Amazing People. Amazing Benefits. Find Your Fit.

Get ready to choose your options Nov. 3 - Nov. 17, 2021.

2022 Annual Enrollment Guide

For COBRA Participants

LUMEN®

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Note:

- 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

Find Your Fit

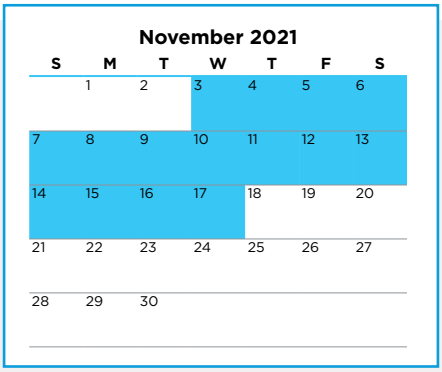
This is your opportunity to find the plans that are right for you and your eligible dependent(s). No matter what stage of life you're in, you'll find an amazing range of options from which to choose to meet your needs and "Find Your Fit". We have a number of significant changes this year, and it's important that you educate yourself before selecting your benefits. Please review this guide in its entirety so that you are aware of the changes for the coming year.

If you are not making any changes or updates to your coverage, no action is required other than updating your communication preference and/or contact information at the Service Center. You may also be required to update your billing and payment information, if applicable.

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.

Note:

- For more information, refer to the Health and Life website at **lumen.com/bschealthbenefits** (during Annual Enrollment) or **lumen.com/healthbenefits** (effective Jan. 1, 2022) or contact the Lumen Health and Life Service Center at Businessolver.
- 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.



Note: Annual Enrollment dates are highlighted above.

What's New for 2022

The information listed below describes what's new for 2022. 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 (SPDs) 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.

Welcome to Annual Enrollment. We are excited to welcome you to a new Health and Life Administrator, Businessolver, beginning Jan. 2022.

When enrolling on the Health and Life website, the coverage level for COBRA participants will be referenced as "Individual". For example, Individual coverage, Individual + Spouse/Domestic Partner, etc.

Benefit Premiums

With costs continuing to increase across the country, premiums for most plans will also increase for 2022. Lumen continues to look for ways to control health care cost increases while still offering programs that offer value and that provide the best health outcomes.

Note: Coverage and benefit costs may increase or decrease throughout the year, in certain situations. Refer to the General Information Summary Plan Description (SPD).

Plan Design Updates

Plan Name Updates:

(The High Deductible Health Plan and the Consumer Driven Health Plans are administered by UnitedHealthcare and the Dental Plans are administered by MetLife).

2022 (New)	2021
Bind Health Plan	Bind Medical or Bind On-Demand Plan
High Deductible Health Plan (HDHP) with Optional Health Savings Account (HSA)	Savings High Deductible Health Plan (HDHP)
Consumer Driven Health Plan (CDHP) Option 1	Standard Consumer Driven Health Plan (CDHP)
Consumer Driven Health Plan (CDHP) Option 2	Premium Consumer Driven Health Plan (CDHP)
Dental Option 1	Basic Dental
Dental Option 2 with Orthodontia	Enhanced Dental

Consumer Driven Health Plan (CDHP) Option 2 -Health Reimbursement Account (HRA) update

The Company-funded Health Reimbursement Account (HRA) contribution limit decreases from **$1,000** to **$800** for Individual Only and **$1,500** to **$1,200** for Individual + Spouse/Domestic Partner or Individual + Child(ren), and **$2,000** to **$1,600** for Family.

Health Savings Account (HSA) Limits Increase - must be enrolled in a High Deductible Health Plan

You may choose to establish your HSA with any financial institution.

- HSA limits are determined by the IRS and are subject to change.
- The Individual contribution limit increases from **$3,600** to **$3,650**, and the Individual + One or more enrolled increases from **$7,200** to **$7,300.** The catch-up contribution for age 55 and older remains at **$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.

Prescription Drug Benefits

New Four (4) tier structure and HDHP core preventive drug list - If enrolled in a UnitedHealthcare Plan

To help control costs for you, your eligible dependents and the Plan, the coinsurance for your medications is changing from a flat 20% to the following: **Tier 1 – 15%, Tier 2 – 20%, Tier 3 – 30%,** and **Tier 4 – 40%.**

All medications apply to the deductible. Once the deductible is satisfied, you would be responsible for your applicable coinsurance.

- **Example:** Sample medication cost **$200, Tier 1:** your responsibility **$30** after deductible, **Tier 2:** your responsibility **$40** after deductible, **Tier 3:** your responsibility **$60** after deductible, **Tier 4:** your responsibility **$80** after deductible.

HDHP only
Non preventive medications will process the same as above.

For certain preventive medications the deductible will be waived, and the applicable coinsurance based on tier will be applied. (These conditions include: Diabetes, High Blood Pressure, High Cholesterol, Blood Clot Prevention, Asthma/COPD).

- **Example**: If your diabetic medication cost is $150: **Tier 1: $22.50, Tier 2: $30, Tier 3: $45, and Tier 4: $60.**

To determine the tier and lower cost alternative for a particular medication effective Jan. 2022, go to the **Standard 4-Tier Advantage PDL** link at **optumrx.com**. This will provide the future tier of the medication.

For additional information or to complete an estimate on cost, go to **myuhc.com**. (Take the "Total price" and apply the appropriate coinsurance for the future tier.)

Note: This does not take deductibles and coinsurance into account.

Tobacco-Free Discount

(Applies only if you are enrolled and eligible for subsidized medical coverage)

If you are eligible for subsidized coverage and enroll, you may be eligible for a discount to your medical benefit cost based on how you answer the question on tobacco products usage. The discount is calculated on the total cost of coverage.

If you and your eligible dependents enrolled in a Lumen medical plan are tobacco uses but not enrolled in a tobacco cessation program - you will see a slight increase in your cost to adjust rates to equal our stated 15% discount for non-tobacco users.

Managed Care Program Updates

Complex Care Concierge (C3) – If enrolled in a UnitedHealthcare Plan

C3 enables a high performing, coordinated system of care tailored to the most complex families. C3 focuses on building trust and delivering what you and providers expect of United Healthcare by optimizing benefits and leveraging trust to build connections across the health system, delivering higher quality care and transformational outcomes.

- You will gain access to a single point of contact health care expert, a dedicated Care Advisor offering compassion and care expertise, and will coordinate care to improve the participant's quality of life.
- Advisors work within the Family Engagement Center® to offer 1-on-1 support — backed by the full breadth of resources, knowledge and expertise from UnitedHealthcare and Optum®.
- Various engagement strategies across multiple methods, channels, and partners are leveraged to connect you and your family to your personal Care Advisor.
- The Family Engagement Center™ leverages new technology which provides better visibility of prior authorizations, claims, and appeals, to proactively monitor and work on the member's behalf while also enabling transparency for you and providers, which removes barriers to care.
- Care Advisors tap into clinical programs, making sure those in the programs are coordinated and connected. They also facilitate expedited access to health system partners for those in the diagnostic odyssey, those with rare diseases, and those with ongoing care-coordination needs for complex conditions.

DayTwo (Diabetes Program) – If enrolled in a UnitedHealthcare Plan

DayTwo (Diabetes Program) is a science backed health program that empowers people by providing food as medicine as an approach to manage glucose levels and improve overall health. Research shows that people process the same foods differently which is why DayTwo analyzes the gut microbiome to provide personalized nutrition recommendations for you, and you alone. DayTwo's science has been shown to:

Reduce A1C and medicines

- Balance blood sugar levels
- Improve energy, sleep, and hunger

Benefits to you:

- A personal, DayTwo registered dietitian focused on you and your health
- An app that shows you what foods work best for your body
- The chance to improve your health

The best part is you CAN eat foods in different combinations that make major differences in your blood sugar and how you feel.

Enhanced Fertility Benefits

Enhanced Fertility Building Benefits - If enrolled in the Bind Health Plan

Progyny – a comprehensive fertility and family building benefit. The journey to become a parent can be physically, emotionally and financially challenging. With this in mind, the Progyny benefit includes comprehensive treatment coverage, leveraging the latest technologies and treatments, access to high-quality care through a premier network of fertility specialists, and personalized emotional support and guidance from dedicated Patient Care Advocates (PCAs).

Progyny's Smart Cycle benefit connects you to leading fertility specialists and allows them to provide the most advanced, effective fertility treatment, the first time—without barriers to treatment—so you can obtain the best chance of achieving a successful pregnancy with the course of treatment that is best for you. Infertility medications will be administered by Progyny.

Infertility drugs will be covered under the Fertility vendor, Progyny, not OptumRx, and will increase to a $15,000 lifetime maximum.

Fertility Solutions - If enrolled in a UnitedHealthcare Plan

This program will connect you with an experienced fertility nurse who understands your challenges. This Specialized nurse can assess your family's needs, provide information about treatment options and lend support in the following ways:

- Guide you on your path to treatment and talk with you about what to expect;
- Give you suggested questions to ask your reproductive endocrinologist, who is a board certified fertility Specialist;
- Help you navigate your benefit plan and provide encouragement throughout your experience and assist you in finding fertility Specialists in the Center of Excellence network.

Infertility drugs will be covered by OptumRx and will increase to a $15,000 lifetime maximum.

K Health – if enrolled in the Bind Health Plan

Virtual visits allow you to receive care—for less—without leaving home.

With K Health, you have 24/7 access to doctors for your routine primary care, acute care, and chronic disease management needs—like colds and coughs, asthma, sinus infections, urinary tract infections, chronic heartburn, allergies, rashes, migraines and more (no appointment needed). For **$0** you can connect and get help from a provider as well as have rapid prescriptions sent to your local pharmacy. With over 300 conditions treated, K Health makes it easy for you to get the care you need on your time.

You can download the K Health app, **khealth.com/bind** beginning Oct. 15 for more information.

For your mental health needs, connect face-to-face over live video with Doctor On Demand behavioral health specialists.

MyCancerJourney - if enrolled in the Bind Health Plan

New this year for those recently diagnosed with cancer, the Bind Health Plan offers support to assist you in choosing the right treatment path. MyCancerJourney, powered by PotentiaMetrics, fills a critical gap in cancer treatment. A personalized report is provided to those diagnosed with cancer and takes into account more than just clinical trials and statistics. Age, gender, co-morbidity and symptoms are factored in, helping you weigh the pros and cons based on unbiased outcomes of others with similar factors.

Quit For Life – if enrolled in the Bind Health Plan or in a UnitedHealthcare Plan

Get help with quitting nicotine! You can quit with free one-on-one coaching over the phone or online with trained coaches. Our coaches can help you quit smoking, vaping or chewing. By participating in the program you can also qualify to receive free patches, gum or lozenges to help you quit. This replaces the prior smoking cessation program.

If you are enrolled in the Quit Tobacco Cessation Program and do not complete the program prior to Dec. 31, 2021, you will be automatically enrolled to the new Quit For Life Program on Jan. 1, 2022.

2nd.MD – for you and your eligible dependent(s) if enrolled in the Bind Health Plan or in a UnitedHealthcare Plan for certain procedures.

You and your eligible dependent(s) have access to 2nd.MD, a service which offers expert-lead education and guidance on any major medical decision 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.

New for 2022! Shoulder surgery has been added to the additional responsibility condition list.

Lumen will require that you consult with 2nd.MD prior to a hip, knee, shoulder (**new**) 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 out-of-pocket cost, whether or not you've met your annual deductible, if applicable. Depending on where you live and the physician you are currently seeing, treatment recommendations can vary widely for certain surgical procedures. Lumen is committed to ensuring you and your family are fully educated by some of the best doctors in the country before making a major medical decision.

Surgical Management Solutions – if enrolled in a UnitedHealthcare Plan

Surgical Management Solutions (SMS) is part of your health plan and exists to simplify your path to affordable, quality surgery. Think of SMS as a surgical concierge service. In one phone call to SMS, you get instant access to a care advocate who will help you find a local surgeon who specializes in your condition, schedule an appointment for you and talk to you about your options for where you can receive care for a surgery or other outpatient procedure. SMS will be available for you or your family member throughout the experience of getting surgery, available to answer questions and provide assistance at any time.

To speak to an SMS surgical care advocate, you can call SMS at **833-344-1640**. For more information: **surgicalmanagementsolutions.com**.

Virtual Physical Therapy

Hinge Health - If enrolled in the Bind Health Plan or in a UnitedHealthcare Plan

Lumen is excited to announce we are partnering with Hinge Health to help you conquer back and joint pain. Best of all, Hinge Health's programs are provided at no cost to you and your eligible dependents enrolled in a Lumen medical plan.

Hinge Health provides all the tools you need to get moving again from the comfort of your home. Here are some of the ways your treatment plan could be tailored to you:

- Get a personal care team, including a physical therapist and health coach
- Schedule as many personal physical therapy sessions as needed
- Receive wearable sensors that give live feedback on your form in their app
- Get a second opinion on your recommended surgery and treatment plan

If you don't have pain and are just looking to stay healthy, you can sign up for their free app. Recommended exercises will be tailored to you based on your job and lifestyle.

Go to **hingehealth.com** to learn more and sign up for the waitlist. Enrollment opens Jan. 1, 2022. For questions, you can call Hinge Health at **855-902-2777** or send an email to **hello@hingehealth.com**.

Kaia - if enrolled in a UnitedHealthcare Plan

Kaia Health offers a next-generation care solution for musculoskeletal pain, delivered on-demand and available 24/7 through a mobile app on your smartphone or tablet. You can do physical therapy from anywhere. The new Kaia app is here to help with pain relief at no extra cost as part of your health plan. Some of the benefits include 1-on-1 coaching with certified professionals, workouts tailored to you, lessons to help you recognize where pain is coming from, strengthening exercises plus relaxation techniques for pain management. Kaia uses technology to guide your movements and ensure you're doing exercises correctly.

Benefit Plan Administration Updates

Lumen Health and Life Service Center - New Plan Administrator for Health and Life Benefits

Effective Jan. 1, 2022, Businessolver will administer eligibility for the Retiree and Inactive Health Plan, hereafter referred to as the "Plan". The Lumen Health and Life Service Center at Businessolver will be referred to as the "Service Center".

Website and Phone Number Updates for the Service Center

Annual Enrollment/Benefit Eligibility	Website	Phone Number
2022 Annual Enrollment	lumen.com/bschealthbenefits	• 833-925-0487 • 317-671-8494 **(International callers)**
2022 Benefit Eligibility	lumen.com/healthbenefits	• 833-925-0487 • 317-671-8494 **(International callers)**
2021 Benefit Eligibility	lumen.com/healthbenefits	• 866-935-5011

Update your Communication Preference on the Service Center website

Go to **lumen.com/bschealthbenefits** during Annual Enrollment or **lumen.com/healthbenefits** (effective Jan. 1, 2022) to update your preferred method to receive health and/or life communication from the Service Center.

Billing and Payments

You will have the below options available to you if you owe a premium for any of your benefits coverage:

- **Monthly Invoices:** If you previously mailed in your premiums on a monthly basis, you will continue to receive invoices. Mail to the following address:

  Bussinessolver.com, Inc.
  PO Box 850512
  Minneapolis, MN 55485-0512

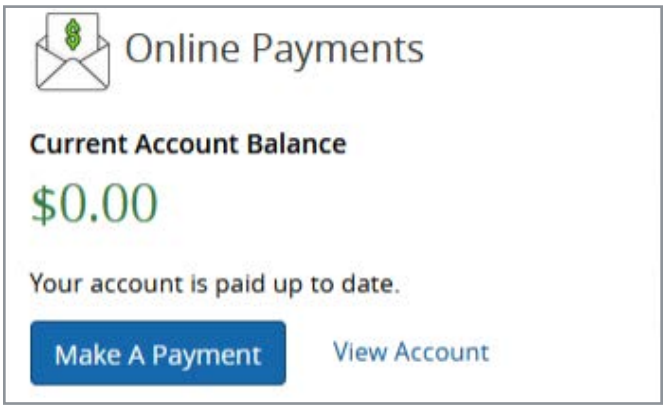
- **One-Time or Recurring Payments**

Note: There is a $2.00 convenience fee each time to process a one-time payment.

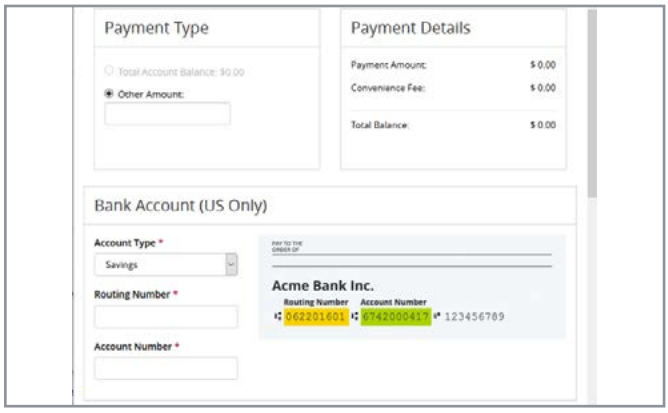
NEW - Follow the below instructions on how to make a one-time or recurring payment. If you previously had recurring payments in 2021, you will be required to follow the below steps in order to set up recurring payments for 2022.

On the home page of the health and life website at **lumen.com/healthbenefits** (effective Jan. 1, 2022), click on the **Make a Payment** link.

1.



2.



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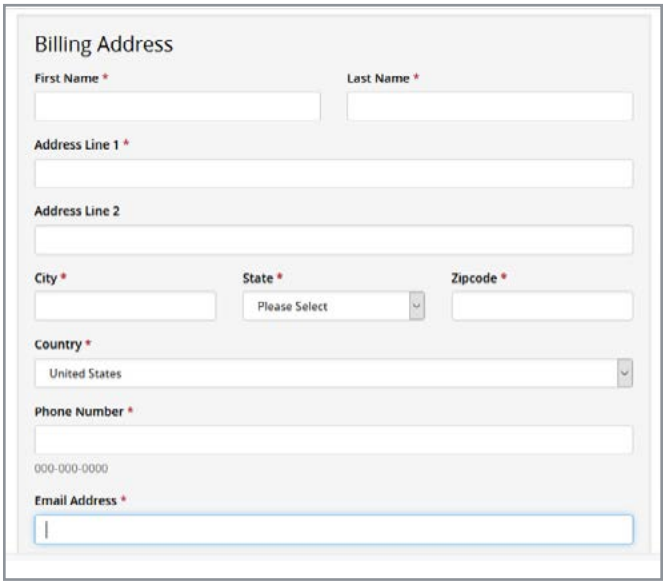

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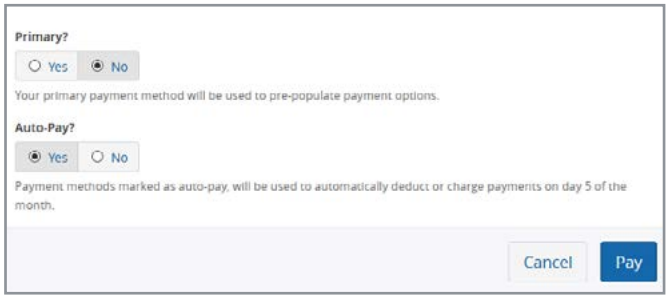


If you want to set up recurring auto payments, answer "Yes" to the last question (Auto-Pay?). If you answer "No" your payment will be considered a one-time payment, and you will be subject to the $2.00 convenience fee. Contact the Service Center at 833-925-0487 if you need assistance.

Be sure to make timely payments!

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

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

Dependent Verification

If you are adding a new dependent to any of your coverage during Annual Enrollment or as a result of a Qualified Life Event (QLE), your dependent(s) will not be eligible for coverage until you have provided documentation that confirms their eligibility under the Plan. The Service Center will email or mail (depending on how you set up your communication preference) information to you with additional details on how to complete the dependent verification process.

You can upload your supporting documentation after you complete your enrollment. A few examples of documentation are birth certificate, marriage certificate, first page of your tax return, etc.

Note: If you do not provide acceptable documentation, your dependent(s) will not be enrolled. If you are adding a new dependent, you should add your dependent(s) before you start your enrollment. If you don't, you will be required to go back and add your dependent(s) to each option you want to enroll them in, e.g., medical, dental, etc.

Form 1095-C

Form 1095-C verifies your health insurance coverage for tax purposes. If you were eligible for or enrolled in health coverage in 2021, you will receive a paper copy of Form 1095-C by Jan. 31, 2022, even if you elected to receive it electronically.

After Jan. 1, 2022, you can elect to receive either a paper or electronic copy of your 2022 Form 1095-C. Visit the Lumen Health and Life website at **lumen.com/healthbenefits** or call **833-925-0487** to make your selection.

Subrogation Update

The Health Plan does not provide Benefits for any accident, injury or sickness for which you or your eligible Dependent(s) have, or may have, any claim for damages or entitlement to recover from another party or parties arising from the acts or omissions of a third party (for example, an auto accident).

The Subrogation Plan administrator, HMS, has been acquired by Gainwell Technologies. Gainwell Technologies will be leveraged across Gainwell and Cotiviti. If you have any questions, you can contact Cotiviti at **888-556-3373** or refer to your General Summary Plan Description on the Health and Life website.

Plan Overviews

Medical and Prescription Drug Overview

Lumen offers you and your eligible dependents four medical plan options. The Bind Health Plan: High Deductible Plan (HDHP) administered by UnitedHealthcare, and two Consumer Driven health plans (CDHPs) with a Company-funded Health Reimbursement Account (HRA) administered by UnitedHealthcare.

Plan Similarities and Differences

Similarities	Differences
• Coverage is the same for medical services and prescription drugs • Preventive Care is covered at 100% (In-Network) • You can enroll in a Health Savings Account, as applicable to assist with your cost share • Plans use the same provider network	• Bind Health Plan has copays for services • Bind Health Plan allows you to activate coverage for 45 non-emergent, plannable treatments. Activation increases your cost for a period of time • HDHP and CDHPs have deductibles and coinsurance for services • HDHP now allows some preventive prescriptions without meeting your deductible first • Bind doesn't require mail in for prescriptions, UHC does after two fills • Premiums

Bind Health Plan

With the Bind Health plan, you can see treatment options and costs before getting treatment or choosing a doctor. With this information, you can make informed decisions and find savings opportunities. If you want an overview of how the Bind Health Plan works, visit **lumen.com/bind**. If you are currently enrolled in the Bind Health Plan, visit **lumen.com/choosebind**, **access code: enroll 2022**, to review updates for the 2022 Plan year.

How it works:

- Your coverage starts at your first doctor's appointment or prescription fill because the Bind plan is a $0 deductible plan.
- See clear, upfront prices for treatments, doctors and prescription drugs. Know before you go what your health care choices will cost.
- Get the coverage you'd expect from your health insurance through the broad, UnitedHealthcare Choice Plus national provider network.
- A unique feature allows you to activate coverage any time during the plan year for less common, non-emergency procedures with large price variations- like an upper GI endoscopy or cataract surgery – should those needs arise. Activate the coverage at least three business days prior to the treatment, test or procedure.

High Deductible Health Plan (HDHP)

This plan is administered by UnitedHealthcare. You can choose your healthcare providers; however, the Plan pays a greater benefit when you use providers that are in the network.

You pay the full cost of the medical expenses until your deductible is met. You can also pay for

covered services with money you have set aside in your HSA.

HSA limits are determined by the IRS and are subject to change. 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.

New for 2022! For Prescriptions that are considered preventive under the plan, the deductible is waived, and coinsurance applies. For non-preventive medications you will be responsible for the cost of the medication until you have met or satisfied your deductible. To help reduce costs and make filling your medications more convenient, maintenance medications must be filled by mail order. You may also pay for covered services with money you have set aside in your HSA.

Consumer Driven Health Plans (CDHPs), Option 1 and Option 2

These plans are administered by UnitedHealthcare. You can choose your healthcare providers; however, the Plan pays a greater benefit when you use providers that are in the network. The Company provides a subsidized Health Reimbursement Account (HRA), refer to the comparison chart for HRA amounts.

The HRA, Participant Responsibility (your out-of-pocket portion of the deductible) and out-of-pocket maximum are all based on the coverage level you elect (Individual Only, Individual/Spouse/Domestic Partner, etc.), even if only one covered person uses the entire HRA benefit. You incur medical expenses and pay the full cost of the medical expenses with money in your HRA first, then you pay out-of-pocket until your deductible is met.

Prescription drug expenses for CDHP options 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 your deductible.

To help 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 two times at a retail pharmacy. After that, it will not be covered, and you will pay the full retail price.

Enrollment Reminders

IMPORTANT – Confirm or update your selection for the Tobacco-Free Discount and the Working Spouse/Domestic Partner Surcharge. (Applies if you are enrolled and eligible for subsidized medical coverage).

Be sure to review the information below during your enrollment as it could impact the cost of your medical premiums as well as your Health Account.

Note: The questions below are for informational purposes only to show how they are displayed on the Health and Life website. If you are not sure how to answer these questions, contact the Service Center for assistance. You may be eligible for a discount to your medical benefit cost based on how you answer the question on tobacco products usage. The discount is calculated on the total cost of coverage.

Tobacco-Free Discount

If you and your eligible dependents enrolled in a Lumen medical plan during your subsidy period and are are tobacco users but not enrolled in a tobacco cessation program – you will see a slight increase in your premiums to adjust rates to equal our stated 15% discount for non-tobacco users.

What is a Company recognized Program? Quit For Life is a Wellness Coaching Program sponsored by Lumen. You can alternatively enroll in a tobacco cessation program of your choice, such as one sponsored by a local hospital, the American Lung Association or one recommended by your doctor. The Plan will accommodate the recommendations of an individual's personal doctor, if needed.

What is a Tobacco Product? Tobacco products include but are not limited to the following: chewing tobacco, cigarettes, cigars, e-cigarettes, hookahs, nicotine gels/dissolvables, pipe tobacco, tobacco snuff, vapors and other products associated with tobacco.

Please Note: The Plan is committed to helping you achieve your best health. Quit For Life is a Wellness Coaching Program available to you and covered dependents over the age of 18 at no cost. You can find more information related to this Program at lumen.com/wellconnected.

IMPORTANT: If you are unsure of how to answer the question below or if you have a medical condition that does not allow you to stop using tobacco products and/or does not allow you to enroll in a tobacco cessation program, please contact the Service Center at **833-925-0487** for further assistance prior to completing your enrollment to learn about alternatives to obtain the discount. The Plan will accommodate the recommendations of an individual's personal doctor, if needed. You will be required to answer the questions below when you elect your benefits.

Please select your response to the following below:

Yes –I and/or my dependents enrolled in my medical plan smoke or use tobacco products and are not enrolled in a Company-recognized tobacco cessation program. Therefore, I am not eligible for the discount.

No – Neither I nor any of my dependent(s) enrolled in my medical plan smoke or use tobacco products; or those that do use tobacco products are enrolled in a Company-recognized Program, a tobacco cessation program of my choice or my doctor's recommendation. Therefore, I am eligible for the discount.

To verify your selection, **please review your confirmation statement after you complete your enrollment**. Under the medical plan details on your statement, it will indicate as a line item either:

a. "You are enrolled in a medical plan where the tobacco free discount was applied," or
b. "You are enrolled in a medical plan where the tobacco free discount was not applied."

Working Spouse/Domestic Partner Surcharge

NEW: You may be subject to a working Spouse/Domestic Partner surcharge during your subsidized medical period based based on the following question:

Yes – All of the following apply and therefore, I **will be** subject to the surcharge.

- I am married or in a Domestic Partner (Domestic Partner) relationship.
- My Spouse/Domestic Partner is NOT employed by Lumen.
- My Spouse/Domestic Partner is currently employed.
- My Spouse/Domestic Partner is eligible to enroll in their Employer group medical plan.
- My Spouse/Domestic Partner has elected not to enroll in their Employer group medical plan.
- I will enroll my Spouse/Domestic Partner in the Lumen group medical plan.

No – At least **one** of the following applies and therefore, I **will not be** subject to the surcharge.

- I am not married or in a Domestic Partner (Domestic Partner) relationship.
- My Spouse/Domestic Partner is employed by Lumen.
- My Spouse/Domestic Partner is not currently employed.
- My Spouse/Domestic Partner is self-employed.
- My Spouse/Domestic Partner is not eligible to enroll in their Employer group medical plan.
- My Spouse/Domestic Partner has elected to enroll in their Employer group medical plan.
- My Spouse/Domestic Partner is enrolled in Medicaid, Medicare or another plan that is not defined as an "Employer group medical plan."
- My Spouse/Domestic Partner's annual enrollment has already passed.
- My Spouse/Domestic Partner's employer has less than 50 employees and my Lumen base salary is less than $100k.

Note: You are not subject to the Working Spouse/Domestic Partner surcharge if your base pay was less than $30,000.

Yes – applies (approximately $216/month surcharge)

No – no surcharge ($0)

To **verify** your selection, please review your confirmation statement after you complete your enrollment.

a. Working Spouse/Domestic Partner Surcharge – **No**-no surcharge, or
b. Working Spouse/Domestic Partner Surcharge -**Yes**, applies.

If you do not make any changes, your current election will continue, if applicable.

Employee Assistance Plan (EAP)

You and your household family members are eligible for the Optum Employee Assistance Program (EAP). You can receive confidential support, 24/7, by calling **866-270-0033**.

- EAP provides confidential help when you need it most and offers quick access to experts who can help you with a wide range of well-being and family support services.
- Included are eight (8) free visits in-person and/or telephonic/virtual support for a variety of topics such as mental health, addiction, family/relationships, grief support, and more. Other services include financial support, legal and mediation services, and childcare referrals.
- Another area is adult/elder care which can help you find eldercare facilities, answer your questions about care services, insurance information, and retirement planning.

Medicare Eligible due to disability

It is your responsibility to notify the Lumen Health and Life Service Center at **833-925-0487** if you or your dependent(s) become Medicare eligible due to a disability. If you have questions regarding Medicare, you go go to the website at **medicare.gov** or contact a representative at **800-medicare**.

If you or your dependent(s) become eligible for Medicare while on COBRA, you will need to notify the Service Center and your COBRA coverage will end. If you are Medicare eligible before you enroll in COBRA, Medicare becomes your primary coverage and the Company medical plan becomes secondary. Your benefits will be reduced if you do not enroll in a timely manner in Medicare Part B coverage.

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, you may have an impact on which medical plan option you choose. You can use the tools below to estimate your costs.

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 during the Annual Enrollment process as options may change (based on your address on file).

Explore Your Options and Enroll

Explore the site to learn about your benefits. You'll find lots of helpful information in the Reference Center on the Health and Life website. The calendar at the top of the Home page lets you know how many days you have left to enroll.

If you are using your mobile device or enrolling online, be sure to visit Sofia, your personal benefits assistant who can answer questions and guide you as you enroll.

Be sure to use one of the latest versions of the following browsers:

- Microsoft Edge
- Firefox
- Safari
- Google Chrome

NOTE: You cannot access the Health and Life website using Internet Explorer.

Start Your Enrollment

Review the three options below to enroll in or update your coverage

1. **Mobile Device Enrollment – Beginning Wed. Nov. 3 through Wed. Nov. 17, starting at 7 a.m. CST.**
   - To complete your enrollment, download the FREE MyChoice™ Mobile App for iOS or Android.

     Search: **MyChoice™ Mobile App**, available for free in the App Store and Google Play
     - You will need to set up a username and password. Start at **lumen.com/bschealthbenefits** in your device's browser. Go to **First time here?** Register a username and password and answer a few security questions. Log in using your new username and password.

2. **Online Enrollment – Beginning Wed. Nov. 3 through Wed. Nov. 17, starting at 7 a.m. CST.**
   - Go to **lumen.com/bschealthbenefits**
   - Click the **Start Here** button to review your personal information and add or edit any dependents you wish to cover.
     - You will need to provide each dependent's legal name. Social Security Number, and birth date to add them to your coverage.*

       *You may be required to provide documentation to prove your relationship to each dependent.

3. **Phone Enrollment - Beginning Wed. Nov. 3 through Wed. Nov. 17, starting at 7 a.m. CST.**
   - We encourage you to enroll through your mobile device or the website; however, if you wish to contact a representative by phone, please call **833-925-0487** or **317-671-8494** (for international callers).

     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.

Enroll in coverage *(mobile device or online)*

Use the **Next** and **Back** buttons to review and elect options available to you. Choose or decline coverage for each option and select which family members you want to cover.

Review plan documents and use the **Compare** and **Plan Details** tools to view details and costs for the options available to you.

Review and finalize your elections *(mobile device or online)*

Make sure your personal information, elections, dependents, and beneficiaries are accurate, then approve your elections.

To Finish, click **I Agree.** When your enrollment is complete, you will receive a confirmation number and can print your **Benefit Summary** for your records.

After you enroll *(mobile device or online)*

Please review all screens until you reach your Benefit Summary and complete your enrollment by clicking **Approve** and then **I Agree**. Make note of your confirmation number on the **Thank You!** page. If you don't receive a confirmation number, your elections will not be saved.

Your elections will become effective on Jan. 1, 2022.

Return to the **Home** page to check for any additional tasks needed to complete your enrollment, or to view or download your **Benefit Summary.**

Visit this website or the app any time you want to learn more about your benefits or make a change to you coverage (if you experience a Qualifying Life Event).

Appendix

Medical Plan Comparison

This chart is only a snapshot summary of medical benefits. For specific details on how services are covered or excluded, please contact Claims Administrator (Bind Health Plan or UnitedHealthcare) or refer to the Summary Plan Description on the Health and Life website, or by calling the Service Center.

	Bind Health Plan		UnitedHealthcare HDHP		UnitedHealthcare CDHP Option 1		UnitedHealthcare CDHP Option 2	
HSA/HRA Contributions	Not Applicable		With Individual-Funded HSA (maximum contribution): • $3,650 Individual • $7,300 Individual + 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 Individual • $750 Individual + Spouse/ Domestic Partner (Domestic Partner) • $750 Individual + Children • $1,000 Family		With Company-Funded HRA Contribution: • $800 Individual • $1,200 Individual + Spouse/Domestic Partner (Domestic Partner) • $1,200 Individual + Children • $1,600 Family	
You Pay	**In-Network**	**Out-of-Network**	**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)							
	Individual		**Individual**		**Individual**		**Individual**	
	$0	$0	$1,500	$3,000	$1,500	$3,000	$1,500	$3,000
					Individual + Spouse/ Domestic Partner		**Individual + Spouse/ Domestic Partner**	
					$2,250	$4,500	$2,250	$4,500
	Individual + Children		**Family**		**Individual + Children**		**Individual + Children**	
	$0	$0	$3,000	$6,000 (deductible must be satisfied before coinsurance applies; no individual limits)	$2,250	$4,500	$2,250	$4,500
					Family		**Family**	
					$3,000	$6,000 (deductible must be satisfied before coinsurance applies; no individual limits)	$3,000	$6,000 (deductible must be satisfied before coinsurance applies; no individual limits)
	Annual Out-of-Pocket Maximum (The Out-of-Pocket Maximums are separate for In-Network and Out-of-Network providers and are not combined)							
	Individual		**Individual**		**Individual**		**Individual**	
	$3,600	$7,200	$3,600	$7,200	$3,600	$7,200	$3,200	$6,400
	Individual + Spouse/ Domestic Partner				**Individual + Spouse/ Domestic Partner**		**Individual + Spouse/ Domestic Partner**	
	$5,400	$10,800			$5,400	$10,800	$4,800	$9,600
	Individual + Children				**Individual + Children**		**Individual + Children**	
	$5,400	$10,800			$5,400	$10,800	$4,800	$9,600
	Family		**Family**		**Family**		**Family**	
	$6,850	$14,400 (Individual out of pocket must be satisfied before eligible expenses are 100% covered)	$6,850	$14,400 (Entire family out of pocket must be satisfied before eligible expenses are 100% covered)	$6,850	$14,400 (Entire family out of pocket must be satisfied before eligible expenses are 100% covered)	$6,400	$12,800 (Entire family out of pocket must be satisfied before eligible expenses are 100% covered)

	Bind Health Plan		UnitedHealthcare HDHP		UnitedHealthcare CDHP Option 1		UnitedHealthcare CDHP Option 2	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Coinsurance	100% covered		85% covered (Tier 1 Premium Provider) 80% covered (Network Provider)	50% covered (you may be responsible for any amount over the eligible expense)	85% covered (Tier 1 Premium Provider) 80% covered (Network Provider)	50% covered (you may be responsible for any amount over the eligible expense)	85% covered (Tier 1 Premium Provider) 80% covered (Network Provider)	50% covered (you may be responsible for any amount over the eligible expense)
Primary care visit to treat an injury or illness	$20-$90	$180	85% covered (Tier 1 Premium Provider) 80% covered (Network Provider)	50% covered (you may be responsible for any amount over the eligible expense)	85% covered (Tier 1 Premium Provider) 80% covered (Network Provider)	50% covered (you may be responsible for any amount over the eligible expense)	85% covered (Tier 1 Premium Provider) 80% covered (Network Provider)	50% covered (you may be responsible for any amount over the eligible expense)
Specialist Visit	$20-$90	$180	85% covered (Tier 1 Premium Provider) 80% covered (Network Provider)	50% covered (you may be responsible for any amount over the eligible expense)	85% covered (Tier 1 Premium Provider) 80% covered (Network Provider)	50% covered (you may be responsible for any amount over the eligible expense)	85% covered (Tier 1 Premium Provider) 80% covered (Network Provider)	50% covered (you may be responsible for any amount over the eligible expense)
Preventive Care: (No Deductible)								
Preventive care/ screening/ immunization	100% covered	100% covered	100%	Not covered	100%	Not covered	100%	Not covered
Inpatient (Facility), Office Visit, Outpatient (Facility), Prescriptions, Urgent Care								
Outpatient Lab and Pathology	$0	$0	85% covered	80% covered (after deductible is met)	85% covered	80% covered (after deductible is met)	85% covered	50% covered (you may be subject to balances over the eligible expense)
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Outpatient Surgery	Up to $2,500 (Coverage requiring activation available for certain procedures, up to $3,000)	Up to $4,000	85% covered (including freestanding facilities)	Not covered	85% covered (including freestanding facilities)	Not covered	85% covered (including freestanding facilities)	Not covered

	Bind Health Plan		UnitedHealthcare HDHP	UnitedHealthcare CDHP Option 1		UnitedHealthcare CDHP Option 2	
Emergency Room Services	$500	$500	• 80% covered after deductible is met; • 50% covered after deductible is met for non-emergency • After 3 ER Visits per year a $300 penalty will apply unless member calls into UHC Nurse when requested (In-Network)	• 80% covered after deductible is met; • 50% covered after deductible is met for non-emergency • After 3 ER Visits per year a $300 penalty will apply unless member calls into UHC Nurse when requested (In-Network)		• 80% covered after deductible is met; • 50% covered after deductible is met for non-emergency • After 3 ER Visits per year a $300 penalty will apply unless member calls into UHC Nurse when requested (In-Network)	
Inpatient Hospital Care	$1,400	$2,800	80% covered (after deductible is met)	80% covered (after deductible is met)	50% covered (after deductible is met)	80% covered (after deductible is met)	50% covered (after deductible is met)

Prescription Drugs

	Bind Health Plan	UnitedHealthcare HDHP	UnitedHealthcare CDHP Option 1	UnitedHealthcare CDHP Option 2
Tier 1 Drugs	• $10 for a 31 day retail supply • $25 for a 90 day retail/mail supply • $200 (In-Network) for Specialty Retail Pharmacy • Not Covered (Out-of-Network) for Specialty Pharmacy	• 85% covered after deductible is met • Mandatory mail after two prescriptions for maintenance Rx • Up to 30-day supply/90 day if mail order (In-Network) • For certain preventive medications the deductible is waived	• 85% covered after deductible is met • Mandatory mail after two prescriptions for maintenance Rx • Up to 30-day supply/90 day if mail order (In-Network)	• 85% covered after deductible is met • Mandatory mail after two prescriptions for maintenance Rx • Up to 30-day supply/90 day if mail order (In-Network)
Tier 2 Drugs	• $70 for a 31 day retail supply • $175 for a 90 day retail/mail supply	• 80% covered after deductible is met • Mandatory mail after two prescriptions for maintenance Rx • Up to 30-day supply/90 day if mail order (In-Network • For certain preventive medications the deductible is waived)	• 80% covered after deductible is met • Mandatory mail after two prescriptions for maintenance Rx • Up to 30-day supply/90 day if mail order (In-Network)	• 80% covered after deductible is met • Mandatory mail after two prescriptions for maintenance Rx • Up to 30-day supply/90 day if mail order (In-Network)
Tier 3 Drugs	• $100 for a 31 day retail supply • $250 for a 90 day retail/mail supply	• 70% covered after deductible is met • Mandatory mail after two prescriptions for maintenance Rx • Up to 30-day supply/90 day if mail order (In-Network) • For certain preventive medications the deductible is waived	• 70% covered after deductible is met • Mandatory mail after two prescriptions for maintenance Rx; up to 30-day supply/90 day if mail order (In-Network)	• 70% covered after deductible is met • Mandatory mail after two prescriptions for maintenance Rx up to 30-day supply/90 day if mail order (In-Network)
Tier 4 Drugs	• Not Applicable	• 60% covered after deductible is met; • Mandatory mail after two prescriptions for maintenance Rx • Up to 30-day supply/90 day if mail order (In-Network) • For certain preventive medications the deductible is waived	• 60% covered after deductible is met • Mandatory mail after two prescriptions for maintenance Rx • Up to 30-day supply/90 day if mail order (In-Network)	• 60% covered after deductible is met • Mandatory mail after two prescriptions for maintenance Rx • Up to 30-day supply/90 day if mail order (In-Network)
Specialty Medications	• **Tier 1**: $200 • **Tier 2**: $225 • **Tier 3:** $300 • Specialty medications are limited to a 31 day supply. **Bind Health Plan:** Out-of-Network prescriptions drugs are not covered.	• **Tier 1:** 85% covered after deductible is met • **Tier 2:** 80% covered after deductible is met • **Tier 3:** 70% covered after deductible is met • **Tier 4:** 60% covered after deductible is met • Specialty medications are limited to a 31 day supply.	• **Tier 1:** 85% covered after deductible is met • **Tier 2:** 80% covered after deductible is met • **Tier 3:** 70 % covered after deductible is met • **Tier 4**: 60% covered after deductible is met • Specialty medications are limited to a 31 day supply.	• **Tier 1:** 85% covered after deductible is met • **Tier 2:** 80% covered after deductible is met • **Tier 3:** 70 % covered after deductible is met • **Tier 4**: 60% covered after deductible is met • Specialty medications are limited to a 31 day supply.
		UnitedHealthcare: Out-of-Network prescription drugs are covered at 50% coinsurance after deductible has been met.		

Dental Plan Comparison

You can choose between two dental plan options; Option 1 or Option 2. These plan options differ in terms of the amount of the annual benefit maximum, annual deductibles, orthodontia coverage, coverage levels and your share of the cost of coverage. Both of the Dental Plan options are administered by MetLife.

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

Option 1	Option 2 (with orthodontia)
Passive PPO In and Out-of-Network (Your Dental PPO plan is passive, meaning that you will pay the same coinsurance levels, have the same deductible requirements and be allotted the same Annual Maximum value regardless of going In or Out-of- Network. In-Network services are subject to MetLife's negotiated Domestic Partner 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.)	
Plan Year Benefit Maximum (per person)	
$1,000 (does not include oral surgery)	$2,000 (does not include oral surgery or orthodontia)
Orthodontia Lifetime Benefit Maximum	
N/A	$1,500 (separate from annual individual benefit maximum)
Plan Year Deductible (per person)	
$25 for general care and major and restorative; no deductible for diagnostic, preventive or oral surgery	$50 for general care and major and restorative (does not include orthodontia); no deductible for diagnostic, preventive or oral surgery
Lifetime Orthodontia Deductible (per person)	
N/A	$50
Plan Pays (after deductible)	**Plan Pays (after deductible)**
Diagnostic and Preventive (cleanings and exams) — No deductible	
100%* up to maximum allowable amount; two visits per year	100%* up to maximum allowable amount; two visits per year
X-rays	
Full mouth X-rays covered once every 60 months; bitewing X-rays covered once per year, except for dependent children under age 26. Children are eligible for bitewing X-rays twice per year.	Full mouth X-rays covered once every 60 months; bitewing X-rays covered once per year, except for dependent children under age 26. Children are eligible for bitewing X-rays twice per year.
General Care (fillings, root canals and periodontics)	
50%* up to maximum allowable amount	80%* up to maximum allowable amount
Major and Restorative (crowns, dentures and bridges)	
50%* up to maximum allowable amount	50%* up to maximum allowable amount
Oral Surgery — No deductible	
80%* no limit	80%* no limit
Orthodontia (adult and children)	
Not covered	50%* up to the maximum allowable amount after the $50 lifetime orthodontia deductible, per person (separate from annual deductible)

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

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

Vision Overview

The vision care benefit has one option offered by EyeMed (aka EyeMed Vision Care/First American Administrators). **NOTE:** You also have the option to waive this coverage. Staying In-Network helps you save money on eye exams, contact lenses, and frames and lenses with a variety of options through INSIGHT (name of the in-network benefit) network to help save you even more. Since PLUS Providers are already in the network, the additional perks are built right into your vision benefits. No promo codes, no coupons, no paperwork but you still have the same vision benefits, plus a little more savings.

Find plenty of In-Network optometrists, including PLUS Providers by going online to **eyemedvirtualbenefitfair.com** and entering **code: CQ98RHAT** whether you are already enrolled or not yet enrolled. You may also call EyeMed at **855-874-4744**. EyeMed's retail stores include but not limited to: **LensCrafters, Target Optical** and most **Pearle Vision** locations. EyeMed offers In-Network online options at: **ContactsDirect.com**, **Glasses.com**. You must not only enroll but also register on EyeMed's site to become eligible for additional and special offers as an "EyeMed member."

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

Summary of Benefits

Vision Care Services	In-Network Cost Using PLUS Providers	In-Network Cost	Out-of-Network Reimbursement
Examination Services			
Exam (with Dilation as necessary)	$0 copay	$10 copay	Up to $40
Retinal Imaging	$0 copay	$0 copay	Up to $20
Contact Lens (allowance includes materials only)			
Conventional	$0 copay; 15% off balance; over $150 allowance	$0 copay; 15% off balance; over $150 allowance	Up to $105
Disposable	$0 copay; 100% of balance over $150 allowance	$0 copay; 100% of balance over $150 allowance	Up to $105
Medically Necessary	$0 copay; paid-in-full	$0 copay; paid-in-full	Up to $210
Contact Lens Fit And Two (2) Follow-Ups (in lieu of lenses)			
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 (any available frames at Provider locations)			
Frame	$0 copay; 20% off balance over $185 allowance	$0 copay; 20% off balance over $160 allowance	Up to $112
Standard Plastic Lenses (in lieu of contacts)			
Single Vision	$25 copay	$25 copay	Up to $30
Bifocal	$25 copay	$25 copay	Up to $50
Trifocal	$25 copay	$25 copay	Up to $70
Lenticular	$25 copay	$25 copay	Up to $70
Progressive - Standard	$25 copay	$25 copay	Up to $50
Progressive - Premium Tier 1	$110 copay	$110 copay	Up to $50
Progressive - Premium Tier 2	$120 copay	$120 copay	Up to $50
Progressive - Premium Tier 3	$135 copay	$135 copay	Up to $50
Progressive - Premium Tier 4	$200 copay	$200 copay	Up to $50
Lens Options			
Anti Reflective Coating - Standard	$45 copay	$45 copay	Up to $5

Summary of Benefits

Vision Care Services	In-Network Cost Using PLUS Providers	In-Network Cost	Out-of-Network Reimbursement
Anti Reflective Coating – Premium Tier 1	$57 copay	$57 copay	Up to $5
Anti Reflective Coating – Premium Tier 2	$68 copay	$68 copay	Up to $5
Anti Reflective Coating – Premium Tier 3	$85 copay	$85 copay	Up to $5
Photochromic – Non-Glass (Plastic)	$0 copay	$0 copay	Up to $5
Polycarbonate – Standard	$40 copay	$40 copay	Not covered
Polycarbonate – Standard – under 19 years of age	$0 copay	$0 copay	Up to $5
Scratch Coating – Standard Plastic	$15 copay	$15 copay	Not covered
Tint – Solid or Gradient	$0 copay	$0 copay	Up to $5
UV Treatment	$15 copay	$15 copay	Not covered
All Other Lens Options	20% off retail price	20% off retail price	Not covered
Low Vision			
Supplemental Exam/Testing	$0 copay	$0 copay	Up to $125 allowance (no reimbursement)
Aids	25% copayment up to the maximum of $1,000	25% copayment up to the maximum of $1,000	25% copayment up to the maximum of $1,000
Member Savings (enrollees who register on EyeMed's website receive additional savings)			
Additional Pairs of Glasses, Conventional Lenses	40% off glasses; 15% discount on lenses (once funded benefit is used)	40% off glasses; 15% discount on lenses (once funded benefit is used)	Not covered
Non-Prescription Sunglasses and other items **not covered by Plan*** ***Note:** Safety Glasses and Provider's professional services or contact lenses are not eligible for coverage under the Plan	20% off	20% off	Not covered
Hearing Care from Amplifon Hearing Health Care Network (Call **877-203-0675**)	40% off hearing exam and low price guarantee on discounted hearing aids (Up to 64% off aids).	40% hearing exam and low price guarantee on discounted hearing aids (Up to 64% off aids).	Not covered
LASIK or PRK from U.S. Laser Network (Call **800-988-4221**)	15% off retail or 5% off promotional price	15% off retail or 5% off promotional price	Not covered
Frequency (Adults and Children)			
Exam	Once every plan year		
Frame	Once every plan year		
Lenses (in lieu on Contact Lenses)	Once every plan year		
Contact Lenses (in lieu of Lenses)	Once every plan year		
Low Vision	Once every other plan year		

Definition of Contact Lens Fit

1. **Standard Contact Lens Fit** - Clear, soft, spherical, daily wear contact lenses for single vision prescriptions. Standard Contact Lens does not include extended or overnight wear lenses, which are intended to be worn during periods of sleep.

2. **Premium Contact Lens Fit** - Toric, multifocal, monovision, post-surgical, gas permeable contact lenses, and other non-Standard Contact Lenses. Premium Contact Lens includes extended and overnight wear lenses, which are intended to be worn during periods of sleep.

You are responsible to pay the Out-of-Network provider in full at the time of service and then submit an Out-of-Network claim for reimbursement. You will be reimbursed up to the amount shown within the Summary of Benefits section of this Guide. For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes. The benefit does not cover Safety eyewear, solutions, cleaning products or frame cases. For other Limitations and Exclusions, refer to the Vision SPD.

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

1) In certain states, Members may be required to pay the full retail rate and not the negotiated discount rate with certain participating Providers. Please refer to EyeMed's website and search Providers to determine which participating Providers have agreed to the discounted rate.
2) Discounts on vision materials may not be applicable to certain manufacturers' products.

Helpful Resources

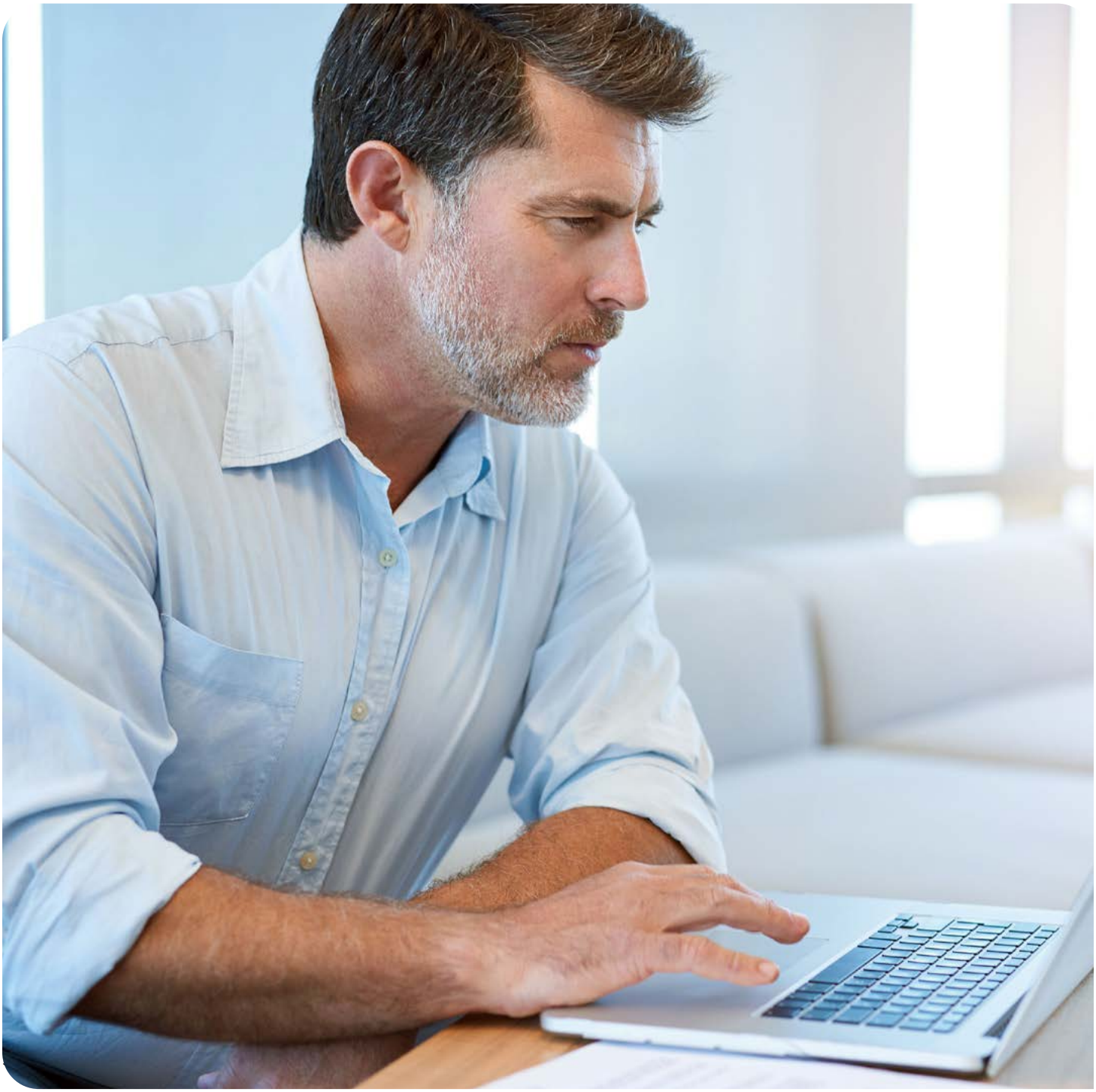
When you need more detailed information about Plan specifics, review your SPDs and SMMs located on the Health and Life website at **lumen.com/bschealthbenefits**. during Annual Enrollment or **lumen.com/healthbenefits** effective Jan. 1, 2022. If you would like a paper copy of these materials, contact the Service Center at **833-925-0487**. Please be advised that mailing time can take up to two weeks.

Benefit Option	Phone	Online
	Health Care	
Service Center • Health and Life Benefit Questions	**833-925-0487** **317-671-8494** (Local DNIS for international callers) Mon-Fri, 7 a.m. - 7 p.m. (CST)During Annual Enrollment, open to 8 p.m. (CST)	**lumen.com/bschealthbenefits** (during Annual Enrollment) **lumen.com/healthbenefits** (effective Jan. 1, 2022) Search: **MyChoice™ Mobile App**, available for Free in the App Store and Google Play
Health Care Advocacy Services • For issues with your Health Care claim(s) that you are unable to resolve on your own or through the Claims Administrator or your Health Care provider.	**833-925-0487** **317-671-8494** (International callers) Mon-Fri, 7 a.m. - 7 p.m. (CST) (During Annual Enrollment, open to 8 p.m. (CST))	N/A
Medical	**Bind:** **833-576-6519** Mon-Fri, 6 a.m. - 9 p.m. (CST) Group Number: 78800186 **UnitedHealthcare:** **800-842-1219** Group Number: 192086	**lumen.com/choosebind** **Access Code: enroll2022** Search: **MyBind**, available for Free in the App Store and Google Play **lumen.com/bind** (This website provides an overview of how this plan can best work for you.) **UnitedHealthcare: myuhc.com** Search: **UHC App**, available for Free in the App Store and Google Play
Employee Assistance Program	**Optum: 866-270-0033**	**lumen.com/EAP**
Prescription Drug Program	**Bind:** **833-576-6519** Mon-Fri, 6 a.m. - 9 p.m. (CST)	**lumen.com/choosebind** **Access Code: enroll2022**
	UnitedHealthcare: **800-842-1219**	**UnitedHealthcare: myuhc.com**
Telemedicine	**Bind:** **Doctor On-Demand** **833-576-6519** **UnitedHealthcare:** **888-632-2738** • UHC Virtual Care Services	**patient.doctorondemand.com** **myuhc.com/virtualvisits** Search: **UHC App**, available for Free in the App Store and Google Play
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**

Benefit Option	Phone	Online
Vision Care Plan	**EyeMed: 855-874-4744**	**eyemedvirtualbenefitfair.com** **Access Code: CQ98RHAT** (during Annual Enrollment) and **eyemed.com** (effective Jan. 1, 2022) Search: **EyeMed**, available for free in the App Store and Google Play

Summary of benefits and coverage availability

We offer an array of resources to help you understand and choose your benefits. This section notifies you of an additional resource required by Health Care Reform—a Summary of Benefits and Coverage Availability (SBC)—that summarizes important information about any health coverage options in a standard format, to help you compare features across Plan options. Look for the SBC on the Health and Life website anytime.



Legal and Important Required Notices

A note about privacy

Keeping your personal information secure is of primary importance. That's why we, along with the benefits administrators, have implemented various security measures and policies to help reduce the risk of unauthorized processing or disclosure of your personal information. You can also help by keeping your User ID and password confidential 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, such as your work email address, may increase your risk of unauthorized disclosure.

Notice of Privacy Practices

You can review the complete notice on **lumen.com/healthbenefits**, or by calling the Service Center at **833-925-0487** to request a copy.

Coverage is not advice

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

Right to amend and/or discontinue

The Company and its delegate, the Plan Design Committee, each has reserved the right in its sole discretion, to change, modify, discontinue or terminate the Plan and/or any of the benefits under the Plan and/or contribution levels, with respect to all participants classes, retired or otherwise, and their beneficiaries at any time without prior notice or consultation, subject to applicable law, Specific written agreement and the terms of the Plan Document. The Employee Benefits Committee, as the Plan Administrator, may adopt, at any time, rules and procedures that it determines to be necessary or desirable with respect to the operation of the Plan. The Plan Administrator has the authority, discretion and the right to interpret and resolve any ambiguities in the Plans or any document relating to the Plans.

Company's reserved rights

This document summarizes certain provisions of the Plan. For specific employee benefit Plan information, refer to the respective official Plan Documents, including the applicable Summary Plan Description and Summaries of Material Modifications, if any. If there is any conflict between the terms of the official Plan Documents and this document, the terms of the official Plan Documents will govern. The Plan Administrator has the authority, discretion and the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan, to supply omissions and resolve conflicts. Benefits and contribution obligations, if any, are determined by the Company in its sole discretion or by collective bargaining, if applicable.

Note: While the Plan has processes in place to prevent errors and mistakes, if a clerical error or mistake happens (however occurring) such error or mistake does not create a right to a Benefit or level of contribution rate under the Plan. You have an obligation to correct any errors or omissions that come to your attention by calling the Service Center to correct the error or omission.

Important note regarding your Annual Enrollment elections

By electing to participate in the Plans, by your submission of information, you have agreed to be bound to and by the provisions of each of the Plans and their administrative practices, including, but not limited to with respect to the recovery of over and underpayments, terms and conditions for eligibility and Benefits. You certify that the submission of information by you in this enrollment process is true and accurate to the best of your knowledge; you agree that you'll submit new information timely as changes occur. You understand that if you are found to have falsified any document in support of a claim for eligibility or reimbursement, the Plan Administrator may, subject to and as may be permitted under the requirements of law, without anyone's consent, terminate your and/or your dependent(s) coverage, and the Claims Administrator may refuse to honor any claim you or your dependent(s) may have made or will make under the Plans if applicable. You understand that you are liable and bear the full financial responsibility for the misappropriation of Plan funds through the filing of false documentation under any of the Plans; You certify that you or your dependent(s) are eligible to enroll in a benefit option, including voluntary or supplemental coverages. Please refer to the applicable Plan document or SPD on the Health and Life website for details about eligibility for coverage or call the Claims Administrator - limitations may apply including, but not limited to, being actively at work in order to be eligible for coverage. You understand that it is your responsibility to confirm your eligibility to enroll in a benefit option, including voluntary or supplemental coverages; enrolling in and paying for coverage for which you are ineligible will not entitle you to Benefits; you understand that it is your responsibility to terminate benefit coverage once you or your dependent(s) become ineligible, for example, due to death of a divorce. This excludes dependents who turn age 26, as they are automatically removed from coverage.

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

Women's Health and Cancer Rights Act

This notice is provided to you in compliance with the federal law entitled the Women's Health and Cancer Rights Act of 1998 (the "Act"). The Plan provides medical and surgical benefits in connection with a mastectomy. In accordance with the requirements of the Act, the Plan also provides benefits for certain reconstructive surgery.

In particular, the Plan will provide, to an eligible participant who is receiving (or who presents a claim to receive) benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and treatment of physical complications associated with all the stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

As with other benefit coverages under the Plan, this coverage is subject to each medical benefit option's annual deductible (if any), required coinsurance payments, benefit maximums, and copay provisions that may apply under each of the benefit options available under the Plan.

You should carefully review the provisions of the Plan, the medical benefit option in which you elect to participate, and its SPD and SMM (if any) on the Health and Life website regarding any applicable restrictions. Contact the Claims Administrator of

Health Insurance Portability and Accountability Act (HIPAA)

Under the Special Enrollment rules under HIPAA, you may enroll yourself and eligible dependents in the Health Plan upon the loss of other coverage, referred to as the "other plan," to include the following:

- Termination of employer contribution toward other coverage;
- Moving out of a service area if the other plan does not offer other coverage;
- Ceasing to be a dependent, as defined in the other plan;
- Loss of coverage to a class of similarly situated individuals under the other plan (for example, when the other plan does not cover temporary/ contractors).

If your Spouse/Domestic Partner or other dependents have special enrollment rights, you may enroll and make changes to your enrollment in any health plan benefit option available to you based upon your home ZIP code and plan service areas within 45 days following the qualifying event. For example, if you have

Employee Only coverage in a benefit option and your Spouse/Domestic Partner loses coverage under his/her employer's plan and has special enrollment rights, both you and your Spouse/Domestic Partner may enroll in any of the benefit options available to you, provided you verify your Spouse's/Domestic Partner's eligibility for the Plan.

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 General Summary Plan Description.

Continuation of coverage

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of employment. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information. Qualifying events for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment. Qualifying events for Spouses/Domestic Partners or dependent children include those events above, plus, the covered employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, death of the covered employee, and the loss of dependent status under the plan rules. If a QB chooses to continue group benefits under COBRA, they must timely enroll and make their premium payment by the due date before eligibility is sent to the Claims Administrators. Upon receipt of premium payment, the coverage will be reinstated. Thereafter, premiums are due on the first of the month. If premium payments are not received in a timely manner, federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Service Center at **833-925-0487.**

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 you may not be able to change 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**