Amazing People. Amazing Benefits. Find Your Fit.

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

2022 Annual Enrollment Guide

For CenturyLink Retirees with Executive Medical

Including Inactive and COBRA Participants

LUMEN®

Contents

Note:

- Lumen (will be referred to hereafter as "the Company")
- The Lumen Health and Life Service Center (will be referred to hereafter as "the Service Center")

LUMEN®

Welcome to Annual Enrollment

Find Your Fit

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

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

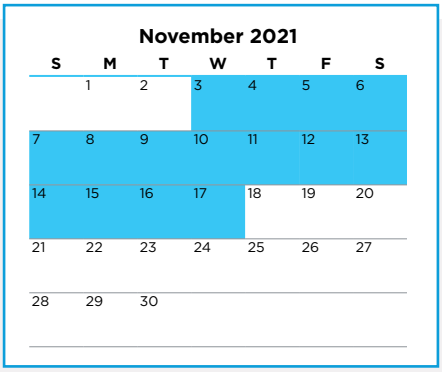
This guide pertains to BOTH non-Medicare eligible and Medicare eligible participants and dependents. If you make changes during Annual Enrollment, your new coverage will begin on the first day of the new calendar year.

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



Note: Annual Enrollment dates are highlighted above.

What's New for 2022

The information listed below describes what's new for 2022. This section serves as a Summary of Material Modifications (SMM), pursuant to the requirements of Section 104 of the Employee Retirement Income Security Act of 1974, as amended (ERISA). This SMM notifies you of certain changes to the Company sponsored Plans (collectively, the "Plan"). For further details, refer to your Summary Plan Descriptions (SPDs) as well as the Legal and Important Required Notices section of this Guide.

Please keep this SMM with your SPD for future reference. This SMM summarizes only certain provisions of the Plan. If there is any conflict between the terms of the Plan documents and this SMM, the terms of the Plan documents will govern. The Company has reserved to the Plan Administrator the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan.

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

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

Benefit Premiums

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

Plan Design Updates

Plan Name Updates:

The High Deductible Health Plan and the Consumer Driven Health Plans are administered by UnitedHealthcare.

2022 (New)	2021
Bind Health Plan	Bind Medical or Bind On-Demand Plan
High Deductible Health Plan (HDHP)	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)

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

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

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

- HSA limits are determined by the IRS and are subject to change.
- The Retiree contribution limit increases from **$3,600** to **$3,650**, and the Retiree + One or more enrolled increases from **$7,200** to **$7,300.** The catch-up contribution for age 55 and older remains at **$1,000** annually.
- If you are Medicare eligible, you should review "Medicare and You", the government's Medicare handbook. While each participant's situation will differ, planning and education are key. You can find this handbook on the official **medicare.gov** website.

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
Retiree	$3,600	$7,200	$5,000	$10,000
Retiree + Spouse/ Domestic Partner	$5,400	$10,800	$7,500	$15,000
Retiree + 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.

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**.

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.

K Health – if enrolled in the Bind Health Plan

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

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

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

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

MyCancerJourney - if enrolled in the Bind Health Plan

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

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

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

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

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

You and your eligible dependent(s) have access to 2nd.MD, a service which offers expert-lead education and guidance on any major medical decision you and your family may be facing. With one of the highest satisfaction ratings in healthcare, 2nd.MD provides you with the answers you need within days, so you can get the care you need.

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

Lumen will require that you consult with 2nd.MD prior to a hip, knee, shoulder (**new**) or spine surgery (on a non emergency basis). It is your choice to follow the guidance of the 2nd.MD specialist. However, if you do not seek a second opinion for these surgeries, you will be responsible for an additional $500 out-of-pocket cost, whether or not you've met your annual deductible, if applicable. Depending on where you live and the physician you are currently seeing, treatment recommendations can vary widely for certain surgical procedures. Lumen is committed to ensuring you and your family are fully educated by some of the best doctors in the country before making a major medical decision.

Surgical Management Solutions – if enrolled in a UnitedHealthcare Plan

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

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

Virtual Physical Therapy

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

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

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

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

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

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

Kaia - if enrolled in a UnitedHealthcare Plan

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

Benefit Plan Administration Updates

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

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

Website and Phone Number Updates for the Service Center

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

Update your Communication Preference on the Service Center website

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

Billing and Payments

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

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

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

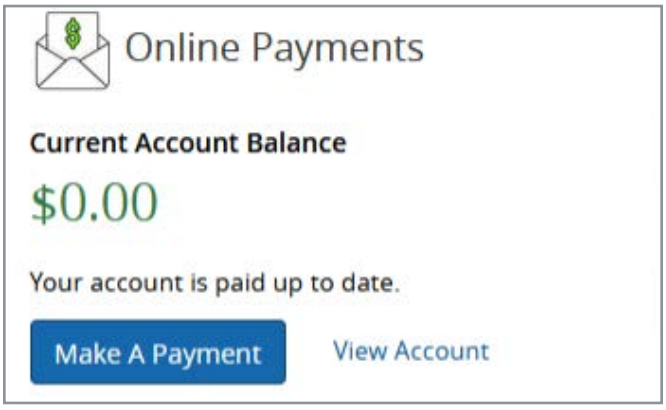
- **Pension Deduction (if applicable):** If your premiums are deducted from your pension check, no action is required, and deductions will continue. If you wish to set up a pension deduction in the future, please contact the Service Center at 833-925-0487.
- **One-Time or Recurring Payments**

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

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

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

1.



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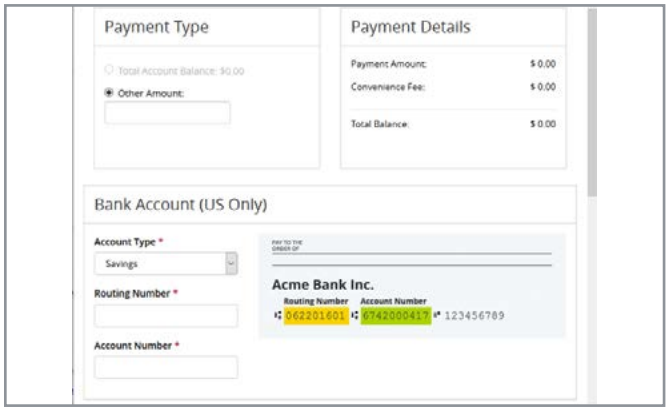

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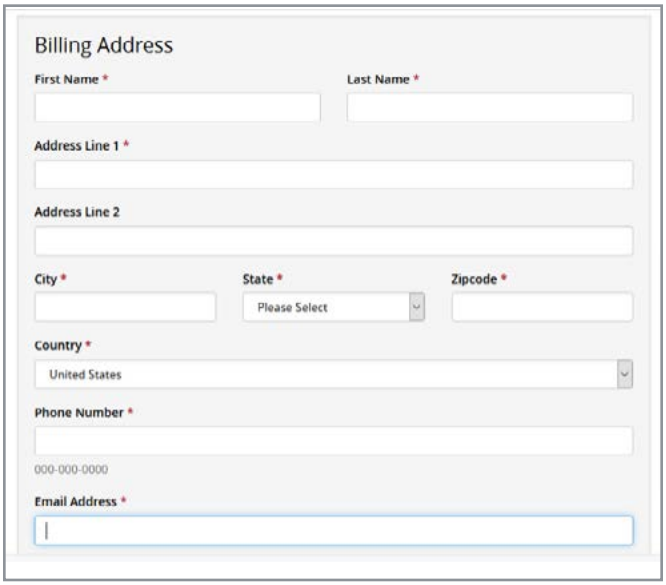

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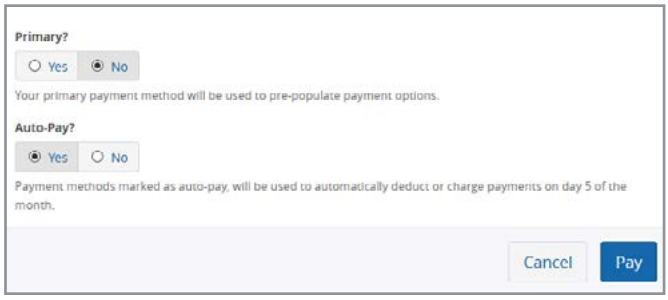

If you want to set up recurring auto payments, answer "Yes" to the last question (Auto-Pay?). If you answer "No" your payment will be considered a one-time payment, and you will be subject to the $2.00 convenience fee. Contact the Service Center at **833-925-0487** if you need assistance.

Be sure to make timely payments!

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

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

Health Reimbursement Account (HRA) Plan

(Excluding those enrolled in a Medicare Policy through the Aon Retiree Health Exchange, formerly Aon Hewitt Navigators)

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)**

Aon Retiree Health Exchange (formerly Aon Hewitt Navigators)

Action is required – Effective Jan. 1, 2022, your current insurance carrier through the Aon Retiree Health Exchange will no longer automatically submit any medical, dental, and/or vision premiums for reimbursement to your Health Reimbursement Account (HRA) as this option is no longer available. You will receive a "Welcome Guide" from MyChoice Accounts in the mail in Jan. 2022.

You will have the following options to choose from:

1. **MyChoice Accounts Recurring Claims Auto-Reimbursement**

Beginning on or after Feb. 1, 2022, you will need to set up your auto reimbursements through the MyChoice Accounts Recurring Claims Auto-Reimbursement Process outlined below.

- Log onto the health and life website at **lumen.com/healthbenefits** and click on the piggy bank icon on the home page. If your premium amount is changing or you have changed carriers, please contact MyChoice Accounts at the Lumen Health and Life Service Center by calling **833-925-0487** to update your account as you may need to complete a new form.

2. **MyChoice Accounts One-Time Reimbursement**

- Log onto the health and life website at **lumen.com/healthbenefits** and follow the instructions on the screen. You must complete required fields. Each time you submit a request for HRA reimbursement, you will be asked to provide documentation.

MyChoice Accounts Contact Information:

- **Online:** lumen.com/healthbenefits
- **Mobile:** MyChoice Mobile App

  Search: **MyChoice™ Mobile App**, available for Free in the App Store and Google Play
- **Email:** claims@mychoiceaccounts.com
- **Fax:** 855-883-8542
- **Mail:**

  MyChoice Accounts
  MSC 345475
  P.O. Box 105168
  Atlanta, GA 30348-5168

Form 1095-C

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

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

Subrogation Update

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

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

Plan Overviews

Medical and Prescription Drug Overview

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

Plan Similarities and Differences

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

Bind Health Plan

With the Bind Health plan, you can see treatment options and costs before getting treatment or choosing a doctor. With this information, you can make informed decisions and find savings opportunities. If you want an overview of how the Bind Health Plan works, visit **lumen.com/bind**. If you are currently enrolled in the Bind Health Plan, visit **lumen.com/choosebind**, **access code: enroll2022**, to review updates for the 2022 Plan year.

How it works:

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

High Deductible Health Plan (HDHP)

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

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

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

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

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

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

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

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

Prescription drug expenses for CDHP options are paid the same as any other medical expense. You will be responsible for the cost of the prescription drugs until you have met or satisfied your deductible.

To help reduce costs and make filling medications more convenient, maintenance medications for conditions, such as diabetes, cholesterol and high blood pressure, must be filled by mail order. You can fill your prescription up to two times at a retail pharmacy. After that, it will not be covered, and you will pay the full retail price.

Enrollment Reminders

Deductibles and Co-Insurance Accumulators reset on Jan. 1

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

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

It will be necessary for you to contact the Advocacy Services team at the Service Center at **833-925-0487** to assist you with the transfer process. The Advocacy Services team will work with UnitedHealthcare or the Bind Health Plan to have the HRA dollars moved to the applicable plan option after the 90-day run-out period.

Medical and Dental Company Cap

Medical and Dental Premiums

Review your Enrollment Worksheet (EWS) as your premiums may have changed for 2022.

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

Reminder: Your contribution was capped at the 2020 amounts and will not increase in the future.

Pharmacy

The Prescription Drug List (PDL) is updated periodically throughout the year.

Depending on the anticipated prescription drug costs you might incur during a plan year, you may have an impact on which medical plan option you choose. You can use the tools below to estimate your costs.

Zip code update

Medical provider networks are determined by ZIP code area, and those ZIP codes are reviewed each Annual Enrollment as providers go in- and out-of-network.

Be sure to review the medical benefit option available to you during the Annual Enrollment process as options may change (based on your address on file).

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!

Explore Your Options and Enroll

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

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

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

- Microsoft Edge
- Firefox
- Safari
- Google Chrome

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

Start Your Enrollment

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

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

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

2. **Online Enrollment – Beginning Wed. Nov. 3 through Wed. Nov. 17, starting at 7 a.m. CST.**
   - Go to **lumen.com/bschealthbenefits**
   - Click the **Start Here** button to review your personal information.

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

     Note: Virtual Hold may be an option for you if you call during peak hours. You will not lose your place in line if you select this option and a representative will call you back, once available.

Enroll in coverage *(mobile device or online)*

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

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

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

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

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

After you enroll *(mobile device or online)*

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

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

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

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

Appendix

Medical Plan Comparison

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

	Bind Health Plan		UnitedHealthcare HDHP		UnitedHealthcare CDHP Option 1		UnitedHealthcare CDHP Option 2	
HSA/HRA Contributions	Not Applicable		With Retiree-Funded HSA (maximum contribution): • $3,650 Retiree • $7,300 Retiree + One or more enrolled **Note:** If you are 55 or older, you can contribute an extra $1,000 "catch-up" contribution.		With Company-Funded HRA Contribution: • $500 Retiree • $750 Retiree + Spouse/ Domestic Partner (Domestic Partner) • $750 Retiree + Children • $1,000 Family		With Company-Funded HRA Contribution: • $800 Retiree • $1,200 Retiree + Spouse/ Domestic Partner (Domestic Partner) • $1,200 Retiree + 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)							
	Retiree		**Retiree**		**Retiree**		**Retiree**	
	$0	$0	$1,500	$3,000	$1,500	$3,000	$1,500	$3,000
					Retiree + Spouse/Domestic Partner		**Retiree + Spouse/Domestic Partner**	
					$2,250	$4,500	$2,250	$4,500
	Retiree + Children		**Family**		**Retiree + Children**		**Retiree + 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)							
	Retiree		**Retiree**		**Retiree**		**Retiree**	
	$3,600	$7,200	$3,600	$7,200	$3,600	$7,200	$3,200	$6,400
	Retiree + Spouse/ Domestic Partner				**Retiree + Spouse/Domestic Partner**		**Retiree + Spouse/Domestic Partner**	
	$5,400	$10,800			$5,400	$10,800	$4,800	$9,600
	Retiree + Children				**Retiree + Children**		**Retiree + Children**	
	$5,400	$10,800			$5,400	$10,800	$4,800	$9,600
	Family		**Family**		**Family**		**Family**	
	$6,850	$14,400 (Individual out of pocket must be satisfied before eligible expenses are 100% covered)	$6,850	$14,400 (Entire family out of pocket must be satisfied before eligible expenses are 100% covered)	$6,850	$14,400 (Entire family out of pocket must be satisfied before eligible expenses are 100% covered)	$6,400	$12,800 (Entire family out of pocket must be satisfied before eligible expenses are 100% covered)

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

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

Prescription Drugs

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

Executive Medical Option Overview

In addition to your other medical options, you are eligible for the Executive Medical option. Enrollment is automatic, and there is no cost to you.

Percentage of Covered Expenses Payable	$100%
Lifetime Maximum Benefit for Orthodontia for Each Covered Person	$4,000
Calendar Year Maximum Benefit for Basic and Major Dental Services for Each Covered Person	$1,500
Services Not Covered	• Any service or supply not allowable as a tax deduction under the Internal Revenue Code • Custodial care • Vision care See your Executive Medical Summary Plan Description for other services not covered.

More to Know About Medicare

If you and/or your dependent(s) are eligible for Medicare, you must enroll in Medicare Parts A and B. If you don't enroll timely, this may result in a gap in health care coverage and possible late penalties imposed by Medicare. These penalties are lifetime, not just a one-time charge.

Once enrolled in an individual Medicare plan, claims should first be submitted to your Medicare plan. Then, submit any remaining eligible out-of-pocket expenses to the Executive Medical Plan for reimbursement.

Those who will become Medicare eligible

Options outside of the Company

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

If you are eligible for a Company Subsidy

When your Non-Medicare Company medical group plan options end, we will fund an HRA with company subsidy dollars (subject to the Company Cap) that help pay for your individual Medicare medical policy and dental premiums. Your HRA dollars will not roll over, and any remaining balance at the end of the year will be forfeited. Your annual Company-funded medical HRA amounts are capped and remain the same for 2022, and will not increase in the future.

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

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

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

Let ViaBenefits Help You Enroll

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

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

Dental Overview

Basic Dental Plan - Passive PPO

Your Dental PPO plan is passive, meaning that you will pay the same coinsurance levels, have the same deductible requirements and be allotted the same Annual Maximum value regardless of going In or Out-of- Network. In-Network services are subject to MetLife's negotiated PDP Plus network rates. Out-of- Network services will be subject to the reasonable and customary charges. You may have additional out of pocket costs for services received from Out-of-Network providers.

For specific details on how services are covered or excluded, please contact MetLife or refer to the Summary Plan Description available on the Health and Life website or by requesting a copy through the Service Center.

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

If you and all of your dependents are Medicare eligible

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

Helpful Resources

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

Benefit Option	Phone	Online
	Health Care	
Service Center • Health and Life Benefit Questions	**833-925-0487** **317-671-8494** (Local DNIS for international callers) Mon-Fri, 7 a.m. - 7 p.m. (CST)During Annual Enrollment, open to 8 p.m. (CST)	**lumen.com/bschealthbenefits** (during Annual Enrollment) **lumen.com/healthbenefits** (effective Jan. 1, 2022) Search: **MyChoice™ Mobile App**, available for Free in the App Store and Google Play
Health Care Advocacy Services • For issues with your Health Care claim(s) that you are unable to resolve on your own or through the Claims Administrator or your Health Care provider.	**833-925-0487** **317-671-8494** (International callers) Mon-Fri, 7 a.m. - 7 p.m. (CST) (During Annual Enrollment, open to 8 p.m. (CST))	**lumen.com/healthbenefits** (effective Jan. 1, 2022)
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
Prescription Drug Program	**Bind:** **833-576-6519** Mon-Fri, 6 a.m. - 9 p.m. (CST)	**lumen.com/choosebind** **Access Code: enroll2022**
	UnitedHealthcare: **800-842-1219**	**UnitedHealthcare: myuhc.com**
Telemedicine	**Bind:** **Doctor On-Demand** **833-576-6519** **UnitedHealthcare:** **888-632-2738** • UHC Virtual Care Services	**patient.doctorondemand.com** **myuhc.com/virtualvisits** Search: **UHC App**, available for Free in the App Store and Google Play
2nd.MD (Second opinions for all conditions) (An expert medical consultation service offered at no cost to you and your eligible dependents over the age of 18 who are enrolled in a Company medical plan.)	**866-842-1151**	**lumen.com/2ndmd** Search: **2nd.MD**, available for Free in the App Store and Google Play
Dental Plan	**MetLife: 866-832-5756** Group Number: 148069	**metlife.com/benefits**
ViaBenefits	**888-825-4252**	**lumen.com/viabenefits**

Additional services provided by MetLife

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

Grief Counseling 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 below 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**

Important Coverage Rules

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

Dual coverage

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

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

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

Covering previously suspended dependents during Annual Enrollment

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

1. To add previously suspended dependents, follow the directions during your online enrollment or contact the Service Center.
2. Plan coverage for your previously suspended 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.

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

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

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

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

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

Once your employment or assignment ends, you may resume your retiree health care, basic and supplemental life insurance coverage, if applicable, in accordance with the terms of the Plan by calling the Service Center at **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.

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/medicalassistancehealthinsurancepremiumpaymenthippprogram/index.htm**
Phone: 800-692-7462

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

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

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

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