Amazing People. Amazing Benefits.

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

2021 Annual Enrollment Guide

For Qwest Post-1990 Occupational Retirees

Including: Inactive and 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®

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.

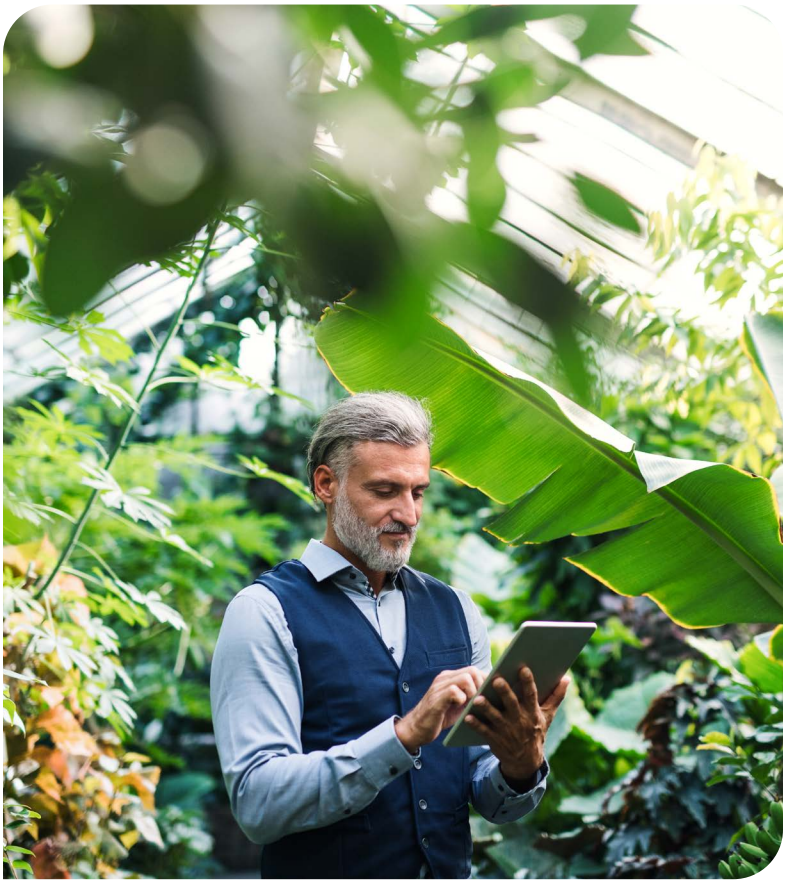
This guide pertains to **BOTH** non-Medicare eligible and Medicare eligible participants and their dependents. If you make changes during Annual Enrollment, your new coverage will begin on the first day of the new calendar year.

COBRA Participants

The benefits detailed in this guide apply to Post-1990 Occupational 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 Post-90 Occupational Retirees. For more information, refer to the Health and Life website at lumen.com/healthbenefits or contact the 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

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

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.

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

What's New for 2021

Health Savings Account (HSA)

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

*To contribute to an HSA, you must be enrolled in the Savings HDHP medical option. You may choose to establish an HSA with any financial institution. You cannot elect an HSA through the Service Center, you would need to enroll in an HSA on your own. Single coverage increases from $3,550 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.

If you are Medicare eligible you should review "Medicare and You", the government's Medicare handbook. While each participant's situation will differ, planning and education are key. You can find this handbook on the official medicare.gov website.

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 (for employees and your eligible dependents over the age of 18 who are enrolled in the UnitedHealthcare (UHC) or Bind Medical Plan) 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. The Specialist 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. They 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.

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 www.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

Current Plan		2021 Plan	
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%

Wellness (Non-Medicare eligible)

Retirees and their spouses/domestic partners who are enrolled in a UHC or Bind medical plan option and who are not Medicare eligible will be eligible to receive up to $55/month for participating in Weight Watchers. In order to receive the reimbursement for a Weight Watchers program, you must submit a prescription from your doctor along with the Weight Watchers Reimbursement Form which can be found on the UHC or Bind website or by calling UHC or Bind directly. You can find the websites and phone numbers in the Helpful Resources section of this guide.

Enrollment Reminders

Deductibles and Co-Insurance Accumulators reset on Jan. 1

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

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

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

Medical and Dental Company Cap

Medical and Dental Premiums

Retirees are responsible for the portion of the cost of medical premium that exceeds the monthly company contribution Cap, as applicable ("Cap"). Be sure to review your medical plan options and premium costs carefully. The Retiree & Inactive Health Plan includes a Cap on the dollar amount of the premium subsidy provided by the Company. Cap amounts vary depending on your legacy company and whether you are enrolling only yourself or any eligible dependents in your coverage. Once the cost of health care coverage exceeds the specified Cap amount, you must pay the entire remaining balance above the Cap amount in addition to your required percentage.

Reminder: Your contribution is capped at the 2020 amounts and will not increase in the future. Visit the Health and Life website at lumen.com/healthbenefits for more information.

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 Option:

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 maximum 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 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 update

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).

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!

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

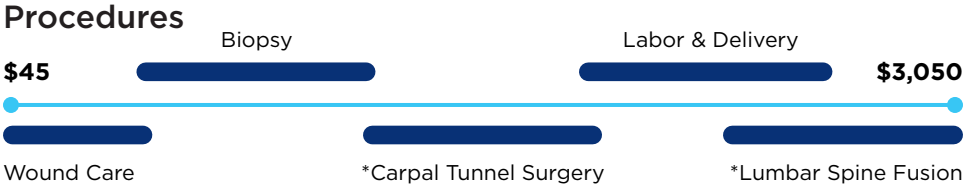
When and where you look for services, we let you know when lower-cost options are around the corner or across town. And you can easily compare provider quality ratings for many providers.

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 associated premium deductions or billing.

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:	
Retiree	$5,000
Retiree + Spouse/Domestic Partner or Retiree + 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 Single (retiree)-Funded HSA (maximum contribution): • $3,600 Single (retiree) • $7,200 Single (retiree) + 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 (retiree) • $750 Single (retiree) + Spouse/ Domestic partner • $750 Single (retiree) + Children • $1,000 Family		With Company-Funded HRA Contribution: • $1,000 Single (retiree) • $1,500 Single (retiree) + Spouse/ Domestic partner • $1,500 Single (retiree) + Children • $2,000 Family	
You Pay	**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 (retiree)		**Single (retiree)**		**Single (retiree)**	
	$1,500	$3,000	$1,500	$3,000	$1,500	$3,000
			Single (retiree) + Spouse/Domestic Partner		**Single (retiree) + Spouse/Domestic Partner**	
			$2,250	$4,500	$2,250	$4,500
	Single (retiree) + One or more enrolled		**Single (retiree) + Children**		**Single (retiree) + 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 (retiree)		**Single (retiree)**		**Single (retiree)**	
	$3,600	$7,200	$3,600	$7,200	$3,200	$6,400
			Single (retiree) + Spouse/Domestic Partner		**Single (retiree) + Spouse/Domestic Partner**	
			$5,400	$10,800	$4,800	$9,600
	Single (retiree) + One or more enrolled		**Single (retiree) + Children**		**Single (retiree) + 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.

Newly Eligible for Medicare

Those who will become Medicare eligible

Options outside of the Company

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

If you are eligible for a Company Subsidy

When your Non-Medicare Company medical group plan options end, the Company will fund an HRA with company subsidy dollars (subject to the Company Cap) that help pay for your individual Medicare medical policy and dental premiums. Your unused HRA dollars will roll over. Your annual Company-funded medical HRA amounts are capped and remain the same for 2021 and will not increase in the future.

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

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

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

Step 1
Enroll in Medicare Part A & Part B
Step 2
Enroll in an individual Medicare policy prior to the month you become Medicare eligible
Step 3

Let ViaBenefits Help You Enroll

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

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

Dental Overview

Basic Dental Plan - Passive PPO

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.

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.

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

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

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

Retiree Life Insurance

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

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

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

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

If you retired on or after Jan. 1, 2003

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

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

Important notes if you have Retiree Supplemental Life Insurance

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

Beneficiary Reminder

Please confirm that you have designated beneficiaries for all of your 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 Option 1.

The Service Center is the recordkeeper of beneficiary designations.

Refer to the 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 Retiree Benefits

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

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

Be Sure to make timely payments

If your premium payments are not received by the Service Center in a timely manner, the payments may be processed due to the delay in updating records internally. In this case, you will receive a refund 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 that checks that are returned or direct debit requests that are refused due to insufficient funds are not re-deposited.

Regardless of how you pay your premiums, be sure that your 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 of the the options listed above.

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 at 866-935-5011 or 800-729-7526, Option 2 and Option 1. Please be advised that mailing time can take up to two weeks.

Benefit Option	Phone	Online
Health Care		
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 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
Dental Plans	**MetLife: 866-832-5756** Group Number: 148069	metlife.com/benefits
ViaBenefits	**888-825-4252**	my.viabenefits.com/centurylink

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

Important Coverage Rules

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

Dual coverage

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

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

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

Covering previously suspended dependents during Annual Enrollment

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

1. To add previously suspended dependents, follow the prompts during your online enrollment or contact the Service Center. A Dependent Verification packet may be sent to you automatically in December 2020. Follow the instructions outlined in the packet, and **respond by the deadline**.
2. Plan coverage for your previously suspended dependents will become effective Jan. 1, 2021, **with the following exception**. If validation is required and verification forms are not received by the Service Center by the deadline, **your dependents will be removed retroactively from coverage.** You will be required to reimburse the Plan for any claims paid while the previously suspended dependents were ineligible under the Plan.

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

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

If you are rehired in a status that is eligible for active employee benefits, you will be offered the same benefits as other similarly situated 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 get 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, 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 Qwest Post-1990 Occupational 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/medicalassistancehealthinsurancepremiumpaymenthippprogram/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