Amazing People. Amazing Benefits.

Get ready to choose your 2021 options Nov. 9 - 20.

2021 Annual Enrollment Guide

For COBRA Participants

LUMEN®

Contents

- Lumen (will be referred to hereafter as "the Company")
- The Lumen Health and Life Service Center (will be referred to hereafter as "the Service Center")

LUMEN®

The information listed below describes what's new for 2021. 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 Company-sponsored Plans (collectively, the "Plan"). For further details, refer to your Summary Plan Descriptions (SPD's) as well as 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.

Annual Enrollment is your opportunity to review and make changes to the benefits offered and to update you on Plan changes. Please review this guide in its entirety.

What's New for 2021

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.

Note: If you are eligible for subsidized COBRA, your premium will calculate based on how you answered the Tobacco-Free Discount and Working Spouse/Domestic Partner Surcharge questions as an active employee. If you are unsure how you answered these questions or your situation has changed, please login to the Health and Life website to make the necessary updates, or you can call the Service Center at **866-935-5011**, or **800-729-7526**, Option 2 and then Option 1 for assistance. If you are not eligible for subsidized COBRA or your subsidy has ended, the Tobacco-Free Discount and Working Spouse/Domestic Partner Surcharge does not apply.

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 contribution limit increases from $3,550 to **$3,600** and Single + One or more increases from $7,100 to **$7,200**. The catch-up contribution for age 55 and older remains $1,000 annually.

Medical

Bind Medical Plan (Bind On-Demand)

There are some plan design changes which include the following:

New - $7,500 out-of-pocket maximum for those within Single + Spouse/Domestic Partner or Single + Child/ren coverage.

Specific Treatment Pricing

Bind is introducing more specific treatment pricing in areas such as **cardiac therapy, chemotherapy, mental health treatment, radiation therapy, surgical procedures and therapies, and pulmonary therapy**. You will see changes to the prices within the Bind option, be sure to check Lumen.com/choosebind and use access code **enroll2021** to see all 2021 prices!

Expansion of Coverage Requiring Activation

There is an expanded set of coverages that require "Activation" (formerly called "Add-In's") which include the following procedures: **Ankle Replacement and Revision, Cardiac Ablation, Cataract Surgery, Elbow Arthroscopy and Tenotomy, Elbow Replacement and Revision, Fibroid Removal (Myomectomy), Gallbladder Removal Surgery (Cholecystectomy), Kidney Stone Ablation and Removal (Lithotripsy), Pace Makers and Defibrillators, Prostate Removal Surgery, Spinal Ablation and Neurostimulators, Valve Replacement, Wrist and Hand Joint Replacement, Wrist Arthroscopy and Repair.**

If you are considering having any of these procedures, or any of the other Activation procedures, you can go to mybind.com for more information.

2nd.MD – required second opinion (COBRA participants and your eligible dependents over the age of 18 who are enrolled in the UnitedHealthcare (UHC) or Bind option) for certain procedures.

Healthcare Decisions Made Clear with 2nd.MD

You and your eligible dependents have access to 2nd.MD, a service which offers expert-lead education and guidance on any major medical decisions you and your family may be facing. With one of the highest satisfaction ratings in healthcare, 2nd.MD provides you with the answers you need within days, so you can get the care you need and deserve. 2nd.MD can help you gain medical certainty by connecting you with an expert who can help you with the following:

- Pair you with a skilled, experienced nurse who can help you understand your medical situation, review important questions to ask your doctor and help you navigate the healthcare system.
- Virtually connect with a doctor who specializes in your specific issue or condition. They will review your medical records and have a detailed conversation with you so you can gain confidence in your diagnosis and treatment plan – all within 3-5 days!
- When you need assistance finding a local doctor or specialist to assist in your care, 2nd.MD helps to identify a specialist in your local area to support your unique needs. The Specialist identify a high-quality, local provider or facility using clinically precise data, quality standards, your preferences (distance from home, language, gender, etc.) and ensure the specialist is covered in network with your medical plan. If you've selected a new specialist, the team takes care of transferring your records to the new doctor or facility and scheduling your first appointment.
- 2nd.MD consultations are **free** for eligible employees and dependents enrolled in a company-sponsored UnitedHealthcare or Bind medical plan option. But costs related to services or procedures 2nd.MD consultants may recommend are subject to the UHC or Bind medical option benefits and coverage. Review your plan documents for specific coverage and benefit details or call the number on the back of your medical ID card.

New for 2021: Lumen will require that you consult with 2nd.MD prior to a **hip, knee or spine surgery** (on a non-emergency basis). It is your choice to follow the guidance of the 2nd.MD specialist. However, if you do not seek a second opinion for these surgeries you will be responsible for an additional **$500 of out-of-pocket** cost, whether or not you've met your annual deductible. Depending on where you live and the physician you are currently seeing, treatment recommendations can vary widely for certain surgical procedures, like joint and spine surgeries. Lumen is committed to ensuring employees and their families are fully educated by some of the best doctors in the country before making major medical decisions.

Employee Assistance Plan (EAP)

The EAP administrator is changing from Beacon Health Options to **Optum**.

We're all balancing a lot. Sometimes we need a little extra help to keep up with our to-do lists and live our healthiest lives. That's why we are excited to announce that starting Jan. 1, 2021, we are partnering with Optum to bring you a new EAP that offers 24/7 support and resources so you can tackle whatever life throws your way.

Available at no cost to employees (including those not enrolled in a medical option), your EAP can help with:

- **Personal health support** — talk with a network specialist via phone at **866-374-6061** anytime or visit liveandworkwell.com to access helpful tools to help you better manage a chronic condition or find the right support for mental and emotional health concerns.
- **Family support** — parenting challenges, finding day care, caring for aging parents, adoption support, marriage and relationship issues, pet services and more.
- **Legal support** — consult an attorney on topics such as landlord/tenant disputes, personal injury and bankruptcy.
- **Financial assistance** — includes 60-minute phone consultations with a credentialed finance professional to discuss

financial planning, debt, investments and other financial topics.

Sanvello - a new app that offers on-demand help for stress, anxiety and depression.

Stay connected with daily mood tracking, coping tools and community support. Sanvello Premium is available at no cost to you. Visit sanvello.com or download the app from the Apple App Store or on Google Play.

Dental

There are several new enhancements described below that will help keep dental visits competitively priced for you and your eligible dependents.

- **Expanded access** to thousands more providers via MetLife's expanded PDP Plus Network.
- **Service** where and when you want it by providing you access to your personal information online at www.metlife.com/mybenefits or on the go via the MetLife Mobile App.
  - **Immediately** locate PDP Plus providers
  - **View** claims
  - **Review** plan design
  - **Download** an ID Card
- **Locate providers** even if you are not enrolled in by visiting metlife.com. Under Find A Provider, choose the PDP Plus Network.

Changes to the MetLife Dental plan:

Current Plan		2021 Plan	
Service Network	**PDP**	**Service Network**	**PDP Plus**
Service	**Benefit**	**Service**	**Benefit**
Periodontal Maintenance	Up to 2 times per year	Periodontal Maintenance	Up to 4 times per year
Missing Tooth Exclusion	Applicable	Missing Tooth Exclusion	Not Applicable
Porcelain Crowns	Not Allowable	Porcelain Crowns	Allowable
Sealant and Prenentive Resins	To age 18	Sealant and Preventive Resins	To age 19
R&C Cost	90%	R&C Cost	80%

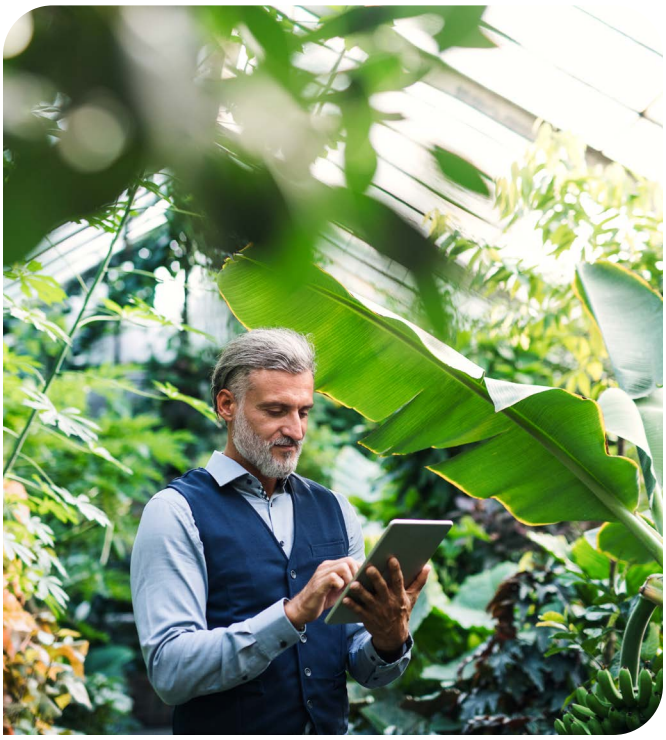
Vision

The Vision Plan administrator is changing from Vision Service Plan (VSP) to **EyeMed**.

Major retail networks have increased which will now include America's Best, Lens Crafters, and Target Optical. Costco and Visionworks will no longer be offered. The Eye 360 Program will be offered which provides a $0 copay on an exam and an additional $25 in frame allowance at over 4,500 VisionPlus providers. You can also receive a savings on non-prescription sunglasses, $20 off any purchase, or, $50 off of $200 or more.

To review detailed network providers and benefits information, visit: http://eye360.eyemedvirtualbenefitfair.com and enter the password- UF677XBD

If enrolled in vision coverage, keep an eye out for your EyeMed welcome kit including ID cards coming to your mailing address on file in December.



Enrollment Reminders

Benefit Details	Plan/Option Information	Take Action
Dependent Eligibility	Adding a new dependent to one or more of your plans.	If you are adding a new dependent to coverage, you will need your dependents' Social Security Number and birthdates before you begin enrollment. A dependent verification packet will be mailed 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 listed in your packet.
Health Reimbursement Account	If you were in enrolled in one of the CDHP's in 2020 and you remain enrolled in one of the CDHP's or Bind Option for 2021, any remaining CDHP Heath Reimbursement Account (HRA) funds from the prior year will be available after 90 days, on April 15, 2021. 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.

Benefit Details	Plan/Option Information	Take Action
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. The contribution limit is $3,600 for Single and $7,200 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.
Pharmacy	The Prescription Drug List (PDL) is updated periodically throughout the year.	Depending on the anticipated prescription drug costs you might incur during a plan year, this may have an impact on which medical plan option you choose. You can use the below tools to estimate your costs. **Bind Medical Plan:** Bind provides medications with a copay instead of charging a deductible and coinsurance dependent on the type and tier of the medication. Bind does not have a deductible and, therefore, starts helping you pay for your prescriptions on the first fill. With Bind, all prescriptions have a set price. You can calculate the price of your upcoming prescriptions or the total of what you may fill throughout the course of the year. For those not enrolled in Bind, visit Lumen.com/choosebind to check your pharmacy coverage, estimate costs and obtain further information. For those currently enrolled in Bind, visit mybind.com if you enroll in Bind. **UnitedHealthcare Options:** 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 maxiumum of 2 times at a retail pharmacy. After that, the prescription will not be covered, and you will pay the full retail price. If you are currently enrolled in a UHC medical plan option, you can refer to the pricing tool on myuhc.com. For those not currently enrolled in a UHC medical plan option and would like an estimate of your prescription costs, visit OptumRx. **Note:** Whichever medical plan option you choose, you cannot opt-out of the prescription drug benefit, including mail order (UHC only). The Plan Administrator for prescription drug benefits is OptumRx.
Zip Code	Medical provider networks are determined by ZIP code area, and those ZIP codes are reviewed each Annual Enrollment as providers go 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 - Bind Medical Plan Option

This chart is only a snapshot summary of Bind benefits. For specific details on how services are covered or excluded, please contact Bind or refer to the Summary Plan Description available on the Health and Life website or by requesting a copy through the Service Center.

Clear prices. No deductible or coinsurance.

Bind is health coverage designed like the other useful services of our daily lives. Choices and costs are clear—designed to be easy to understand. And you have personal control over how your benefit works for you.

Fewer barriers

With the Bind Option, there is no deductible and you don't chip away at anything before your plan starts to pay benefits. Without a deductible, the plan starts paying whenever you use it.

An easy, intuitive experience

The MyBind app and website were built to answer your coverage and cost questions with clarity and ease. Like the other useful services in our daily lives, the MyBind app shows your full cost of a visit before you see the doctor.

Opportunities to save

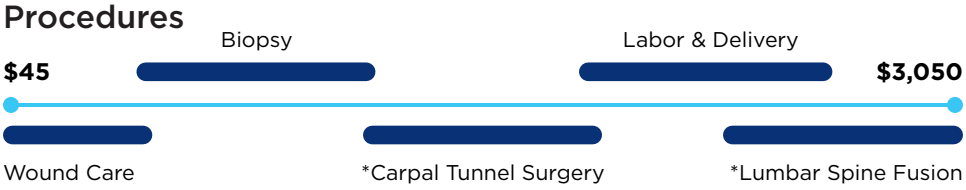
When and where you look for services, we let you know when lower-cost options are around the corner or across town. And you can easily compare provider quality ratings for many providers.

How Bind prices work

Bind provides you with simple, straightforward prices that vary by provider. That means you can know what it's going to cost before you enter the doctor's office. If that sounds different, well, it is—and it's a powerful way to make health care choices.

Some tips:

- People can easily compare provider quality ratings for many providers. And they can map-view prices of lower-cost pharmacies across the street or across town.
- When a price says $0, that means no additional out-of-pocket cost to you.
- Treatment prices include all the services needed to complete the treatment.
- A subset of 45 plannable treatments few people need can be activated during the year--if you need it. Inactive coverage must be activated at least three business days prior to the covered procedure. The additional paycheck deductions for the activated coverage will not count toward the out-of-pocket maximum.



*Indicates coverage that requires activation, the price noted above does not include COBRA premium payments.

Bind Pricing

Drugs		
Prescription Drugs	**30-day**	**90-day**
Tier 1	$10	$25
Tier 2	$70	$175
Tier 3	$100	$250
Medical Infusions		$425 to $1,350
Mental Health and Substance Use Disorder		
Virtual Visit		$10
Office Visit		$20
Partial Day Treatment		$175
Inpatient Setting		$1,400
Preventative		
Annual Physical		$0
Vaccinations		$0
Mammograms		$0
Parental Care		$0
Testing and Diagnostics		
Basic Lab Tests, X-Rays and Ultrasounds		$0
Sleep Study		$75 to 240
MRI, CT Scan		$150 to $575
Therapies and Rehab		
Acupuncture		$20
Chiropractic		$20
Physical Therapy		$10 to $30
Occupational Therapy		$10 to $30
Speech Therapy		$10 to $30
Urgent and Emergency Care		
Urgent Care Visit		$65
Emergency Room Visit		$500
Ambulance		$600
Emergency Hospitalization		$1,400

Out-of-Pocket Max

The most you will pay out of your wallet:	
Employee	$5,000
Single + Spouse/Domestic Partner or Single + Child/ren	$7,500
Family	$10,000

Questions?

Compare costs at: Lumen.com/ChooseBind **Access Code:** enroll2021 **Call:** 833-576-6519

Medical and Prescription Drug Overview - UnitedHealthcare Medical Plan Options

This chart is only a snapshot summary of UHC options. For specific details on how services are covered or excluded, please contact UHC or refer to the Summary Plan Description available on the Health and Life website or by requesting a copy through the Service Center.

	Savings HDHP		Standard CDHP		Premium CDHP	
	With Employee-Funded HSA (maximum contribution): • $3,600 SIngle • $7,200 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	**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 in excess of the Plan's allowable amount are not covered by the Plan.)	$5,400	$10,800	$4,800	$9,600
			Family		**Family**	
			$6,850	$14,400 (Charges in excess of the Plan's allowable amount are not covered by the Plan.)	$6,400	$12,800 (Charges in excess of the Plan's allowable amount are not covered by the Plan.)
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**

Note: When accessing Network Premium Providers or certain Freestanding Facilities, the Plan pays 85% rather than the 80% where available for services such as: Family Practice, General Surgery, OB-GYN and Pediatrics. See www.myuhc.com for these designations on providers/facilities. A freestanding symbol helps you identify opportunities to save money when you need care at an out-patient facility, diagnostic or ambulatory center, physician office or independent laboratory.

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 Savings HDHP or the Standard or Premium CDHP. 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 administrator, OptumRx, available for enrollment in the Savings HDHP, Standard CDHP or Premium CDHP. Eligible expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines.

Dental

You can choose between two dental plan options; a Basic Option and an Enhanced Option. 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 Dental Plan options are administered by MetLife.

This chart is only a snapshot summary of dental benefits. For specific details on how services are covered or excluded, please contact MetLife or refer to the Summary Plan Description available on the Health and Life website or by requesting a copy through the Service Center.

Basic option	Enhanced option (includes orthodontia)
Passive PPO In and Out-of-Network (Your Dental PPO plan is passive, meaning that you will pay the same coinsurance levels, have the same deductible requirements and be allotted the same Annual Maximum value regardless of going In or Out-of- Network. In-Network services are subject to MetLife's negotiated PDP Plus network rates. Out-of- Network services will be subject to the reasonable and customary charges. You may have additional out of pocket costs for services received from Out-of-Network providers.)	
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)
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, per person (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 vision care benefit option is administered by EyeMed. Staying in-network (Insight-Walmart Network) helps you save money on eye exams, frames and lenses. Visiting a PLUS Provider is designed to help save you even more. Since PLUS Providers are already in our network, the additional perks are built right into your vision benefits. No promo codes, no coupons, no paperwork. The same vision benefits, plus a little more savings. Find plenty of in-network eye doctors, including **PLUS Providers** (http://eye360.eyemedvirtualbenefitfair.com password - UF677XBD) or call **855-874-4744**.

This chart is only a snapshot summary of vision benefits. For specific details on how services are covered or excluded, please contact EyeMed or refer to the Summary Plan Description available on the Health and Life website or by requesting a copy through the Service Center.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST AT PLUS PROVIDERS	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES			
Exam	$0 copay	$10 copay	Up to $40
Retinal Imaging	Up to $39	Up to $39	Not covered
CONTACT LENS FIT AND FOLLOW-UP			
Fit and Follow-Up - Standard	Up to $40	Up to $40	Not covered
Fit and Follow-Up - Premium	10% off retail price	10% off retail price	Not covered
FRAME			
Frame	$0 copay; 20% off balance over $185 allowance	$0 copay; 20% off balance over $160 allowance	Up to $112
STANDARD PLASTIC LENSES			
Single Vision	$25 copay	$25 copay	Up to $30
Bifocal	$25 copay	$25 copay	Up to $50
Trifocal	$25 copay	$25 copay	Up to $70
Lenticular	$25 copay	$25 copay	Up to $70
Progressive - Standard	$25 copay	$25 copay	Up to $50
Progressive - Premium Tier 1	$110 copay	$110 copay	Up to $50
Progressive - Premium Tier 2	$120 copay	$120 copay	Up to $50
Progressive - Premium Tier 3	$135 copay	$135 copay	Up to $50
Progressive - Premium Tier 4	$200 copay	$200 copay	Up to $50
LENS OPTIONS			
Anti Reflective Coating - Standard	$45	$45	Up to $5
Anti Reflective Coating – Premium Tier 1	$57	$57	Up to $5
Anti Reflective Coating – Premium Tier 2	$68	$68	Up to $5
Anti Reflective Coating – Premium Tier 3	$85	$85	Up to $5
Photochromic – Non-Glass	$0 copay	$0 copay	Up to $5
Polycarbonate – Standard	$40	$40	Not covered
Polycarbonate – Standard – < 19 years of age	$0 copay	$0 copay	Up to $5
Scratch Coating – Standard Plastic	$15	$15	Not covered
Tint – Solid or Gradient	$0 copay	$0 copay	Up to $5
UV Treatment	$15	$15	Not covered
All Other Lens Options	20% off retail price	20% off retail price	Not covered

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST AT PLUS PROVIDERS	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
CONTACT LENSES			
Contacts – Conventional	$0 copay; 15% off balance over $150 allowance	$0 copay; 20% off balance over $150 allowance	Up to $105
Contacts – Disposable	$0 copay; 100% of balance over $150 allowance	$0 copay; 100% of balance over $150 allowance	Up to $105
Contacts – Medically Necessary	$0 copay; paid in full	$0 copay; paid in full	Up to $210
OTHER			
Hearing Care from Amplifon Network	Discounts on hearing exam and aids; call 877-203-0675	Discounts on hearing exam and aids; call 877-203-0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 800-988-4221	15% off retail or 5% off promo price; call 800-988-4221	Not covered
FREQUENCY			
Exam	Once every plan year		
Frame	Once every plan year		
Lenses	Once every plan year		
Contact Lenses (Plan allows member to receive either contacts and frame, or frames and lens services)	Once every plan year		

Administrator: EyeMed, **Group number:** 1029819, **Phone number:** **855-874-4744**

Enroll

Annual Enrollment begins Nov. 9 and ends on Nov. 20, 2020.

Be sure to review your mailing address, phone number and personal email address to ensure they are up-to-date. You can go online to the Health and Life website or contact the Service Center to make changes.

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 also print a copy of your 2021 elections until Dec. 31, 2020, by following the instructions below.

- Go to Lumen.com/healthbenefits 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, 2021)**
- To print, click the **Print** icon on the top right side of the screen.
- Keep a copy of this page for your records.

Online enrollment

1. Go to Lumen.com/healthbenefits 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 during your enrollment.
2. Locate the Annual Enrollment banner that says: **Welcome to Annual Enrollment. To start, click here.** and then make your Annual Enrollment elections.
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. Review your plan options, coverage level, and premiums. Then, make your elections.
5. Confirm your elections by selecting the **Complete Enrollment** button.
6. Look for the Completed Successfully! message listing your confirmation number 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. 9, but before Friday, Nov. 20 at 5:30 p.m. Mountain time, to complete your enrollment.

If you have questions that are not answered in this guide, Summary Plan Descriptions, or Summary of Material Modifications, log on to the Health and Life website at Lumen.com/healthbenefits and navigate to the scrolling message entitled **"Ways to Contact Us"** and select from the following options:

- Chat with a representative or
- Email a representative

You can also schedule an appointment be selecting the scrolling message on the left-hand side of the home page entitled: **"Schedule an appointment with a representative."**

Note: Virtual Hold may be an option for you if you call during peak hours. You will not lose your place in line if you select this option and a representative will call you back once available.

You must enroll between Nov. 9 and Nov. 20. Weekends are available for online enrollment only. Customer Care Representatives are available Monday through Friday, 7:30 a.m. to 5:30 p.m. Mountain time.

Helpful Resources

When you need more detailed information about Plan specifics, review your SPDs and SMMs located on the Health and Life website at Lumen.com/healthbenefits. 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		
Service Center **Advocacy Services** Free assistance with health claims and accessing health care services if enrolled in health care benefits.	**866-935-5011** or **800-729-7526**, Option 2 and then Option 1 M-F, 7:30 a.m. - 5:30 p.m., MST **Advocacy Services:** **866-935-5011** or **800-729-7526**, Option 2 and then Option 1. M-F 7:30 a.m. - 5:00 p.m. MST	Lumen.com/healthbenefits Email a representative at AlightHealthPro@Alight.com
Medical	**Bind:** **833-576-6519** M-F 6:00 a.m. - 9:00 p.m., CST Group Number: 78800186 **Access Code: enroll2021** **UnitedHealthcare:** **800-842-1219** Group Number: 192086	Lumen.com/choosebind Search: **MyBind**, available for Free in the App Store and Google Play **UnitedHealthcare:** myuhc.com Search: **UHC App**, available for Free in the App Store and Google Play
Prescription Drug Program	**Bind:** **833-576-6519** M-F 6:00 a.m. - 9:00 p.m., CST **UnitedHealthcare**: **800-842-1219**	Lumen.com/choosebind **UnitedHealthcare:** myuhc.com
Telemedicine	**Bind:** **Doctor On-Demand** **833-576-6519**	patient.doctorondemand.com
	UnitedHealthcare: **888-632-2738** • MDLive • Teledoc • Virtual Visits	Lumen.com/MDLive Search: **MDLive**, available for Free in the App Store and Google Play myuhc.com/virtualvisits
2nd.MD (Second opinions for all conditions) (An expert medical consultation service offered at no cost to you and your eligible dependents over the age of 18 who are enrolled in a Company medical plan.)	**866-842-1151**	Lumen.com/2ndmd Search: **2nd.MD**, available for Free in the App Store and Google Play
Wellness		
Employee Assistance Program	**Optum: 866-374-6061**	Lumen.com/EAP

Summary of benefits & coverage availability

We offer 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 Health and Life website anytime. You can view the SBC by following the below directions:

1. Log onto the Health and Life website at Lumen.com/healthbenefits
2. Click on the Tile**, Benefit Information and Documents**
3. 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 2 then Option 1. Representatives are available Monday through Friday from 7:30 a.m. to 5:30 p.m., MST.

Legal and Important Notices

A note about privacy

Keeping your personal information secure is of primary importance. 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 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 Lumen.com/healthbenefits, or 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.

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 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 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 Health Care Plan, the Life Insurance Plan and the 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 the Company 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 Health Care Plan, the Life Insurance Plan, Business Travel Accident Insurance Plan, the Disability Plan, or if applicable, 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 on the Company Intranet 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, due to death of a divorce. 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 available on the Health and Life website or by requesting a copy through the Service Center 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 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 benefit options available to you, provided you verify your spouse's/domestic partner's eligibility for the Plan.

Working After Retirement

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 had VEBA Life Insurance, that coverage will not be impacted.

If you are rehired in a status that is eligible for active benefits, you will be offered the same benefits as other similarly situated employee based on your employee classification. If you had 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 your 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 insurance coverage, if applicable.

If you return to work for a supplier on assignment to the Company, you are not eligible to continue your retiree health care benefits, so this means that while you are working for the supplier, your retiree health care benefits will be suspended. You will, however, 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 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 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 have your benefits reinstated.

Once your employment or assignment ends, you may resume your retiree health care, basic and supplemental life insurance coverage, if applicable, in accordance with terms of the Plan by calling the Service Center at **866-935-5011**. If you returned to work for a supplier on assignment to the Company, the Company will validate that your assignment has ended before you will be allowed to resume your retiree health care coverage.

Note: If you are Medicare eligible and have enrolled in an individual Medicare policy, you may need to complete a disenrollment process to be released by that carrier from the individual plan (which can take up to 60 days).

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 qualifying events due to employment termination or reduction of hours of employment. 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, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information. Qualifying events for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment. 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 before eligibility is sent to the Plan Administrator. Upon receipt of premium payment, the 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**.

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 provider, Optum, has a grievance procedure in place for California employees. This notice is required to comply with California Department of Managed Health Care (DMHC) regulations. You can find the grievance from on the Optum **website** at **www.liveandworkwell.com**, at the bottom of the home page. If you have any questions, contact Optum at **800-999-9585**.

877-453-8353 | lumen.com | info@lumen.com