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

2021 Annual Enrollment Guide

Qwest Enhanced Retirement Offer in 1992 (ERO '92), Including:

- Retiree
- Inactive
- COBRA participants

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Contents

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Welcome to Annual Enrollment

Annual Enrollment is your opportunity to review and make changes to your 2021 benefits under the Company Retiree and Inactive Health Plan ("the Plan").

We encourage you to read this guide as it contains important benefit information. If you are not making any changes or updates to your coverage, no action is required.

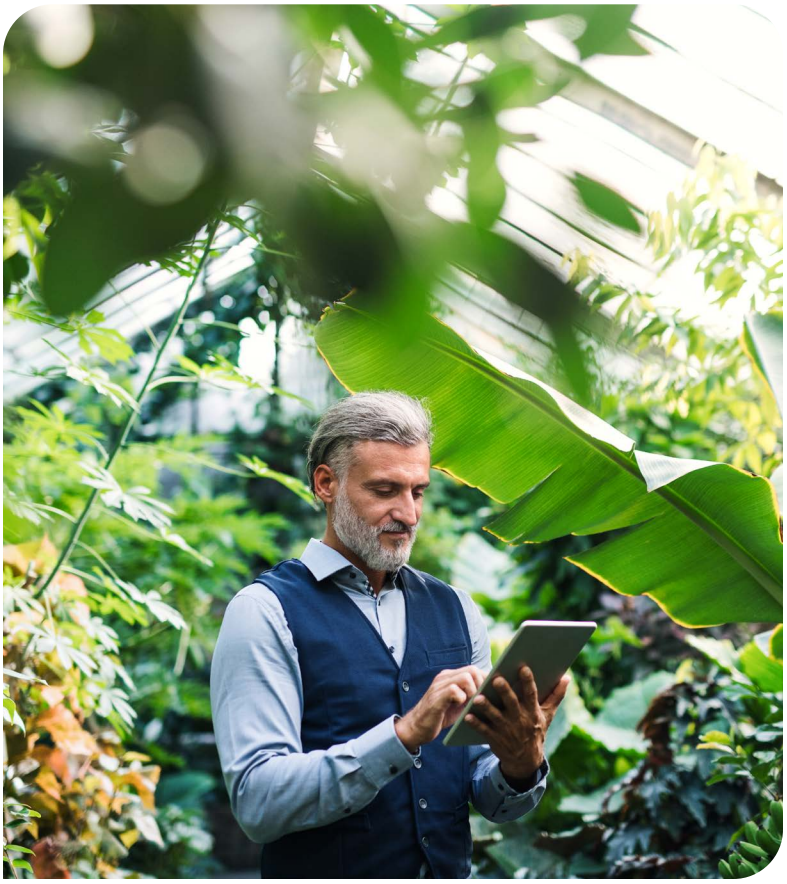
This guide pertains to **BOTH** non-Medicare eligible and Medicare eligible participants and their dependents. If you make changes during Annual Enrollment, your new coverage will begin on the first day of the new calendar year. (However, if enrolling in the UnitedHealthcare (UHC) Group Medicare Advantage PPO Plan (enhanced MA PPO Plan), enrollment and approval by UHC must occur prior to the month coverage is to be effective.)

COBRA Participants

The benefits detailed in this guide apply to ERO '92 Retirees and their eligible dependent(s). As a COBRA participant, coverage is limited to medical and/or, dental coverage, as applicable. COBRA rates have changed. Please refer to your Enrollment Worksheet (EWS) that you received with this guide.

Note:

- Some references and benefit options in this document apply **only** to ERO '92 Retirees. For more information, refer to the Health and Life website at lumen.com/healthbenefits or contact the Lumen Health and Life Service Center (referred to hereafter as the Service Center).
- Refer to the Helpful Resources page in this guide or your Summary Plan Description (SPD) for further details.
- The SPDs are available on the Health and Life website or by requesting a copy through the Service Center. Please allow time for mailing.



November 2020

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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.

What's New for 2021

Group Medicare Advantage PPO Plan (enhanced MA PPO Plan)

The enhanced MA PPO Plan has been enriched even more. The co-pay to see a Primary Care Physician (PCP) (general practioner, internist and OB/GYN) will be reduced from $5 to **$0**. Also, the MOST a retiree on the plan will have to pay in a calendar year is reduced from $250 to **$150**. That is your Out-of-Pocket Maximum (OOP Max). Lastly, the plan will now include up to 12 Acupuncture visits, if approved by Medicare.

Enrollment Reminders

Qualified Life Event (QLE)

If you experience a QLE such as marriage, death, divorce, adoption or birth, or losing other coverage, you must contact the Service Center at **866-935-5011** or **800-729-7526**, Option 2 and then Option 1, within 45 days of the event in order to change your coverage elections.

Be sure to gather your dependents' Social Security numbers and birthdates before you start the enrollment process, so you are prepared to enter them into the system or provide them to the representative. You will be required to go through the Dependent Verification process. if you add a new dependent who does not currently have Company coverage.

Dependent Social Security numbers required

The Medicare Secondary Payer provisions of the Social Security Act require all employers provide eligibility data to the Centers for Medicare & Medicaid Services (CMS). This means the Plan must provide CMS with Social Security numbers of all covered retirees and dependents. If you have covered dependents whose Social Security numbers are not on file at the Service Center, please contact the Service Center to provide this information as soon as possible.

Medicare Part B and/or Income-Related Monthly Adjustment Amount (IRMAA) reimbursement

Medicare Part B

If you are receiving Medicare Part B reimbursement, the same amount you received in 2020 will carry over to 2021.

If your Medicare Part B premium has changed for 2021, you will need to notify the Service Center by providing a copy of the letter from the Social Security Administration with your updated amount, postmarked by March 31, 2021 for the

updated reimbursement to be effective retroactive to Jan. 1, 2021. If your letter is postmarked after March 31, 2021, the updated reimbursement amount will begin the first of the following month after the postmarked date. Notifications can be mailed or faxed to:

Service Center
PO Box 661068
Dallas, TX 75266-1068
Fax: 847-554-1333

IRMAA

If you are enrolled in the UHC Group Medicare Advantage PPO Plan (enhanced MA PPO Plan) and are receiving reimbursement for the Income-Related Monthly Adjustment Amount (IRMAA) related to Medicare Part D, the same amount you received in 2020 will carry over to 2021.

The IRMAA is an amount you are required to pay in addition to your monthly premium if your modified adjusted gross income on your IRS tax return from two years ago is above a certain limit.

If your Medicare Part D premium has changed or you are a new participant in this Plan, you will need to notify the Service Center by providing a copy of the letter from the Social Security Administration with your amount postmarked by March 31, 2021 for the reimbursement to be retroactive to Jan. 1, 2021. If your letter is postmarked after March 31, 2021, the reimbursement amount will begin the first of the following month after the postmarked date. Notifications can be mailed or faxed to:

Service Center
PO Box 661068
Dallas, TX 75266-1068
Fax: 847-554-1333

Stay up-to-date with the Retiree Newsletter

Visit lumenbenefits.com or lumen.com/healthbenefits to get the latest retiree news. This newsletter is designed to share information about benefits, the Company and other topics. Don't miss out!

About Medicare

Medicare health insurance is provided by the U.S. federal government. Generally, you become eligible for Medicare on the first of the month in which you turn age 65. You may be eligible for Medicare benefits at an earlier age if you have permanent kidney failure or certain disabilities. If you and/or your dependents are eligible for Medicare, or will be this year, please review the following information carefully. There are three parts to Medicare that apply to you.

Medicare Part A

Medicare Part A covers most inpatient hospital services, skilled nursing facility services, certain home health services and hospice care. Medicare does not cover 100% of these services so you would be responsible for the balance. Generally, it is available at no cost to you.

Medicare Part B

Medicare Part B covers doctor services, outpatient hospital services, certain home health services, medical equipment and supplies, and other health services and supplies. Medicare does not cover 100% of these services and therefore you would be responsible for the balance.

As an ERO '92 Retiree, the Retiree and Inactive Health Plan will reimburse the premium you pay for this coverage for you and your dependents who are not Class II dependents.

NOTE: If you wish to opt-out or discontinue your Medicare Part B reimbursement, please contact the Service Center at **866-935-5011** or **800-729-7526**, Option 2 and then Option 1.

Medicare Part D (Prescription Drug Coverage)

Medicare Part D covers the cost of certain prescription drugs for eligible seniors and individuals with disabilities. The cost of this coverage depends on the Medicare Part D plan you select.

If you enroll in either the Guaranteed Coverage benefit option or enhanced MA PPO Plan, you do not need to enroll in Medicare Part D because prescription drug coverage is included in these benefit options, as defined by the Plan.

If you elect the HRA benefit option, you may need to enroll in a Medicare Part D plan, depending on which type of individual Medicare medical plan/policy you elect on your own.

Refer to the Medical and Prescription Drug overview in this guide for more information.

For more information about Medicare benefits, review the **Medicare & You handbook** at **medicare.gov** or call **800-MEDICARE (800-633-4227)** and ask to have a copy mailed to you.

TTY users should call **877-486-2048.**

Medical and Prescription Drug Overview

Your 2021 Annual Enrollment Worksheet (EWS) that you received with this guide will show the following four options:

Point of Service (POS) Company Plan

(the current Company Medical plan option is available to both Medicare and non-Medicare eligible participants) referred to as "Retiree Health Care Commitment" or "Guaranteed Coverage".

Enrollment in Medicare Parts A **and** B are required.

UnitedHealthcare (UHC) Group Medicare Advantage PPO Plan (enhanced MA PPO Plan)

(option only for Medicare eligible participants)

You can enroll on the Health and Life website, or by calling the Service Center at **866-935-5011** or **800-729-7526**, Option 2 and then Option 1.

In order to enroll in this Plan, the Service Center must have a physical address on file, not a P.O. Box. If you have a P.O. Box on file, this may delay enrollment. Please contact the Service Center if you have questions.

If you and your dependent are enrolling in this Plan and one or both applications are denied by Medicare, you will both be placed into the "Retiree Health Care Commitment" or "Guaranteed Coverage" Plan.

Enrollment in Medicare Parts A **and** B are required.

Note: If you enroll in the MA PPO Plan and it doesn't work for you, contact the Service Center at **866-935-5011** or **800-729-7526**, Option 2 and then Option 1.

Health Reimbursement Account (HRA) Plan Option

(option only for Medicare eligible participants)

No Medical/Prescription drug benefits provided. Instead, subsidy dollars will be placed in an account to reimburse you for Medicare policy premiums that you elect outside of the Company. This option cannot be used to reimburse you for expenses incurred; only for the Medicare policy premiums.

Waived Coverage (no coverage)

(for both Medicare and non-Medicare eligible participants who do not enroll in the Company medical coverage options or the HRA plan).

Note: If you enroll in the Health Reimbursement Account (HRA) Plan option above and cancel that coverage during the Plan year, you will default to the Waived Coverage (No Coverage) option for the remainder of the year, unless you experience a Qualified Life Event (QLE).

Medicare-Eligible and/or Non-Medicare Eligible:

If you and your dependents are Medicare eligible, you must enroll in the same benefit plan option. If you were enrolled in the enhanced MA PPO Plan in 2020 and you are not changing benefit plan options, you will not be required to re-enroll. Therefore, no action is required and you can keep your Enrollment Worksheet (included with this Guide) as your confirmation statement for 2021. If you are enrolling in an individual policy outside of the Company for the HRA benefit option, you must complete that insurance carrier's enrollment form and follow their process.

If you or one or more of your dependent(s) are not Medicare eligible, you can make separate elections for Medicare and non-Medicare participants. The non-Medicare participant may remain in the Company plan option or Waived Coverage (No Coverage) option, while the Medicare eligible participant may select from one of the three Medical plan options listed above.

Note: If the non-Medicare eligible participant becomes Medicare eligible during the plan year, that participant must enroll (and complete forms, if applicable) in the same benefit plan option that the Medicare eligible participant is enrolled in.

Medicare-Eligible Participants Only

Additional health care benefit options

These are additional benefit options you can elect instead of coverage under the Guaranteed Coverage Commitment. Refer to the comparison charts available in this guide for more information.

UnitedHealthcare Group Medicare Advantage Preferred Provider Option (PPO) Plan

The enhanced MA PPO plan option includes benefits, programs and services to help you live a healthier life, such as:

- You can see any provider (in-network or out-of-network) that participates in Medicare and accepts the plan, at the same cost.
- 100% coverage for preventive services.
- Care and disease management programs (e.g., diabetes, heart failure, etc.).
- UnitedHealthcare® HouseCalls – designed to complement your doctor's care. A licensed and knowledgeable health care practitioner will review your health history and current medications, perform a health screening, identify health risks and provide health education.
- NurseLine – You're never alone. Registered nurses answer your call 24 hours a day, seven days a week.
- Silver Sneakers® – get access to exercise equipment, classes and more at 14,000+ fitness locations.

To enroll in this plan, please provide your new Medicare Beneficiary Identification (MBI) number to the Service Center. This can be found on your red, white and blue Medicare ID card.

Contact UnitedHealthcare for additional information regarding these benefits, services and offerings at **877-886-7313**, TTY 711, 8:00 a.m.-8:00 p.m. Mountain time, seven days a week.

You can enroll on the Health and Life website, or by calling the Service Center at **866-935-5011** or **800-729-7526**, Option 2 and then Option 1 , do not contact UHC to enroll in this benefit plan option.

If you and your dependent are enrolling in this Plan and one or both applications are denied by Medicare, you will both be placed into the Company Plan, the "Retiree Health Care Commitment or "Guaranteed Coverage" Plan.

If you were enrolled in the enhanced MA PPO Plan in 2020 and you are not changing benefit plan options, you will not be required to re-enroll. Therefore, no action is required and you can keep your Enrollment Worksheet (included with this guide) as your confirmation statement for 2021.

Note: If you enroll in the MA PPO Plan and it doesn't work for you, contact the Service Center at **866-935-5011** or **800-729-7526**, Option 2 and then Option 1.

Health Reimbursement Account (HRA) plan option combined with an individual policy

- You are waiving coverage in the Company group retiree medical plan benefits each year you elect this option.
- The HRA provides you with Company-subsidized dollars to help you purchase the individual Medicare plans/policies that the Company does not offer.
- The HRA account is credited annually, on Jan. 1 of each year, by the Company in the amount of $3,800. Unused dollars are forfeited at the end of each year.
- The HRA is part of the the Company group retiree health plan, but the individual Medicare plan/policy you choose is not.
- You purchase the individual Medicare and prescription drug policy directly from the insurance carrier(s) ("carrier") of your choice—pay the insurance premium directly to them— and then receive reimbursement for the premium from your HRA.
- In order for your individual Medicare medical policy to be effective Jan. 1, 2021, you must enroll with Medicare between Oct. 15 and Dec. 7, 2020. For assistance, you can call ViaBenefits at **888-825-4252.** Please do not contact the Service Center to enroll in an individual Medicare medical policy as they will be unable to assist you.

Note: If you and your Medicare eligible dependent select the HRA plan option and you later want to change options or return to the coverage you had under the Company Plan, "Retiree Health Care Commitment" or "Guaranteed Coverage" Plan, you will be required to wait until the next Annual Enrollment period due to Centers for Medicare or Medicaid Services (CMS) rules.

Company Plan Options

Company plan option (for non-Medicare and Medicare eligible participants)

The Plan benefit option below summarizes your coverage available under the "Retiree Health Care Commitment" or "Guaranteed Coverage" benefit option, which includes Medical/Prescription drug coverage.

Point of Service (POS)

In-network Medical/Prescription drug coverage

- You may receive services from any provider without coordinating your care through a primary care physician (PCP). The option pays greater benefits if you receive care from a network provider or facility.
- If you receive covered services from a non-network provider, you may be responsible for paying a larger portion of the costs associated with those services.
- Before receiving services from a non-network provider, contact UnitedHealthcare (UHC) to ask for the total out-of-pocket expenses associated with that service or treatment.
- For covered services, such as surgery, office visits and others, you are responsible for paying a copay if you receive care from an in-network provider.
- Prescription drug coverage is administered by OptumRx, a UnitedHealthcare Group company.
- Talk to a nurse anytime day or night at **888-887-4112**, 24 hours a day, seven days a week to answer your non-emergency health care questions.

No-network medical/prescription drug coverage

This is not an option you can elect.

- If you live in an area where there is no UHC network of doctors, you may be eligible for the No-Network Plan benefit option administered by UHC.
- Preventive care services (including routine physical exams) are covered at 100 percent with no deductible. For all other services, you will be responsible for paying a deductible before the Plan starts paying for services.
- Prescription drug coverage is administered by OptumRx, a UnitedHealthcare Group company.
- Discounts from network providers for certain services may be available to you. Contact UHC.
- You also share the cost of services by paying coinsurance when you receive care, up to an out-of-pocket maximum. The benefits you receive are based on "eligible expenses," as determined by UHC; you are responsible for costs in excess of the eligible expenses.
- If No-network coverage is your only medical/prescription drug benefit option based on the medical options listed on your Enrollment Worksheet that was included with this Guide, you may request to opt-in to the POS option if you can verify that there are UHC Choice Plus network providers in your area. Contact the Service Center at **866-935-5011** or **800-729-7526,** Option 2 and then Option 1, and request to opt-in to the POS benefit option.

Medical Overview

	UnitedHealthcare Group Medicare Advantage PPO Plan* (enhanced MA PPO Plan)	Point of Service (POS) - Company Plan ERO '92 Retiree Plan Options	
	Your in- and out-of-network costs	**In-network costs**	**Out-of-network costs**
Annual Out-of-Pocket Maximum (Medical Only)	$150	N/A	$3,000
Deductible	$0	$0	$300
Coordination of Benefits with Medicare	UnitedHealthcare (UHC) handles on your behalf	Claims must be submitted to Medicare Part A or B first by you or your provider(s), then to UHC for Coordination with Company Plan ERO '92 Retiree Plan Options	
Medical Benefits			
Primary Care Physician Office Visit	$0	$10	20% after deductible
Specialist Physician	$10	$10	20% after deductible
Preventive Services	$0	$10	20% after deductible
Emergency	$50	$50	$50
Hospital Copay Per Admit	$0	$100 (max $300/yr/person)	20% after deductible
Outpatient Services	$0	$50	20% after deductible
Additional Benefits and Programs not Covered by Medicare			
Hearing Aids	Plan pays up to $500 (every three years)	Plan pays up to $300 (every three years)	
NurseLine℠	Speak with a registered nurse (RN) 24 hours a day, seven days a week	Speak with a registered nurse (RN) 24 hours a day, seven days a week	
Vision Services – Eye Exam	$10	Not Covered	
Routine Eyeglass Allowance (every two years)	$130	Not Covered	
Fitness Program	Stay active with a basic membership at a participating location at no extra cost to you	Not Covered	

*The UnitedHealthcare Group Medicare Advantage PPO plan is available to Medicare eligible participants ONLY.

REMINDER: When you become Medicare eligible, you must timely enroll in Medicare Part B.

If you are enrolled in the Point of Service (POS) Plan, Medicare becomes your primary coverage and the Company plan becomes secondary. Your benefits will be reduced if you do not enroll in a timely manner in Medicare Part B coverage.

	UnitedHealthcare Group Medicare Advantage PPO Plan* (enhanced MA PPO Plan)	Point of Service (POS) - Company Plan ERO '92 Retiree Plan Options	
	Your in- and out-of-network costs	**In-network costs**	**Out-of-network costs**
Prescription Drug Benefits Retail (30-day supply)			
Tier 1 (Preferred Generic)	$4 copay	$5	Not Covered
Tier 2 (Preferred Brand & Non-Preferred Generic)	$15 copay	$10	Not Covered
Tier 3 (Non-Preferred Brand)	$40 copay	$10	Not Covered
Tier 4 (Specialty)	$40 copay	$10	Not Covered
Coverage Gap	Full Coverage	Full Coverage	Not Covered
Prescription Drug Benefits Retail (90-day supply)			
Tier 1 (Preferred Generic)	$0	$5	Not Covered
Tier 2 (Preferred Brand & Non-Preferred Generic)	$0	$10	Not Covered
Tier 3 (Non-Preferred Brand)	$0	$10	Not Covered
Tier 4 (Specialty)	$0	$10	Not Covered

	ERO '92 Retiree Plan for MN, ND, WI (United Healthcare Choice Plus Plan)	
	In-network costs	**Out-of-network costs**
Annual Out-of-Pocket Maximum (Medical Only)	$1,000	$3,000
Deductible	$0	$300
Coordination of Benefits with Medicare	Claims must be submitted to Medicare Part A or B first, then to UHC for Coordination with the ERO '92 Plan	
Medical Benefits		
Primary Care/Specialist Physician Office Visit	$10	20% after deductible
Preventive Services	$0	100% covered
Emergency	$40	$40
Hospital Copay Per Admit	$0	20% after deductible
Outpatient Services	$0	20% after deductible
Additional Benefits and Programs not Covered by Medicare		
Hearing Aids	Plan pays up to $300 (every three years)	
NurseLine℠	24 hours a day, seven days a week	
Vision Services – Eye Exam	Not Covered	
Routine Eyeglass Allowance (every two years)		
Fitness Program		
Prescription Drug Benefits Retail (30-day supply)		
Tier 1 (Preferred Generic)	$8	Not Covered
Tier 2 (Preferred Brand & Non-Preferred Generic)	$12	
Tier 3 (Non-Preferred Brand)	$12	
Tier 4 (Specialty)	$12	
Coverage Gap	Full Coverage	
Prescription Drug Benefits Retail (90-day supply)		
Tier 1 (Preferred Generic)	$5	Not Covered
Tier 2 (Preferred Brand & Non-Preferred Generic)	$5	
Tier 3 (Non-Preferred Brand)	$5	
Tier 4 (Specialty)	$5	

Dental Overview

Dental Plan Benefit Option

The Plan benefit options available to you are indicated on your **Enrollment Worksheet** (EWS) that you received with this guide.

It pays to use network Dentists

You may receive services from any provider under your Plan benefit option, but your out-of-pocket costs may be less if you receive care from MetLife network providers (in the Preferred Dentist Program).

If you receive services from a non-network provider, your out-of-pocket costs may be more and you may need to complete and submit claim forms for reimbursement.

Here's a brief look at how the Dental Plan benefit option pays benefits.

Preventive and Diagnostic Care Services (cleanings, oral exams, x-rays)

The Plan pays 100% up to reasonable and customary (R&C) rates, but no more than what the dentist charges. If costs exceed R&C rates, you will be responsible for paying the excess charges.

All Other Services

You pay according to a schedule of allowances. Review the schedule of allowances in the applicable Summary Plan Description (SPD) available on the Health and Life website or by requesting a copy from the Service Center to determine the out-of-pocket expenses you must pay. Call MetLife for details about covered services.

For questions or benefit information, visit the MetLife website at metlife.com/mybenefits or call **866-832-5756**.

To enroll, you will need to log on to the Health and Life website or contact the Service Center. If you are already enrolled and would like to continue your coverage into the new year, no action is required and you can keep your Enrollment Worksheet as your confirmation statement for 2021.

Retiree Life Insurance

Retiree Basic Life Insurance (automatic and company-paid)

For eligible retirees, the Company provides Retiree Basic Life Insurance coverage that pays a $10,000 benefit to your designated beneficiary(ies) on file upon your death.

Retiree Supplemental Life Insurance (if applicable, you pay the cost)

If you elected Retiree Supplemental Life Insurance coverage prior to your retirement and continued it after your retirement, you may continue coverage up to age 65, provided you pay your monthly premium contributions in a timely manner. You may notice a slight change in premiums as the rounding calculation has been updated for consistency within the Life Insurance Plan.

Note: Coverage ends on the last day of the month in which you turn age 65, but you can apply to convert your coverage to an individual policy. Contact MetLife for details if this applies to you.

If your coverage is terminated due to non-payment or insufficient payment, you will not be allowed to re-enroll. You have the right to appeal the determination and can contact the Service Center if you wish to discuss the appeals process.

REMEMBER: To report a death, contact the Service Center at **800-729-7526**, Option number 3. It is very important to contact the Service Center as soon as possible as this can impact benefits under the Retiree and Inactive Health Plan, the Life Insurance Plan and/or the Combined Pension Plan.

Important notes if you have Retiree Supplemental Life Insurance

You may cancel or decrease coverage at any time by calling the Service Center. The coverage change will be effective the first of the month following your request. You may not re-enroll or increase coverage during your retirement.

You may convert your Retiree Supplemental Life coverage once you turn age 65, according to the laws of the state of Washington where the policy is issued. Conversion is not automatic, and you must apply for converted life insurance coverage through MetLife. You can reach MetLife at **877-275-6387** to request a conversion application if you experience a qualified loss in coverage. **MetLife must receive your completed application and premium for conversion within 31 days from the date your retiree supplemental life insurance coverage terminates.** Applications received by MetLife after the 31-day period will be denied.

Beneficiary Reminder

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

The Service Center is the recordkeeper of beneficiary designations.

Refer to the Retiree Life Insurance SPD for Facility of Payment to find out what happens when no beneficiaries are on file.

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

Paying for your coverage

We make it easy to pay for your supplemental life insurance benefits

Your 2020 benefit payment will continue in 2021 unless you make a change, reach age 65, or pass away. If you do not have an automatic payment plan in place for your Supplemental Life Insurance premiums, then your premiums are due on the first day of each month for the current month's benefit coverage. You can contact the Service Center for payment options such as:

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

Be sure to make timely payments!

If your premium payments are not received by the Service Center in a timely manner, your payment may still be processed due to the delay in processing your records internally. In this case, you will receive a refund within 21 days for the untimely payment and your coverage will not be reinstated, You have the right to appeal and can contact the Service Center if you wish to discuss the appeals process. Please note checks that are returned or direct debit requests that are refused due to insufficient funds are not re-deposited.

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

Enroll

Annual Enrollment begins Nov. 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.

Due to high call volume usually on the first and last day of Annual Enrollment, we encourage you to use the options listed above.

Helpful Resources

Benefit Option	Phone	Online
	Health Care	
Service Center • Health and Life Benefit Questions	**866-935-5011** or **800-729-7526**, Option 2 and then Option 1. M-F, 7:30 a.m. - 5:30 p.m., MST	lumen.com/healthbenefits
Advocacy Services Free assistance with health and life claims and accessing health care services if enrolled in Company health care benefits.	**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	Email a representative at AlightHealthPro@Alight.com
Retiree Medical (Guaranteed Coverage Options)/Prescription Drug Plans	**UnitedHealthcare: 800-842-1219**	**UnitedHealthcare:** myuhc.com
UnitedHealthcare Group Medicare Advantage Preferred Provider Option (PPO) Plan (enhanced MA PPO Plan)	**877-886-7313** **Do not enroll through this number.** Enrollment is completed through the Service Center.	
Dental Plan	**MetLife: 866-832-5756** **Do not enroll through this number.** Enrollment is completed through the Service Center.	metlife.com/mybenefits
	Retiree Life Insurance	
Life Insurance Administrator	**Metropolitan Life Insurance Company** 200 Park Avenue New York, NY 10166 **800-638-6420**	

Additional services provided by MetLife

Will Preparation and Probate Services are provided at no additional cost to retirees who are covered by the Company Retiree Supplemental Life Insurance Plan through MetLife. If you are eligible to receive these services, please call Legal Plans, Inc. at **800-821-6400**.

Grief Support and Funeral Assistance Services, which are provided through LifeWorks US Inc. for you, your dependents and your beneficiaries at no extra cost. If you are interested in learning more about this service, please call **888-319-7819**.

Follow the steps below to update your address and/or phone number:

Online

For Health and Life Benefits	For Pension Benefits
Log in to lumen.com/healthbenefits. Follow these steps: From the home page, go to Your Profile and click on Personal Information. 7. On the Personal Information page, under Addresses, click on Change next to Permanent Address. 8. You will then be routed to a page that will allow you to update your permanent address.	**Contact the Service Center** Visit the retiree website at lumen.com/pension; OR Submit your information in writing to Retiree Service Center Attention: Lumen P.O. Box 24989 Jacksonville, FL 32241 Your written request must include your name, first five digits of your Social Security number, complete old address, complete new address, signature and date.

By Phone

For Health and Life Benefits	For Pension Benefits
Contact the Service Center Dial **866-935-5011** or **800-729-7526, Option 2 and then Option 1**.	**Contact the Service Center** Dial **800-729-7526** Option 2, Option 8 and then Option 4.

When you need more detailed information about Plan specifics, review your SPDs and SMMs located at lumenbenefits.com or the Health and Life website at lumen.com/healthbenefits. You can request a copy by calling the Service Center. Pelase be advised that mailing time can take up to two weeks.

Important Coverage Rules

Adding dependents during enrollment

To cover newly eligible dependents during Annual Enrollment, **action is required**.

1. Add your newly eligible dependents during your online enrollment by following the prompts or by contacting the Service Center. A Dependent Verification packet will be sent to you automatically in Dec. 2020. Follow the instructions outlined in the packet and respond by the deadline.
2. Plan coverage for your newly eligible dependents will become effective Jan. 1, 2021, with the following exception: If validation is required and the supporting documentation is not received by the Service Center by the deadline, your dependents will be removed retroactively from coverage and you will be required to reimburse the Plan for any claims paid while the dependents were ineligible under the Plan.

Ending coverage for dependents during Annual Enrollment

You may remove dependents from your Plan coverage during Annual Enrollment by following the prompts during your online enrollment or by contacting the Service Center. COBRA will not be offered for dependents removed during Annual Enrollment.

During the year, if dependents no longer meet eligibility requirements for coverage, you are required to contact the Service Center **within 45 days** to terminate their coverage. You must notify the Service Center and coverage will end for the affected individuals retroactively to the end of the month that your dependent was no longer eligible for coverage. You will be responsible for any claims paid while the dependents were ineligible under the Plan.

If you have a Qualified Life Event and need to make changes before 2021

If you make changes during Annual Enrollment and have a subsequent change to your coverage before the end of December 2020, because of a QLE (for example, you add a spouse to your coverage), your 2020 changes/enrollment will not automatically be applied to 2021. **As a result, you will need to update BOTH your 2020 and 2021 coverage by contacting the Service Center.**

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.

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

If you return to work for a supplier on assignment to the company, you are not eligible to continue your Company retiree health care benefits. This means that while you are working for the supplier, your retiree health care benefits will be suspended. However, you will be offered the opportunity to continue your retiree medical and/or dental options under COBRA. Your retiree basic and supplemental life coverage, if applicable, will continue under the terms of the 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 the terms of the Plan by calling the Service Center at **866-935-5011** or **800-729-7526**, Option 2 and then Option 1. 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.

Legal and Important Required Notices

A note about privacy

Keeping your personal information secure is of primary importance to the Company. 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**. You may obtain a paper copy upon request by calling the Service Center at **866-935-5011** or **800-729-7526**, Option 2 and then Option 1.

This Is a Summary of Material Modifications (SMM)

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

Coverage is not advice

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

The company's reserved rights

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

Right to Amend and/or discontinue and make rules

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 and with respect to the Health Plan, the written agreement specific to ERO '92 Retirees. 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.

Notice of "Exempt" Retiree Medical Plan status

The Retiree and Inactive Health Plan, and all of its

benefit options meet the requirements of a stand-alone exempt retiree medical benefit plan under Section 732 of ERISA and, therefore, is not required to comply with benefit mandates of the Patient Protection and Affordable Care Act (PPACA). However, the Company has decided to voluntarily apply certain provisions of the PPACA to these benefit options. This voluntary application of certain PPACA provisions is separate from and not part of the health care commitment to the Qwest Pre-1991 and Qwest ERO '92 Retiree populations. This means that for all retirees, this voluntary compliance with PPACA may be changed or ended at any time and does not waive the Plan's status as "exempt" from PPACA. If you choose to participate in the new Medicare Advantage PPO or HRA, the policy you elect is an individual policy.

Important note regarding your Annual Enrollment elections

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

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

Women's Health and Cancer Rights Act

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

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

Note: This is an updated notice.

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WYOMING – Medicaid
Website: wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

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

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

If You Voluntarily Elect to Drop Coverage

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

Continuation of Coverage

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

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

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

Other coverage options

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

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

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

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

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