



Lumen Health Care Plan*

Vision Plan Option

(Administered by EyeMed)

Summary Plan Description (SPD) For Eligible Active Employees

Effective Jan. 1, 2021

This SPD must be read in conjunction with the *General Information SPD*, which explains many details of your coverage and provides a listing of the other benefit options under the Plan.

* The Lumen brand was launched on September 14, 2020. As a result, CenturyLink, Inc. is referred to as Lumen Technologies, or simply Lumen. The legal name CenturyLink, Inc. is expected to be formally changed to Lumen Technologies, Inc. upon the completion of all applicable requirements.

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INTRODUCTION

Lumen Technologies* (hereinafter “Lumen” or “Company”) is pleased to provide you with this Summary Plan Description (“SPD”). This SPD presents an overview of the Benefits available under the Vision Plan benefit option of the Lumen Health Care Plan* (the “Plan”).

This SPD must be read in conjunction with the *General Information SPD* which explains many details of your coverage and provides a listing of the other benefit options under the Plan.

The effective date of this updated SPD is January 1, 2021. If you are a Covered Person in the Vision Plan benefit option of the Plan on or after January 1, 2021, this SPD supersedes and replaces, in its entirety, any other SPD describing Vision Plan Benefits that you currently may possess. In the event of any discrepancy between this SPD and the official *Plan Document*, the *Plan Document* shall govern.

This SPD, together with other plan documents (such as the Summary of Material Modifications (SMMs), the *General Information SPD* and materials you receive at Annual Enrollment) (hereafter “Plan documents”) briefly describe your Benefits as well as rights and responsibilities, under the Health Care Plan (the “Plan”). These documents make up your official Summary Plan Description for the Vision Plan benefit option(s) as required by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). The Vision Plan benefit option under the Plan is self-funded; however, certain other benefit plan options under the Plan may be insured.

This SPD is for eligible active Employees.

Company’s Reserved Rights

The Company reserves the right to amend or terminate any of the Benefits provided in the Plan – with respect to all classes of Covered Person, retired or otherwise – without prior notice to or consultation with any Covered Person, subject to applicable laws and if applicable, the collective bargaining agreement.

The Plan Administrator, the Employee Benefits Committee, and its delegates(s), has the right and discretion to determine all matters of fact or interpretation relative to the administration of this Vision Plan benefit option—including questions of eligibility, interpretations of the Plan provisions and any other matter. The decisions of the Plan Administrator and any other person or group to whom such discretion has been delegated, including the Claims Administrator, shall be conclusive and binding on all persons. More information about the Plan Administrator and the Claims Administrator can be found in the General Information SPD.

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. There are deadlines to file claims and benefit related actions; please refer to “Time Deadline to File a Benefit Claim and the Time Deadline to File a Benefit-Related Lawsuit,” page 15, in this SPD for more information about the timing of these deadlines.

The Required Forum for Legal Disputes. After the claims and appeals procedures are exhausted as explained above, and a final decision has been made by the Plan Administrator, if an Eligible Employee wishes to pursue other legal proceedings, the action must be brought in the United States District Court in Denver, Colorado.

How to Use This Document

The SPD is designed to provide you with a general description, in non-technical language of the Benefits currently provided under the Vision Plan benefit option without describing all the details set forth in the *Plan*

* The Lumen brand was launched on September 14, 2020. As a result, CenturyLink, Inc. is referred to as Lumen Technologies, or simply Lumen. The legal name CenturyLink, Inc. is expected to be formally changed to Lumen Technologies, Inc. upon the completion of all applicable requirements.

Document. The SPD is not the *Plan Document*. Other important details can be found in the *Plan Document* and the *General Information SPD*. The legal rights and obligations of any person having any interest in the Plan are determined solely by the provisions of the Plan. If any terms of the *Plan Document* conflict with the contents of the SPD, the *Plan Document* will always govern.

Capitalized terms are defined throughout this SPD and in the *General Information SPD*. All uses of “we,” “us,” and “our” in this document, are references to the Claims Administrator. References to “you” and “your” are references to people who are Covered Persons as the term is defined in the *General Information SPD*.

You are encouraged to keep all the SPDs and any attachments (summary of material modifications (“SMMs”), amendments, and addendums) for future reference.

Please note that your health care Provider does not have a copy of the SPD and is not responsible for knowing or communicating your Benefits.

See the *General Information SPD* for more information as noted in the *General Plan Information* section and throughout this SPD.

Health Plan Coverage Is Not Health Care Advice

Please keep in mind that the sole purpose of the Plan is to provide for the payment of certain health care expenses and not to guide or direct the course of treatment of any Employee, or eligible Dependent. Just because your health care Provider recommends a course of treatment does not mean it is approved and payable under the Plan. A determination by the Claims Administrator or the Plan Administrator that a particular course of treatment is not eligible for payment or is not covered under the Plan does not mean that the recommended course of treatments, services or procedures should not be provided to the individual or that they should not be provided in the setting or facility proposed. ***Only you and your health care Provider can decide what is the right health care decision for you. Decisions by the 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 right to use your Social Security number for administration of benefits

The Company retains the right to use your Social Security Number for benefit administration purposes, including tax reporting. If a state law restricts the use of Social Security Numbers for benefit administration purposes, The Company generally takes the position that ERISA preempts such state laws.

GENERAL PLAN INFORMATION

The Vision Plan benefit option is just one benefit option offered under the Plan. This SPD must be read in conjunction with the General Information SPD which explains details of your coverage and provides a listing of the other benefit options under the plan.

Refer to the **General Information SPD** for important and general Plan information including, but not limited to, the following sections:

- Eligibility
- When Coverage Begins
- When Coverage Ends
- How to Appeal a Claim
- Circumstances that May Affect Your Plan Benefits
- The Plan’s Right to Restitution
- Coordination of Benefits
- Plan Information (e.g. Plan Sponsor and EIN, administration, contact information, Plan Number, etc.)
- A statement of your ERISA Rights
- Notice of HIPAA Rights
- Your Rights to COBRA and Continuation Coverage

- General Administrative Provisions
- Required Notice and Disclosure
- Glossary of Defined Terms
- Qualified Medical Child Support Order (QMSCO)

You can go online to lumen.com/healthandlife (if actively working) or lumen.com/healthbenefits to obtain an electronic copy or call the Service Center at 866-935-5011 or 800-729-7526, option 1 and option 1 to request a paper copy of the General Information SPD.

Consequences of Falsification or Misrepresentation

You will be given advance written notice that coverage for you or your Dependent(s) will be terminated if you or your Dependent(s) are determined to falsify or intentionally omit information, submit false, altered, or duplicate billings for personal gain, allow another party not eligible for coverage to be covered under the Plan or obtain Plan Benefits, or allow improper use of your or your Dependent's coverage.

Continued coverage of an ineligible person is considered to be a misrepresentation of eligibility and falsification of, or omission to, update information to the Plan, which is in violation of the Code of Conduct and may result in disciplinary action, up to and including termination of employment. This misrepresentation/omission is also a violation of the Plan document, Section 8.3 which allows the Plan Administrator to determine how to remedy this situation. For example, if you divorce, your former spouse is no longer eligible for Plan coverage and this must be timely reported to the Service Center within 45 days, regardless if you have an obligation to provide health insurance coverage for your former spouse/domestic partner through a Court Order.

- You and your Dependent(s) will not be permitted to benefit under the Plan from your own misrepresentation. If a person is found to have falsified any document in support of a claim for Benefits or coverage under the Plan, the Plan Administrator may without anyone's consent terminate coverage, possibly retroactively, if permitted by law (called "rescission"), depending on the circumstances, and may seek reimbursement for Benefits that should not have been paid out. Additionally, the Claims Administrator may refuse to honor any claim under the Plan or to refund premiums
- While a court may order that health/vision coverage must be maintained for a former spouse/domestic partner, that is not the responsibility of the Company or the Plan.
- You are also advised that by participating in the Plan you agree that suspected incidents of this nature may be turned over to Plan Administrator and/or Corporate Security to investigate and to address the possible consequences of such actions under the Plan. All Covered Persons are periodically asked to submit proof of eligibility to verify claims.

Note: All Participants by their participation in the Plan authorize validation investigations of their eligibility for Benefits and are required to cooperate with requests to validate eligibility by the Plan and its delegates.

For other loss of coverage events, refer to the *General Information SPD* as applicable.

You Must Follow Plan Procedures

Please keep in mind that it is very important for you to follow the Plan's procedures, as summarized in this SPD, in order to obtain Plan Benefits and to help keep your personal health information private and protected. For example, contacting someone at the Company other than the Claims Administrator or Plan Administrator (or their duly authorized delegates) to try to get a Benefit claim issue resolved is not following the Plan's procedures. If you do not follow the Plan's procedures for claiming a Benefit or resolving an issue involving Plan Benefits, there is no guarantee that the Plan Benefits for which you may be eligible will be paid to you on a timely basis, or paid at all, and there can be no guarantee that your personal health information will remain private and protected

Plan Number

The Plan Number for the Health Care Plan is 512.

CLAIMS ADMINISTRATORS AND CONTACT INFORMATION

855-874-4744

Group Number: 1029819

Website Address: www.member.eyemedvisioncare.com/lumen

Service Center
P.O. Box 1407 866-935-5011 or 800-729-7526
Lincolnshire, IL 60069

Website Address: lumen.com/healthandlife (if actively working) or lumen.com/healthbenefits

VISION PLAN BENEFIT FEATURES

Procedures for Using the Vision Plan Benefits

If you choose to receive plan benefits from a member provider, contact EyeMed or a EyeMed member provider. A list of names, addresses and phone numbers of member providers in your geographic location can be obtained from EyeMed at **855-874-4744**. For the TTY, the caller should dial 711 and ask the relay operator to call 844-230-6498. or visit www.member.eyemedvisioncare.com/lumen.

EyeMed will provide benefit authorization directly to the EyeMed member provider. If you contact the EyeMed member provider directly, you must identify yourself as a EyeMed member, so the provider knows to obtain benefit authorization from EyeMed.

When such benefit authorization is provided by EyeMed and services are performed prior to the expiration of the benefit authorization, this will constitute a claim against the Plan in spite of your termination of coverage or the termination of the Plan. Should you receive services from a member provider without such benefit authorization or obtain services from a provider who is an out-of-network provider, you are responsible for payment in full to the provider.

You pay only the copayment to a EyeMed member provider for services covered by the Plan. EyeMed will pay the member provider directly according to their agreement with the provider.

When you use an out-of-network provider, you should pay the provider his/her full fee. You will be reimbursed by EyeMed up to the the maximums as outlined in the Summary of Vision Care Services. Refer to the “**Benefit Summary Chart**,” page 8, in this SPD.

To receive your out-of-network reimbursement, complete and sign an out-of-network claim form, attach your itemized receipts and send to:

FAA/EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

For your convenience, a FAA/EyeMed out-of-network claim can be completed online. Please [click here](#).

You may also print a claim form and email it to us at oonclaims@eyemed.com or call the EyeMed’s Customer Care Center at **855-874-4744**.

In emergency conditions, when immediate vision care is necessary, you can obtain covered services by contacting a EyeMed member provider. Emergency vision care is subject to the same benefit frequencies, plan allowances, copayments and exclusions.

In the event of termination of a member provider’s membership with EyeMed, EyeMed will remain liable to the

member provider for services rendered to you at the time of termination and permit the member provider to continue to provide with plan benefits until the services are completed or until EyeMed makes reasonable and appropriate arrangements for the provision of such services by another authorized provider.

Benefit Authorization Process

EyeMed authorizes plan benefits in accordance with the latest eligibility information furnished to EyeMed by the Company. When you request services under the Plan, your prior utilization of plan benefits will be reviewed by EyeMed to determine if you are eligible for new services based upon the Plan's level of coverage.

HOW TO FILE A BENEFIT CLAIM

This section provides you with information about how and when to file a claim.

If You Receive Covered Health Services from a EyeMed Member Provider

When you obtain services from a EyeMed member provider, the EyeMed member provider will file the claim on your behalf. You are responsible for paying the co-payments to the EyeMed member provider at the time you receive care.

If You Receive Covered Vision Services from an Out of Network Provider

Typically, when you obtain services from an Out of Network Provider, you are responsible for requesting payment from EyeMed, the Claims Administrator. You must file the claim in a format that contains all of the information required as described below.

Members are required to complete an Out of Network Claim Form, along with paid receipts, when seeking reimbursement for an Out of Network Claim. Required information is noted on the form, which can be submitted online or via mail. Reimbursement will be sent directly to the member."

You must submit a request for payment of benefits no later than 15 months after the date of service. However, you should pay the full bill and send your itemized statement of charges along with a claim form to EyeMed.

Claim forms can be obtained by calling EyeMed Customer Service at **855-874-4744** or visiting the EyeMed website at www.member.eyemedvisioncare.com/lumen.

Payment of Vision Plan Benefits

The EyeMed Vision Plan will make a benefit determination as set forth below. Benefits will be paid to the EyeMed member provider. Benefits will be paid to you when using an Out of Network Provider, except as noted above.

Note: If you are enrolled in the Health Care Flexible Spending Account, you may be able to pay your portion of the Vision expense with your Health Care Spending Card and avoid the need to file for a claim reimbursement. See the *Flexible Spending Account(s) SPD* for more information.

Claim for Payroll Adjustment and the Deadlines

There is a separate claims process if you dispute the deductions from your paycheck for your Plan Benefits, see "**Reminder to Review Your Paycheck Deductions,**" below for further information.

Reminder to Review Your Paycheck Deductions

- Review your paycheck along with the Company Benefits and Payroll schedule (available online) to confirm your benefit premium deductions for Health & Welfare including Savings and Spending Accounts. Any questions related to benefit premiums should be directed to the Lumen Health and Life Service Center 866-935-5011 at 800-729-7526, option 1, option 1 and then option 1 again. Do not contact the Payroll Department as the Payroll staff will be unable to assist you.
- If your benefit premium deductions are not correct or not what you expect you must make a claim to the Plan Administrator in accordance with the claim's procedures as soon as possible after the year's payroll deductions begin.
 - ▶ **If your claim is denied, be advised that there is a deadline to file an appeal and if you miss the deadline, your deductions remain in place for the benefit plan year.** The time period to make an appeal is the **earlier of**:
 1. within 180 days of an adverse 1st level decision by the Plan Administrator, or
 2. the earlier of (a) within 180 days of the effective date of an election that is later claimed to be erroneous, or (b) by the last day of the plan year of when the election error is claimed to have occurred.

If the appeal is not filed by this deadline it shall be deemed untimely and denied on that basis.

Explanation of Benefits. You can view your EyeMed Explanation of Benefits (EOB) at www.member.eyemedvisioncare.com/lumen. Or you may contact EyeMed Customer Care at **855-874-4744** for assistance or additional information and to request to receive a paper copy of your statements in the mail.

COVERED VISION PLAN BENEFITS

This section is a summary of expenses covered by the EyeMed Vision Plan Option.

EyeMed Provider Benefits

If you use the services of a EyeMed member provider, the Vision Plan Option will pay covered vision care services as follows:

Eye Exam

One eye examination each plan year, paid in full after your \$10 co-payment. At VisionPlus Providers you will have no co-payment. This includes a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities. This does not include exams needed to evaluate medical symptoms (i.e. eye pain) or contact lens fitting and evaluation.

Retinal Screening

The Retinal Screening enhancement allows members to have retinal screening done with their routine exam. Retinal screening uses high-resolution imaging systems to take pictures of the inside of the eye. This enhancement helps increase pathology detection and documentation of suspicious cases of glaucoma through retinal images. It does not replace pupil dilation as that is still considered the gold standard. Please note retinal screening technology may not be available in all EyeMed provider locations as it is dependent upon whether the provider has purchased the necessary equipment to do the imaging.

Glasses

Certain lenses and frames are paid in full after your \$25 co-payment, as follows:

Lenses are covered in full each plan year after \$25 co-payment. The EyeMed member provider will order the proper lenses if needed. The provider also verifies the accuracy of the finished lenses.

Full coverage is available for polycarbonate lenses for children up to age 19.

There will also be an extra charge if you select special lenses, including but not limited to contact lenses

(except as noted), oversize lenses, premium or custom progressive multi focal lenses, certain coating for lenses.

A frame is available once every plan year. If you select a frame that costs more than the amount allowed by the plan, there will be an additional charge. You will receive a \$160 allowance towards any frame of your choice plus 20% off any amount over the allowance. At VisionPlus Providers, you receive a \$185 allowance toward any frame of your choice plus 20% off any amount over the frame allowance.

Contact Lenses

Benefits for contact lenses are available in lieu of lenses for glasses. The Vision Plan benefit option pays 100% for routine eye exam after \$10 copayment plus up to \$150 for contact lenses. Contact lens fitting and evaluation exam for standard and premium fit wearers is covered in full after a, not to exceed, \$40 copay. 15% discount is applied to the contact lens exam.

Medically necessary contact lenses are covered in full when a EyeMed member provider secures proper approval. Medically necessary contact lenses may be prescribed by a EyeMed provider for certain conditions. A EyeMed provider will determine eligibility for these types of lenses at the time of service.

Laser Vision Correction Discounts

Laser vision correction discounts are available using participating EyeMed providers. You receive on average a 15% discount off laser surgery or an additional 5% off the center's promotional price.

Note: Employees can use their benefit to obtain prescription safety glasses in lieu of their regular dress wear benefit if they choose to at a EyeMed in-network provider's office.

To Request Benefits

Once you have made an appointment with a member provider, the provider will verify benefit coverage on your behalf prior to rendering service. If you need to locate a member provider in your area or wish to verify your level of coverage prior to your appointment, call EyeMed at **855-874-4744** or visit the web site at www.member.eyemedvisioncare.com/lumen.

Out of Network Reimbursement

Eye Exams

Eye examination, up to \$40

Lenses and Frames

Single vision lenses, up to \$30

Lined Bifocal lenses, up to \$50

Lined Trifocal lenses, up to \$65

Lenticular lenses, up to \$100

Progressive lenses, up to \$50

Frames, up to \$70

Contact Lenses

Elective Contact lenses and contact lens fitting, and evaluation exam covered up to \$105

Medically Necessary, up to \$210

Low Vision

One supplemental exam every two years covered in full. \$1,000 maximum benefit every two years toward

low vision materials. If low vision supplemental testing is approved, it will be covered in full by EyeMed at an in network provider or reimbursed up to \$125 out of network every two years. If low vision aids are approved, EyeMed will pay 75% of the approved amount up to a maximum of \$1,000 per covered individual every two years. The patient is responsible for the remaining 25% of the approved amount plus any amount over the maximum.

PLUS Providers

You can choose to visit an in-network PLUS Provider for access to enhanced benefits to help you save even more. At PLUS Providers, you'll receive a \$0 exam copay, plus an additional \$25 frame allowance (on top of your base benefits and standard discounts). PLUS Providers are located nationwide and easy to find – just look for them using our Provider Locator at www.eyemed.com.

Summary of Vision Benefits

	Your In-Network Cost at PLUS Providers	Your In-Network Cost	Your Out-of-Network Reimbursement*
EXAM SERVICES			
Exam	\$0 copay	\$10 copay	Up to \$40
Retinal Imaging	\$0 copay	\$0 copay	Not covered
CONTACT LENS FIT AND FOLLOW- UP			
Fit and Follow-Up - Standard	Up to \$40	Up to \$40	Not covered
Fit and Follow-Up - Premium	10% off retail price	10% off retail price	Not covered
FRAME			
Frame	20% off balance over \$185 allowance	20% off balance over \$160 allowance	Up to \$112
STANDARD PLASTIC LENSES			
Single Vision	\$25 copay	\$25 copay	Up to \$30
Bifocal	\$25 copay	\$25 copay	Up to \$50
Trifocal	\$25 copay	\$25 copay	Up to \$70
Progressive - Standard	\$25 copay	\$25 copay	Up to \$50
Progressive – Premium Tier 1	\$110 copay	\$110 copay	Up to \$50
Progressive – Premium Tier 2	\$120 copay	\$120 copay	Up to \$50
Progressive – Premium Tier 3	\$135 copay	\$135 copay	Up to \$50
Progressive – Premium Tier 4	\$200 copay	\$200 copay	Up to \$50
LENS OPTIONS			
Anti-Reflective Coating - Standard	\$45 copay	\$45 copay	Not covered
Anti-Reflective Coating – Premium Tier 1	\$57 copay	\$57 copay	Not covered
Anti-Reflective Coating – Premium Tier 2	\$68 copay	\$68 copay	Not covered
Anti-Reflective Coating – Premium Tier 3	\$85 copay	\$85 copay	Not covered
Photochromic – Plastic	\$0	\$0	Up to \$5
Polycarbonate – Standard – Dependent Children	\$40 copay Standard, \$0 Dependent Children	\$40 copay Standard, \$0 Dependent Children	Adults not covered, Up to \$5 for Dependent Children
Scratch Coating – Standard Plastic	\$15	\$15	Not covered

	Your In-Network Cost at PLUS Providers	Your In-Network Cost	Your Out-of-Network Reimbursement*
Tint – Solid or Gradient	\$0	\$0	Up to \$5
UV Treatment	\$15	\$15	Not covered
All Other Lens Options	20% off retail price	20% off retail price	Not covered
CONTACT LENSES**			
Contacts - Conventional	15% off balance over \$150 allowance	15% off balance over \$150 allowance	Up to \$105
Contacts - Disposable	100% of balance over \$150 allowance	100% of balance over \$150 allowance	Up to \$105
Contacts - Medically Necessary	\$0 copay; paid in full	\$0 copay; paid in full	Up to \$210
OTHER			
Hearing Care from Amplifon Network	Discounts on hearing aids	Discounts on hearing aids	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	15% off retail price or 5% off promotional price	Not covered
FREQUENCY			
Based on calendar year			
Exam	Once every 12 months	Once every 12 months	Once every 12 months
Frames	Once every 12 months	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months	Once every 12 months

* You are responsible to pay the out-of-network provider in full at time of service and then submit an out-of-network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.

** For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes.

Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

Limitations and Exclusions

- No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures
- Refraction, when not provided as part of a Comprehensive Eye Examination
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof
- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing;
- Aniseikonic lenses
- Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment
- Safety eyewear; solutions, cleaning products or frame cases
- Non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices;
- Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.
 - Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be

paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy.

- Allowances provide no remaining balance for future use within the same Benefit Frequency.
- Some provisions, benefits, exclusions or limitations listed herein may vary by state.
- Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers.
- Please see online provider locator to determine which participating providers have agreed to the discounted rate.

CLAIMS AND APPEALS PROCEDURES

Questions and Appeals – What to Do First

The Plan Administrator believes that most claim issues, such as a denied claim, can be addressed informally if promptly and objectively raised with the appropriate Claims Administrator, and that the best time to solve a problem or answer a question is when it first arises, not days, weeks or months later. In no event should it be more than a year after you have been notified and are aware of the issue. There is a separate claims process if you dispute the deductions from your paycheck for your Plan Benefits. Refer to “**Claim for Payroll Adjustment and the Deadlines**” on page 5.

Participants who have had a claim denied, have questions or complaints, etc., may informally contact the Claims Administrator before requesting a formal appeal. If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in the How to File a Benefit Claim section, you may appeal it without first informally contacting the Claims Administrator.

How to Appeal a Denied Service Claim

Time Frames and Procedures for Appealing Claims – First Level

If your claim is denied, in whole or in part, you may file a first-level appeal. The first-level appeal must be in writing and received by FAA within 180 days of your notice of the denial. If you do not receive an EOB within 30 days of submission of your claim, you may submit a first-level appeal within 180 days after this 30-day period has expired. Your written letter of appeal should include the following:

The applicable claim number or a copy of the written denial or a copy of the EOB, if applicable.

The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.

Additional information from the member’s eye care provider that will assist FAA in completing its review of the member’s first-level appeal, such as documents, records, questions or comments.

The appeal should be mailed or faxed to the following address FAA/EyeMed Vision Care

Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-3259

FAA/EyeMed will review your first-level appeal, **providing acknowledgment within 3 business days after receipt**, and notify you in writing of its decision **within 30 days**.

Complaint Procedure

If you are dissatisfied with an EyeMed Provider’s quality of care, services, materials or facility or with EyeMed’s Benefit administration, you should first call EyeMed Customer Care Center at **855-874-4744** to request

resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you may file a formal complaint with EyeMed's Quality Assurance Department at the address noted above. You may also include written comments or supporting documentation.

The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

EyeMed

Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
800-877-7195

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. Most of these are typically medical related claims, vision services are typically only post-service claims. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Review of an Appeal

The Claims Administrator will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if the Claims Administrator upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Time Frames for and Procedures for Appealing Claims – Second Level

If your first-level appeal is denied, in whole or in part, you may file a second-level appeal. The second-level appeal must be in writing and received by FAA within 180 days after the denial of your first-level appeal. If you do not receive first-level appeal decision within 60 days after it was filed, you may submit a second-level appeal within 180 days after this 60-day period has expired. Your written letter of appeal should include the same items detailed above, plus any new information that you believe supports your position.

The appeal should be mailed or faxed to the following address:

FAA/EyeMed Vision Care
Attn: Quality Assurance Dept.
4000 Luxottica Place

Mason, OH 45040
Fax: 1-513-492-3259

FAA/EyeMed will review your first-level appeal, **providing acknowledgment within 3 business days after receipt**, and notify you in writing of its decision **within 30 days**.

Explanation of Benefits. You can view your Explanation of benefits at www.member.eyemedvisioncare.com/lumen. Information on your claims and EOB is also available by calling EyeMed Customer Service at **855-874-4744**.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. The Claims Administrator will review all claims in accordance with the rules established by the U.S. Department of Labor.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by the Claims Administrator, or if the Claims Administrator fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of the Claims Administrator's determination.

You may request an external review of an adverse benefit determination if the denial is based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address sent out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling EyeMed, this is the External Review a participant can request after an appeal is denied, or by sending a written request to the address sent out in the determination letter.

Please Note this Deadline: A request must be made within four (4) months after the date you received the Claims Administrator's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Participants name, address, and SSN;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). The Claims Administrator has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by the Claims Administrator of the request;
- a referral of the request by the Claims Administrator to the IRO; and

- a decision by the IRO.

Within the applicable timeframe after receipt of the request, the Claims Administrator will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the vision service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the preliminary review, the Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Claims Administrator will assign an IRO to conduct such review. The Claims Administrator will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

The Claims Administrator will provide to the assigned IRO the documents and information considered in making the Claims Administrator's determination. The documents include:

- all relevant vision records;
- all other documents relied upon by the Claims Administrator; and
- all other information or evidence that you or your Provider submitted. If there is any information or evidence you or your Provider wish to submit that was not previously provided, you may include this information with your external review request and the Claims Administrator will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Claims Administrator. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and the Claims Administrator, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing the Claims Administrator's determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the vision service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency

services, but has not been discharged from a facility.

Immediately upon receipt of the request, the Claims Administrator will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the review, the Claims Administrator will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Claims Administrator will assign an IRO in the same manner the Claims Administrator utilizes to assign standard external reviews to IROs. The Claims Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Claims Administrator. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to the Claims Administrator.

You may contact the Claims Administrator at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined by the medical benefit option; (**Urgent Care claims do not apply to vision services**) and
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify before non-Urgent Care is provided; (**Pre-Service claims do not apply to vision services**) and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and the Claims Administrator are required to follow.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

How to Appeal a Denied Eligibility/Participation Claim

After you receive an initial denial of a submitted claim, there are **two** levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Claims Administrator within 180 days from the receipt of the first level appeal determination. The below chart outlines both the timeline for filing an appeal by you and for receiving responses from the Claims Administrator.

Time Deadline to File a Benefit Claim and the Time Deadline to File a Benefit-Related Lawsuit

The Health Plan provides that no person has the right to file a civil action, proceeding or lawsuit against the Health Plan, including, but not limited to, the Company, any Participating Company, the Committee or any other fiduciary, or any third party service provider unless it is filed within the timing explained as follows below:

Initial Claim: The time frame for filing an initial claim for a premium Payroll Adjustment is the earlier of:

1. Within 180 days of an adverse decision by the Plan Administrator, or
2. The earlier of:
 - a. Within 180 days of the effective date of an election that is later claimed to be erroneous, or
 - b. By the last day of the Plan Year of when the election error is claimed to have occurred. If the initial claim is not filed by this deadline, it shall be deemed untimely and denied on that basis. Appeals from a claim denial must also be timely filed as described in the Summary Plan Description.

Agent for Service of Legal Process:

Associate General Counsel
931 14th Street, 9th Floor
Denver, CO 80202

Legal process may also be served on:

The Corporation Company (a.k.a. CT Corp)
1675 Broadway, Suite 1200
Denver, Colorado 80202

Legal Action Deadline: After you have exhausted or completed the claims and appeals procedures as explained above, you may pursue any other legal remedy, such as bringing a lawsuit or civil action in court provided, that you file a civil action, proceeding or lawsuit against the Plan or the Plan Administrator or the Claims Administration no later than the last day of the twelfth month following the later of (1) the deadline for filing an appeal under the Plan or (2) the date on which an adverse benefit determination on appeal was issued to you with respect to your Plan benefit claim.

This means that you cannot bring any legal action against the Plan, the Employee Benefits Committee or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action, you must do so no later than the last day of the 12th month from the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan or the Claims Administrator.

Claim for Payroll Adjustment and the Deadlines

There is a separate claims process if you dispute the deductions from your paycheck for your Plan Benefits.

Reminder to Review Your Paycheck Deductions

- Review your paycheck along with the Company Benefits and Payroll schedule (available online) to confirm your benefit premium deductions for Health & Welfare including Savings and Spending Accounts. Any questions related to benefit premiums should be directed to the Service Center at 866-935-5011 or 800-729-7526, option 1, option 1 and then

option 1 again. Do not contact the Company Payroll Department as the Payroll staff will be unable to assist you.

- If your benefit premium deductions are not correct or not what you expect you must make a claim to the Plan Administrator in accordance with the claim's procedures as soon as possible after the year's payroll deductions begin.

► **If your claim is denied, be advised that there is a deadline to file an appeal and if you miss the deadline, your deductions remain in place for the benefit plan year. The time period to make an appeal is the *earlier of*:**

(1) within 180 days of an adverse 1st level decision by the Plan Administrator, or

(2) the earlier of (a) within 180 days of the effective date of an election that is later claimed to be erroneous, or (b) by the last day of the plan year of when the election error is claimed to have occurred.

If the appeal is not filed by this deadline it shall be deemed untimely and denied on that basis.

The Required Forum for Legal Disputes. After the claims and appeals procedures are exhausted as explained above, and a final decision has been made by the Plan Administrator, if an Eligible Employee wishes to pursue other legal proceedings, the action must be brought in the United States District Court in Denver, Colorado

SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. See the *General Information SPD* for more details regarding the Plan's right of recovery or Subrogation.

GENERAL ADMINISTRATIVE PROVISIONS

This section summarizes the legal information about the Plan. For more information, refer to the *General Information SPD*.

Plan Document

This Benefits Summary presents an overview of your Benefits. In the event of any discrepancy between this summary and the official *Plan Document*, the *Plan Document* shall govern.

Records and Information and Your Obligation to Furnish Information

At times, the Plan or the Claims Administrator may need information from you. You agree to furnish the Plan and/or the Claims Administrator with all information and proofs that are reasonably required regarding any matters pertaining to the Plan, including eligibility and Benefits. If you do not provide this information when requested, it may delay or result in the denial of your claim.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you, to furnish the Plan or the Claims Administrator with all information or copies of records relating to the services provided to you. The Plan or the Claims Administrator has the right to request this information at any reasonable time as well as other information concerning your eligibility and Benefits. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed an enrollment form, if applicable.

The Plan agrees that such information and records will be considered confidential. We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required by law or regulation.

For complete listings of your vision records or billing statements, we recommend that you contact your Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request vision forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we and the Claims Administrator will designate other persons or entities to request records or information from or related to you and will release those records as necessary. Our designees have the same rights to this information as we have.

During and after the term of the Plan, we and our related entities may use and transfer the information gathered under the Plan, including claim information for research, database creation, and other analytic purposes.

Interpretation of Plan

The Plan Administrator, and to the extent it has delegated to the Claims Administrator, have sole and exclusive authority and discretion in:

- Interpreting Benefits under the Plan
- Interpreting the other terms, conditions, limitations, and exclusions set out in the Plan, including this SPD
- Determining the eligibility, rights, and status of all persons under the Plan
- Making factual determinations, finding and determining all facts related to the Plan and its Benefits
- Having the power to decide all disputes and questions arising under the Plan

The Plan Administrator and to the extent it has delegated to the Claims Administrator may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Plan Administrator, or its authorized delegate, may, in its sole discretion, offer Benefits for services that would not otherwise be Covered Health Services. The fact that the Plan Administrator does so in any particular case shall not in any way be deemed to require them to do so in other similar cases.

Right to Amend and Right to Adopt Rules of Administration

The Plan Administrator, the Employee Benefits Committee, may adopt, at any time, rules and procedures that it determines to be necessary or desirable with respect to the operation of the Plans. The Company, in its separate and distinct role as the Plan Sponsor has the right, within its sole discretion and authority, at any time to amend, modify, or eliminate any benefit or provision of the Plan or to not amend the Plan at all, to change contribution levels and/or to terminate the Plan, subject to all applicable laws. The Company has delegated this discretion and authority to amend, modify or terminate the Plan to the Plan Design Committee.

Circumstances that May Affect Your Benefit

There are limitations that may apply to your Benefit under the Vision Plan benefit option. Some of these are listed in this SPD, but there may be other circumstances that are listed in the *General Information SPD* and you are encouraged to review that document to fully understand your benefit coverage.

Clerical Error

If a clerical error or other mistake occurs, however occurring, that error does not create a right to Benefits. Clerical errors include, but are not limited to, providing misinformation on eligibility or benefit coverages or entitlements or relating to information transmittal and/or communications, perfunctory or ministerial in nature,

involving claims processing, and recordkeeping. Although every effort is and will be made to administer the Plan in a fully accurate manner, any inadvertent error, misstatement or omission will be disregarded, and the actual Plan provisions will be controlling. A clerical error will not void coverage to which a Participant is entitled under the terms of the Plan, nor will it continue coverage that should have ended under the terms of the Plan. When an error is found, it will be corrected or adjusted appropriately as soon as practicable. Interest shall not be payable with respect to a Benefit corrected or adjusted. It is your responsibility to confirm the accuracy of statements made by the Plan or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan Documents.

Administrative Services

The Plan may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing and utilization management services. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Workers' Compensation Not Affected

Benefits provided under the Health Plan do not substitute for and do not affect any requirements for coverage by Worker's Compensation insurance.

Conformity with Statutes

Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered), is hereby amended to conform to the minimum requirements of such statutes and regulations. As a self-funded plan, the Plan generally is not subject to State laws and regulations including, but not limited to, State law benefit mandates. This benefit option is an "excepted benefit" not subject to the mandated requirements of the Affordable Care Act.

Refund of Benefit Overpayment

If the Plan pays Benefits for expenses incurred by a Covered Person, that Covered Person, or any other person or organization that was paid, must refund the overpayment if either of the following apply:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person
- All or some of the payment we made exceeded the cost of Benefits under the Plan
- All or some of the payment was made in error.

The refund equals the amount the Plan paid in excess of the amount the Plan should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future Benefits including adding the amount of the overpayment to your W-2 income.

Additionally, if the Covered Person was determined not to be eligible for the Benefits under the Plan, that individual must refund the amount of the excess Benefit payment and the Plan may undertake collection actions, subject to the requirements of applicable law.