directly at **866-935-5011**. You are still able to reach the Service Center for Health and Welfare benefits by calling **800-729-7526**, Option 2 and then Option 1.

COBRA Participants

As a COBRA participant, coverage is limited to medical and/or dental coverage, as applicable. COBRA rates have changed. Please refer to your Enrollment Worksheet (EWS) that was included in your packet with this guide.

Important changes to Plan rules

Eligibility for Retiree Medical and/or Dental Benefits - Rules on Suspend versus Waived Coverage

- **Suspend coverage** - If you are enrolled in medical and/or dental coverage under the Plan, you have a **one-time** opportunity to suspend your coverage and still be able to enroll in the Plan at a later date as a result of a Qualified Life Event (QLE), or during Annual Enrollment.
- **Waived coverage** - If at any time, you elect to waive your medical and/or dental coverage under the Plan, you will **not** be able to elect coverage at a later date regardless if you experience a QLE or during Annual Enrollment. Waiver of coverage means you are no longer eligible under the Plan.

Note: If you are currently in waived status under the prior rules, your 2020 Enrollment Worksheet (EWS) will reflect that you waived your retiree medical and/or dental coverage; however, your record will automatically update to suspend coverage in early 2020 for coverage effective Jan. 1, 2020. By placing you into suspend coverage effective Jan. 1, 2020 does not count as your one-time opportunity to unsuspend coverage.

Please Note: This change in "suspending" coverage versus "waiving" coverage is very important and affects your eligibility under the Plan.

If you have questions regarding these terms and how they are used, please contact the CenturyLink Service Center at **866-935-5011** or **800-729-7526**, Option 2 and Option 1.

What's new for 2020 (cont.)

Important changes in Rules on Termination due to Non-Payment, Untimely or Insufficient Payment

The previous Summary of Material Modification (SMM) effective Jan. 1, 2014 concerning failure to pay health plan premiums in full when due will no longer apply. If you have been reinstated in the past due to non-payment, untimely payments or insufficient funds, your prior reinstatements (one through four) will no longer apply. All Qwest-Post-1990 Occupational retirees will have only a **one-time** opportunity beginning Jan. 1, 2020 for reinstatement due to non-payment, untimely payments or insufficient funds. You will have 180 calendar days from the date of notice of termination/denial of coverage to file and submit a claim and appeal for consideration of reinstatement of coverage in accordance with the Plan's provisions. The one-time opportunity does not re-set each year but is for the life of your participation in the Plan.

If you have questions regarding this process, please contact the CenturyLink Service Center at **866-935-5011** or **800-729-7526**, Option 2 and Option 1.

Medical

Review the Medical section of this guide. You have five medical plan benefit options to choose from for 2020. If you enroll in a medical benefit plan option, you will receive a new medical ID card for 2020.

The PPO Plan through Highmark Blue Cross Blue Shield or UnitedHealthcare will no longer be an available medical plan option to choose from. If you were previously enrolled in the PPO Plan, you will be defaulted to the Standard CDHP plan option unless you make a change during the Annual Enrollment period.

- **Waive Medical Plan Coverage** (this means you do not have medical coverage)
- **Two Consumer Driven Health Plans (CDHPs)** - The Standard CDHP and the Premium CDHP, each with a company-funded Health Reimbursement Account (HRA). These Plan options are administered by UnitedHealthcare.
- **Savings High Deductible Health Plan (HDHP)** - You will continue to have a Savings HDHP available with the option to enroll in an retiree-funded Health Savings Account (HSA), if eligible. This Plan option is administered by UnitedHealthcare.
- **NEW - Bind On-Demand Health Plan** - Bind On-Demand is a health coverage option made simple designed to give you more control of your cost and coverage.

  Cost clarity - The Bind On-Demand plan has a $0 deductible and straightforward menu-based costs across treatment categories: emergency care, maternity, prescription drugs, preventive, primary care, virtual visits, etc. Like other useful services of our daily lives, the user-friendly Bind On-Demand mobile App and web experience can provide you with instant answers on what's covered and what things cost, so you can know before you step foot in a doctor's office.

  Coverage flexibility - With Bind On-Demand, you have the flexibility to purchase Add-in coverage for a small set of procedures you can plan for, like foot bone fusion or knee replacement. Less than 5% of people obtain these services during the year, so Bind On-Demand lets you keep your cost lower without coverage you likely won't need, along with the ability to add the coverage through direct bill if and when you elect to obtain one of these specific procedures.

  Helpful support - With Bind On-Demand, you have access to one of the largest in-network doctors, clinics and hospitals. You also have access to a supportive Help Team and online tools that provide instant answers to coverage questions, cost and treatment comparisons, help finding the doctors and clinics you need and answers to any plan questions you may have. Call Bind On-Demand at 833-576-6519.

What's new for 2020 (cont.)

Learn more about Bind On-Demand

Visit **centurylink.com/choosebind** (Access Code: **CTL2020**), to explore costs, coverage and providers.

Note: If you are considering this medical plan option, you are advised to read all of the materials available and to ensure you understand what is not covered and how this plan works.

2nd.MD – Second opinions expanded to all conditions

(For those enrolled in UnitedHealthcare plan options (Savings HDHP, Standard CDHP or the Premium CDHP) and those enrolled in the Bind On-Demand plan option).

We have expanded 2nd.MD's benefit from spine- and joint-only benefits to all conditions! 2nd.MD can connect you and your eligible dependents with board-certified, experienced doctors for free with your UnitedHealthcare or Bind On-Demand medical plan. Get informed advice regarding chronic conditions, medications, new or existing diagnosis, surgery or a treatment plan.

2nd.MD experts are industry leaders across hundreds of thousands of subspecialties and thousands of conditions, such as ankle surgery, cancer, digestive problems, heart disease, hip, immunological disorders (rheumatoid arthritis, type 1 diabetes), infertility, knee, mental health issues, stroke and more.

Back-to-Basics Program – no cost coverage

(For those enrolled in UnitedHealthcare plan options (Savings HDHP, Standard CDHP or the Premium CDHP).

You are eligible for three (3) visits for lower back pain with an in-network physical therapist or chiropractor at no cost to you. Visit **myuhc.com** or call UnitedHealthcare at the number on the back of your medical ID card to find an in-network provider near you.

In- and out-of-network providers

(For those enrolled in UnitedHealthcare plan options (Savings HDHP, Standard CDHP or the Premium CDHP).

You will now have a separate deductible and out-of-pocket maximum when using either an In-Network or Out-of-Network provider, it will no longer be a combined amount. For example, if your dermatologist is out-of-network, the amount you're responsible for will only apply to your out-of-network deductible and out-of-pocket maximum. This amount **will not** apply to your in-network deductible and in-network out-of-pocket limits.

Out-of-network coinsurance

(For those enrolled in UnitedHealthcare plan options (Savings HDHP, Standard CDHP or the Premium CDHP).

The coinsurance for ALL out-of-network reimbursement is changing from 60% (you pay 40%) to 50% (you pay 50%). You will pay more when you use an out-of-network provider.

Out-of-network providers set their own rates and may bill you for the difference between their rates and what UnitedHealthcare pays based on eligible rates. This is called above "reasonable and customary charges", ("R&C"). **If you receive a bill for this difference, you are responsible for the cost and it will not apply to your out-of-pocket limit.**

Out-of-network outpatient surgery

(For those enrolled in UnitedHealthcare plan options (Savings HDHP, Standard CDHP or the Premium CDHP).

Out-of-network outpatient surgery **is not** covered by the Plan. You will be responsible for all associated costs.

Before getting care with any of your existing providers or new providers, make sure they are in-network by contacting the provider before your visit. This includes any ambulance transfer services, doctors, hospitals, lab facilities, and outpatient services such as pain injections. Before you get care, use the cost estimator tool at **myuhc.com** or the UnitedHealthcare mobile app to estimate costs on more than 500 services and procedures.

Note: If a provider says they'll accept your insurance plan, this doesn't always mean they're in-network. To get the most out of your plan coverage (and pay less), make sure to ask the provider ahead of time, "Are you in-network with UnitedHealthcare?"

What's new for 2020 (cont.)

Need help finding an in-network provider?

» Visit myuhc.com and click "Find a Doctor".

» Download the free UnitedHealthcare mobile app.

» Call UnitedHealthcare at the number of the back of your medical ID card Monday through Friday, 8 a.m. to 8 p.m. in your time zone.

Emergency room — non-emergency (For those enrolled in UnitedHealthcare plan options (Savings HDHP, Standard CDHP or the Premium CDHP).

1. When you use the Emergency Room for non-life-threating services you will pay more for the visit. If your visit is deemed non-emergent (non-life threatening), the coinsurance plan will only pay 50% of the cost after the annual deductible is met. You will be responsible for meeting your annual deductible and the remaining 50%. This includes both in-network and out-of- network providers.

   Here are some examples of when to go to the emergency room: chest pain, difficulty breathing, heavy bleeding, large open wounds, major broken bones, major burns, severe head injury, spinal injuries, sudden change in vision or sudden weakness or trouble talking.

   Here are some examples of services that are generally deemed not to be a true emergency: ear infection, minor infections, rashes, small cuts, sore throat, sprains or strains.

2. A $300 penalty will be charged on your fourth and any subsequent ER visits within the calendar year for each covered family member. The $300 penalty will not apply towards your annual deductible or out-of-pocket maximums and will not apply if you are admitted to the hospital. The penalty will only apply to participants over the age of 18 and doesn't apply to children under age 18. And, the penalty will not apply if the participant is admitted to the hospital.

   Note: This penalty resets every calendar year. The penalty will be waived if you contact the UHC at the number on the back of your medical ID card within seven days from the ER visit.

2020 Medical Plan Dependent Audit

As part of CenturyLink's ongoing efforts to ensure our Health Plan meets its own eligibility requirements, we will be conducting a dependent audit to validate whether your spouse/domestic partner or common law spouse remains eligible for coverage under your medical and/or dental plan benefit option.

Note: There are significant consequences for covering someone who isn't eligible such as an ex-spouse or ex-domestic partner (even if you have a court order that indicates you must have health coverage for your ex-spouse or ex-domestic partner.)

» **Immediate termination of coverage due to ineligibility.** If your enrolled person is determined to be ineligible, they will be removed from medical and/or dental coverage, as applicable. There are also tax consequences; for example, if a person was identified by a retiree as a "spouse" now, but is later determined to be a "former spouse" , they are not eligible for coverage under the Plan and must be removed. If the "former spouse" also has covered children (the Participant's step-children) under the Plan, the step children will also be removed from the Plan.

What should you do now? Confirm those already enrolled meet the Plan's definition of eligibility. If you have questions about eligibility, check the Summary Plan Description or contact the CenturyLink Service Center. Remove any ineligible persons. Unless the removal from coverage is coincident with a Qualified Life Event (QLE), COBRA coverage is not available and will not be offered.

Documents to validate eligibility. For your spouse/domestic partner or common law spouse whom you wish to maintain as enrolled in your medical and/or dental benefit option, you will be required to provide proof of eligibility such as your 2019 Federal Tax Return listing your dependent/s (first page only), proof of joint ownership that was issued within the last 6 months, for example, mortgage statements, joint credit card statements, joint

bank statements or residential leasing agreement listing both parties’ names as co-owners.

Note: Watch for additional information prior to the Dependent Audit period.

Health Reimbursement Account (HRA)

If you experience a Qualified Life Event (QLE) that allows you to suspend your CenturyLink retiree CDHP medical benefit plan option, your remaining HRA balance will be suspended and available upon reenrollment in a CDHP benefit plan option, if applicable. If you have questions, contact the Service Center at **866-935-5011** or **800-729-7526**, Option 2 and Option 1.

Health Saving Account (HSA)

IRS Limits for Annual HSA Contributions*

*If enrolled in the Savings HDHP Plan. Retiree-funded (single) coverage increases from $3,500 to $3,550 and Retiree (single) + one or more increases from $7,000 to $7,100. The catch-up contribution for age 55 and older remains $1,000 annually. You can contribute as much as you would like, up to IRS maximums. If you are Medicare-eligible, you should review the “Medicare and You” handbook on the official medicare.gov website.

Note: You cannot elect an HSA through the Service Center, you would need to enroll in an HSA on your own.

Supplemental Life Insurance

If you currently have Supplemental Life insurance, you will experience a rate increase. Please review your Enrollment Worksheet (EWS). If you want to cancel your supplemental life insurance for 2020, go to the Service Center website at **centurylinkhealthandlife.com** or contact the CenturyLink Service Center at **866-935-5011** or **800-729-7526**, Option 2 and Option 1. The effective date of the cancellation will be January 1, 2020, as long as you cancel during the Annual Enrollment window. If you call in to change after the window closes, the effective date of the cancellation will be the first of the month following notification to the Service Center.

Enrollment reminders

Deductibles and Co-Insurance Accumulators reset on Jan. 1

If you elect to move from the CDHP plan to the HDHP or Bind On-Demand plan option, any Health Reimbursement Account (HRA) dollars will be transferred to your post-deductible HRA after a run-out period of **90** days.

If you enroll as a dependent under your spouse's group plan, any HRA dollars will be moved after a run-out period of **90** days.

It will be necessary for you to contact the Advocacy Services team at the Service Center at **866-935-5011** or **800-729-7526**, Option 2 and Option 1 to assist you with the transfer process. The Advocacy Services team will work with UnitedHealthcare or Bind On-Demand to have the HRA dollars moved to the applicable plan option after the 90-day run-out period.

Medical and Dental Company Cap

Medical and Dental Premiums

Review your Enrollment Worksheet (EWS) as your premiums may have changed for 2020.

Reminder: Retirees are responsible for the portion of the cost of medical premium that exceeds the monthly company contribution Cap, as applicable ("Cap").

Note: Be sure to review your medical plan options and premium costs carefully. The CenturyLink Retiree & Inactive Health Plan includes a Cap on the dollar amount of the premium subsidy provided by CenturyLink. Cap amounts vary depending on your legacy company and whether you are enrolling only yourself or any eligible dependents in your coverage. Once the cost of health care coverage exceeds the specified Cap amount, you must pay the entire remaining balance above the Cap amount in addition to your required percentage. CenturyLink's contribution is capped at the 2020 amounts and will not increase in the future. Visit the Health and Life website at **www.centurylinkhealthandlife.com** for more information.

Pharmacy

The Prescription Drug List (PDL) is updated in January and July of each year.

For Bind On-Demand: Visit **centurylink.com/choose-bind** to check your pharmacy coverage, estimate costs or to obtain further information. Once you are a member, visit **mybind.com**.

For UnitedHealthcare Plans:

Visit **myuhc.com** to see if your prescription is on the list or for further information. To reduce costs and make filling medications more convenient, maintenance medications for conditions such as cholesterol, diabetes and high blood pressure must be filled by mail order. You can fill your prescription up to a maximum of 2 times at a retail pharmacy. After that, it will not be covered, and you will pay the full retail price and not be eligible to be reimbursed from the Plan.

If you are already enrolled in a UHC medical plan option, you can refer to the pricing tool on **myuhc.com** to obtain pricing for your prescriptions. Once logged into the site, the pricing tool is available under Prescriptions and Coverage.

If you are considering enrolling in a UHC plan and would like to have an estimate of your prescription costs, visit **OptumRx**.

Note: You are not able to opt-out of the mail order program. Optum Rx is the only vendor available under the mail order program.

ZIP code update

Be sure to review the medical benefit options available to you as networks are determined by ZIP code areas and are revised annually. Review your Annual Enrollment Worksheet to learn what benefit plan options are available.

Stay up-to-date with the CenturyLink Retiree Newsletter

Visit **centurylinkbenefits.com** or **centurylinkhealthandlife.com** to get the latest retiree news. This newsletter is designed to share information about benefits, the company and other topics. Don't miss out!

UPoint mobile HR app

Be sure to download the **UPoint Mobile HR App**, which provides easy access to benefits information from your phone. Download the mobile app today for free from the App Store or Google Play.

Medical and prescription drug - HDHP

Savings High Deductible Health Plan (Savings HDHP) option

The Savings HDHP is similar to the Standard and Premium CDHP but has important differences. The Savings HDHP option premiums typically cost less than the Standard or Premium CDHP option, but it has a higher deductible with no HRA dollars. The key feature of this Plan is that you have the option of opening a personal tax-advantaged Health Savings Account (HSA) to save your own money and pay for your qualified medical expenses now and in the future. You cannot elect an HSA through the Service Center, you would need to enroll in an HSA on your own.

Or, you can save the money for future needs. It's your money, your account, your choice.

The Savings HDHP is administered by UnitedHealthcare. You have the freedom to choose your healthcare providers, but the Plan pays greater benefits when you use providers that are in the network. Refer to the What's Changing section of this guide for additional information regarding out-of-network providers and out-of-network coinsurance coverage.

Here's how it works

1

You incur eligible medical and prescription expenses.

2

You pay the full cost of eligible medical and prescription expenses until you meet a deductible (your Responsibility.)

Preventive services are covered at 100% - with no deductible - when you use network providers.

You can choose to pay for covered expenses with your own money (cash, check, credit or debit card).

OR

You can pay for covered services with money you have set aside in your HSA, if eligible.

3

After you reach the Employee or Family deductible (as applicable), the Plan pays a percentage of the cost of covered services up to the out-of-pocket maximum.

4

After you reach the Employee or Family out-of-pocket maximum (as applicable), the Plan pays 100% of covered services for the remainder of the calendar year for all covered plan participants.

Note: If you elect the HDHP for 2020 and were in enrolled in the CDHP plan in 2019, any remaining CDHP Heath Reimbursement Account (HRA) funds from the prior year will become available to you after 90 days, on April 15th, 2020. The 90 days allow enough time for prior year claims to process.

Do not use your Health Care Savings Card for the roll-over amount, download a claim form from, or send electronically through, **myuhc.com**.

Medical and prescription drug - CDHP

Consumer Driven Health Plans (CDHPs)

The CDHP options let you play a larger role in how your health care dollars are spent by using a health reimbursement account (HRA) funded by the Company.

Note: The HRA, Participant Responsibility (your out-of-pocket portion of the deductible) and out-of-pocket maximum are all based on the coverage level you elect (Retiree Only, Retiree + Family, etc.) under the medical Plan option you choose, even if only one covered person uses the entire HRA benefit.

Here's how it works

1 CenturyLInk funds your HRA

Company-Funded HRA Contribution

Standard CDHP

» $500 Retiree
» $750 Retiree + Spouse/Domestic partner
» $750 Retiree + Children
» $1,000 Family

Premium CDHP

» $1,000 Retiree
» $1,500 Retiree + Spouse/Domestic partner
» $1,500 Retiree + Children
» $2,000 Family

2 You incur medical and prescription expenses and pay the full cost of them with money in your HRA first, then you pay out-of-pocket until your deductible is met.

Preventive services are covered at 100% with no deductible when you use network providers. Preventive services are not covered when you use an out-of-network provider.

HRA funds can be used for any covered dependent/s.

3 After you meet your deductible, the Plan works like a traditional health plan.

You meet a deductible using your HRA plus your Responsibilty.

After you meet the deductible, you pay a percentage of the cost of covered services up to the out-of-pocket maximum.

4 After you reach the Retiree or Family out-of-pocket maximum (as applicable), the Plan pays 100% of covered services for the remainder of the calendar year for all covered plan participants.

5 If you don't use all of your HRA funds, the money carries over to the next year (with no interest) for you to use the following plan year, assuming you stay enrolled in one of the CDHP's (Standard or Premium).

Medical and Prescription Drug overview

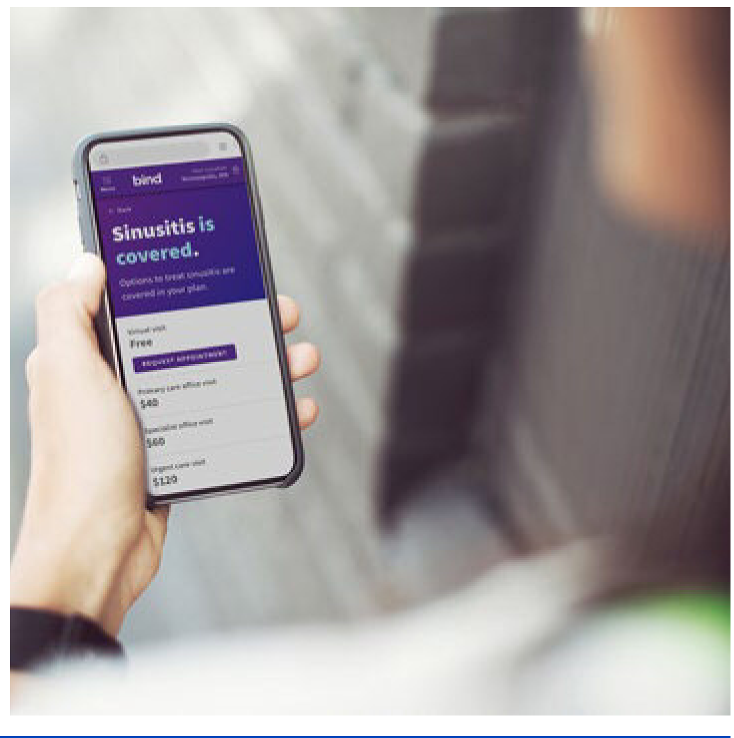
Prescription drug expenses are paid the same as any other medical expense. You will be responsible for the cost of the prescription drugs until you have met or satisfied the deductible under the Standard or Premium CDHP or the Savings HDHP. Any maintenance prescription, after two (2) retail fills, will require future fills through the mail order program through OptumRx. There is only one prescription drug plan, OptumRx, available for enrollment in the Savings HDHP, Standard CDHP or Premium CDHP. "Charges above the allowable amounts not included" refers to reasonable and customary (R&C) charges. Refer to the Summary Plan Description for information on what's not covered or excluded. This chart is only a snapshot summary of your benefits. For specific details on how services are covered or excluded, please contact UnitedHealthcare at the number on the back of your ID card. If you enroll in one of the below options, you will receive a new id card for 2020.

Savings HDHP		Standard CDHP		Premium CDHP	
With Retiree-Funded HSA: $3,550 Single (retiree) $7,100 Single (retiree) + One or more **Note:** If you are age 55 or older, you can contribute an extra $1,000 "catch-up" contribution annually.		With Company-Funded HRA Contribution: $500 Single (retiree) $750 Single (retiree) + Spouse/Domestic partner $750 Single (retiree) + Children $1,000 Family		With Company-Funded HRA Contribution: $1,000 Single (retiree) $1,500 Single (retiree) + Spouse/Domestic partner $1,500 Single (retiree) + Children $2,000 Family	
You Pay		You Pay		You Pay	
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (The Deductibles are separate for In-Network and Out-of-Network providers and are not combined)					
Single		Single		Single	
$1,500	$3,000	$1,500	$3,000	$1,500	$3,000
		Retiree + Spouse/Domestic Partner		Retiree + Spouse/Domestic Partner	
		$2,250	$4,500	$2,250	$4,500
Single + One or more enrolled		Single + Children		Single + Children	
$3,000	$6,000	$2,250	$4,500	$2,250	$4,500
		Family		Family	
		$3,000	$6,000	$3,000	$6,000
Annual Out-of-Pocket Maximum (The Out-of-Pocket Maximums are separate for In-Network and Out-of-Network providers and are not combined)					
Single		Single		Single	
$3,600	$7,200	$3,600	$7,200	$3,200	$6,400
		Retiree + Spouse/Domestic Partner		Retiree + Spouse/Domestic Partner	
		$5,400	$10,800	$4,800	$9,600
Single + One or more enrolled		Single + Children		Single + Children	
$6,850	$14,400 (charges above allowable amount not included)	$5,400	$10,800	$4,800	$9,600
		Family		Family	
		$6,850	$14,400 (charges above allowable amount not included)	$6,400	$12,800 (charges above allowable amount not included)
Plan Pays (After Deductible)		Plan Pays (After Deductible)		Plan Pays (After Deductible)	
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Care: (No Deductible)					
100%	Not Covered	100%	Not Covered	100%	Not Covered
Inpatient (Facility), Office Visit, Outpatient (Facility), Prescriptions, Urgent Care					
80%	50% of allowable amount	80%	50% of allowable amount	80%	50% of allowable amount

Administrator: UnitedHealthcare, **Group Number:** 192086, **Phone Number:** 800-842-1219

Medical and prescription drug overview - Bind On-Demand

The Bind On-Demand plan option has a $0 deductible and straightforward menu-based costs across treatment categories: emergency care, maternity, prescription drugs, preventive, primary care, virtual visits, etc. Bind On-Demand allows you to pay for what you need—not what you don't—and to adjust your coverage when those needs change. With Bind On-Demand, you have access to one of the largest networks of doctors, clinics and hospitals, which is the same as the UnitedHealthcare Choice Plus Network.



Common Medical and Pharmacy Costs with Bind On-Demand This is the amount you pay, out-of-pocket, directly to the in-network* provider for covered health care services.

Note: Out-of-Network coverage is available. Visit centurylink.com/choosebind or contact the Bind On-Demand Help Team at **833-576-6519** for additional information related to out-of-network coverage.

In-Network Benefits	
Preventive care	Free
Vitual visit	Free
Basic imaging (bloodwork, x-rays)	Free
Office visits (primary care or specialist)	$10-$70*
Mental health visit	$35
Urgent care	$125
Emergency room	$300
Complex imaging (CT/PET scans/MRI)	$150-$575*
Outpatient hospital/ambulatory surgery center	$750
Maternity/delivery	$400-$1,100*
Cancer	$10-$70* office visits $750 outpatient hospital $1,100 inpatient stay
Inpatient hospital	$1,100
Prescriptions (30-day supply)	
» Tier 1	$10
» Tier 2	$60
» Tier 3	$90
Out-of-pocket maximum	$5,000 per person $10,000 per family

*Visit centurylink.com/choosebind (Access Code: CTL2020) for out-of-network coverage options, 90 day prescription supply prices and costs. The full range of costs may not be available in all areas or for all services. After you are enrolled in the Bind On-Demand plan, visit **mybind.com** or download the myBind app on your mobile device.

Prefer the phone? Call the Bind On-Demand Help Team at **833-576-6519**, M-F 6:00 a.m.-9:00 p.m. CST.

Group number: 78800186

Bind On-Demand Plan

With Bind On-Demand, you have the flexibility to purchase Add-in coverage for a set of procedures you can plan for. Generally, these procedures are needed infrequently by most people during the year, and the premise of the Bind On-Demand plan design is that you keep more of your paycheck without carrying coverage for things you won't use. But, if you do end up needing this coverage*, you can still Add-in coverage for these specific procedures during the year if and when you do. It's simple—keep the coverage out unless you need it. Add it in when you do.

*If you need any of these procedures due to an emergency, you do not need to purchase additional coverage. If you need any of these procedures on a non-emergency basis, the amount you pay to the in-network facility for the procedure will count toward your out-of-pocket maximum. Add-in coverage must be purchased three days prior to the procedure. The additional premium you pay is on an after-tax basis.

What does this coverage cost? You would pay $0-$2,500* directly to the in-network facility for the procedure, plus $50-$200* per paycheck (after-tax) for 13-26 paychecks*.

- Adenoidectomy
- Ankle arthroscopy and ligament repair
- Ankle and foot bone fusion
- Back surgery, cervical spine disc decompression
- Back surgery, cervical spine fusion
- Back surgery, lumbar spine disc decompression
- Back surgery, lumbar spine fusion
- Bariatric surgery
- Breast reduction surgery
- Bunionectomy and hammertoe surgery
- Carotid endartectomy and stents
- Carpal tunnel surgery
- Coronary artery bypass graft surgery
- Coronary catheterization and percutaneous coronary interventions
- Ear tubes
- Ganglion cyst surgery
- Hernia repair
- Hip arthroscopy
- Hip replacement, repair and revision
- Hysterectomy
- Hysteroscopy and endometrial ablation
- Knee arthroscopy and repair
- Knee replacement and revision
- Morton's Neuroma surgery
- Plantar fasciitis surgery
- Reflux and hiatal hernia surgery
- Shoulder arthroscopy and repair
- Shoulder replacement and revision
- Sinus and nasal septum surgery
- Sling surgery for female urinary incontinence
- Tonsillectomy
- Upper GI endoscopy

* Visit **centurylink.com/choosebind** (Access Code: CTL2020) for out-of-network coverage options, 90 day prescription supply prices and costs for other covered. After you are enrolled in the Bind On-Demand plan, visit **mybind.com** or download the myBind app on your mobile device. The full range of costs may not be available in all areas or for all services.

Prefer the phone? Call the Bind On-Demand Help Team at **833-576-6519**, M-F 6:00 a.m.-9:00 p.m. CST.

Group number: 78800186

Note: If you elect the Bind On-Demand option for 2020 and were in enrolled in the one of the CDHP plans in 2019, any remaining CDHP Heath Reimbursement Account (HRA) funds from the prior year will become available to you after 90 days, on April 15th, 2020. The 90 days allow enough time for prior year claims to process.

Do not use your Health Care Savings Card for the roll-over amount, download a claim form from **mybind.com** to submit a claim manually or, you may also submit electronically through **myuhc.com**.

Newly eligible for Medicare

Those who will become Medicare eligible

Options outside of CenturyLink

- Your group health care coverage ends the first day of the month in which you or your dependent become eligible for Medicare.
- You can purchase any individual Medicare Supplement, Medicare Advantage and/or Medicare Prescription Drug Policy available to you. These policies are not associated with CenturyLink.
- Group dental coverage continues to be offered under the CenturyLink Retiree Plan.
- If you have access to other coverage, such as through another employer or your spouse's/domestic partner's employer plan, you may want to defer Step 1 and Step 2 (listed to the right).

If you are eligible for a Company Subsidy

When your Non-Medicare CenturyLink medical group plan options end, CenturyLink will fund an HRA with company subsidy dollars (subject to the Company Cap) that help pay for your individual Medicare medical policy and dental premiums. Your unused HRA dollars will roll over. Your annual Company-funded medical HRA amounts are capped and remain the same for 2020 and will not increase in the future.

Note: It is your responsibility to notify the Service Center if you or your dependents become Medicare eligible prior to age 65 (for example, if you are disabled). If you don't advise CenturyLink when you become Medicare eligible due to a disability, Medicare may assess penalties to you or you may experience a gap in your coverage.

Note: If you currently have a Company dental subsidy (subject to the Company Cap), those subsidy dollars will be placed in your HRA account. You will see changes in your dental premium displayed on your Annual Enrollment Worksheet as well as a change in the payment process.

To continue benefits once you become Medicare eligible and avoid a gap between your group and individual coverage, **Here's what to do:**

Step 1

Enroll in Medicare Part A & Part B

Step 2

Enroll in an individual Medicare policy prior to the month you become Medicare eligible

Step 3

Let ViaBenefits Help You Enroll

- You will receive a letter from the Service Center regarding enrollment in a Medicare policy approximately 120 days prior to you or your dependent's 65th birth date
- ViaBenefits will contact you approximately 90-120 days prior to the month you turn age 65
- You can contact ViaBenefits within 90 days of your Medicare enrollment deadline at 888-825-4252 to help you select a medical and/or prescription drug policy.

Note: You are not obligated to enroll in a Medicare policy through ViaBenefits.

Dental overview

Basic Dental Plan - Passive PPO In-Network

Annual Benefit Maximum (per person)	$1,000 (not including oral surgery)
You Pay	
Annual Deductible (per person)	$25 for General Care and Major and Restorative; no deductible for Diagnostic, Preventive or Oral Surgery
Plan Pays (after deductible)	
Diagnostic and Preventive (no deductible) Cleanings, exams, x-rays	100% up to maximum allowable amount
General Care Fillings, root canals, periodontics	50% up to maximum allowable amount
Major Restorative Crowns, dentures and bridges	50% up to maximum allowable amount
Oral Surgery (no deductible)	80% no limit
Passive PPO Network	When you use network dentists, you pay a percentage of discounted fees
Administrator	MetLife Group Number: 148096 Phone Number: 866-832-5756

Dental

If you and all of your dependents are Medicare eligible...

- Once you choose to waive your group dental coverage, you will not be eligible to enroll at Annual Enrollment or if you experience a Qualified Life Event (QLE).
- If you waive or suspend coverage, you can enroll in an individual dental policy of your choice outside of CenturyLink.
- You may enroll in an individual dental policy through ViaBenefits (**my.viabenefits.com/centurylink**) or on your own directly with a dental insurance carrier or a local broker of your choice.

Retiree Life Insurance

For eligible retirees, CenturyLink provides Retiree Basic Life Insurance coverage that pays a $10,000 benefit to your designated beneficiary/beneficiaries upon your death.

If you retired between Jan. 1, 1991, and Dec. 31, 2002

If you continued Retiree Supplemental Life Insurance coverage after your retirement, you may continue coverage to age 65, provided you pay your monthly premium contributions in a timely manner.

Once you reach age 65, you can apply to convert your coverage to an individual policy with MetLife. Coverage ends on the last day of the month in which you turn age 65.

If you retired on or after Jan. 1, 2003

If you continued Retiree Supplemental Life Insurance coverage after your retirement, your coverage will be reduced by 10% of your coverage amount each year, beginning on the first day of the year following your 66th birthday, up to a total reduction of 50% by age 70. Coverage may continue to age 70 provided you continue to pay your monthly premium contributions in a timely manner. Once you reach age 70, you can apply to convert your coverage to an individual policy with MetLife. Coverage ends on the last day of the month in which you turn age 70.

If you have Retiree Supplemental Life Insurance, unless otherwise specified, the coverage amount is payable to the same beneficiary/beneficiaries as named for your Retiree Basic Life Insurance in the event of your death.

Important notes if you have Retiree Supplemental Life Insurance

- You may cancel or decrease coverage at any time by calling the Service Center. You may not enroll, re-enroll or increase coverage during your retirement.
- You may convert your Retiree Supplemental Life coverage, if applicable, according to the laws of the state of Washington where the policy is issued. Conversion is not automatic, and you must apply for converted life insurance coverage through MetLife. You can reach MetLife at **877-275-6387** to request a conversion application if you experience a qualified loss in coverage. **MetLife must receive your completed application and premium for conversion within 31 days from the date your retiree supplemental life insurance coverage terminates.** Applications received by MetLife after the 31-day period will be denied.

Beneficiary Reminder

Please confirm that you have designated beneficiaries for all of your CenturyLink Life Insurance Plan coverage by going to **centurylinkhealthandlife.com** or calling the Service Center at **866-935-5011** or **800-729-7526**, Option 2 and Option 1.

The Service Center is the recordkeeper of beneficiary designations.

Refer to the SPD for specific beneficiary information, including how benefits are paid if no beneficiary is living on the date of your death, or you have not elected a beneficiary.

Refer to the Helpful Resources section of this Guide for instructions on how to access SPDs and SMMs for detailed information.

Paying for your coverage

CentturyLink makes it easy to pay for your Retiree Benefits

Your 2019 benefit payment election will continue in 2020 unless you make a change. If you do not have an automatic payment plan in place for your health and/or life insurance premiums, then your premiums are due on the first day of each month for the current month's benefit coverage. You can contact the Service Center for payment options, such as:

- check or money order,
- deductions from your pension check,
- direct debit (automatic monthly withdrawal from your checking or saving account), or
- a reimbursement account, if applicable.

Be Sure to make timely payments

If your premium payments are not received by the Service Center in a timely manner, the payments may be processed due to the delay in updating records internally. In this case, you will receive a refund for the untimely payment; however, your coverage will not be reinstated (except as may be determined upon a written appeal made by you and approved by the Plan).

Please note that checks that are returned or direct debit requests that are refused due to insufficient funds are not re-deposited.

Regardless of how you pay your premiums, be sure that your total amount due is received by the Service Center by the last day of the month. If not, your coverage will be terminated retroactively to the last day of the prior month for which full payment was received.

Enroll

Annual Enrollment begins Nov. 4 and ends on Nov. 22, 2019.

If you don't enroll, you will default to your current medical/prescription drug, dental and/or life insurance benefit options, if applicable shown on your Enrollment Worksheet (EWS).

Online enrollment

To make online changes or updates to your coverage:

1. Go to **centurylinkhealthandlife.com** and log in with your User ID and password. We recommend using the latest versions of Chrome, Firefox, Safari and MS Edge for the best performance on UPoint during your online enrollment.
2. Once you are logged in, select **Make Your Elections** to begin enrolling.
3. You will be taken to a step-by-step page with helpful enrollment resources. Use the tools to find:
   - information on your benefit options
   - comparisons of Plan deductibles and coinsurance, if applicable
   - whether a doctor or other medical provider is an in-network or out-of-network provider
   - links to vendor websites
   - printable copies of Summary Plan Descriptions (SPDs) and Summaries of Material Modifications (SMMs)
4. Click **Enroll in Your Benefits**, then **Enroll Now**.
5. Review your plan options and associated premiums to make your elections.
6. After you have made your elections, click **Complete Enrollment**.
7. Look for the **Completed Successfully!** message and print a **Confirmation of Enrollment** for your records.

If you forgot your User ID and/or password, click **I Forgot My Password** and enter the correct information. First, confirm your identity, then reset your password. You'll receive your login information via email if you have a valid email address on file. If not, your login information will be mailed to the address on file. **It can take up to 10 business days to receive this information by mail.**

On-the-phone enrollment

Service Center representatives will be available to answer your questions or help with your enrollment. You must call **866-935-5011** or **800-729-7526**, Option 2 and then Option 1 on or after Monday, Nov. 4, but before Friday, Nov. 22 at 5:30 p.m. MST to complete your enrollment.

You will receive a Confirmation of Enrollment at your address on file.

REMEMBER: If you need to call the Service Center during Annual Enrollment, please keep in mind that the first and last days of Annual Enrollment are usually the busiest. You can also find answers to many of your benefit questions in this **Annual Enrollment Guide** or on the **Health and Life website**. You also have the ability to ask questions via the **Web Chat** or **email** feature on the **Health and Life website**.

If you do not make any changes, your Enrollment Worksheet (EWS) that you received with this guide will serve as your Confirmation of Enrollment Statement. You can print a copy of your 2020 elections until Dec. 31, 2019, by following the instructions below.

- Go to **centurylinkhealthandlife.com** and log in with your User ID and password.
- Click the **Health and Insurance** tab.
- Click the tile labeled **View Pending Coverage Costs (effective Jan. 1, 2020)**
- To print, click the **Print** icon on the top right side of the screen.
- Keep a copy of this page for your records.

Helpful resources

When you need more detailed information about Plan specifics, review your SPDs and SMMs located on the Health and Life website at **centurylinkhealthandlife.com**. If you would like a paper copy of these materials, contact the Service Center at **866-935-5011** or **800-729-7526**, Option 2 and Option 1. Please be advised that mailing time can take up to two weeks.

Benefit Option	Phone	Online
Health Care		
CenturyLink Service Center » Health Reimbursement Account (HRA) » Service Center Advocacy Services Free assistance with health and life claims and accessing health care services if enrolled in health care benefits through CenturyLink » Retiree Life Insurance	866-935-5011 or 800-729-7526, Option 2 and the Option 1 M-F, 7:30 a.m. - 5:30 p.m., MST	**centurylink.com/healthandlife** Search: **UPoint Mobile HR App**, available for Free in the App Store and Google Play
Medical	**UnitedHealthcare:** 800-842-1219 Group Number: 192086 Standard CDHP, Premium CDHP and Savings HDHP **Bind On-Demand Health Coverage:** 833-576-6519 M-F 6:00 a.m. - 9:00 p.m., CST Group Number: 78800186	**UnitedHealthcare: myuhc.com** Search: **Health4Me**, available for Free in the App Store and Google Play **centurylink.com/choosebind** Access Code: CTL2020 Search: **MyBind**, available for Free in the App Store and Google Play
Prescription Drug Program	**UnitedHealthcare**: 800-842-1219 for OptumRx prescription questions **Bind On-Demand:** 833-576-6519 M-F 6:00 a.m. - 9:00 p.m., CST	**UnitedHealthcare: myuhc.com** for OptumRx prescription questions **centurylink.com/choosebind**
Telemedicine	**Doctor On-Demand (Bind On-Demand):** 833 576-6519	**patient.doctorondemand.com**
Dental Plans	**MetLife:** 866-832-5756 **Group Number:** 148069	**metlife.com/mybenefits**
2nd.MD–Second opinions expanded to all conditions	**866-842-1151**	**centurylink.com/2ndmd** Search: **2nd.MD**, available for Free in the App Store and Google Play
ViaBenefits	888-825-4252	**my.viabenefits.com/centurylink**

Need to update your address or phone number? Log on to **centurylinkhealthandlife.com** or contact the Service Center at **866-935-5011** or **800-729-7526**, Option 2 then Option 1.

Important coverage rules

Refer to your Summary Plan Description for a complete description of coverage rules

Dual coverage

CenturyLink retirees are prohibited from being enrolled in more than one CenturyLink medical/prescription drug or dental Plan benefit option (except as noted below).

- **If you elect coverage during Annual Enrollment, and are also covered as a dependent on another employee's/retiree's coverage**, you will remain covered under your own record, but you will be removed as a dependent from the other employee's/retiree's coverage once the enrollment period ends.
- **If you are a retired CenturyLink employee enrolled as a dependent through a Qwest Pre-1991 retiree's coverage**, you will be allowed to remain enrolled as both a dependent and as a retiree, and you may also cover the Pre-1991 retiree as your dependent.

NOTE: Pre-1991 retirees must be enrolled in the Company Guaranteed Plan; otherwise, dual coverage does not apply.

Covering previously suspended dependents during Annual Enrollment

To cover previously suspended dependents during Annual Enrollment, **your action is required.**

1. To add previously suspended dependents, follow the prompts during your online enrollment or contact the Service Center. A Dependent Verification packet may be sent to you automatically in December 2019. Follow the instructions outlined in the packet, and **respond by the deadline**.
2. Plan coverage for your previously suspended dependents will become effective Jan. 1, 2020, **with the following exception**. If validation is required and verification forms are not received by the Service Center by the deadline, **your dependents will be removed retroactively from coverage.** You will be required to reimburse the Plan for any claims paid while the previously suspended dependents were ineligible under the Plan.

What happens to your benefits if you return to work directly for the company as an active employee or work for a supplier on assignment to the company after you retire or leave employment? If you are eligible for retiree health care or life insurance from the company, refer to the applicable section below to see how your retiree benefits may be impacted.

NOTE: If you have VEBA life insurance, that coverage will not be impacted.

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

If you return to work for a supplier on assignment to the company, you are not eligible to continue your CenturyLink retiree health care benefits. This means that while you are working for the supplier, your retiree health care benefits will be suspended. However, you will be offered the opportunity to continue your retiree medical and/or dental options under COBRA. Your retiree basic and supplemental life coverage, if applicable, will continue under the terms of the CenturyLink Life Insurance Plan ("the Plan"). In addition, please be advised that as a worker for a supplier or company contractor, you are not eligible for CenturyLink active employee health care benefits. Retiree health care benefits are reinstated once your work with the supplier/contractor for the company has ended. You will need to call the Service Center to get your benefits reinstated.

*If you can't locate your SPD, you can access it on the Health and Life website at **www.centurylinkhealthandlife.com**. Alternatively, you can request a paper copy by calling the Service Center at **866-935-5011** or **800-729-7526**, Option 2 then Option 1.

Legal and important required notices

A note about privacy

Keeping your personal information secure is of primary importance to CenturyLink. That's why we, along with the benefits administrators, have implemented various security measures and policies to help reduce the risk of unauthorized processing or disclosure of your personal information. You can also help by keeping confidential your User ID and password for accessing the CenturyLink Health and Life website. Please keep this information safe and don't share it with anyone. Never use your Social Security number as your password. Together, we can make sure your personal information stays safe and secure. Please be advised that using an email that is not secured may increase your risk of unauthorized disclosure.

Notice of privacy practices

You can review and print the complete notice at **centurylinkhealthandlife.com**. You may obtain a paper copy upon request by calling the Service Center at **866-935-5011** or 800-729-7526, Option 2 and then Option 1.

This Is a Summary of Material Modifications (SMM)

This document is intended to serve as a Summary of Material Modifications (the "SMM") pursuant to the requirements of Section 104 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This SMM notifies you of certain changes to the CenturyLink sponsored Plans (the "Plan"). Please keep this SMM with your Summary Plan Description for the Plan for future reference. This document summarizes only certain provisions of the Plan. If there is any conflict between the terms of the Plan documents and this SMM, the terms of the Plan documents will govern. The company has reserved to the Plan Administrator the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan.

Coverage Is not advice

Health Plan coverage is not health care advice. Please keep in mind that the sole purpose of the Plan is to provide payment for certain eligible health care expenses – not to guide or direct the course of treatment for any employee, inactive retiree or eligible dependent. If your health care provider recommends a course of treatment, be sure to check with the Plan to determine whether or not that course of treatment is covered under the Plan. However, only you and your health care provider can decide what the right health care decision is for you. Decisions by a claims administrator or the Plan Administrator are solely decisions with respect to Plan coverage and do not constitute health care recommendations or advice.

The company's reserved rights

This document summarizes certain provisions of the CenturyLink Disability Plan, the CenturyLink Life Insurance Plan and the CenturyLink Retiree and Inactive Health Plan (collectively referred to as the "Plan"). For specific employee benefit Plan information, refer to the respective official Plan Documents, including the applicable Summary Plan Description and Summaries of Material Modifications, if any. If there is any conflict between the terms of the official Plan Documents and this document, the terms of the official Plan Documents will govern. The Plan Administrator has the authority, discretion and the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan, to supply omissions and resolve conflicts. Benefits and contribution obligations, if any, are determined by CenturyLink in its sole discretion or by collective bargaining, if applicable.

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

Right to amend and/or discontinue and make rules

The company and its delegate, the CenturyLink Plan Design Committee, each has reserved the right in its sole discretion, to change, modify, discontinue or terminate the Plan and/ or any of the benefits under the Plan and/or contribution levels, with respect to all participants classes, retired or otherwise, and their beneficiaries at any time without prior notice or consultation, subject to applicable law, specific written agreement and the terms of the Plan Document and with respect to the Health Plan, the written agreement specific to Qwest Pre-1991 Retirees and Qwest ERO '92 Retirees. The CenturyLink Employee Benefits Committee, as the Plan Administrator, may adopt, at any time, rules and procedures that it determines to be necessary or desirable with respect to the operation of the Plan. The Plan Administrator has the authority, discretion and the right to interpret and resolve any ambiguities in the Plans or any document relating to the Plans.

Notice of "Exempt" Retiree Medical Plan status

The CenturyLink Retiree and Inactive Health Plan, and all of its benefit options meet the requirements of a stand- alone exempt retiree medical benefit plan under Section 732 of ERISA and, therefore, is not required to comply with benefit mandates of the Patient Protection and Affordable Care Act (PPACA). However, CenturyLink has decided to voluntarily apply certain provisions of the PPACA to these benefit options. This means that for all retirees, this voluntary compliance with PPACA may be changed or ended at any time and does not waive the Plan's status as "exempt" from PPACA. If you choose to participate in the new Medicare Advantage PPO or HRA, the policy you elect is an individual policy.

Important note regarding your Annual Enrollment elections

By electing to participate in the Plans (the CenturyLink Disability Plan, the CenturyLink Life Insurance Plan and the CenturyLink Retiree and Inactive Health Plan), by your submission of information, you have agreed to be bound to and by the provisions of each of the Plans and their administrative practices, including, but not limited to with respect to the recovery of over and underpayments, terms and conditions for eligibility and Benefits. **You certify that the submission of information by you in this enrollment process is true and accurate to the best of your knowledge, unless you submit changes as instructed; you agree that you'll submit new information timely as changes occur. You understand that if you are found to have falsified any document in support of a claim for eligibility or reimbursement, the Plan Administrator may, subject to and as may be permitted under the requirements of law, without anyone's consent, terminate your and/ or your dependent(s') coverage, and the Claims Administrator may refuse to honor any claim you or your dependent(s) may have made or will make under the Plans if applicable. You understand that**

Legal and important required notices (cont.)

you are liable and bear the full financial responsibility for the misappropriation of Plan funds through the filing of false documentation under any of the Plans; you certify that you or your dependent(s) are eligible to enroll in a benefit option, including voluntary or supplemental coverages. Please refer to the applicable Plan document or SPD for details about eligibility for coverage or call the Claims Administrator – limitations may apply including, but not limited to, being actively at work in order to be eligible for coverage. You understand that it is your responsibility to confirm your eligibility to enroll in a benefit option, including voluntary or supplemental coverages; enrolling in and paying for coverage for which you are ineligible will not entitle you to Benefits; you understand that it is your responsibility to terminate benefit coverage once you or your dependent(s) become ineligible, for example, divorce, death, etc.

For specific employee benefit plan information, including terms and conditions for eligibility, limitations and Benefits refer to the respective Plan Documents, including the applicable Summary Plan Description and Summaries of Material Modifications, if any. If there is any conflict between the terms of the Plan Documents and this correspondence, the terms of the Plan Documents will govern.

Women's Health and Cancer Rights Act

- This notice is provided to you in compliance with the federal law entitled the Women's Health and Cancer Rights Act of 1998 (the "Act"). The Plan provides medical and surgical benefits in connection with a mastectomy. In accordance with the requirements of the Act, the Plan also provides benefits for certain reconstructive surgery.
- In particular, the Plan will provide, to an eligible participant who is receiving (or who presents a claim to receive) benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and treatment of physical complications associated with all the stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.
- As with other benefit coverages under the Plan, this coverage is subject to each medical benefit option's annual deductible (if any), required coinsurance payments, benefit maximums, and copay provisions that may apply under each of the benefit options available under the Plan.
- You should carefully review the provisions of the Plan, the medical benefit option in which you elect to participate, and its SPD and SMM (if any) regarding any applicable restrictions. Contact the Claims Administrator of your medical benefit option for more information.

Health Insurance Portability and Accountability Act (HIPAA)

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

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

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

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

NOTE: This is an updated notice.

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

Legal and important required notices (cont.)

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: **myalhipp.com**
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: **myakhipp.com**
Phone: 1-866-251-4861
Email: **CustomerService@MyAKHIPP.com**
Medicaid Eligibility: **dhss.alaska.gov/dpa/ Pages/ medicaid/default.aspx**

ARKANSAS – Medicaid
Website: **myarhipp.com**
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)Health First Colorado
Website: **healthfirstcolorado.com**
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: **colorado.gov/pacific/hcpf/child-health-plan-plus**
CHP+ Customer Service: 1-800-359-1991/ State Relay 711

FLORIDA – Medicaid
Website: **flmedicaidtplrecovery.com/ hipp/**
Phone: 1-877-357-3268

GEORGIA – Medicaid
Website: **medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Click on Health Insurance Premium Payment (HIPP)
Phone: 678-564-1162 Ext. 2131

INDIANA – Medicaid
Healthy Indiana Plan for Low-Income Adults 19-64
Website: **in.gov/fssa/hip/**
Phone: 1-877-438-4479
All other Medicaid
Website: **indianamedicaid.com**
Phone 1-800-403-0864

IOWA – Medicaid
Website: **dhs.iowa.gov/hawki**
Phone: 1-800-257-8563

KANSAS – Medicaid
Website: **kdheks.gov/hcf/**
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: **chfs.ky.gov**
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: **dhh.louisiana.gov/index.cfm/ subhome/1/n/331**
Phone: 1-888-695-2447

MAINE – Medicaid
Website: **maine.gov/dhhs/ofi/public-assistance/ index.html**
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: **mass.gov/eohhs/gov/ departments/ masshealth/**
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: **mn.gov/dhs/people-we-serve/ seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp**
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: **dss.mo.gov/mhd/participants/ pages/hipp.htm**
Phone: 573-751-2005

MONTANA – Medicaid
Website: **dphhs.mt.gov/ MontanaHealthcare Programs/HIPP**
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: **ACCESSNebraska.ne.gov**
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Website: **dhcfp.nv.gov**
Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: **dhhs.nh.gov/oii/hipp.htm**
Phone: 603-271-5218
Toll-free number for HIPP: 800-852-3345 ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: **state.nj.us/ humanservices/dmahs/clients/medicaid/**
CHIP Website: **njfamilycare.org/index. html** Medicaid Phone: 609-631-2392
CHIP Phone: 800-701-0710

NEW YORK – Medicaid
Website: **health.ny.gov/health_care/ medicaid/** Phone: 800-541-2831

NORTH CAROLINA – Medicaid
Website: **dma.ncdhhs.gov/**
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: **nd.gov/dhs/services/ medicalserv/ medicaid/**
Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: **insureoklahoma.org**
Phone: 1-888-365-3742

OREGON – Medicaid
Website: **healthcare.oregon.gov/Pages/ index.aspx** or **oregonhealthcare.gov/ index-es.html**
Phone: 800-699-9075

PENNSYLVANIA – Medicaid
Website: **dhs.pa.gov/provider/ medicalassistancehealthinsurance premiumpaymenthippprogram/index.htm**
Phone: 800-692-7462

RHODE ISLAND – Medicaid
Website: **eohhs.ri.gov**
Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: **scdhhs.gov**
Phone: 888-549-0820

SOUTH DAKOTA – Medicaid
Website: **dss.sd.gov**
Phone: 888-828-0059

TEXAS – Medicaid
Website: **gethipptexas.com**
Phone: 800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: **medicaid.utah.gov**
CHIP Website: **health.utah.gov/chip**
Phone: 877-543-7669

Legal and important required notices (cont.)

VERMONT – Medicaid
Website: **greenmountaincare.org**
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: **coverva.org**
Medicaid Phone: 800-432-5924
CHIP Phone: 855-242-8282

WASHINGTON – Medicaid
Website: **hca.wa.gov**
Phone: 800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: **mywvhipp.com/**
Phone: 855-MyWVHIPP (699-8447)

WISCONSIN – Medicaid and CHIP
Website: **dhs.wisconsin.gov/publications/p1/ p10095.pdf**
Phone: 800-362-3002

WYOMING – Medicaid
Website: **wyequalitycare.acs-inc.com/**
Phone: 307-777-7531
To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

If you voluntarily elect to drop coverage

If you voluntarily drop coverage for yourself or a dependent during Annual Enrollment, without there being a Qualified Life Event (QLE), you and/or your dependent will not be eligible for continuation of health care coverage under the federal law known as COBRA. Eligibility for COBRA continuation coverage occurs only in cases of QLEs. For more information on what is a QLE, refer to the Summary Plan Description.

Continuation of coverage

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for certain qualifying events such as marriage, divorce, etc. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Upon termination of coverage or another COBRA qualifying event, the former participant and any other QBs will receive COBRA enrollment information.

Qualifying events for spouses/domestic partners or dependent children include those events above, plus, the covered employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, death of the covered employee, and the loss of dependent status under the plan rules. If a QB chooses to continue group benefits under COBRA, they must timely enroll and make their premium payment by the due date. Then, coverage will be reinstated. Thereafter, premiums are due on the first of the month. If premium payments are not received in a timely manner, federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Service Center at **866-935-5011** or **800-729-7526**, Option 2 and then Option 1.

Other coverage options

There may be other, more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period," even if the plan generally doesn't accept late enrollees. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA doesn't limit your eligibility for coverage for a tax credit through the Marketplace.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out of pocket than you would under COBRA, because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

More information on health insurance options through the Marketplace can be found at **healthcare.gov**.

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