Amazing People. Amazing Benefits. Find Your Fit.

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

2022 Annual Enrollment Guide

For Active Employees

LUMEN®

Contents

Lumen (referred to hereafter as the Company) is committed to green initiatives. You can help by saving this guide as a PDF instead of printing on paper. However, if you would like a paper copy of this guide you may print it, or alternatively, contact the Lumen Health and Life Service Center at Businessolver (referred to hereafter as the Service Center) at 833-925-0487 to request one to be mailed to you.

Note: If you leave the Company before the end of the year, you should review the Benefits Resource Guide for Departing Employees on the **Intranet** for more information.

LUMEN®

Welcome to Annual Enrollment

We are on a mission to further human progress through the technologies we deliver over the Lumen platform. Whether you're working with our customers directly or supporting them from behind the scenes, you play an important part in our ability to make amazing things happen.

Our people help our customers do inspiring things, so we're proud to offer benefits that inspire you to be your best, both at work and at home. 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.

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 Employee will be referenced as "Individual". For example, Employee coverage will be shown as Individual coverage, Employee + Spouse/Domestic Partner will be shown as Individual + Spouse/Domestic Partner, etc.

You can add, change or waive your health benefit coverage for you and/or your eligible dependent(s). If you don't enroll by Nov. 17, you will be automatically enrolled in the plans and coverage levels listed on the Health and Life website, with the exception of FSAs and/or an HSA. You must enroll in these accounts each year, if applicable.

You will need to take action during your 2022 Annual Enrollment:

- **Review and update** your personal information on the Health and Life website. Be sure to add your personal email address as well as your preferred method to receive communication as this information did not carry over from the prior Health and Life Administrator. Remember, the company email does not guarantee privacy. If you need to update your mailing address, you will need to go to SuccessFactors on the **Intranet**.
- **Ask ALEX.** ALEX can help you learn about benefits including Flexible Spending Accounts (FSAs), Health Savings Account (HSA) options and more. You must enroll through the Health and Life website.

- **Use** your **Personal Benefits Budget Worksheet** on the **Intranet**. Use this worksheet together with a recent pay statement to look at your total benefits costs per pay period to help you make decisions during Annual Enrollment.
- **Watch** short benefit videos that provide you with a 2–3 minute, high-level summary of available benefit plans and programs. You can find these on the Annual Enrollment home page on the **Intranet**.
- **Update/Review** the Tobacco-Free Discount and the Working Spouse Surcharge questions, as they can impact your medical premium.

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.

Benefit Premiums

For the fourth year in a row, **Lumen will not pass along any premium increases to you,** if you live a smoke-free or tobacco-free lifestyle, or if you're enrolled in a tobacco cessation program. If you and your eligible dependents enrolled in a Lumen medical plan 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.

This is possible because so many of you have embraced our wellness and condition management programs, and you continue to be smart healthcare consumers. Keep up the great work! You may want to consider contributing to or increasing the amount you contribute to the 401(k) retirement plan, a Health Care or Dependent Day Care Flexible Spending Account (FSAs) or Health Savings Account (HSA), as applicable.

Note: Coverage and benefit costs may increase or decrease throughout the year, in certain situations. Refer to the General Information Summary Plan Description (SPD) and the Life Insurance SPD on the Intranet or the Health and Life website for more information.

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 Employee Only and **$1,500** to **$1,200** for Employee + Spouse/Domestic Partner or Employee + Child(ren), and **$2,000** to **$1,600** for Family.

Flexible Spending Accounts (FSAs)

If you are enrolled in a Health Care Flexible Spending Account (Traditional or Limited Purpose) or Dependent Day Care Flexible Spending Account in 2021, the 2021 balance will not be forfeited at the standard expiration date, March 15, 2022. But instead, the time period in which to use and exhaust any 2021 Health Care or Dependent Day Care FSA carryover balance will be extended to December 31, 2022, allowing you to access those 2021 contributions through the end of the 2022 calendar year.

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

- You must enroll each year to take advantage of an HSA. HSA limits are determined by the IRS and are subject to change.

- The Employee contribution limit increases from **$3,600** to **$3,650**, and the Employee + 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 wish to contribute and receive a pre-tax benefit, Lumen will submit your payroll contributions to Optum Bank. Optum Bank must first approve (vet) your account before deductions begin.

  You may be requested to provide further documentation, i.e., current driver's license/ Identification Card/ Social Security Card and a recent bill to open your account. A welcome kit and debit card will be sent shortly after you are successfully enrolled and your payroll contributions will begin. If an HSA deduction is missed or the full amount is not deducted, the payroll system will re-amortize and adjust the amount taken on subsequent pay periods.

  Note: Due to IRS regulations, you must use a physical mailing address. Use of a PO Box as your mailing address is prohibited.

- If you elect to have your Health Account as your 2022 Wellness Reward option, you must open an HSA through OptumBank. You can contribute as much as you would like up to the IRS maximum. It's important to note that if you elect your Well Connected rewards to be deposited into your Health Account, these amounts do count towards the IRS maximum.

- When you become Medicare Eligible due to age, your contributions will end.

Note: If you are Medicare eligible and planning to retire, you should review the "Medicare and You" handbook from Medicare. While each employee's situation will differ, planning and education is key. You can find this handbook on the official medicare.gov website.

Decreased Out-of-Pocket Maximum – if enrolled in the Bind Health Plan

Cost Comparison:	2022 Out-of-Pocket Maximum		2021 Out-of-Pocket Maximum	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Employee	$3,600	$7,200	$5,000	$10,000
Employee + Spouse/ Domestic Partner	$5,400	$10,800	$7,500	$15,000
Employee + Children	$5,400	$10,800	$7,500	$15,000
Family	$6,850	$14,400	$10,000	$20,000

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.

Short and Long-Term Disability for Part-time employees

Part-time Non-Union employees will be eligible for participation under the Disability Plan.

Tobacco-Free Discount

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, not the actual medical bi-weekly premium amount.

If you and your eligible dependents enrolled in a Lumen medical plan 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.

Well Connected Program - Wellness Reward Option Update

The Well Connected program is designed to help you achieve a state of balance in your personal and professional life and can improve your well-being. It doesn't matter if you are working on your physical, mental or financial wellness, Lumen's wellness program is designed to help you live an optimal life. The Well Connected program provides access to a number of resources and activities to support your health and performance. You can earn up to $600 each year for you and your enrolled Spouse/Domestic Partner.

New in 2022, you do not need to select your Rally reward method during Annual Enrollment. You will now be able to select how you want to earn your rewards at the time of redemption. If you are enrolled in a Lumen medical plan, you can receive your rewards in multiple methods such as gift cards, Health Reimbursement Account (HRA) and Health Savings Account (HSA). If you are not enrolled in a Lumen medical plan, you are only eligible for gift cards.

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. **Note: When you complete five (5) program sessions with Quit For Life, you can earn $250 towards your wellness rewards.**

Note: Once you are no longer an active employee or eligible for the Plan for any reason, (i.e., termination, retiree, LTD, COBRA, leave the U.S., etc.) or your eligible Spouse/Domestic Partner are no longer covered by the Plan, you and your eligible Spouse/Domestic Partner's eligibility for the Well Connected Rewards Program will end. If you have unredeemed rewards in the form of gift cards, you are encouraged to redeem the rewards prior to the last day of the month or your rewards will be forfeited. Similarly, any outstanding HRA/HSA deposits will not be deposited after the last day of the month which you or your Spouse/Domestic Partner's coverage or your employment with Lumen ends.

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.

Note: When you complete five (5) program sessions with Quit For Life, you can earn $250 towards your wellness rewards.

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

New Plan Administrator for Health and Life Benefits

Effective Jan. 1, 2022, Businessolver will administer eligibility for the Lumen Health Care Plan, Lumen Bind Health Plan, Lumen Disability Plan, Lumen Business Travel Accident Insurance Plan, Lumen Life Insurance Plan, Lumen Survivor Benefit Plan and Lumen Qualified Transportation Plan, referred to hereafter as the "Plan".

Website and Phone Number Updates for the Service Center

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

Update your Communication Preference on the Service Center website

Go to **lumen.com/bschealthandlife** during Annual Enrollment or **lumen.com/healthandlife** (effective Jan. 1, 2022) to update your preferred method to receive health and/or life communication from the Service Center. Please be advised that using an email that is not secured, such as your work email address, may increase your risk of unauthorized disclosure.

The Service Center will not send any communication to your work email address even if you set it as your preference to receive communications.

Commuter & Transit (Qualified Transportation Plan)

To enroll in the Qualified Transportation Plan in 2022, you can visit the health and life website at **lumen.com/healthandlife**. You must enroll by the 10th of the month for this benefit to become effective the first of the following month.

If you were previously enrolled in this benefit in 2021, the prior Lumen Health and Life Service Center, Alight, will be responsible for processing and paying claims for the 2021 plan year provided your claim is received by Jan. 14, 2022. Any claims after this date should be submitted to the Lumen Health and Life Service Center at Businessolver at the address below:

Lumen Health and Life Service Center at Businessolver	**Email:** claims@mychoiceaccounts.com	**Mail:** MyChoice Accounts, MSC 345475, PO Box 105168, Atlanta, GA 30348-5168	**Fax:** 855-883-8542

If you are enrolled in this Plan, you will receive a MyChoice™ Accounts Commuter Spending Account Card from the Lumen Health and Life Service Center at Businessolver. The card is designed to work at all transit agency terminals and parking service providers. Refer to the Qualified Transportation Plan Summary Plan Description on the **Intranet** for more information.

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/healthandlife** 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 **Intranet**.

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) with an optional Health Savings Account (HSA) 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 either a Flexible Spending Account or 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) with Optional Health Savings Account (HSA)

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.

The HDHP has the option for you to open a personal tax-advantage, HSA, to save your own

money and pay for qualified medical expenses now and in the future. You can choose to establish your HSA with any financial institution; however, Lumen partners with OptumBank to allow your contributions to be set up as pre-tax through bi-weekly payroll deductions. Contribution elections do not carry over into the new year; therefore, you must elect to participate annually.

Note: Temporary Full-time, Temporary Part-time and Incidental employees are not eligible to open up an HSA.

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.

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 (Employee Only, Employee/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.

Dental

There are two dental plan options to choose from. However, you can elect to waive your dental coverage. Both of these options cover exams, cleanings and fillings, as well as comprehensive dental work – such as crowns and root canals for covered participants. Both of the dental plan options are offered by MetLife.

Vision

There is one vision plan option. However, you can elect to waive your vision coverage. The vision plan is offered by EyeMed (First American Administrators/EyeMed Vision Care, LLC.).

You can save money if you select “INSIGHT” (in-network). You can receive access to enhanced benefits and save even more if you choose to visit an in-network PLUS Provider within the INSIGHT

network. Your vision care services include but are not limited to contact lenses, eye exams, glasses (frames and lenses), retinal screening and laser vision correction.

Flexible Spending Accounts (FSA)

You must enroll each year to contribute to a dependent day care or health care (traditional or limited purpose) FSA. Contributions are pre-tax and are fully funded by you. FSA limits are determined by the IRS and are subject to change.

Note: If you enroll in the High Deductible Health Plan (HDHP) and elect an FSA, you will be enrolled in the Limited Purpose FSA whether or not you choose to enroll in a Health Savings Account (HSA).

- Dependent Day Care FSA – You can contribute between $150-$5,000 per year. You can use this FSA for eligible out-of-pocket day care expenses for eligible dependents so you (and your spouse, if married) can work or attend school Full-time. Funding is available as contributions are deducted from your paycheck and loaded to UnitedHealthcare's system.
- Traditional Health Care FSA – You can contribute between $150-$2,750 per year. You can use this FSA for a range of eligible out-of-pocket health care expenses not covered by medical, prescription drug, dental or vision for you and any eligible dependent, even those not covered by a Company health care plan option. The annual amount you elect to contribute is available for you to use on Jan. 1 of each year.
- Limited Purpose FSA (for those enrolled in the HDHP) - You can contribute between $150-$2,750 per year. You can use this FSA for eligible out-of-pocket dental and vision care expenses, including deductibles, copayments and coinsurance not covered by other plans. Medical and prescription drug expenses are not eligible for reimbursement. The annual amount you elect to contribute is available for you to use on Jan. 1 of each year.

Health Savings Account (HSA)

HSAs are designed to help you to save for qualified medical expenses if you are enrolled in the High Deductible Health Plan (HDHP), including prescriptions and eligible dental and vision expenses. You can use your HSA money tax free for medical expenses for your dependents whether or not they are on your health insurance. An HSA allows you to set aside pre-tax money from your paycheck to pay for expenses you will have now and in the future. This account rolls over from year to year and the money in the account is 100% yours. You can open up an HSA at any time throughout the year.

Health Savings Accounts are the most tax advantaged account ever created (three tax advantages in one account). Tax deductible, tax free growth, and tax free distribution.

Important Note: This program is not a Company-sponsored plan or benefit. It is not a plan covered under the federal law known as "ERISA." The Company has simply chosen to allow OptumBank to make its programs available to Lumen employees, but please be advised that this is a voluntary program and only you can decide whether the benefits provided by this program are appropriate for you and your family. You are encouraged to research all suitable alternatives and consult with your personal advisors. The Company is not able to provide you with advice regarding the program. Your participation is your decision, completely voluntary and at your own expense.

Health Reimbursement Account (HRA)

Eligibility: All who are enrolled in one of the CDHP options.

Overview: If you are enrolled in either the Consumer Driven Health Plan Option 1 or Option 2, you will receive a Company funded HRA to help with your out-of-pocket portion of the deductible and out-of-pocket maximum expenses. You incur medical and prescription drug expenses and pay the full cost of them with money in your HRA first, then you pay out-of-pocket until your deductible is met.

Note: If you elect a CDHP and a Health Care FSA, money will be taken from your HRA first and then once exhausted, money will be taken from your FSA. You do not have the option to have your FSA pay first as the HRA is part of the medical plan. In addition, you receive the full allocation on Jan. 1st or whatever day you become eligible.

Life & Accidental Death & Dismemberment (AD&D)

The Lumen Life and AD&D Insurance Plans provide a wide range of benefits in the event of death or other covered losses.

Coverage and benefit premium deductions may increase or decrease throughout the year in certain situations (for example, if you have a change in pay or change age brackets; age brackets update every 5 years: 30, 35, 40, 45, etc.).

In some cases you may be required to provide Evidence of Insurability (EOI).

Be sure to confirm that you have current and up-to-date beneficiaries for all of your Life Insurance plan options. The Lumen Health and Life Service Center at Businessolver is the record keeper of beneficiary designations. You can refer to the Life Insurance and AD&D Summary Plan Description on the **Intranet** for Facility of Payment to find out what happens when no beneficiaries are on file.

Short-Term Disability

When you have medical circumstances that require time off work, Lumen provides Short-Term Disability benefits to continue all or a portion of pay to eligible employees when you are disabled. Short-Term Disability benefits begin on the 8th calendar day after you meet the waiting period (7 consecutive full or partial calendar days).

Please refer to the applicable Short-Term Disability Summary Plan Description and/or your governing Collective Bargaining Agreement (CBA) on the **Intranet** for more information.

Long-Term Disability

Long-Term Disability is designed to help protect your income in the event you are unable to work due to a covered disability.

Long-Term Disability (LTD) provides partial income protection for you in the event of an extended disability after the Short-Term Disability (STD) elimination period. You are eligible for this plan after completing one year of service. Supplemental LTD is available the first Annual Enrollment after you complete one year of service.

You can elect to enroll during a subsequent Annual Enrollment period; however, you will be required to go through Evidence of Insurability (EOI).

Voluntary Lifestyle Benefits

Voluntary Lifestyle Benefits provides you and your family with voluntary benefits choices, in addition to your Lumen Health & Welfare Benefits options, at affordable rates.

Enrollment Reminders

IMPORTANT – Confirm or update your selection for the Tobacco-Free Discount and Working Spouse/Domestic Partner Surcharge.

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, not the actual medical bi-weekly premium amount.

Tobacco-Free Discount

If you and your eligible dependents enrolled in a Lumen medical plan 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

You may be subject to a working Spouse/Domestic Partner per pay period surcharge 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 is less than $30,000. If your base pay amount changes during the benefit plan year, the surcharge will be automatically reassessed and effective on the date of the change, if applicable.

Yes – applies ($100 per pay period surcharge)

No – no surcharge ($0)

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, Pay Period Working Spouse/Domestic Partner Surcharge either:

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.

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/bschealthandlife** 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/bschealthandlife**
   - 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

Eligibility

Businessolver will administer eligibility for the Lumen Health Care Plan, Lumen Bind Health Plan, Lumen Disability Plan, Lumen Business Travel Accident Insurance Plan, Lumen Life Insurance Plan, Lumen Survivor Benefit Plan and Lumen Qualified Transportation Plan.

Employee Classification	Eligibility	Premiums
Full-time or **Term Full-time** employees	As a Full-time employee, you and your eligible dependent(s) may enroll in: • Medical/prescription drug • Dental • Vision • Flexible Spending Accounts (Health Care, Limited Purpose Health Care, and Dependent Day Care) • Health Savings Account (HSA) when enrolled in the High Deductible Health Plan with Optional Health Savings Account (HSA) • Well Connected Wellness Program (employees do not need to be enrolled in the medical/prescription drug plan to participate in the Wellness Program) • Fitness Reimbursement Program • Disability • Life Insurance • Commuter Spending Accounts (Parking and Transit) • Voluntary Lifestyle Benefits (not Company-Sponsored ERISA benefits)	Premiums are determined based on how you answer questions during your enrollment. Premiums can be adjusted up or down based on: • Tobacco-Free Discount • Working Spouse/Domestic Partner Surcharge
Part-time, Term Part-time or **Seasonal** (Qwest Union Represented only) employees	As a Part-time, Term Part-time or Seasonal employee, you and your eligible dependent(s) may enroll in: • Medical/prescription drug • Flexible Spending Accounts (Health Care, Limited Purpose Health Care, and Dependent Day Care) • Health Savings Account (HSA) when enrolled in the High Deductible Health Plan with Optional Health Savings Account (HSA) • Well Connected Wellness Program (employees do not need to be enrolled in the medical/prescription drug plan to participate in the Wellness Program) • Disability (only available to Part-time Seasonal Qwest Union Represented employees if hired before Jan. 1, 2018 and Part-time Non-Union Employees)	Premiums are 150% of the Full-time rates and are determined based on how you answer the questions during your enrollment: • Tobacco-Free Discount • Working Spouse/Domestic Partner Surcharge
Temporary Full-time, Temporary Part-time and **Incidental** (Qwest Union Represented only) employees **Note:** > or = 20 hours but <30 hours per week	As a Temporary Full-time, Temporary Part-time or an Incidental employee, you and your eligible dependent(s) may enroll in: • Medical/prescription drug • Well Connected Wellness Program (employees do not need to be enrolled in the medical/prescription drug plan to participate in the Wellness Program)	• Premiums are 100% of the total cost

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 **Intranet**.

	Bind Health Plan		UnitedHealthcare HDHP with Optional HSA		UnitedHealthcare CDHP Option 1		UnitedHealthcare CDHP Option 2	
HSA/HRA Contributions	Not Applicable - See Flexible Spending Account Options for more information		With Employee-Funded HSA (maximum contribution): • $3,650 Employee • $7,300 Employee + 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 Employee • $750 Employee + Spouse/ Domestic Partner (Domestic Partner) • $750 Employee + Children • $1,000 Family		With Company-Funded HRA Contribution: • $800 Employee • $1,200 Employee + Spouse/Domestic Partner (Domestic Partner) • $1,200 Employee + 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)							
	Employee		**Employee**		**Employee**		**Employee**	
	$0	$0	$1,500	$3,000	$1,500	$3,000	$1,500	$3,000
					Employee + Spouse/ Domestic Partner		**Employee + Spouse/ Domestic Partner**	
					$2,250	$4,500	$2,250	$4,500
	Employee + Children		**Family**		**Employee + Children**		**Employee + 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)							
	Employee		**Employee**		**Employee**		**Employee**	
	$3,600	$7,200	$3,600	$7,200	$3,600	$7,200	$3,200	$6,400
	Employee + Spouse/ Domestic Partner				**Employee + Spouse/ Domestic Partner**		**Employee + Spouse/ Domestic Partner**	
	$5,400	$10,800			$5,400	$10,800	$4,800	$9,600
	Employee + Children				**Employee + Children**		**Employee + 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 with Optional HSA		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)

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

	Bind Health Plan		UnitedHealthcare HDHP with Optional HSA		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**
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
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)

	Bind Health Plan	UnitedHealthcare HDHP with Optional HSA	UnitedHealthcare CDHP Option 1	UnitedHealthcare CDHP Option 2
Prescription Drugs				
	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 or, you can waive this coverage. 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 **Intranet**.

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 **Intranet**, 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.

Flexible Spending Accounts (FSAs) and Health Savings Account (HSA)

To participate in FSAs or an HSA, you must enroll each year. Your FSA and/or HSA contribution elections will not carry over from one year to the next. HSA and FSA contributions are fully funded by you and your contributions are pre-tax, meaning, free from federal taxes.

Traditional Health Care FSA	Limited Purpose Health Care FSA (for HDHP with Optional HSA)	Dependent Day Care FSA (for child/day care services)	Health Savings Account (HSA) (for HDHP with Optional HSA)
How much can you contribute?			
Between $150–$2,750 per plan year **Note:** FSA limits are determined by the IRS and subject to change for 2022.	Between $150–$2,750 per plan year **Note:** FSA limits are determined by the IRS and subject to change for 2022.	Between $150–$5,000 per plan year **Note:** The maximum for highly compensated employees is $2,000; if you are married and filing taxes separately, the maximum is $2,500. If you are determined to be a highly compensated employee, the Plan Administrator may need to adjust your contribution election, and you will be notified.	Up to $3,650 Employee-only Up to $7,300 Employee + one or more enrolled **Note:** If you are age 55 or older, you can contribute an extra $1,000 "catch-up" contribution per plan year.
What types of expenses can you use it for?			
A range of eligible out-of-pocket health care expenses not covered by a medical, prescription drug, dental or vision care plan can be used for any eligible dependent, even those not covered by a Company health care plan.	Only eligible out-of-pocket dental and vision care expenses, including deductibles, copayments and coinsurance not covered by other plans. Medical and prescription drug expenses are not eligible for reimbursement. Elect to enroll in a Health Savings Account (HSA) for eligible medical expense reimbursement.	Eligible out-of-pocket child care/elder care expenses for eligible dependents so you (and your Spouse, if married) can work or attend school Full-time.	Eligible medical, prescription, over-the-counter drugs, dental and vision care expenses.
How does it work?			
The plan year amount you elect to contribute is available for you to use on Jan. 1, 2022. **Note:** If you enroll in the HDHP with Optional HSA and elect an FSA, you will automatically be enrolled in the Limited Purpose FSA whether or not you contribute in an HSA.		FSA money is available as contributions are deducted from your paycheck and loaded to UnitedHealthcare's system.	• You can open an HSA with Optum Bank (through payroll deductions), a bank of your choice, or an insurance Company or other IRS-approved trustee. • HSA money is available as contributions are deducted from your paycheck and loaded to Optum Bank's system. Optum Bank must first approve (vet) your account before an account can be set up and contributions deposited. • There are no federal taxes on contributions, interest earned or expenses paid from the HSA (except for Alabama, California and New Jersey).

Reminder: Pay period 1 includes 2022 life, disability (imputed income calculated for STD post-tax election), FSA and HSA premium deductions.

- **NOTE:** If an FSA deduction is missed or the full amount is not deducted, an adjustment is made in your account reflecting a balance. The balance is taken on subsequent pay periods, in addition to the regular deduction amount, until the balance is reduced to zero. If an HSA deduction is missed or the full amount is not deducted, the system will re-amortize and adjust the amount taken on subsequent pay periods. The FSA and/or HSA adjustment is made to ensure the total contribution amount you elected to contribute is met at the end of the Plan year.
- 2022 FSA funds can be used for eligible expenses incurred from Jan. 1, 2022, to March 15, 2023. You have until April 30, 2023, to file claims, or remaining funds are forfeited. The Internal Revenue Service (IRS) does not allow expenses incurred by Domestic Partners or their dependents to be reimbursed through an FSA unless you claim your Domestic Partner or their dependents on your income tax return.
- If you are enrolled in the traditional Health Care Spending Account, keep your Health Care Spending Card (HCSC) from 2021, as 2022 elections will be added to your existing card. If your HCSC has expired, you will automatically be mailed a new card in December. HCSC are not issued for the Limited Purpose Health Care FSA.

Life and Accident

Automatic and Company-Paid Plan Benefits	
Employee Basic Life Insurance	Eligible employees have a benefit of 1x eligible pay (Base Pay + anticipated Short-Term Incentive) rounded up to the next higher $1,000 up to $2,000,000 maximum benefit. If your Employee Basic Life Insurance is more than $50,000, the IRS requires you pay taxes on imputed income, which is the cost of Company-provided Employee Basic Life Insurance over $50,000. **To avoid paying taxes on imputed income, you have the option to choose the $50,000 in coverage.** If you are in this category, you will see $50,000 as an option when you go online to enroll, as well as your 1x Base Pay + anticipated Short-Term Incentive. You have the option to change your Basic Life Insurance coverage amount to $50,000 and, therefore, you would not be subject to imputed income. **Note:** When you turn age 70, your Basic Life Insurance coverage will be reduced by 50%. If you enroll in the $50,000 coverage or choose to enroll in this coverage before turning age 70, there will be no reduction and you will keep the same coverage amount ($50,000).
Employee Basic Accidental Death & Dismemberment Insurance (AD&D)	Eligible employees have a benefit of 1x eligible pay (Base Pay + anticipated Short-Term Incentive) rounded up to the next higher $1,000 up to $2,000,000 maximum benefit.
Business Travel Accident	Eligible employees have a benefit of 3x eligible pay (Base Pay + anticipated Short-Term Incentive) rounded up to the next higher $1,000 up to $500,000 maximum benefit.
You Pay the Cost	
Employee Supplemental Life Insurance (Statement of Health/Evidence of Insurability (EOI) may be required.)	1x, 2x, 3x, 4x, 5x, 6x, 7x or 8x Base Pay rounded up to the next higher $1,000 up to $2,000,000 maximum benefit.
Employee Supplemental Accidental Death & Dismemberment Insurance (AD&D)	1x, 2x, 3x, 4x, 5x, 6x, 7x or 8x eligible (Base Pay + anticipated Short-Term Incentive) rounded up to the next higher $1,000 up to $2,000,000 maximum.
Spouse/Domestic Partner Supplemental Life Insurance (Statement of Health/Evidence of Insurability (EOI) may be required.)	$5,000, $10,000, $25,000, $50,000, $75,000, $100,000 or $200,000 (cannot elect more than 100% of Employee Basic Life + Employee Supplemental Life coverage).
Child Supplemental Life Insurance (Can be for more than one child)	Each child: $3,000, $5,000, $10,000 or $20,000 (cannot elect more than 100% of Employee Basic Life + Employee Supplemental Life coverage).
Spouse/Domestic Partner Supplemental Accidental Death & Dismemberment Insurance (AD&D)	50% of Employee Supplemental AD&D Coverage up to $750,000 maximum benefit.
Child Supplemental Accidental Death & Dismemberment Insurance (AD&D)	25% of Employee Supplemental AD&D Coverage up to $100,000 maximum benefit.

Reminders:

- Please confirm that you have current and up-to-date beneficiaries for all of your Life Insurance plan options by going to **lumen.com/bschealthandlife** during Annual Enrollment, or **lumen.com/healthandlife** effective Jan. 1, 2022. The Service Center is the record keeper of beneficiary designations. Refer to the Life Insurance and AD&D SPD on the **Intranet** for Facility of Payment to find out what happens when no beneficiaries are on file.
- Coverage and benefit premium deductions may increase or decrease throughout the year in certain situations (for example, if you have a change in pay or change age brackets; age brackets are every 5 years, i.e., 30, 35, 40, 45, etc.). If your benefit costs increase or decrease, you will receive a notification from the Service Center. Refer to the Life Insurance and AD&D SPD on the **Intranet**.
- If both you and your Spouse/Domestic Partner are employed by the Company, or on long-term disability, or in a parent/child relationship, you cannot be covered for Supplemental Life Insurance as an employee, long-term disability participant and a dependent on each other's benefit coverage. If both you and your Spouse/Domestic Partner are employed by the Company and one of you is not enrolled in the Employee Supplemental Life plan, you may enroll under the Dependent Spouse/Domestic Partner Supplemental Life plan of the other Spouse/Domestic Partner. You cannot be covered for both Employee Supplemental Life and Dependent Supplemental Life. Also, you cannot both purchase Child Supplemental Life and AD&D Insurance coverage for the same dependent children. You must decide which parent will cover the children.

Short-Term Disability (STD) - Qwest Union Represented Employees

A brief overview of your STD benefits.

You must be a Regular Full-time or Term Full-time employee to be eligible for Short-Term Disability benefits. Seasonal employees are eligible if hired, rehired or transferred prior to Jan. 1, 2018.

Qwest Represented Hired Before Jan. 1, 2009	Qwest Represented Hired, Rehired Or Transferred On Or After Jan. 1, 2009	Qwest Represented Hired, Rehired Or Transferred On Or After Jan. 1, 2018
You must have six months of service to be eligible for this benefit.	You must have one year of service to be eligible for this benefit and have an Equivalent Work Week (EWW) of at least 20 hours.	You must have one year of service to be eligible for this benefit, employed Full-time.
Maximum Benefit Period (Duration of Benefits)		
39 weeks	39 weeks	26 weeks
Benefit Election Options		
You are automatically enrolled.	You may elect to have STD benefits paid on a pre-tax basis, which means STD benefits would be subject to tax. If an election is not made, you will default to the after-tax option, which means STD benefit payments are not subject to tax. No changes can be made until the next Annual Enrollment period.	
Benefit Amount		
After completing your Eligibility Period, you will receive an allowance of 100% to 60% of your Normal Take Home Pay, per your collective bargaining agreement. See the STD Summary Plan Description (SPD) on the **Intranet**.	70% Base Pay after- or pre-tax option If you choose the **after-tax** election, your STD benefit amount is not taxed when you receive payment. Imputed income* is added to your taxable pay so that you will not have to pay taxes on benefits you may receive from the Plan. • When electing the **post-tax** option, your Confirmation of Enrollment (COE) will show two lines under Short-Term Disability: Pay Period Price and Pay Period STD Credit. • Although these amounts offset, it is based on excluding imputed income as part of your Total Pay Period Cost (at the bottom of your COE). The Pay Period Price will appear as imputed income on your paycheck. If you choose the **pre-tax** option, your STD benefit amount is taxed when you receive benefits from the Plan. When selecting the STD (**pre-tax**) option, there will not be a line item on your paycheck as the cost and credit amount offsets. **Note:** If you are eligible and on STD for longer than 6 months, and enrolled in the **pre-tax** option, your STD benefit becomes FICA Free due to IRS regulations.	

*Imputed income is the term the IRS applies to the value of any benefit or service that should be considered income for the purposes of calculating your federal, state and local taxes. On your paycheck, the STD post-tax Benefit in the "Imputed Income" section is the taxable amount that reflects the value of the STD Benefit. Seeing this line item on your check does not mean you are on STD but that you elected the post-tax STD benefit option.

This chart is only a snapshot summary of STD benefits. For specific details refer to the STD Summary Plan Description and the collective bargaining agreement (CBA), if applicable, on the **Intranet**.

Short-Term Disability (STD) - Non-Union and Union Represented Employees

A brief overview of your STD benefits.

Represented	Non-Union and Qwest Union Represented Outside Sales Representatives
Eligibility	
You must have one year of service to be eligible for this benefit.	You must have one year of service to be eligible for this benefit.
Benefit Election Options	
For those employees in the unions listed below, refer to the Non-Union and Qwest Union Represented Outside Sales Representatives Benefit Election Options columns to the right. New hires, rehires and transfers on or after Jan. 1, 2021 in the following unions: • **CWA:** 6171N, 6171C • **IBEW**: 257A New hires, rehires and transfers on or after Jan. 1, 2020 in the following unions: • **CWA:** 1101, 2204, 3176A, 2680, 3601A, 3682, 3685, 6372, 6372A • **IBEW:** 199N, 688, 1106, 1181, 1912 For all other employees in those unions not listed above, refer to the information below, and your collective bargaining agreement (CBA) for more information.	You may elect to have STD paid on a post-tax basis, which means your STD benefits are not subject to tax. Or, you may elect to have STD paid on a pre-tax basis, which means if STD benefits are paid, it would be paid subject to tax at the time you qualify to receive STD. If you do not make any changes, your current tax treatment enrollment election will continue, if applicable.
Maximum Benefit Period (Duration of Benefits)	
Generally 26 weeks	Generally 26 weeks
Maximum Benefit Period (Duration of Benefits)	
Tier level ranges from 100% to 60% based on years of service. **Note:** You are not eligible to supplement your STD with accrued domestic Paid Time Off (PTO) or vacation time.	70% of your base pay If you choose to elect the **post-tax** option, your STD benefit amount is not taxed if/when the benefit is paid. You are not eligible to supplement your STD with accrued Paid Time Off (PTO) or Flexible Time Off (FTO). Imputed income* is added to your taxable pay so that you will not have to pay taxes on benefits you receive from the Plan. If you do not make a choice when you first become eligible, you will default to the post tax option. • Although the post-tax amounts offset, it is based on excluding imputed income as part of your Total Pay Period Cost (at the bottom of your COE). The Pay Period Price will appear as imputed income on your paycheck. If you choose to elect the **pre-tax** option, your STD benefit amount is taxed if/when the benefit is paid. You are eligible to supplement your STD with accrued PTO or FTO only if you elect the pre-tax option. When selecting the STD (pre-tax) option, there will not be a line item on your paycheck as the cost and credit amount offset.

*Imputed income is the term the IRS applies to the value of any benefit or service that should be considered income for the purposes of calculating your federal, state and local taxes. On your paycheck, the STD Benefit in the "Imputed Income" section is the taxable amount that reflects the value of the STD benefit. Seeing this line item on your check does not mean you are on STD but that you elected the post-tax STD benefit option.

This chart is only a snapshot summary of STD benefits. For specific details refer to the STD Summary Plan Description and the collective bargaining agreement (CBA), if applicable, on the **Intranet**.

Long-Term Disability (LTD)

A brief overview of your LTD benefits.

Basic LTD (Fully paid by the Company, basic level of LTD coverage)	Supplemental LTD (Employee-paid, higher level of LTD coverage)
Eligibility	
You are eligible for Basic LTD after you have completed one year of service.	You are eligible for the Supplemental LTD the first Annual Enrollment after completing one year of service. **Note:** If you were hired in 2021, you are not eligible to enroll in Supplemental LTD until 2023 Annual Enrollment. If you are eligible for Supplemental LTD for the first time and do not enroll during this Annual Enrollment period, but decide to enroll later, you will be required to complete the Statement of Health/Evidence of Insurability (EOI). Refer to the LTD Summary Plan Description (SPD) for limitations that apply.
Benefit Amount	
Maximum of 50% of Pre-disability earnings up to $12,000 maximum per month.	65% of Pre-disability earnings up to $25,000 maximum per month.

Rates

If you elect Supplemental LTD, calculate your bi-weekly premium rate by using the table below. Benefit cost for Supplemental LTD will be deducted per pay period directly from your paycheck. If you do not enroll in Supplemental LTD, subject to eligibility requirements, you will automatically be enrolled under Basic LTD with no cost to you.

If you have questions regarding how to determine your earnings, please review the Basic & Supplemental LTD Highlights found on the **Intranet**.

1. Enter your bi-weekly pre-disability Earnings, not to exceed $17,752. **Line 1:** $_____
2. Your bi-weekly premium rate: **Line 2:** $_____
   - .00238 for Qwest Union Represented employees hired, rehired, or transferred prior to Jan. 1, 2018
   - .00297 for Qwest Union Represented employees hired, rehired, or transferred on or after Jan. 1, 2018; Non-Union; Union Represented; Qwest Represented Outside Sales Representatives
3. Multiply the amount on **Line 1** by the amount on **Line 2**, and enter the total here. **Line 3:** $_____

The amount on Line 3 is your estimated bi-weekly cost for coverage under Supplemental LTD.

Note: If you are on STD as of Jan. 1, 2022, and enroll in Supplemental LTD, your Supplemental LTD will not become effective until the day you complete one full day of Active work or until your Supplemental LTD is approved. Refer to the actively at work provisions in the LTD SPD on the **Intranet**.

This chart is only a snapshot summary of LTD benefits. For specific details refer to the LTD SPD and the collective bargaining agreement (CBA), if applicable, on the **Intranet**.

Voluntary Lifestyle Benefits

You must be a Full-time employee to enroll in Voluntary Lifestyle Benefits. Information on these programs can be found on the Intranet.

This Voluntary Lifestyle Benefits program is not a Company-Sponsored plan or benefit. It is not a plan covered under the federal law known as "ERISA". The Company has simply chosen to allow these vendors to make these programs available to employees. Please be advised that this is a voluntary program and only you can decide whether the benefits provided by this program are appropriate for you and your family. You are encouraged to research all suitable alternatives and consult with your personal advisors. Employees are encouraged to review the privacy and security policies and the practices of the various vendors and make sure they are comfortable with them prior to entering into any transactions. The Company is not able to provide you with advice regarding these programs. Your participation is your decision, completely voluntary and at your own expense. The Company does not endorse and is not responsible for any of the products, services or practices promoted on the voluntary lifestyle benefit website, lumen.com/voluntarybenefits or the Health and Life website. Access to this website is provided at no cost to you, and the Company does not benefit from your participation. There are no commissions or incentives paid to the Company as a result of the products or services you may choose to purchase.

Enroll for the following Voluntary Lifestyle Benefits only during Annual Enrollment, Nov. 3 - Nov. 17, 2021	Enroll for the following Voluntary Lifestyle Benefits at any time
Subject to the policy terms: **Accident Insurance** Helps cover out-of-pocket costs if you are injured in a covered accident. **Cancer Insurance** Helps supplement certain traditional medical insurance, which may only cover a small portion of the non-medical expenses that can be incurred. **Critical Illness Insurance** Pays a lump-sum benefit directly to you if you are diagnosed with a covered condition. **Hospital Indemnity Insurance** Designed to help offset some of the costs associated with a hospital stay, such as copayments, deductibles or even lost income. **Legal Services*** Gives you access to a network of attorneys for advice and representation on a wide range of legal matters.	**Choice Auto and Home Program**** Comparison shop for coverage and rates from multiple top-rated carriers. **Employee Perks** A free one-stop-shop program for exclusive discounts to national and local merchants. **Identity Protection Program** Provides comprehensive identity, credit and privacy protection with full-service remediation. **Pet Insurance** Affordable, comprehensive medical plans for your pet that you can use with any veterinarian, anywhere. **Purchasing Power Program** Gives you the ability to purchase products such as electronics, appliances, furniture and more. Eligible after 6 months of employment. **SmartPath Financial Coaching** SmartPath Financial Coaching offers unbiased, sales-free guidance from certified coaches that are focused on you. Whether it be through the budgeting app, webinars or a full library of video tutorials, articles and other helpful tools, SmartPath assists employees in making decisions about their financial journey.

Visit lumen.com/voluntarybenefits or call **800-380-0378** Mon-Fri, 7 a.m. - 6 p.m. (MST)

Benefits elected during the annual enrollment period will be effective Jan. 1, 2022. You may have the option for payroll deductions from the programs listed above.

***Note:** You can only cancel participation in Legal Services during the Annual Enrollment period.

**The Choice Home Program may not be part of the benefit offering in Florida and Massachusetts.

Reminders

Note: If both you and your Spouse/Domestic Partner are a Company couple whether actively employed, retired, on disability or you and your child are in a parent/child relationship, you cannot be covered on each other's benefit coverage.

Benefit Details	Plan/Option Information	Take Action
Dependent Day Care Flexible Spending Account (FSA)	You have the option each Annual Enrollment to elect to contribute to the Dependent Day Care FSA. Between $150-$5,000 per year. FSA limits are determined by the IRS and are subject to change for 2022. This is a employee-paid plan.	**Enroll each annual enrollment!** Contribution elections do not carry over into the new year.
Dependent Eligibility	Adding a dependent to one or more of your Health or Welfare plans.	If you are adding a dependent to any of your coverages during Annual Enrollment, your dependent(s) will not be eligible for coverage until you have provided documentation that confirms their eligibility under the Plan. 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.
Employee Assistance Plan (EAP)	You and your household family members are eligible for the Optum Employee Assistance Program (EAP). • 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.	Receive confidential support, 24/7, by calling 866-270-0033 or visit the EAP page on the **Intranet**.

Benefit Details	Plan/Option Information	Take Action
Health Care Flexible Spending Account (FSA)	You have the option each Annual Enrollment to elect to contribute to the Health Care FSA. Between $150-$2,750 per year. FSA limits are determined by the IRS and are subject to change for 2022. This is an employee-paid plan. **Note:** If you enroll in the HDHP with Optional HSA and elect an FSA, you will be automatically enrolled in the Limited Purpose FSA which covers eligible out-of-pocket dental and vision care expenses. Medical and prescription drug expenses are not eligible for reimbursement. Elect to contribute in a Health Savings Account (HSA) for eligible medical expense reimbursement.	**Enroll each annual enrollment!** Contribution elections do not carry over into the new year.
Health Savings Account (HSA)	You have the option each Annual Enrollment to elect to contribute to a Health Savings Account (HSA) when enrolling with the HDHP medical option. You may choose to establish your HSA with any financial institution. However, we partner with Optum Bank to allow your contributions set up as pre-tax through payroll bi-weekly deductions. The contribution limit is $3,650 for employee and $7,300 for Employee + One or more enrolled under the HDHP medical option. The catch-up contribution limit for age 55 and older remains $1,000. **Note:** If you enroll in the HDHP and elect an FSA, you will be automatically enrolled in the Limited Purpose FSA which covers eligible out-of-pocket dental and vision care expenses. Medical and prescription drug expenses are not eligible for reimbursement. Elect to contribute in a Health Savings Account (HSA) for eligible medical expense reimbursement.	**Enroll each annual enrollment!** If you contribute in the HSA through Optum Bank, payroll contributions will occur each pay period and will be administered through Optum Bank. • Contribution elections do not carry over into the new year. • Optum Bank must first approve (vet) your account before your account can be set up and contributions deposited. You may be requested to provide further documentation, e.g., current driver's license/ Identification Card/ Social Security Card and a recent bill to open your account. A welcome kit and debit card will be sent shortly after you are successfully enrolled and your payroll contributions will begin. **Note:** Due to IRS regulations, you must use a physical mailing address. Use of a PO Box as your mailing address is prohibited.

Benefit Details	Plan/Option Information	Take Action
Imputed Income	Imputed Income is income that the IRS requires you to be taxed on in certain circumstances as noted below: • **Your Company-paid basic life insurance is over $50,000.** This is listed as GROUP TERM LIFE INS TXBLE under the imputed income section of your paystub located on the left-hand side. • **Your Company-paid Short-Term Disability enrollment election is Post-Tax.** This is listed as STD BENEFIT under the imputed income section of your paystub located on the left-hand side. • **You are covering your Domestic Partner or your Domestic Partner's child/ren under the Medical/Prescription Drug, Dental and/or Vision plan.** This is listed as HEALTHCARE IMPUTED INCOME under the imputed income section of your paystub located on the left-hand side. Domestic Partners (Domestic Partner) are not considered Spouses under the Internal Revenue Code (IRC). Unless the Domestic Partner otherwise qualifies as a tax dependent under the Internal Revenue Code, he or she may not receive tax-free benefits from employer benefit plans. • **You receive Wellness rewards via gift card (calculated each quarter).** This is listed as WELLNESS REWARD under the imputed income section of your paystub located on the left-hand side. • **Your Company-paid Incentive Award based on a recognition** - e.g., exceeding sales goal, Milestone Anniversary such as 20, 30, 40 years of service, etc. This is listed as IMP – INCENTIVE AWARDS under the imputed income section of your paystub located on the left-hand side.	If any of the circumstances apply to you, please make sure you review your bi-weekly paychecks. Calculations of imputed income is based on the effective date and may adjust your taxable amount as a lump sum if the effective date is retroactive. The imputed income calculation is otherwise processed bi-weekly.
Basic Life Insurance	Company-paid. Coverage may increase throughout the year in as a result in a change in pay.	Any prior beneficiaries listed on the Lumen Health and Life Service Center at Alight will transition to the new administrator, the Lumen Health and Life Service Center at Businessolver. If you didn't have a beneficiary on file, you will be asked to provide beneficiary information during the enrollment process. The Service Center is the record keeper of beneficiary designations. Refer to the Life Insurance and AD&D SPD on the **Intranet** for Facility of Payment to find out what happens when no beneficiaries are on file.
Life Insurance • Supplemental – Employee – Spouse/Domestic Partner – Child/ren	Supplemental life insurance coverage and Coverage and benefit cost for supplemental life coverages may increase throughout the year in certain scenarios (for example, if you have a change in pay or change age bracket). Age brackets are updated every 5 years, e.g., 30, 35, 40, 45, etc. Refer to the Life Insurance and AD&D SPD on the **Intranet**.	Any prior beneficiaries listed on the Lumen Health and Life Service Center at Alight will transition to the new administrator, the Lumen Health and Life Service Center at Businessolver. If you didn't have a beneficiary on file, you will be asked to provide beneficiary information during the enrollment process. The Service Center is the record keeper of beneficiary designations. Refer to the Life Insurance and AD&D SPD on the **Intranet** for Facility of Payment to find out what happens when no beneficiaries are on file.

Benefit Details	Plan/Option Information	Take Action
Basic Long-Term Disability	You are eligible for coverage after completing one year of service. The basic LTD plan is Company-paid. **Note:** Part-time Non-Union employees will become eligible effective Jan. 1, 2022. Incidental and, Incidental and Temporary employees are not eligible to participate.	No action is required as you will be automatically enrolled based on the eligibility waiting period. You will receive notification from the Service Center once you meet your one year of service.
Supplemental Long-Term Disability	The Supplemental LTD option is employee-paid and provides additional LTD coverage. You are eligible to elect coverage during the first Annual Enrollment after you have completed one year of service. **Note:** Part-time Non-Union employees will become eligible effective Jan. 1, 2022, Incidental and Temporary employees are not eligible to participate.	If you are eligible for Supplemental LTD for the first time and do not enroll but decide to elect during a subsequent Annual Enrollment, you will be required to complete the Statement of Health/Evidence of Insurability (EOI) form and our vendor will determine if you qualify for this benefit. Refer to the LTD Summary Plan Description (SPD) available on the **Intranet**.
Short-Term Disability	Full-time employees are eligible for tax treatment election on the first day following one year of continuous service. **Note:** Part-time Non-Union employees will become eligible effective Jan. 1, 2022, Incidental and Temporary employees are not eligible to participate.	We provide a tax treatment option to have your benefit paid on a pre-or post-tax basis. If you elect "pre-tax", your STD benefit would be taxed. If you elect "post-tax", your STD benefit would not be taxed; however imputed income will be calculated. **Note:** Some unions don't allow an employee to make a tax treatment election for a tax election. Please refer to your respective Collective Bargaining Agreement (CBA) for more information. If you do not make any changes, your current enrollment election will continue, if applicable. Changes to this tax treatment election can only be made during Annual Enrollment. Refer to the STD Summary Plan Description available on the **Intranet**.
Survivor Benefit	The Survivor Benefit Plan will pay your payee six months (6) of your base pay in the unlikely event of your death as an active Full-time Non-Union employee. **New in 2022:** You will no longer need to add or update your payee (designee) during Annual Enrollment.	Refer to the Survivor Benefit Policy available on the **Intranet** for more information. **Note:** A payee will be subject to the verification process. If you have any questions, please contact the Service Center.
Voluntary Lifestyle Benefits* * These are not Company-Sponsored ERISA plans.	Refer to the Voluntary Lifestyle Benefits section of this guide for further information.	Visit **lumen.com/voluntarybenefits** to learn about voluntary lifestyle benefits. Electing voluntary lifestyle benefits is through a separate enrollment platform.

Miscellaneous Reminders

Benefit Details	Plan/Option Information	Take Action
Medical Benefit Costs	The amount you pay for your medical coverage is determined by your base pay, the medical plan elected, coverage level and tobacco use. Refer to the Tobacco-Free Discount details within this guide. If your base pay increases or decreases during the year, you may see your medical costs increase or decrease. Similarly if your tobacco use changes during the year, or the number of dependents changes, these events should be reported to the Service Center and will affect your cost accordingly. Pay period 1 includes 2022 health, life, disability (imputed income calculated when electing STD post-tax election), FSA and HSA premium deductions if applicable.	Refer to the **Benefits and Payroll** schedule on the **Intranet**, or the Health and Life website. Any questions related to benefit costs should go to **lumen.com/healthandlife**. Please do not contact the Payroll department or submit a ticket through HRconnect, as they will be unable to assist you with benefit cost questions. Be sure to verify your payroll deductions are correct each pay check. **Please Note:** There is a June 30, 2022, deadline to dispute any deductions you believe to be inaccurate retroactive to Jan. 1, 2022.
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, there may be an impact on which medical plan option you choose. You can use the tools below to estimate your costs. **Bind Health Plan:** Bind provides medications with a copay instead of charging a deductible and coinsurance, dependent on the type and tier of the medication. Bind does not have a deductible and, therefore, starts helping you pay for your prescriptions on the first fill. With Bind, all prescriptions have a set price. You can calculate the price of your upcoming prescriptions or the total of what you may fill throughout the course of the plan year. If you want an overview of how the Bind Health Plan works, visit **lumen.com/bind** to walk you through how this plan can best work for you. 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. **UnitedHealthcare Options:** To reduce costs and make filling medications more convenient, maintenance medications for conditions such as diabetes, cholesterol and high blood pressure **must be** filled by mail order. You can fill your prescription up to a maximum of 2 times at a retail pharmacy. After that, the prescription will not be covered, and you will pay the full retail price. If you are currently enrolled in a UHC medical plan option, you can refer to the pricing tool on **myuhc.com**. **Note:** Whichever medical plan option you elect, you cannot opt-out of the prescription drug benefit, including mail order (UHC only). The Plan Administrator for prescription drug benefits is OptumRx.
ZIP Code	Medical provider networks are determined by ZIP code area, and those ZIP codes are reviewed each Annual Enrollment as providers go in- and out-of-network.	Be sure to review the medical benefit option available to you during the Annual Enrollment enrollment process as options may change (based on your address on file).

Helpful Resources

When you need more detailed information about Plan specifics, review your SPDs and SMMs located on the **Intranet**, or the Health and Life website. If you would like a paper copy of these materials, contact the Service Center. Please be advised that mailing time can take up to two weeks.

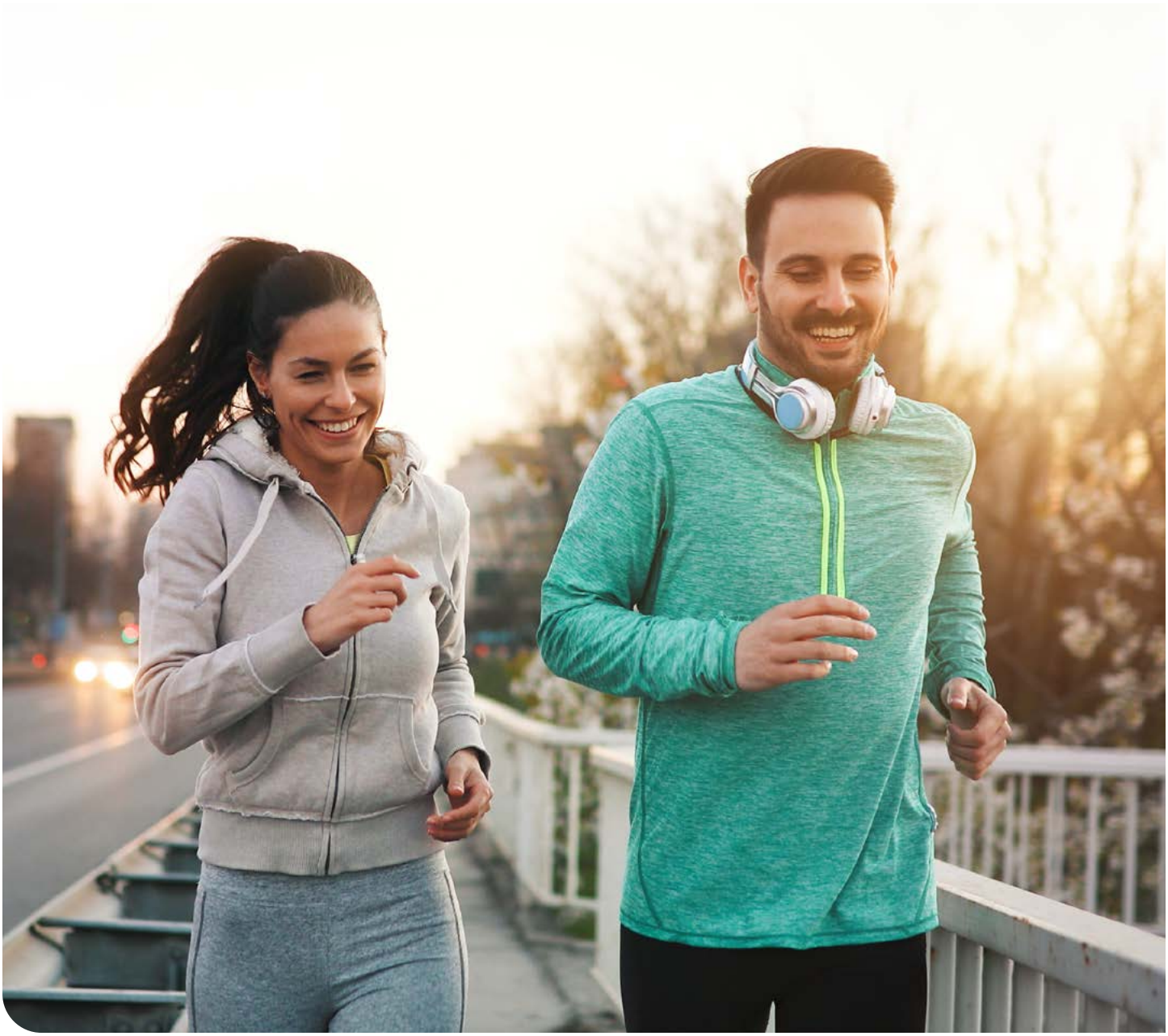
Benefit Option	Phone	Online
	Health Care	
Health and Life Service Center	**833-925-0487** **317-671-8494** (International callers) Mon-Fri, 7 a.m. - 7 p.m. (CST) (During Annual Enrollment, open to 8 p.m. (CST))	**lumen.com/bschealthandlife** (during Annual Enrollment) **lumen.com/healthandlife** (effective 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
	Blue Cross/Blue Shield: Hawaii Medical Services Association (HMSA) **800-776-4672**	**HMSA: hmsa.com**
Flexible Spending Accounts	**UnitedHealthcare: 877-311-7849** **Group Number:** 199383	**myuhc.com** Search: **UHC App**, available for free in the App Store and Google Play
Optum Bank	**Optum Bank: 866-234-8913**	**optumbank.com/resources** Search: **Optum Bank App**, available for Free in the App Store and Google Play
Maternity Support Program	**Bind:** **833-576-6519** M-F 6:00 a.m. - 9:00 p.m., CST **UnitedHealthcare**: **800-842-1219**	**mybind.com** **UnitedHealthcare: myuhc.com** Search: **UHC App**, available for Free in the App Store and Google Play

Benefit Option	Phone	Online
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:** • MDLive: **888-632-2738** • UHC Virtual Care Services	**patient.doctorondemand.com** **lumen.com/MDLive** Search: **MDLive**, available for free in the App Store and Google Play **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**	**metlife.com/benefits**
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
Life Insurance & Disability		
Life, Accident, & Business Travel Accident (BTA)	**Service Center: 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))	**lumen.com/bschealthandlife** (during Annual Enrollment), **lumen.com/healthandlife** (effective Jan. 1, 2022)
Short-Term Disability	**Sedgwick: 844-223-7153**	**lumen.com/disability**
Long-Term Disability	**The Standard: 855-290-9480**	N/A
Retirement		
401(k) Savings Plan	**Retirement Service Center:** **877-379-0118**	**lumen.com/401k**
Combined Pension Plan	**Service Center: 800-729-7526**, Option 1, then Option 3	**lumen.com/pension**
Wellness		
Employee Assistance Program	**Optum: 866-270-0033**	**lumen.com/EAP**
Real Appeal	**844-344-7325**	**lumen.com/realappeal**
Well Connected, Rally, and Coaching Programs (Prevention and Well Being)	**877-818-5826**	**lumen.com/wellconnected** Search: **Rally Coach™** available for Free in the App Store and Google Play
Fitness Reimbursement Program	**N/A**	Access on the **Intranet**

Benefit Option	Phone	Online
	Voluntary Lifestyle Benefits	
Voluntary Lifestyle Benefits	**Mercer: 800-380-0378** Mon-Fri, 8 a.m. - 5 p.m. (CST)	lumen.com/voluntarybenefits

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

Honesty is the Best Policy

As an employee, you are held to the Code of Conduct's standard of honesty and truthfulness. Falsifying or omitting information when enrolling for coverage under the Plan will be cause for disciplinary action, up to and including termination. If you have questions about whether your responses in the enrollment process are accurate, please call the Service Center.

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.

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 the **Intranet** and **lumen.com/bschealthandlife**, 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 **Intranet** for details about eligibility for coverage or call the Claims Administrator - limitations may apply including, but not limited to, being actively at work in order to be eligible for coverage. You understand that it is your responsibility to confirm your eligibility to enroll in a benefit option, including voluntary or supplemental coverages; enrolling in and paying for coverage for which you are ineligible will not entitle you to Benefits; you understand that it is your responsibility to terminate benefit coverage once you or your dependent(s) become ineligible, for example, due to death of a divorce. This excludes dependents who turn age 26, as they are automatically removed from coverage.

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

Wellness Program Notice

Lumen's Well Connected program is a voluntary wellness program available to all employees and eligible Spouses. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health survey through Rally, our wellness platform, that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., diabetes, heart disease, or COPD). You will also be asked to complete a biometric screening, which will include a blood test for cardiac disease or diabetes. You are not required to complete the health survey or to participate in the biometric screening or other medical examinations.

However, employees and eligible Spouses who choose to participate in the wellness program will receive an incentive in the form of gift cards or a deposit into a medical account for completing both the health survey and biometric screening. Although you are not required to complete the health survey or participate in the biometric screening, only those who do so will receive the $150 incentive.

Additional incentives of up to $450 total may be available for employees who participate in certain health-related activities such as preventive screenings, walking activities, or health coaching. **If you are unable to participate in any of the health-related activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Rally at 877-818-5826.**

The information from your health survey and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as nurse engagement or the Total Health Immersion Program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Lumen may use aggregate information it collects to design a program based on identified health risks in the workplace, Rally will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) a registered nurse or a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

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 **Intranet** 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.

Working After Retirement

What happens to your benefits if you return to work directly for the Company as an active employee or work for a supplier on assignment to the Company after you retire or leave employment?

If you are eligible for retiree health care or life insurance from the Company, refer to the applicable section below to see how your retiree benefits may be impacted.

Note: If you had VEBA Life Insurance, that coverage will not be impacted.

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

If you return to work for a supplier on assignment to the Company, you are not eligible to continue your retiree health care benefits, so this means that while you are working for the supplier, your retiree health care benefits will be suspended. You will, however, be offered the opportunity to continue your retiree medical and/or dental options under COBRA. Your retiree basic and supplemental life coverage, if applicable, will continue under the terms of the Life Insurance Plan ("the Plan"). In addition, please be advised that as a worker for a supplier or Company contractor, you are not eligible for active employee health care benefits. Retiree health care benefits are reinstated once your work with the supplier/contractor for the Company has ended. You will need to call the Service Center to have your benefits reinstated.

Once your employment or assignment ends, you may resume your retiree health care, basic and supplemental life insurance coverage, if applicable, in accordance with terms of the Plan by calling the Service Center at **833-925-0487**. If you returned to work for a supplier on assignment to the Company, the Company will validate that your assignment has ended before you will be allowed to resume your retiree health care coverage.

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

If you voluntarily elect to drop coverage

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

California Department of Managed Health Care Notification

Grievance Process and Independent Medical Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your behavioral health care service plan, you should first telephone your plan at **800-999-9585** or 711 for TTY (at operator request say "1-800-999-9585") and use the plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance.

You may also be eligible for an independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

- The department also has a toll-free telephone number (**888-466-2219**) and a TDD line (**877-688-9891**) for the hearing and speech impaired.
- The department's internet website: **dmhc.ca.gov** has compliant forms IMR application forms and instructions online.

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