Amazing People. Amazing Benefits. Find Your Fit.

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

2022 Annual Enrollment Guide

Qwest Enhanced Retirement Offer (ERO '92) for Retirees,
Including Inactive and COBRA participants.

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Welcome to Annual Enrollment

Find Your Fit

Annual Enrollment is your opportunity to find the plans that are right for you and your eligible dependent(s). Please review this guide in its entirety.

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

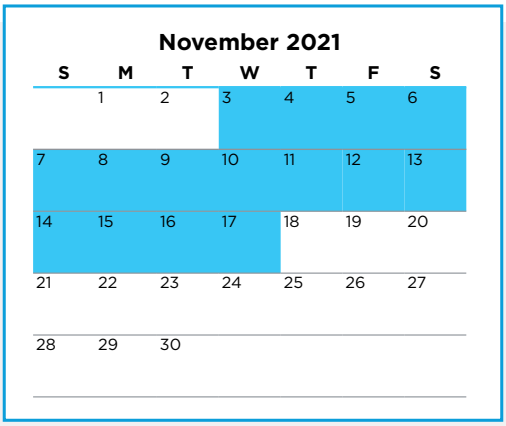
This guide pertains to BOTH non-Medicare eligible and Medicare eligible participants and their dependents. If you make changes during Annual Enrollment, your new coverage will begin on the first day of the new calendar year. (However, if enrolling in the UnitedHealthcare (UHC) Group Medicare Advantage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

COBRA Participants

As a COBRA participant, coverage is limited to medical and/or, dental coverage, as applicable. COBRA rates have changed. Not all provisions of this guide apply to COBRA participants, please refer to your Enrollment Worksheet (EWS) that you received with this guide.

Note:

- **Some references and benefit options in this document apply only to ERO '92 Retirees. For more information, refer to the Health and Life website at lumen.com/bschealthbenefits (during Annual Enrollment) or lumen.com/healthbenefits (effective Jan. 1, 2022) or** contact the Lumen Health and Life Service Center at Businessolver.
- Refer to the Helpful Resources page in this guide or your Summary Plan Description (SPD) for further details.
- The SPDs are available on the Health and Life website or by requesting a copy through the Service Center. Please allow time for mailing.



Note: Annual Enrollment dates are highlighted above.

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.

What's New for 2022

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

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

Website and Phone Number Updates for the Service Center

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

Update your Communication Preference on the Service Center Website

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

Billing and Payments

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

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

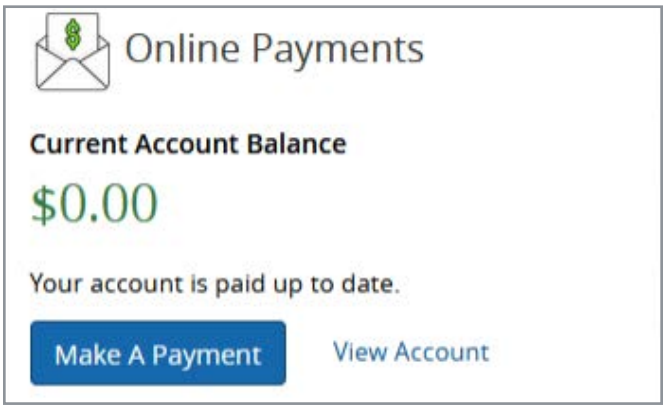
  Bussinessolver.com, Inc.
  PO Box 850512
  Minneapolis, MN 55485-0512

- **Pension Deduction (if applicable):** If your premiums are deducted from your pension check, no action is required, and deductions will continue. If you wish to set up a pension deduction in the future, please contact the Service Center at 833-925-0487.
- **One-Time or Recurring Payments Note:** There is a $2.00 convenience fee each time to process a one-time payment.

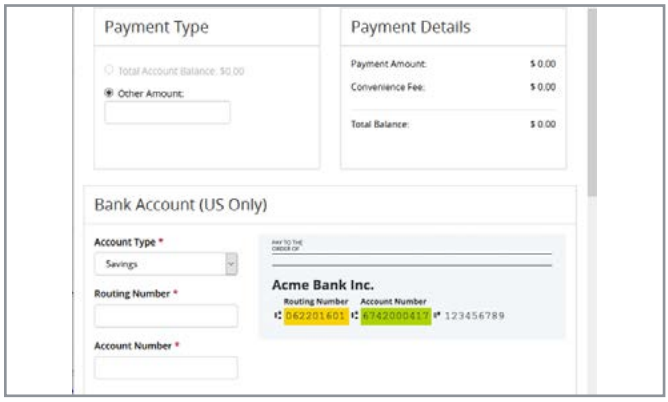
NEW - Please use the following instructions to make a one-time or recurring payment. If you previously had recurring payments in 2021, you will be required to follow these steps to establish recurring payments for 2022.

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

1.



2.



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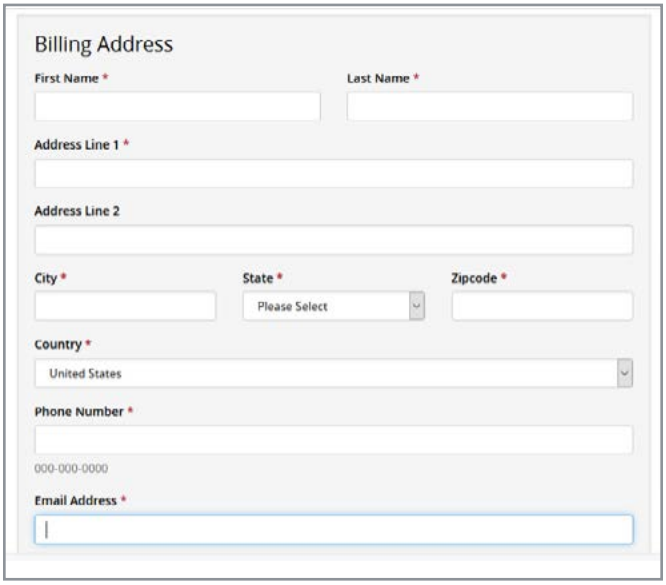

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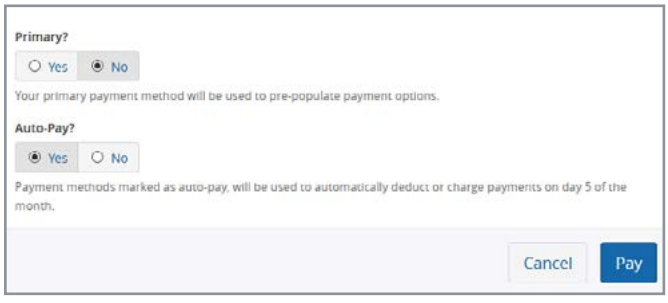


If you want to set up recurring auto payments, answer "Yes" to the last question (Auto-Pay?). If you answer "No" your payment will be considered a one-time payment, and you will be subject to the $2.00 convenience fee. Contact the Service Center at 833-925-0487 if you need assistance.

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 added to 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. Upon approval, Plan coverage for your newly eligible dependents will become effective Jan. 1, 2022, or the applicable QLE effective date.

Health Reimbursement Account (HRA) Plan

Please read below for claim submission updates and deadlines

2022

If you are eligible for an HRA, you will receive a "Welcome Guide" from MyChoice Accounts in the mail in Jan. 2022 that explains how to access reimbursement from your HRA and how to submit claims. You will purchase the individual Medicare and/or prescription drug policy directly from the insurance carrier(s) of your choice and pay the insurance premium directly to the carrier.

2021

If you were were eligible for an HRA in 2021, you will have access to review and submit your claims to the Lumen Health and Life Service Center at Alight. Paper claims must be postmarked and submitted to the YSA address below by Dec. 31, 2021, and received by Jan. 7, 2022, or you can upload them at **lumen.com/healthbenefits**. If you are unable to submit claims by that date, you will need to send them to YSA at the address below. Please keep a copy of your claims for your record.

- **Your Spending Account**
  P.O. Box 64012
  The Woodlands, TX 77387-4012
- **866-935-5011 (Phone)**

If your claims are submitted **after** Dec. 31, 2021, please submit them to the Lumen Health and Life Service Center at Businessolver. Claims must be postmarked, emailed or faxed by Dec. 31, 2022, to:

- **MyChoice Accounts, MSC 345475**
  P.O. Box 105168
  Atlanta, GA
  30348-5168
- **claims@mychoiceaccounts.com**
- **855-883-8542 (Fax)**

2020

If you have claims to submit for processing, online claim reimbursements need to be submitted to **lumen.com/healthbenefits** by Dec. 20, 2021, in order to be processed. Paper claims must be postmarked by Dec. 31, 2021, and received by the end of the day on Jan. 7, 2022, in order for YSA to process them. Submit them to the following address:

- **Your Spending Account**
  P.O. Box 64012
  The Woodlands, TX 77387-4012
- **866-935-5011 (Phone)**

If your claims are submitted **after** Dec. 31, 2021, please submit them to the Lumen Health and Life Service Center at Businessolver. Claims must be postmarked, emailed or faxed by Dec. 31, 2022, to:

- **MyChoice Accounts, MSC 345475**
  P.O. Box 105168
  Atlanta, GA
  30348-5168
- **claims@mychoiceaccounts.com**
- **855-883-8542 (Fax)**

Updated mailing address and fax number for the Service Center for Medicare Part-B and/or Income-Related Monthly Adjustment Amount (IRMAA) Reimbursement

If you are receiving Medicare Part B and/or IRMAA reimbursement, the same amount you received will carry over to 2022, if applicable. If your Medicare Part B and/or IRMAA premium has changed for 2022, you will need to notify the Service Center at the updated address or fax number as noted below. Please refer to the Enrollment Reminders section of this guide for additional information.

Service Center
Businessolver.com, Inc.
P.O. Box 850552
Minneapolis, MN 55485-0552
Fax: 515-273-1545

Voluntary Lifestyle Benefits

PerkSpot – A one-stop online shop with exclusive discounts that help you save money on many of your favorite national and local merchants. It's completely free and optimized for use on any device. Access thousands of discounts in over 25 different categories, updated daily.

You can start using PerkSpot at any time by visiting **lumen.com/retireeperks**. For questions, call **800-380-0378**.

Legal Services – Provides easy access to professional legal counsel for many legal matters with no additional fee. Coverage typically covers a wide range of personal legal matters such as: wills and estate planning, buying or selling a home, debt collection, traffic tickets, family law and more.

You can enroll in Legal Services during Annual Enrollment, Nov 3-17, by visiting **retirees.legalplans.com/9904598**. For questions, call **800-821-6400**.

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. This form verifies your health insurance for tax purposes.

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 **lumen.com/healthbenefits** or call **833-925-0487** to make your selection.

Enrollment Reminders

Qualified Life Event (QLE)

If you experience a QLE in 2022 such as marriage, death, divorce, adoption or birth, or losing other coverage, you can go to the health and life website at **lumen.com/healthbenefits** or contact the Service Center at **833-925-0487** within 45 days of the event in order to change your coverage elections. Be sure to gather your dependent(s) Social Security numbers and birthdates before you start the enrollment process so you are prepared to enter them into the system or provide them to the representative. You will be required to go through the Dependent Verification process if you add a new dependent who does not currently have Company coverage. If you experience a QLE prior to Jan. 1, 2021, you will need to also contact the Lumen Health and Life Service Center at Alight at **866-935-5011.**

Dependent Social Security numbers required

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

Medicare-eligible and/or non-Medicare-eligible

If you and your dependent(s) are Medicare eligible, you must enroll in the same benefit plan option. If you were enrolled in the UnitedHealth Group Medicare Advantage PPO Plan in 2021 and you are not changing benefit plan options, you will not be required to re-enroll. Therefore, no action is required and you can keep your Enrollment Worksheet (included with this Guide) as your confirmation statement for 2022. If you are enrolling in an individual policy outside of the Company for the HRA benefit option, you must complete that carrier's enrollment form and follow their process.

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

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

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

Medicare Part-B

If you are receiving Medicare Part B reimbursement, the same amount you received in 2021 will carry over to 2022. If your Medicare Part B premium has changed for 2022, you will need to notify the Service Center by providing a copy of the letter from the Social Security Administration with your updated amount, postmarked by March 31, 2022, for the updated reimbursement to be retroactive to Jan. 1, 2022. If your letter is postmarked after March 31, 2022, the updated reimbursement amount will begin the first of the following month after the postmarked date. Notifications can be mailed or faxed to:

Service Center
Businessolver.com, Inc.
P.O. Box 850552
Minneapolis, MN 55485-0552
Fax: 515-273-1545

IRMAA

If you are enrolled in the UHC Group Medicare Advantage PPO Plan and are receiving reimbursement for the Income-Related Monthly Adjustment Amount (IRMAA) related to Medicare Part D, the same amount you received in 2021 will carry over to 2022.

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

If your Medicare Part D premium has changed or you are a new participant in this Plan, you will need to notify the Service Center by providing a copy of the letter from the Social Security Administration with your amount by March 31, 2022, for the reimbursement to be retroactive to Jan. 1, 2022. If your letter is postmarked after March 31, 2022, the reimbursement amount will begin the first of the following month after the postmarked date. Notifications can be mailed or faxed to:

Service Center
Businessolver.com, Inc.
P.O. Box 850552
Minneapolis, MN 55485-0552
Fax: 515-273-1545

Stay up-to-date with the Retiree Benefit News

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

More to Know About Medicare

If you and/or your dependent(s) are eligible for Medicare, please review the following information carefully.

Medicare Part A – Hospital Insurance

- This covers in-patient care in a hospital, skilled nursing facility care, nursing home care (inpatient care in a skilled nursing facility that's not custodial or long-term care), certain home health services and hospice care.
- Generally, it is available at no cost to eligible participants and is paid for by a portion of Social Security taxes. You are automatically enrolled when you and or your dependent(s) turn age 65.

Medicare Part B – Medical Insurance

Part B covers two types of services: Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice. Part B also covers preventive services to prevent illness or detect it at an early stage when treatment is most likely to work best.

Part B covers things like:

- Clinical research, ambulance services, durable medical equipment, Mental health (inpatient, outpatient, and partial hospitalization) and limited outpatient prescription drugs.
- There is a cost for Medicare Part B since the health plan requires coordination with Medicare Part B. If you do not enroll in Medicare Part B, your benefits, if any, will be reduced, and you will be responsible for paying your healthcare expenses.

A delay in enrollment in Medicare Part B could also result in ongoing penalties for the cost of Medicare Part B. As a Pre-1991 Retiree, the Retiree and Inactive Health Plan will reimburse the premium you pay for this coverage for you and your dependents, excluding Class II dependents.

Medicare Part D – Prescription Drug Coverage

This covers the cost of certain prescription drugs. Details are available in the Notice of Creditable Coverage the Company provides each year. You can refer to the Medical and Prescription Drug overview in this guide for more information.

Important Note:

- **If you enroll in the Guaranteed Coverage benefit option or UnitedHealthcare Group Medicare Advantage PPO Plan, you do not need to enroll in a separate Medicare Part D plan because prescription drug coverage in included in these benefit options, as defined by the Plan.**
- **If you elect the HRA benefit option, you may need to enroll in a Medicare Part D plan, depending on which type of individual medical policy you elect on your own.**

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

Medical Options for Medicare Eligible Participants

Enrollment in Medicare Parts A and B are required. If you and your dependents are Medicare eligible, you must enroll in the same benefit plan option.

The Medical Plan (Guaranteed Coverage Commitment Plan)

- The Medical Plan pays a substantial share of the costs of the Hospital, surgical and medical care you and your family receive each year.

Health Reimbursement Account (HRA) Plan Option Combined with an Individual Medicare Policy

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

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

UnitedHealthcare Group Medicare Advantage Preferred Provider Option (MA PPO)

- You can see any provider (in or out-of-network) that participates in Medicare and accepts the plan, at the same cost.
- 100% coverage for preventive services.
- Care and disease management programs (e.g., diabetes, heart failure, and more)
- UnitedHealthcare House Calls are designed to complement your doctor's care. A licensed and knowledgeable health care practitioner will review your health history and current medications, perform a health screening, identify risks and provide health education in the comfort of your home.
- NurseLine – Registered nurses answer your call 24 hours a day, seven days a week.
- Renew Active (Previously Silver Sneakers) – Free gym memberships, brain games, cooking classes, etc.

To enroll in this plan, please provide your Medicare Beneficiary Identification (MBI) number to the Service Center. This can be found on your red, white, and blue Medicare ID card. Contact UnitedHealthcare for additional information regarding these benefits, services, and offerings at **877-866-7313**.

Note: If you and your dependent(s) are enrolling in this Plan and one or both applications are denied by Medicare, you will both return to the coverage you had under the Company Medical Plan, The Medical Plan (Guaranteed Coverage Commitment Plan).

Company Plan Options

Company Plan Option (for non-Medicare and Medicare eligible participants)

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

Point of Service (POS)

In-network medical/prescription drug coverage

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

No-network medical/prescription drug coverage

This is not an option you can choose to elect, you will automatically be placed in this option if you live in an area where there is no UHC network of doctors, you may be eligible for the No-Network Plan benefit option administered by UHC.

- Preventive care services (including routine physical exams) are covered at 100 percent with no deductible. For all other services, you will be responsible for paying a deductible before the Plan starts paying for services.
- Prescription drug coverage is administered by OptumRx, a UnitedHealthcare Group company.
- Discounts from network providers for certain services may be available to you. Contact UHC. for more information.
- You also share the cost of services by paying coinsurance when you receive care, up to an out-of-pocket maximum. The benefits you receive are based on "eligible expenses," as determined by UHC; you are responsible for costs in excess of the eligible expenses.
- If No-network coverage is your only medical/prescription drug benefit option based on the medical options listed on your Enrollment Worksheet that was included with this Guide, you may request to opt-in to the POS option if you can verify that there are UHC Choice Plus network providers in your area. Contact the Service Center at **833-925-0487**.

Note: Non-Medicare-eligible retirees retirees and non-medicare-eligible dependents can only enroll in the applicable Guaranteed Coverage Option.

Medical Overview

Non-Medicare eligible retirees and non-medicare eligible dependents can only enroll in the applicable Guaranteed Coverage Option, Point of Service.

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

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

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

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

Medical Overview

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

	ERO '92 Retiree Plan for MN, ND, WI (United Healthcare Choice Plus Plan)	
	In-network costs	**Out-of-network costs**
Annual Out-of-Pocket Maximum (Medical Only)	$1,000	$3,000
Deductible	$0	$300
Coordination of Benefits with Medicare	Claims must be submitted to Medicare Part A or B first, then to UHC for Coordination with the ERO '92 Plan	
Medical Benefits		
Primary Care/Specialist Physician Office Visit	$10	20% after deductible
Preventive Services	$0	100% covered
Emergency	$40	$40
Hospital Copay Per Admit	$0	20% after deductible
Outpatient Services	$0	20% after deductible
Additional Benefits and Programs not Covered by Medicare		
Hearing Aids	Plan pays up to $300 (every three years)	
NurseLine℠	24 hours a day, seven days a week	

Medical Overview

	ERO '92 Retiree Plan for MN, ND, WI (United Healthcare Choice Plus Plan)	
	In-network costs	**Out-of-network costs**
Vision Services – Eye Exam	Not Covered	
Routine Eyeglass Allowance (every two years)		
Fitness Program		
Prescription Drug Benefits Retail (30-day supply)		
Tier 1 (Preferred Generic)	$8	Not Covered
Tier 2 (Preferred Brand & Non-Preferred Generic)	$12	
Tier 3 (Non-Preferred Brand)	$12	
Tier 4 (Specialty)	$12	
Coverage Gap	Full Coverage	
Prescription Drug Benefits Retail (90-day supply)		
Tier 1 (Preferred Generic)	$5	Not Covered
Tier 2 (Preferred Brand & Non-Preferred Generic)	$5	
Tier 3 (Non-Preferred Brand)	$5	
Tier 4 (Specialty)	$5	

Dental Overview

Dental Plan Benefit Option

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

It pays to use network Dentists

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

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

Here's a Brief Look at How The Dental Plan Benefit Option Pays Benefits

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

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

All Other Services

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

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

To enroll, you will need to log on to the Health and Life website or contact the Service Center. If you are already enrolled and would like to continue your coverage into the new year, no action is required and you can keep your Enrollment Worksheet as your confirmation statement for 2022.

Retiree Life Insurance

Retiree Basic Life Insurance (automatic and Company-paid).

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

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

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

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

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

Important notes if you have Retiree Supplemental Life Insurance

You may cancel or decrease coverage at any time by going to the health and life website at **lumen.com/healthbenefits** or contact the Service Center at **833-925-0487**. The coverage change will be effective the first of the month following your request. You may not re-enroll or increase coverage during your retirement.

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

Beneficiary reminder

Please confirm that you have designated beneficiaries for all of your Company Life Insurance Plan coverage by going to **lumen.com/bschealthbenefits** (during Annual Enrollment) or **lumen.com/healthbenefits** (effective Jan. 1, 2022) or calling the Service Center at **833-925-0487.** Confirm or update your beneficiaries for all applicable plans. 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 Retiree Life Insurance SPD for Facility of Payment to find out what happens when no beneficiaries are on file.

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

Paying for your coverage

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

Your 2021 benefit election will continue in 2022 unless you make a change, reach age 65, or pass away. Refer to the **Billing and Payments** in the **What's New for 2022** section of this guide. Premiums are due on the first day of each

month for the current month's benefit coverage. You can contact the Service Center for payment options such as:

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

Be sure to make timely payments!

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

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

Explore Your Options and Enroll

Note: If you are not making changes or updates to your coverage, No Action is required.

Enrollment checklist

Review:

- Your personal information on the Health and Life website, e.g., email address, mailing address, phone number, communication preference, etc. If you need to update this information, you can do so on the health and life website or by calling the Service Center.

Note: To update your communication preference, this must be done on the Health and Life website.

- Your enrollment options on the Health and Life website. If you don't enroll by Nov. 17, you will be automatically enrolled in the plans and coverage levels listed on your Enrollment Worksheet and displayed on the Health and Life website.

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

Explore your options

Explore the health and life website 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.

Start your Enrollment

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

1. **Mobile Device Enrollment** – Beginning Nov. 3 at 7 a.m. CST. To complete your enrollment, download the **FREE MyChoice™ Mobile App.** for iOS or Android.
   - You will need to set up a username and password. Start at **lumen.com/bschealthbenefits** in your device's browser. Go to **First time here?** And register a username and password and answer a few security questions. Log in using your new username and password.
   - In the app, use your Benefitsolver username and password to sign in. Log in using your Benefitsolver username and password.

2. **Online Enrollment** (use the latest versions of Chrome, Firefox, Safari or MS Edge for the best performance on the Health and Life website) – Beginning Nov. 3 at 7 a.m. CST.
   - You will need to set up a username and password. Start at **lumen.com/bschealthbenefits** in your browser. Go to **First time here?** Enter a username and password and answer a few security questions. Log in using your new username and password.

Click the **Start Here** button to review your personal information.

3. **Phone Enrollment** - Beginning Nov. 3 at 7 a.m. to 8 p.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)*

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 anytime you want to learn more about your benefits or make a change to you coverage (if you experience a Qualifying Life Event).

Helpful Resources

Benefit Option	Phone	Online
	Health Care	
Service Center • Health and Life Benefit Questions	**833-925-0487** **317-671-8494** (Local DNIS for international callers) Mon-Fri, 7 a.m. - 7 p.m. (CST) During Annual Enrollment, open to 8 p.m. (CST)	**lumen.com/bschealthbenefits** (during Annual Enrollment) **lumen.com/healthbenefits** (effective Jan. 1, 2022) Search: **MyChoice™ Mobile HR App**, available for Free in the App Store and Google Play
Health Care Advocacy Services • For issues with your Health Care claims(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** (Local DNIS for international callers) Mon-Fri, 7 a.m. - 7 p.m. (CST) During Annual Enrollment, open to 8 p.m. (CST)	**lumen.com/healthbenefits** (effective Jan. 1, 2022)
Retiree Medical (Guaranteed Coverage Options)/Prescription Drug Plans	**UnitedHealthcare: 800-842-1219**	**UnitedHealthcare: myuhc.com** Search: **UHC App**, available for Free in the App Store and Google Play
UnitedHealthcare Group Medicare Advantage Preferred Provider Option (PPO) Plan	**877-886-7313** **Do not enroll through this number.** Enrollment is completed through the Service Center.	
Dental Plan	**MetLife: 866-832-5756**	**metlife.com/mybenefits**
	Retiree Life Insurance	
Life Insurance Administrator	**Metropolitan Life Insurance Company** 200 Park Avenue New York, NY 10166 **800-638-6420**	

Additional services provided by MetLife

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

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

Follow the steps on the next page to update your address and/or phone number.

Change of Address Updates

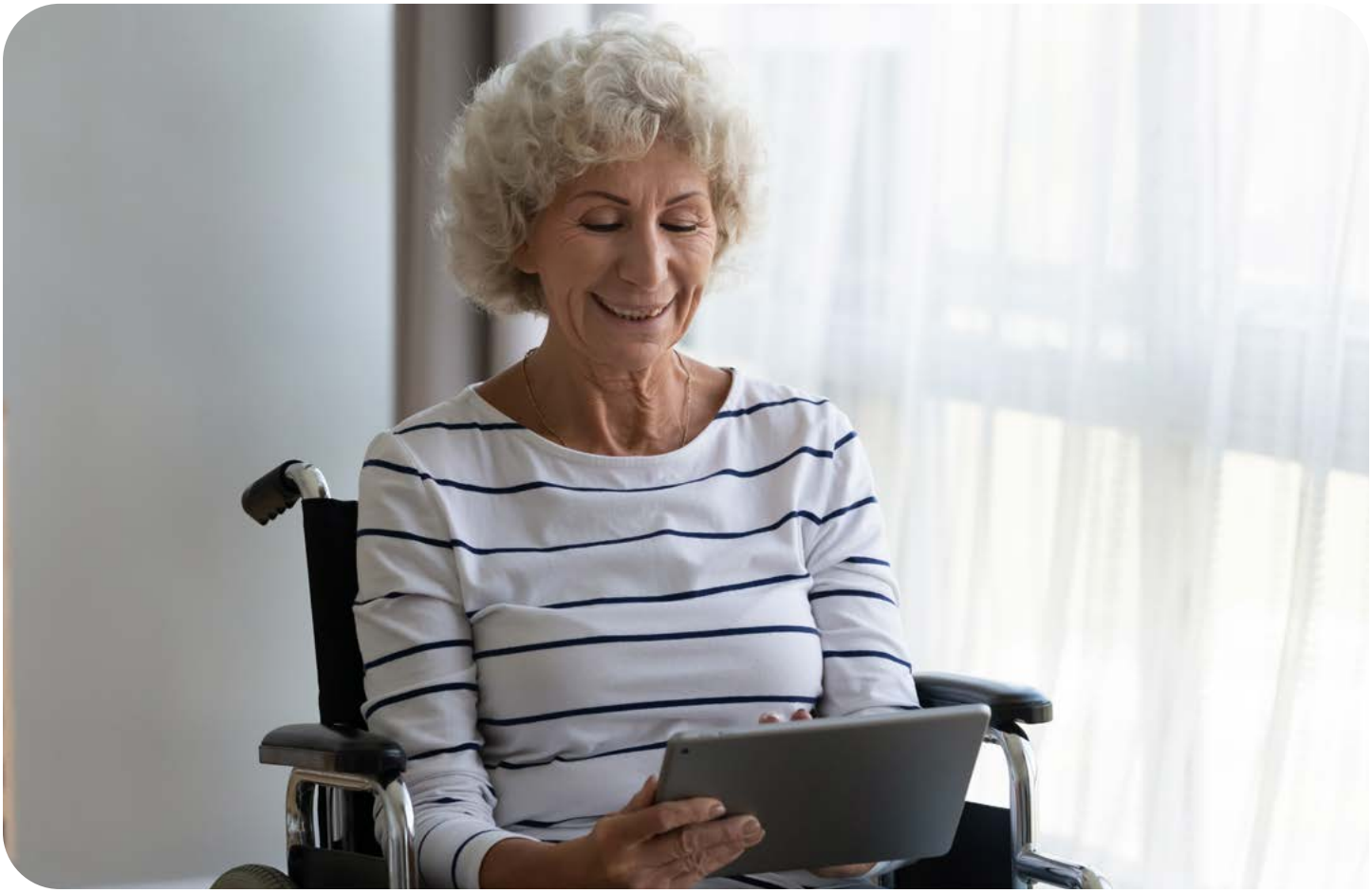
Online

For Health and Life Benefits	For Pension Benefits
lumen.com/bschealthbenefits (during Annual Enrollment) **lumen.com/healthbenefits** (effective Jan. 1, 2022)	**Contact the Lumen Pension Center** Log in to **lumenpension.ehr.com** OR Submit your information in writing to Lumen Pension Service Center DEPT: LUM P.O. Box 981909 El Paso, TX 79998 OR Fax to: **844-286-1281** Your written request must include your full name, last four digits of your Social Security number, complete old address, complete new address, signature and date.

By Phone

For Health and Life Benefits	For Pension Benefits
Contact the Service Center **833-925-0487** (The local DNIS for international callers is **317-671-8494**).	**Contact the Lumen Pension Center** **844-286-1282**

You can review your SPDs and SMM's located at **lumen.com/bschealthbenefits** (during Annual Enrollment) or **lumen.com/healthbenefits** (effective Jan. 1, 2022). You can request a copy by calling the Service Center. Please be advised that mailing time can take up to two weeks.



Important Coverage Rules

Adding dependents during enrollment

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

1. Add your newly eligible dependents during your online enrollment by following the directions or contact the Service Center
2. Coverage for your dependents will become effective Jan. 1, 2022, providing supporting documentation to verify eligibility for your dependent is received timely. You can upload your supporting documentation after you complete your enrollment.

Ending coverage for dependents during annual enrollment

You may remove dependents from your Plan coverage during your online enrollment or by contacting the Service Center.

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

If you have a qualified life event and need to make changes before 2022

If you make changes during Annual Enrollment and have a subsequent change to your coverage before the end of December 2021, because of a QLE (for example, you add a spouse to your coverage), your 2021 changes/ enrollment will not automatically be applied to 2022. **As a result, you will need to update BOTH your 2021 and 2022 coverage by contacting the Service Center at Alight and Businessolver. Refer to the What's Changing section of the guide for more information.**

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

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

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

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

Once your employment or assignment ends, you may resume your retiree health care, basic and supplemental life insurance coverage, if applicable, in accordance with the terms of the Plan by calling the Service Center at **833-925-0487** (The local DNIS for international callers is **317-671-8494**). If you returned to work for a supplier on assignment to the Company will validate that your assignment has ended before you will be allowed to resume your retiree health care coverage. **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).

Legal and Important Required Notices

A note about privacy

Keeping your personal information secure is of primary importance to the Company. That's why we, along with the benefits administrators, have implemented various security measures and policies to help reduce the risk of unauthorized processing or disclosure of your personal information. You can also help by keeping confidential your User ID and password for accessing the Health and Life website. Please keep this information safe and don't share it with anyone. Never use your Social Security number as your password. Together, we can make sure your personal information stays safe and secure. Please be advised that using an email that is not secured may increase your risk of unauthorized disclosure.

Notice of Privacy Practices

You can review and print the complete notice at **lumen.com/healthbenefits**. You may obtain a paper copy upon request by calling the Service Center at **833-925-0487** (The local DNIS for international callers is **317-671-8494**).

This Is a Summary of Material Modifications (SMM)

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

Coverage is not advice

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

The Company's reserved rights

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

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

Right to Amend and/or discontinue and make rules

The Company and its delegate, the Plan Design Committee, each has reserved the right in its sole discretion, to change, modify, discontinue or terminate the Plan and/ or any of the benefits under the Plan and/or contribution levels, with respect to all participants classes, retired or otherwise, and their beneficiaries at any time without prior notice or consultation, subject to applicable law, specific written agreement and the terms of the Plan Document and with respect to the Health Plan, the written agreement specific to Pre-1991 Retirees. The Employee Benefits Committee, as the Plan Administrator, may adopt, at any time, rules and procedures that it determines to be necessary or desirable with respect to the operation of the Plan. The Plan Administrator has the authority, discretion and the right to interpret and resolve any ambiguities in the Plans or any document relating to the Plans.

Notice of "Exempt" Retiree Medical Plan status

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

Important note regarding your Annual Enrollment elections

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

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

Women's Health and Cancer Rights Act

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

Health Insurance Portability and Accountability Act (HIPAA)

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

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

If your spouse/domestic partner or other dependents have special enrollment rights, you may enroll and make changes to your enrollment in any health plan benefit option available to you based upon your home ZIP code and plan service areas within 45 days following the qualifying event. For example, if you have Employee Only coverage in a Company benefit option, and your spouse/ domestic partner loses coverage under his/ her employer's plan and has special enrollment rights, both you and your spouse/domestic partner may enroll in any of the Company benefit options available to you, provided you verify your spouse's/domestic partner's eligibility for the Plan.

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

Note: This is an updated notice.

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility.

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

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

ARIZONA - AHCCCS-KidsCare
Website: **azahcccs.gov/Members/GetCovered/Categories/KidsCare.html**
Phone: 800-654-8713

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

CALIFORNIA - Medi-Cal
Website: **medi-cal.ca.gov/**
Phone: 1-800-541-5555

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

CONNECTICUT - HUSKY Program
Website: **portal.ct.gov/HUSKY**
Phone: 855-626-6632

DELAWARE - Delaware Healthy Children Program
Website: **dhss.delaware.gov/dss/dhcp.html**
Phone: 800-372-2022

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

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

HAWAII - Med Quest
Website: **humanservices.hawaii.gov/mqd/quest-overview/**
Phone: 855-643-1643

IDAHO - Idaho CHIP
Website: **healthandwelfare.idaho.gov/services-programs/medicaid-health/childrens-health-insurance-program-chip**
Phone: 800-926-2588

ILLINOIS - Illinois All Kids
Website: **Ilinois.gov/hfs/MedicalPrograms/AllKids/Pages/default.aspx**
Phone: 866-255-5437

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

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

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

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

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

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

MARYLAND - Maryland Children's Health Program (MCHIP)
Website; **health.maryland.gov/mmcp/chp/pages/home.aspx**
Phone: 855-642-8572

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

MICHIGAN - Michigan MIChild
Website: **michigan.gov/mdhhs/0,5885,7-339-71547_2943_4845_4931---,00.html**
Phone: 888-988-6300

MINNESOTA – Medicaid
Website: **mn.gov/dhs**
Phone: 1-800-657-3739

MISSISSIPPI - Mississippi Children's Health Insurance Program (CHIP)
Website: **medicaid.ms.gov/programs/childrens-health-insurance-program-chip/**
Phone: 800-421-2408

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

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

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

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

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

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

NEW MEXICO – Medicaid
Website: **insurekidsnow.gov/coverage/nm/index.html**
Phone: 877-543-7669

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

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

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

OHIO Medicaid - Healthy Start
Website:**benefits.gov/benefit/1610**
Phone: 800-324-8680

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

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

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

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

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

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

TENNESSEE TennCare – CoverKids
Website: **tn.gov/coverkids.html**
Phone: 855-259-0701

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

UTAH – Medicaid and CHIP
Medicaid Website: **medicaid.utah.gov**
CHIP Website: **health.utah.gov/chip**
Phone: 877-543-7669
VERMONT – Medicaid
Website: **greenmountaincare.org**
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: **coverva.org**
Medicaid Phone: 800-432-5924
CHIP Phone: 855-242-8282
WASHINGTON – Medicaid
Website: **hca.wa.gov**
Phone: 800-562-3022 ext. 15473

WASHINGTON D,C. - DC Medicaid - Healthy Families
Website: **dhcf.dc.gov/service/dc-healthy-families**
Phone: 202-442-5988

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

WISCONSIN – Medicaid and CHIP
Website: **dhs.wisconsin.gov**
Phone: 800-362-3002

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

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

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

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

If You Voluntarily Elect to Drop Coverage

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

Continuation of Coverage

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

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

Qualifying events for spouses/domestic partners or

dependent children include those events above, plus, the covered employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, death of the covered employee, and the loss of dependent status under the plan rules. If a QB chooses to continue group benefits under COBRA, they must timely enroll and make their premium payment by the due date before eligibility is sent to the Plan Administrators. Then, coverage will be reinstated. Thereafter, premiums are due on the first of the month. If premium payments are not received in a timely manner, federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Service Center at **833-925-0487** (The local DNIS for international callers is **317-671-8494**).

Other coverage options

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

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

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

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

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