2020 **Annual Enrollment guide**

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

CenturyLink Non-Represented and CenturyLink Represented COBRA Participants
(excludes COBRA participants represented by Qwest/CWA or Qwest/IBEW 206)

CenturyLink®

Contents

What's new for 2020

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

Annual Enrollment is your opportunity to review the benefits CenturyLink offers and to update you on Plan changes. Please review this guide in its entirety and carefully consider the options that are right for you and your eligible dependents.

CenturyLink Service Center (referred to hereafter as the 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 1 and then Option 1.

Health Savings Account (HSA)

IRS limits for Annual Health Savings Account (HSA) contributions*

*To contribute to an HSA, you must be enrolled in the Savings HDHP medical option. You may choose to establish an HSA with any financial institution. You cannot elect an HSA through the Service Center, you would need to enroll in an HSA on your own.

Single coverage increases from $3,500 to **$3,550** and Single + One or more increases from $7,000 to **$7,100**. The catch-up contribution for age 55 and older remains $1,000 annually.

Medical

New option – Bind On-Demand

CenturyLink offers you a new plan option called Bind On-Demand. Bind On-Demand is made simple—designed to give you more control of your cost and coverage.

Cost clarity

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 visit, 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-in coverage on a direct bill basis if and when you elect to obtain one of these specific procedures.

What's new for 2020 (cont.)

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.

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

(available to participants and their spouse/domestic enrolled in UnitedHealthcare or Bind On-Demand)
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)

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)

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)

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)

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)

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 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 UHC at the number on the back of your medical ID card within seven days from the ER visit.

Virtual Telehealth (for those enrolled in UnitedHealthcare)

UnitedHealthcare members can now take advantage of a Virtual Visit experience using myuhc.com or the UnitedHealthcare app. With Virtual Visits, participants and covered family members can see and speak to a doctor anywhere, anytime on a mobile device or computer. No appointment is necessary — and a Virtual Visit usually takes less than 20 minutes. Doctors are able to diagnose a wide range of nonemergency medical conditions and prescribe medications. If needed, a prescription can be sent to your local pharmacy. Virtual Visits are covered subject to deductible and coinsurance and follows standard medical plan rules. You pay full cost of Virtual Visit until deductible is met. Each Virtual Visit cost is generally less than $50. Once deductible is met, you pay your coinsurance. Once out-of-pocket limit is met, you pay $0. The UHC Virtual Visits provider groups are aligned with American Medical Association (AMA) and Federation of State Medical Boards (FSMB) guidelines. Contracted provider groups are currently operating in all 50 states and the District of Columbia and include AmWell, Doctors on Demand and Teladoc.

Newborn deductible (for those enrolled in UnitedHealthcare)

If you are expecting a new baby, the Annual Medical Deductible will now apply to all newborn claims regardless if the length of stay in the hospital is the same as the mother's length of stay. Both the baby and the mother will have a separate deductible for all charges. As a reminder, dependent delivery charges are not covered except where required by state law. Refer to the Summary Plan Description (SPD) for more details.

Employee Assistance Plan (EAP), if eligible

The EAP offered by Beacon Health Options is available to eligible COBRA participants or persons that live in the COBRA participants household to resolve personal problems before they negatively affect your health, relationship with others or job performance. Professional counselors will help you decide which counseling option fits your needs. As a participant, the EAP offers up to 8 free confidential Counseling Sessions per problem per year to you

What's new for 2020 (cont.)

or anyone who lives in your household – even if you are not on CenturyLink's medical plan. The EAP offers Face-To-Face, Telephonic or Online Counseling Services.

- **Autism Care Coach** – Autism Care Coach Services assist employees who have a family member affected by autism spectrum disorder ("ASD"). The Autism Care Coach aids in locating resources to assist them with the challenges of ASD. An appointment is made for a conference facilitated by an Autism Care Coach. The Autism Care Coach assesses challenges for both the care recipient and the caregiver, evaluates where additional support is needed, and identifies available resources, creates a detailed care plan, which includes recommendations based on the Autism Care Coach's findings. The Autism Care Coach will follow up with the participant to review the resources and answer additional questions. In addition to the initial conference, the participant has up to three (3) 60-minute additional sessions with the Autism Care Coach.
- **Beacon Wellbeing Services** – Through a holistic approach, Beacon Wellbeing focuses on all aspects of one's wellbeing—emotional, physical, financial, community and resiliency. Beacon Wellbeing enables participants to engage in services most meaningful to them—online, by phone or in person. Participants will have the opportunity to select a Clinician and self-schedule online and phone appointments with a Counselor. Participants can call to schedule face-to-face counseling sessions in their local area.

Contact Beacon Health Options at **centurylink.com/EAP** or **800-803-3737**.

Vision

If you are enrolled in vision coverage, Standard Progressive Lenses will be covered in full if you see a VSP doctor or affiliate provider. If you see an open-access provider, all types of Progressive Lenses will be reimbursed up to a maximum of $50.

Note: Premium and Custom Progressives will continue to be discounted 20%-25%, with the average out-of-pocket cost for Premium Progressives at $95-$105 and Custom Progressive Lenses at $150-$175 at a VSP doctor or affiliate provider.*

*Costco pricing applies; there are no discounts.

Enrollment reminders

Benefit Plan option	Changes that may require action	Action requirement
Dependent Eligibility	Adding a dependent to one or more of your plans.	You will need your dependents' Social Security Number and birthdates before you begin enrollment. A dependent verification packet will be mailed to you to complete and return as part of the dependent verification process. Follow the instructions as you will be required to provide information to the Service Center by the deadline in your packet.
Health Reimbursement Account	If you were in enrolled in one of the CDHP's in 2019 and you remain enrolled in one of the CDHP's or Bind On-Demand for 2020, any remaining CDHP Heath Reimbursement Account (HRA) funds from the prior year will be available after 90 days, on April 15th, 2020. The 90 days allow enough time for prior year claims to process.	If you have questions, contact the number on the back of your medical id card.
Health Savings Account (HSA)	You have the option each Annual Enrollment to elect to participate in a Health Savings Account (HSA) when enrolled/enrolling in a HDHP medical option. $3,550 for Single and $7,100 for Single + One or more. The catch-up contribution for age 55 and older remains $1,000.	You may choose to establish an HSA with any financial institution. You cannot elect an HSA through the Service Center, you would need to enroll in an HSA on your own.

Enrollment reminders (cont.)

Benefit Plan option	Changes that may require action	Action requirement
Pharmacy	The Prescription Drug List (PDL) is updated in January and July of each year.	**For Bind On-Demand:** Visit **centurylink.com/choosebind** to check your pharmacy coverage, estimate costs or obtain further information. Visit **mybind.com** starting Jan. 1, 2020 if you enroll in the Bind On-Demand Plan. **For UnitedHealthcare Plans:** To reduce costs and make filling medications more convenient, maintenance medications for conditions such as diabetes, cholesterol 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. **Note:** You cannot opt-out of the prescription drug benefit, including mail order. 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 a new UHC member and would like an estimate of your prescription costs, visit **myuhc.com/OptumRx**.
ZIP Code	Networks are determined by ZIP code area, and those ZIP codes are reviewed each Annual Enrollment as providers come in- and out-of-network.	Be sure to review the medical benefit option available to you as options may change (based on your address on file).

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.

Savings HDHP		Standard CDHP		Premium CDHP	
With Participant-Funded HSA (maximum contribution): $3,550 Single $7,100 Single + One or more enrolled Note: If you are 55 or older, you can contribute an extra $1,000 "catch-up" contribution.		With Company-Funded HRA Contribution: $500 Single $750 Single + Spouse/Domestic partner $750 Single + Children $1,000 Family		With Company-Funded HRA Contribution: $1,000 Single $1,500 Single + Spouse/Domestic partner $1,500 Single + 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
		Single + Spouse/Domestic Partner		Single + 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
		Single + Spouse/Domestic Partner		Single + 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

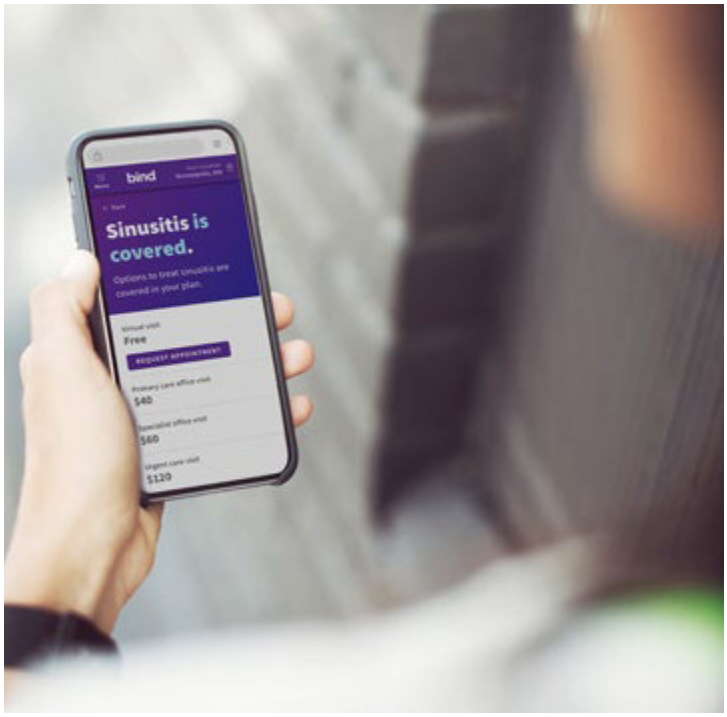
Administrator: UnitedHealthcare, **Group number:** 192086, **Phone Number:** 800-842-1219

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

Medical and prescription drug overview - Bind On-Demand (cont.)

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 money 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. 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* to the in-network facility for the procedure, plus $50-$200* through direct bill for 6 months to 1 year, on an after-tax basis.

- 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 be available after 90 days, on April 15th, 2020. The 90 days allow enough time for prior year claims to process.

You can download a claim form from mybind.com to submit a claim manually or, you may also submit electronically through myuhc.com.

Dental

You can choose between two dental plan options; a Basic Option and an Enhanced Option or, you have the option to waive this coverage. These plan options differ in terms of the amount of the annual benefit maximum, annual deductibles, orthodontia coverage, coverage levels and your share of the cost of coverage. Both of the CenturyLink Dental Plan options are administered by MetLife.

Basic Option	Enhanced Option (includes orthodontia)
Passive PPO In and Out-of Network Note: Out-of Network benefits are subject to reasonable and customary charges.	
Annual Benefit Maximum (per person)	
$1,000 (does not include oral surgery)	$2,000 (does not include oral surgery or orthodontia)
Orthodontia Lifetime Benefit Maximum	
N/A	$1,500 (separate from annual individual benefit maximum)
You Pay	You Pay
Annual Deductible (per person)	
$25 for general care and major and restorative; no deductible for diagnostic, preventive or oral surgery	$50 for general care and major and restorative (does not include orthodontia); no deductible for diagnostic, preventive or oral surgery
Lifetime Orthodontia Deductible (per person)	
N/A	$50
Plan Pays (after deductible)	Plan Pays (after deductible)
Diagnostic and Preventive (cleanings and exams) — No deductible	
100%* up to maximum allowable amount; two visits per year	100%* up to maximum allowable amount; two visits per year
X-rays	
Full mouth X-rays covered once every 60 months; bitewing X-rays covered once per year, except for dependent children under age 26. Children are eligible for bitewing X-rays twice per year.	Full mouth X-rays covered once every 60 months; bitewing X-rays covered once per year, except for dependent children under age 26. Children are eligible for bitewing X-rays twice per year.
General Care (fillings, root canals and periodontics)	
50%* up to maximum allowable amount	80%* up to maximum allowable amount
Major and Restorative (crowns, dentures and bridges)	
50%* up to maximum allowable amount	50%* up to maximum allowable amount
Oral Surgery — No deductible	
80%* no limit	80%* no limit
Orthodontia (adult and children)	
Not covered	50%* up to the maximum allowable amount after the $50 lifetime orthodontia deductible (separate from annual deductible)

Administrator: MetLife, **Group number:** 148069, **Phone number:** 866-832-5756

*Up to the plan maximum allowable amount. Subject to MetLife Preferred Dental Provider pre-negotiated fees or reasonable and customary charges if you see an out-of-network provider.

Vision

The CenturyLink vision care benefit option is administered by the Vision Service Plan (VSP) Network. You also have the option to waive this coverage.

VSP Doctor and Affiliate Providers	Open Access Provider
Eye Exams (once every plan year)	
Plan pays 100% after $10 copayment	VSP reimburses you (after $10 copayment) up to a maximum of $45
Lenses (once every plan year)	
Plan pays 100% after $25 copayment. The $25 material copayment is charged only once when lenses and frames are purchased at the same visit » **Single Vision:** Covered in full » **Lined Bifocals:** Covered in full » **Lined Trifocals:** Covered in full » **Lenticular:** Covered in full (Includes polycarbonate lenses for children under the age of 26) » **Tints/photochromic lenses:** Covered in full » **Standard Progressive Lenses:** Covered in full	VSP reimburses you (after $25 copayment) up to the following maximums: » **Single Vision:** $30 » **Lined Bifocals:** $50 » **Lined Trifocals:** $65 » **Lenticular:** $100 (Does not include polycarbonate lenses for children) » **Tints/photochromic lenses:** $5 » **Progressive Lenses:** $50
Frames (one pair every plan year)	
Plan pays 100% of VSP allowable amount up to $160 after $25 copayment; you will receive a 20% discount on the charges over the VSP allowable amount. **Note:** The $25 material copayment is charged only once when lenses and frames are purchased at the same visit. The frame allowance at Costco is up to $90; however, you must be a Costco member to purchase glasses.	VSP reimburses you up to a maximum of $70 after $25 copayment
Contacts (contact lenses may be purchased once every plan year instead of eyeglass frames and lenses)	
Plan pays 100% for routine eye exam after $10 copayment plus up to $150 for contact lenses; contact lens fitting and evaluation exam is discounted by 15% and then covered in full after $40 maximum copayment.	VSP reimburses you up to $105 for contact lens exam (fitting and evaluation) and contacts
Laser Eye Surgery is not covered, but VSP offers a discounted price. Contact VSP for details	

Administrator: Vision Service Plan (VSP); **Group number:** 30016605; **Phone number:** 800-877-7195

You will not receive an ID card from VSP for your vision plan coverage. When you and/or your covered dependents have an office visit, tell the office staff that you are covered under VSP through CenturyLink.

Note: Coverage with a retail chain affiliate may be different, depending on which affiliate you choose. Visit **vsp.com** or call VSP at 800-877-7195 for additional information.

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 vision 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 the SPDs and SMMs located on the CenturyLink Health and Life website at **centurylinkhealthandlife.com**. If you would like a paper copy of these materials, contact the Service Center. Please be advised that mailing time can take up to two weeks.

Benefit Option	Phone	Online
Health Care		
CenturyLink Service Center	866-935-5011 or 800-729-7526, Option 1 and the Option 1 M-F, 7:30 a.m. - 5:30 p.m., MST	**centurylinkhealthandlife.com** Search: **UPoint Mobile HR App**, available for Free in the App Store and Google Play
Medical	**UnitedHealthcare:** 800-842-1219 Group number: 192086 **Bind On-Demand:** 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	**MDLive (UnitedHealthcare):** 888-632-2738 **Doctor On-Demand (Bind On-Demand):** 833 576-6519	**centurylink.com/MDLive** Search: **MDLive**, available for Free in the App Store and Google Play **patient.doctorondemand.com**
Dental Plans	**MetLife:** 866-832-5756 **Group number:** 148069	**metlife.com/mybenefits**
Vision Care Plan	**Vision Service Plan:** 800-877-7195 **Group number:** 30016605	**vsp.com**
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
Virtual Telehealth	**UnitedHealthcare: 800-842-1219**	**UnitedHealthcare: myuhc.com**
Wellness		
Employee Assistance Program	**Beacon Well-Being:** 800-803-3737	**centurylink.com/EAP**

Helpful resources (cont.)

Summary of benefits & coverage availability

CenturyLink offers an array of resources to help you understand and choose your benefits. This section notifies you of an additional resource required by Health Care Reform—a Summary of Benefits and Coverage Availability (SBC)—that summarizes important information about any health coverage options in a standard format, to help you compare features across Plan options. Look for the SBC on the CenturyLink Health and Life website anytime. You can view the SBC by opening the Plan Information page. Here's how:

1. Log onto the Health and Life website at **centurylinkhealthandlife.com**
2. Click on the **Health & Insurance** tab
3. Select **Summary of Benefits and Coverage** under the **More Resources** section
4. Choose the Summary of Benefits and Coverage you'd like to review. A paper copy is also available, free of charge, by calling the Service Center at **866-935-5011** or 800-729-7526, Option 1 then Option 1. Representatives are available Monday through Friday from 7:30 a.m. to 5:30 p.m., MST.

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 the complete notice on the Company intranet, InsideLink, or at **centurylink.com/healthandlife**, or call the CenturyLink Service Center at **866-935-5011** or 800-729-7526, Option 1 and then Option 1 to request a copy.

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.

Right to amend and/or discontinue
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. 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.

Company's Reserved Rights
This document summarizes certain provisions of the CenturyLink Health Care Plan, the CenturyLink Life Insurance Plan and the CenturyLink Disability 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.

Important note regarding your Annual Enrollment elections
By electing to participate in the Plans (the CenturyLink Health Care Plan, the CenturyLink Life Insurance Plan, CenturyLink Business Travel Accident Insurance Plan, the CenturyLink Disability Plan, or if applicable, 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; 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 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

Legal and important required notices (cont.)

responsibility to terminate benefit coverage once you or your dependent(s) become ineligible, such as when a dependent is no longer eligible for coverage. This excludes dependents who turn age 26, as they are automatically removed from coverage.

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.

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**.

California employees

The Employee Assistance Program (EAP) provider, Beacon Health Options/Value Options of California (VOC) has a grievance procedure in place for California employees. This notice is required to comply with California Department of Mental Health Care (DMHC) regulations. You can find it on the VOC website at **valueoptionsofcalifornia.com**, under the Member tab. If you have questions, contact VOC at **800-228-1286**.

Notes

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