Amazing People. Amazing Benefits. Find Your Fit.

Review and Enroll Nov. 7 - Nov. 18, 2022.

2023 Annual Enrollment Guide

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

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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/healthbenefits 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. SPDs are available on the Health and Life website or by requesting a copy through the Service Center. Please allow time for mailing.**

Welcome to Annual Enrollment

Find Your Fit

Annual Enrollment is your opportunity to find the options and plans that are right for you and your eligible dependent(s).

Go to the Health and Life website to learn about your 2023 benefits. On the website you'll find helpful information in the **Reference Center** located next to your name at the top of the screen as well as a calendar that tells you how many days you have to enroll.

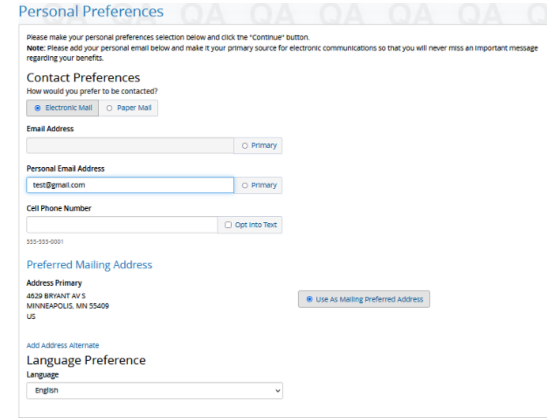
Enrollment Checklist

- ☐ Select your Contact Preference, do you want benefit communication through email or sent by regular mail?
- ☐ Review your Profile on the Health and Life website. You can update personal information such as email address, mailing address, home and mobile phone numbers. This is important to ensure you receive future benefit communications.
- ☐ Confirm your designated beneficiary information for the Company Paid Life Insurance plan.

If you don't enroll by Nov. 18, you will be automatically enrolled in the plans and coverage levels listed on your Enrollment Worksheet and displayed on the Health and Life website.

To confirm your information, you can go online to the Health and Life website or call the Service Center.

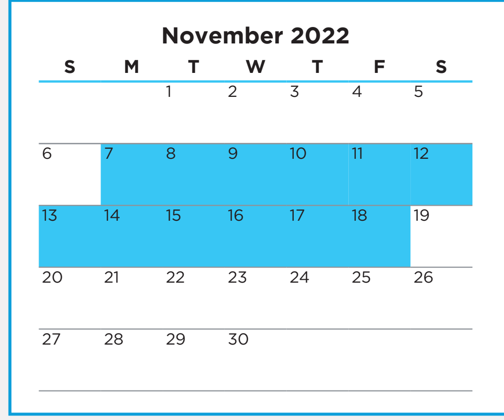
Note: To update your Contact Preference, this must be done on the Health and Life website by following the steps from the screen shot on the right.



This guide pertains to BOTH non-Medicare and Medicare eligible participants and their eligible 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 outside of the Annual Enrollment period, please enroll at least 30 days prior to your desired plan effective date. Enrollment must be approved by Medicare prior to the plan effective date. For example, if approved by UHC in Dec., coverage under the UHC Group Medicare Advantage PPO Plan would become effective Jan 1. Please have your Medicare Beneficiary Identifier (MBI) number ready as you will be required to provide this to the Service Center during your enrollment.

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) for further information.



November 2022

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

Note: Annual Enrollment dates are highlighted here.

New: The Service Center will be available to assist you on:

Nov. 7 - Nov. 12 and Nov 14 - Nov. 18 from 7 a.m. - 7 p.m. (CST)

Service Center advocates are not available on Sun., Nov. 13; however, you can enroll on the Health and Life website at lumen.com/healthbenefits.

What's New for 2023

The information listed in this guide describes what's new for 2023. 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 the Plan Administrator the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan.

UnitedHealthcare Group Medicare Advantage Preferred Provider Option (MA PPO)

Healthy at Home – Meals, transportation and in-home personal care at no charge for up to 30 days following an in-patient facility visit.

NurseLine – Will now be referred to as Telephonic Support, speak with a registered nurse (RN) 24 hours a day, seven days a week.

Personal Emergency Response System (PERS) – PERS is a wearable monitoring device at no charge to you that provides access to emergency assistance to give your family peace of mind, should you experience a fall.

Routine Vision Coverage – Eye Exam, $0 co-pay every 12 months (previously $10 co-pay every 24 months) and eyewear available every 12 months (previously every 24 months).

UnitedHealthcare Website update – retiree.uhc.com

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

Be sure to review this notification on page 25 in this guide as it will no longer be mailed to you.

Medicare Part B Reimbursement

If you are receiving the standard Medicare Part B reimbursement, your monthly reimbursement will automatically update to the standard 2023 Medicare Part B premium as determined by Medicare. If your Medicare Part B is different than this amount, you will need to provide the Service Center your and/or your dependent's Social Security Administration letter indicating your 2023 Medicare Part B premium. Send a copy of the SSA letter postmarked no later March 31, 2023 to the updated address or fax number as noted below. If your letter is postmarked by March 31, 2023, the reimbursement will be retroactive to Jan. 1, 2023. If your letter is postmarked after March 31, 2023, the reimbursement amount will begin the first of the following month after the postmarked date.

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

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 2022, you will receive Form 1095-C based on your communication preference on the Health and Life website. This form verifies your health insurance for tax purposes.

To update your Contact Preference, log in to the Health and Life website at lumen.com/healthbenefits and under Contact Preferences, enter your personal email address and select it as primary. Then all emails will be sent to that address.

Below Contact Preferences you can select “Yes” you consent to the deliver of Form 1095-C or “No”, then a paper copy will be mailed.

Important Note: Questions related to health and life eligibility should be directed to the Lumen Health and Life Service Center at Businessolver at 833-925-0487.

Voluntary Lifestyle Benefits

We’ve made robust enhancements to your Voluntary Lifestyle Benefits offerings and reduced costs. If you haven’t reviewed these benefits, now is the year to do it to ensure you’re getting the most out of your benefits while protecting your pocket. Please review the following information for instructions on accessing and/or enrolling in these benefits. **Note:** You can enroll in these benefits at any time.

For access to specific plan documents, go to the Reference Center at lumen.com/healthbenefits. Once in the Reference Center, you can search for the Voluntary Benefits folder and review each benefit plan.

As a retiree of Lumen, you have access to the following voluntary lifestyle benefit programs:

- **NEW! Disaster Insurance -** Protect your home and finances from a natural disaster.
- **Employee Perks/Discounts -** PerkSpot is a members-only discount site that provides you with access to hundreds of exclusive deals from brand-name retailers and local merchants.
- **NEW! Identity and Fraud Protection -** Protects you and your family from fraud.
- **Legal Services -** Legal experts on your side, whenever you need them.

Disaster Insurance through Recoop

Protect your home and finances from a natural disaster. Recoop is the first and only multi-peril disaster insurance product that pays a lump-sum cash benefit (up to $25,000) after a natural disaster -- dust storm, earthquake, gas explosion, hurricane (with storm surge), tornado, wildfire, or winter storm.

Most homeowners insurance policies leave gaps in coverage. Recoop picks up where insurance stops, so you can bounce back faster after a disaster.

Unlike homeowners or renters insurance, which might take 30+ days to pay full benefits, Recoop is lightning-fast recovery cash that arrives in your account within just a few days.

Premiums are determined by property zip codes and risk zones.

How this benefit works...

- **Step 1:** Get a quote and Enroll by answering just a couple of quick questions (Recoop is guaranteed issue/no underwriting!)
- **Step 2:** Set up an account and upload 2 photos of your house or apartment dwelling per the directions on your welcome email.
- **Step 3:** Following a covered disaster submit a claim online or by calling **877-2-RECOOP**.
- **Step 4:** Take damage photos and upload to fulfill your claim.
- **Step 5:** Upon approval of your claim, typically the Recoop cash gets deposited into your account within 24 - 48 hours.

*You must carry an existing homeowners or renters insurance policy.

**Your home or apartment must be in a state or federally declared disaster area and have sustained damages of $1,000 or more.

How to enroll:

- **Step 1:** Go to lumen.com/recoop
- **Step 2:** Review plan options and select coverage
- **Step 3:** Pay via credit card
- **Step 4:** Save your account login information for when you need to file a claim

Questions? Go to recoopinsurance.com/faq

Employee Perks/Discounts Offered through PerkSpot - (you can use Employee Perks/Discounts at any time, no membership fee required)

You have access to Employee Perks through PerkSpot as part of your benefits program. PerkSpot is a members-only discount site that provides you with access to hundreds of exclusive deals from brand-name retailers and local merchants.

PerkSpot offers travel deals, great gifts, and practical everyday necessities—all at specially negotiated prices. From discounted theater tickets to incredible deals at Target and Costco. Your family members can save, too.

How this benefit works…

- **Step 1:** Visit lumen.com/retireeperks and create an account
- **Step 2:** Search through hundreds of discounts offered on goods and services
- **Step 3:** Select a discount and start saving

Questions? Go to support.perkspot.com.

Identity and Fraud Protection offered through MetLife

Our personal information is more at risk than ever. MetLife's Identity and Fraud Protection, powered by Aura, protects you and your family from fraud by helping to ensure your private information is not anywhere it shouldn't be.

Keep your identity secure with extensive monitoring of your personal information, like your accounts, credit, SSNs, IDs, and more. You'll also get near real-time alerts on suspicious credit inquiries, like if someone was opening a loan or credit card in your name. Live with peace of mind that your online personal and financial information is secure.

How this benefit works…

- **Step 1:** Select the level of protection you want.
- **Step 2:** Aura will monitor your personal information and alert you of any suspicious activity.

How to enroll:

- **Step 1:** Go to lumen.com/idprotection to access your Identity and Fraud Protection benefit
- **Step 2:** Review plan options and select coverage
- **Step 3:** Pay via credit card

Questions? Call **833-552-2123**

Legal Services offered through MetLife

Like health insurance, legal assistance is there to help you when the unexpected happens. This can include helping you with matters such as divorce, identity theft, traffic citations, and more. Other times, legal assistance can help you avoid issues ahead of time, such as credit monitoring or preparing a will or trust.

With MetLife Legal Plans, you will have access to full attorney representation of legal matters including:

- Identity theft defense
- Preparation of wills, living wills, and trusts
- Divorce
- Traffic ticket defense
- Buying, selling, and refinancing your home
- Consumer protection
- And more

What's new in 2023:

- We've maximized your legal benefit to now include custody (up to 8 hours) and enforcement/modification of support orders.
- We've increased divorce coverage from 20 hours to unlimited.

How this benefit works...

- **Step 1:** Find an attorney by going to retirees.legalplans.com/9904598, or call **800-821-6400** to speak with an experienced service team member that can match you with the right attorney and give you a case number.
- **Step 2:** Call the attorney you select, provide your case number, and schedule a time to talk or meet.

How to enroll:

- **Step 1:** Go to retirees.legalplans.com/9904598
- **Step 2:** Create an account using the email and password of your choice
- **Step 3:** Answer a few questions to verify your eligibility

Questions? Call **800-821-6400**

Important Note

Questions related to health and life eligibility should be directed to the Lumen Health and Life Service Center at Businessolver at **833-925-0487**.

It has come to our attention that a Company called "Lumen Insurance Technologies, LLC" located in Austin, TX has received calls from numerous Lumen retirees. This is not the company you retired from, now known as Lumen Technologies. Please do not contact the commercial insurance company in Austin Texas for inquiries related to your health insurance and/or retirement benefits as that insurance company is not in the position to discuss any financial or health details with you and will not be able to answer any of your questions.

Reminders

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 or log in to **lumen.com/healthbenefits** and select: change my benefits/life event and then dependent demographic information to update your record.

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 2022 will carry over to 2023.

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, 2023, for the reimbursement to be retroactive to Jan. 1, 2023. If your letter is postmarked after March 31, 2023, 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, Inc.
P.O. Box 310512
Des Moines, IA 50331-0512
Fax: 515-273-1545

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 2022 and you are not changing medical benefit plan options, you will not be required to re-enroll. Therefore, no action is required and your Enrollment Worksheet will serve as your confirmation statement for 2023. If you are enrolling in an individual policy outside of the Company in the HRA Plan 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.

Qualified Life Event (QLE)

If you experience a QLE in 2023 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 can 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.

Stay Up-To-Date with Retiree Articles

Visit lumenbenefits.com or lumen.com/healthbenefits to get the latest retiree news. These articles are 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:

- Clinical research, ambulance services, durable medical equipment, Mental health (inpatient, outpatient, and partial hospitalization) and limited outpatient prescription drugs.

Note: 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 an ERO'92 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 that is mailed each fall. 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 Plan or UnitedHealthcare Group Medicare Advantage PPO Plan, you do not need to enroll in a separate Medicare Part D plan because prescription drug coverage included in those benefit options, as defined by the Plan.**
- **If you elect the HRA Plan 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 dependent(s) are Medicare eligible, you must enroll in the same benefit plan option.

The Medical Plan - shown as the ERO'92 Guaranteed Coverage Point of Service Plan on your Worksheet and the Health and Life website

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

Health Reimbursement Account (HRA) Plan Option Combined with an Individual Medicare Policy - shown as the Pre-1991 and ERO'92 Health Reimbursement Account on your Worksheet and the Health and Life website

- If you elect to participate in this Plan option, you are waiving coverage under the Guaranteed Coverage Commitment Plan as well as the UHC Medicare Advantage PPO benefit options.
- The HRA provides you with Company-subsidized dollars to help you purchase the individual Medicare policies.
- The HRA 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 a Plan option under the Company group retiree plan. You must purchase an 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. For additional information, review the Navigation Guide located in the Reference Center in the General Information folder and then the Retiree sub folder.
- 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. Starting Nov. 7, you will need to contact the Service Center letting them know you enrolled in an individual Medicare and/or prescription drug policy.

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 had under The Medical Plan (Guaranteed Coverage 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) - shown as the Pre-1991 and ERO'92 UHC Group Medicare Advantage PPO Plan on your Worksheet and the Health and Life website

- 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.
- **New -** Personal Emergency Response System (PERS) - PERS is a wearable monitoring device at no cost to you that provides access to emergency assistance to give your family peace of mind, should you experience a fall.
- Telephonic Support (Previously referred to as NurseLine) – Registered nurses answer your call 24 hours a day, seven days a week.
- Renew Active – Free gym memberships, brain games, cooking classes, etc.
- **New -** Healthy at Home - Meals, transportation and in-home personal care at no charge for up to 30 days following an inpatient facility visit.

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 **877-886-7313.** You must call the Service Center to enroll in this plan.

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 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 Guaranteed Coverage Plan benefit option, which includes Medical/Prescription drug coverage.

Point of Service (POS) - shown as the ERO'92 Guaranteed Coverage Point of Service Plan on your Worksheet and the Health and Life website

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 **877-365-7949**, 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 Health and Life Service Center at **833-925-0487**.

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

Medical Overview

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

	UnitedHealthcare Group Medicare Advantage PPO Plan*	Guaranteed Coverage Plan - Point of Service (POS) - ERO'92 Retiree Plan Option	
	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 3 years, In-Network Providers only)	Plan pays up to $300 (every three years)	
Telephonic Support (previously referred to as 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	$0	Not Covered	
Routine Eyeglass Allowance (every twelve months)	$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*	Guaranteed Coverage Plan - Point of Service (POS) - ERO'92 Retiree Plan Option	
	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	
Vision Services – Eye Exam	Not Covered	
Routine Eyeglass Allowance (every two years)	Not Covered	
Fitness Program	Not Covered	

Medical Overview

	ERO'92 Retiree Plan for MN, ND, WI (United Healthcare Choice Plus Plan)	
	In-network costs	**Out-of-network costs**
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	

*The UnitedHealthcare Group Medicare Advantage PPO plan is availble 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 Guaranteed Coverage Plan, Medicare becomes your primary coverage and the Guaranteed Coverage Plan becomes secondary. Your benefits will be reduced if you do not enroll timely in Medicare Part B coverage. Refer to your Annual Enrollment Worksheet to determine which plan option you are currently eligible for or enrolled in.

Dental Overview

Dental Plan Benefit

The Plan benefit option available to you is indicated on your **Enrollment Worksheet (EWS)**.

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 to continue the dental plan option.

Retiree Life Insurance

Retiree Basic Life Insurance (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).

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.

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 contacting 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.

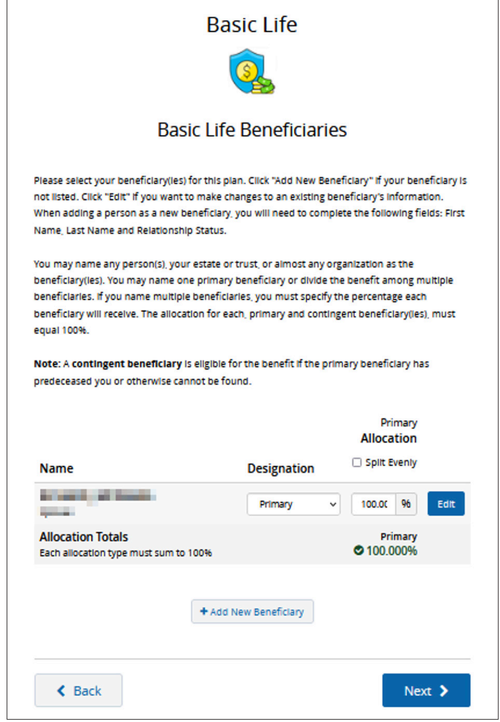
Coverage ends on the last day of the month in which you turn age 65. You may convert your Retiree Supplemental Life coverage once you turn age 65, according to the laws of the state of Washington where the policy is issued. Conversion is not automatic, and you must apply for converted life insurance 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

Confirm and/or update your designated beneficiaries for your Company Life Insurance Plan coverage by going to lumen.com/healthbenefits or calling the Service Center at **833-925-0487**. Refer to the screen shot from the Health and Life website to the right.

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.



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 at this number 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.

Paying for your coverage

We make it easy to pay for your Supplemental Life Insurance benefits

Premiums are due on the first day of each month for the prior month's benefit coverage. You can contact the Service Center for payment options such as:

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

Important: We no longer allow deductions to be set up and taken from pension checks. If you currently have deductions taken from your pension check, that will not change and deductions will continue.

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. 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 for the prior months coverage. If not, your coverage will be terminated retroactively to the last day of the prior month for which full payment was received.

Review Your Options and Enroll

If you don't enroll by Nov. 18, you will be automatically enrolled in the plans and coverage levels listed on your Enrollment Worksheet which is also displayed on the Health and Life website. If you are not making changes or updates to your coverage, no action is required.

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.

Start your Enrollment

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

1. **Mobile App Enrollment** – Beginning Nov. 7 at 7 a.m. (CST)
   To complete your enrollment, download the
   FREE MyChoice™ Mobile App. for iOS or Android.
   - If you have not already done so, you will need to set up a username and password. Enter lumen.com/healthbenefits 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.

MyChoice Mobile App

- Quick access to benefit details
- Store your ID cards

Get Access Code

2. **Online Enrollment** (use the latest versions of Chrome, Firefox, MS Edge or Safari for the best performance on the Health and Life website) – Nov. 7 through Nov. 18, 7 a.m. - 7 p.m. (CST).
   - If you have not already done so, you will need to set up a username and password. Start at lumen.com/healthbenefits in your browser. Go to **First time here?** Enter a username and password and answer a few security questions. Log in using your username and password.

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

3. **Phone Enrollment** - Beginning Nov. 7 at 7 a.m. to 7 p.m. (CST)
   - We encourage you to enroll through your mobile device or the website; however, if you wish to enroll 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 an advocate will call you back, once available. Your call back may not occur until the next business day.

Important: Longer than normal wait times usually occur on the first and last day of Annual Enrollment. Please consider this when you contact the Service Center. The best times to call is early in the morning on a Tuesday or Wednesday.

Enroll in coverage *(mobile device or online)*

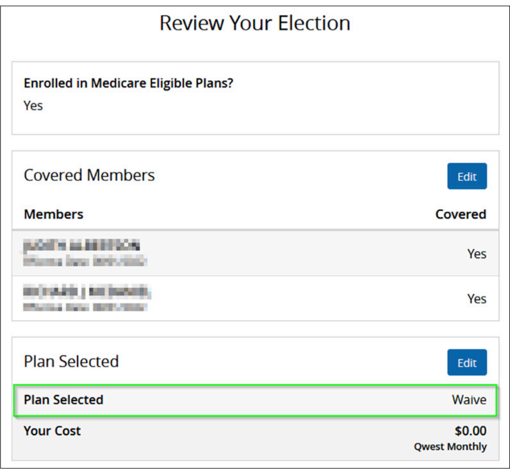
Use the **Next** and **Back** buttons to review and elect plans and options available to you. Choose or decline coverage for each option and select which eligible dependent(s) you want to cover.

Make sure to click on the **Compare** and **Plan Details** tools to view details and costs for the plans and options available to you.

Important Note for Medical and Dental Enrollment/Review: If you are not making changes or updates to your coverage, no action is required.

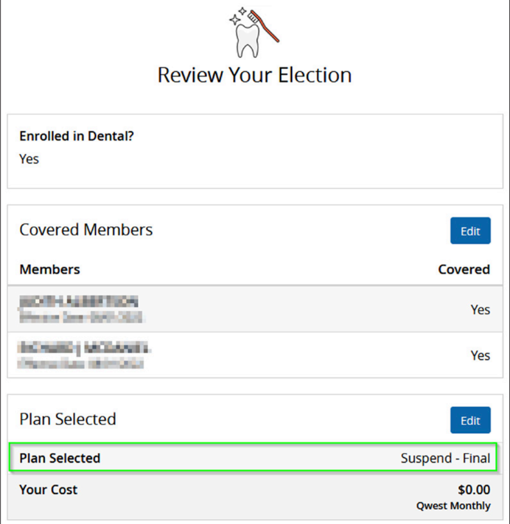
Medical coverage –

- The first screen will ask you who should be covered. Anyone who should be enrolled should be checked on this screen. Click Next.
- Review your plan options. The plan highlighted in green shows your current election. If a change is made, that new selection will be highlighted in green to indicate what was elected.
- When you review your elections on the review screen (as shown on the right), if your medical coverage shows "Waive", **this means you do not have medical coverage for 2023**.



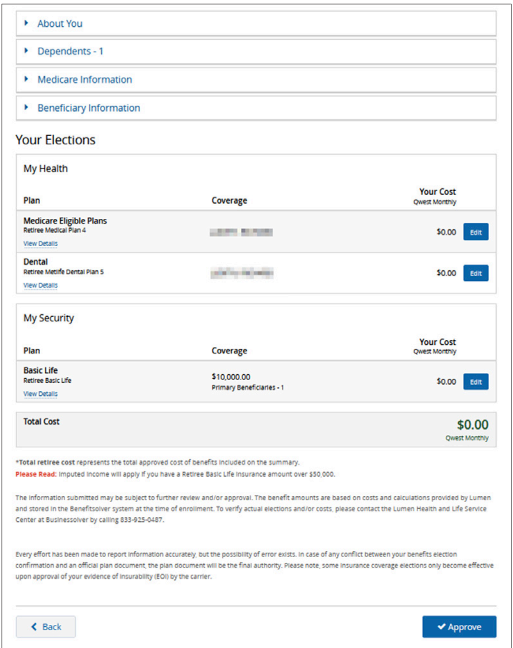
Dental coverage –

- The first screen will ask you who should be covered. Anyone who should be enrolled should be checked on this screen. Click Next.
- The box highlighted in green shows your current election. If a change is made, that new selection will be highlighted in green to indicate what was elected.
- When you review your elections on the review screen (as shown on the right), if your dental coverage shows "Waive or Suspend", **this means you do not have dental coverage for 2023**.

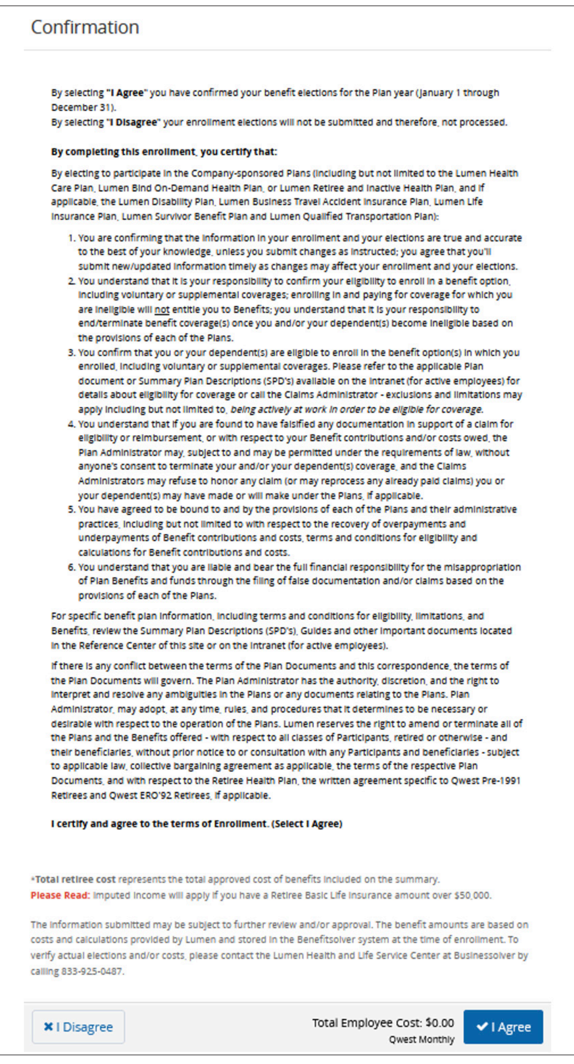


Review and finalize Your elections *(mobile device or online)*

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.



Confirmation

By selecting **"I Agree"** you have confirmed your benefit elections for the Plan year (January 1 through December 31).
By selecting **"I Disagree"** your enrollment elections will not be submitted and therefore, not processed.

By completing this enrollment, you certify that:

By electing to participate in the Company-sponsored Plans (including but not limited to the Lumen Health Care Plan, Lumen Bind On-Demand Health Plan, or Lumen Retiree and Inactive Health Plan, and if applicable, the Lumen Disability Plan, Lumen Business Travel Accident Insurance Plan, Lumen Life Insurance Plan, Lumen Survivor Benefit Plan and Lumen Qualified Transportation Plan):

1. You are confirming that the information in your enrollment and your elections are true and accurate to the best of your knowledge, unless you submit changes as instructed; you agree that you'll submit new/updated information timely as changes may affect your enrollment and your elections.
2. 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 end/terminate benefit coverage(s) once you and/or your dependent(s) become ineligible based on the provisions of each of the Plans.
3. You confirm that you or your dependent(s) are eligible to enroll in the benefit option(s) in which you enrolled, including voluntary or supplemental coverages. Please refer to the applicable Plan document or Summary Plan Descriptions (SPD's) available on the intranet (for active employees) for details about eligibility for coverage or call the Claims Administrator - exclusions and limitations may apply including but not limited to, *being actively at work in order to be eligible for coverage.*
4. You understand that if you are found to have falsified any documentation in support of a claim for eligibility or reimbursement, or with respect to your Benefit contributions and/or costs owed, the Plan Administrator may, subject to and may be permitted under the requirements of law, without anyone's consent to terminate your and/or your dependent(s) coverage, and the Claims Administrators may refuse to honor any claim (or may reprocess any already paid claims) you or your dependent(s) may have made or will make under the Plans, if applicable.
5. 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 overpayments and underpayments of Benefit contributions and costs, terms and conditions for eligibility and calculations for Benefit contributions and costs.
6. You understand that you are liable and bear the full financial responsibility for the misappropriation of Plan Benefits and funds through the filing of false documentation and/or claims based on the provisions of each of the Plans.

For specific benefit plan information, including terms and conditions for eligibility, limitations, and Benefits, review the Summary Plan Descriptions (SPD's), Guides and other important documents located in the Reference Center of this site or on the intranet (for active employees).

If there is any conflict between the terms of the Plan Documents and this correspondence, the terms of the Plan Documents will govern. The Plan Administrator has the authority, discretion, and the right to interpret and resolve any ambiguities in the Plans or any documents relating to the Plans. 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 Plans. Lumen reserves the right to amend or terminate all of the Plans and the Benefits offered - with respect to all classes of Participants, retired or otherwise - and their beneficiaries, without prior notice to or consultation with any Participants and beneficiaries - subject to applicable law, collective bargaining agreement as applicable, the terms of the respective Plan Documents, and with respect to the Retiree Health Plan, the written agreement specific to Qwest Pre-1991 Retirees and Qwest ERO'92 Retirees, if applicable.

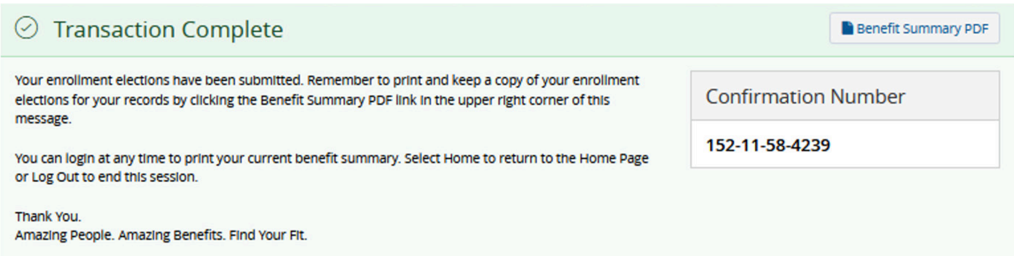
I certify and agree to the terms of Enrollment. (Select I Agree)

***Total retiree cost** represents the total approved cost of benefits included on the summary.
Please Read: Imputed income will apply if you have a Retiree Basic Life Insurance amount over $50,000.

The information submitted may be subject to further review and/or approval. The benefit amounts are based on costs and calculations provided by Lumen and stored in the Benefitsolver system at the time of enrollment. To verify actual elections and/or costs, please contact the Lumen Health and Life Service Center at Businessolver by calling 833-925-0487.

✖ I Disagree | Total Employee Cost: $0.00 Qwest Monthly | ✔ I Agree

After you approve your elections, there will be a Transaction Complete screen with a Confirmation Number. There is an option to download a Benefit Summary PDF where you can again review the elections you finalized. If you made changes, you will receive a Confirmation Statement by email or mail, based on how your contact preference is set up on the Health and Life website.



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.**

Helpful Resources

	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)	lumen.com/healthbenefits 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)	lumen.com/healthbenefits
The Medical Plan (Guaranteed Coverage Option)/Prescription Drug Plans	**UnitedHealthcare: 800-842-1219** **Do not enroll through this number.** Enrollment is completed through the Service Center.	**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.	**UnitedHealthcare:** retiree.uhc.com Search: **UHC App**, available for Free in the App Store and Google Play
Dental Plan	**MetLife: 866-832-5756** **Do not enroll through this number.** Enrollment is completed through the Service Center.	metlife.com/mybenefits Search: **MetLife**, available for Free in the App Store and Google Play
	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**.

Change of Address Updates

Online

For Health and Life Benefits	For Pension Benefits
lumen.com/healthbenefits	**Contact the Lumen Pension Service 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: **844-286-1282** 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 Service Center** **888-324-0689**

You can review the SPDs and SMM's located under the Reference Center at lumen.com/healthbenefits. 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 by following the directions on the Health and Life website, or by contacting the Service Center.
2. Coverage for your dependents will become effective Jan. 1, 2023, providing supporting documentation to verify eligibility for your dependent is received timely and approved. You can upload your supporting documentation after you complete your enrollment. You can also elect to fax or mail the supporting documentation but uploading will expedite the dependent verification process.

   Fax: 515-273-1545
   Email: dv@businessolver.com
   Mail: Lumen (Businessolver.com, Inc.)
   PO BOX 850552
   Minneapolis, MN 55485-0552

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. If you voluntarily end 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.

If you have a qualified life event and need to make changes before 2023

If you make changes during Annual Enrollment and have a subsequent change to your coverage before the end of December 2022, because of a QLE (for example, you add a spouse to your coverage), your 2022 changes/ enrollment will not automatically be applied to 2023. **As a result, you will need to update BOTH your 2022 and 2023 coverage by contacting the Service Center.**

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/or retiree supplemental life coverage, if applicable, will continue under the terms of the Life Insurance Plan (the Plan). In addition, please be advised that as a worker for a supplier or Company contractor, you are not eligible for active employee health care benefits. Retiree health care benefits are reinstated once your work with the supplier/contractor for the company has ended. You will need to call the Service Center to have your benefits reinstated.

Once your employment or assignment ends, you may resume your retiree health care, basic and supplemental life insurance coverage, if applicable, in accordance with 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, 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).

Income Related Monthly Adjustment Amount Reimbursement and/or Medicare Part B Reimbursement Notification

The Social Security Administration (SSA) makes initial determinations whether the income-related monthly adjustment amount (IRMAA) applies to Medicare beneficiaries with Part B, or Medicare prescription drug coverage (or both if enrolled in both at the time a determination is made) using IRS data.

IRMAA reimbursement (if enrolled in the Medicare Advantage PPO Plan):

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 you are a new Participant to the Medicare Advantage PPO Plan and are subject to IRMAA and are requesting reimbursement, refer to the Request for Reimbursement below for further information. You will not be eligible to receive reimbursement from the Company until you notify and provide the Service Center with a copy of the notification letter from the Social Security Administration.

If you are enrolled in the UHC Medicare Advantage PPO Plan and your IRMAA premium has changed, you will need to provide a copy of the notification letter from the Social Security Administration which lists the premium amount in order to receive the accurate reimbursement for the IRMAA premium in 2023.

Medicare Part B reimbursement:

The Centers for Medicare & Medicaid Services (CMS) requires high-income Medicare-eligible individuals who are enrolled in the Part B program to pay a monthly Part B premium that is higher than the 2023 standard Medicare premium. The premium for high-income individuals, as defined by CMS, will vary depending upon your modified adjusted gross income and income tax filing status. The income amounts will be indexed annually by CMS for inflation.

If you are receiving the standard Medicare Part B reimbursement, your monthly reimbursement will automatically update to the standard 2023 Medicare Part B premium, as determined by Medicare. If your Medicare Part B is different than the standard amount, you will need to provide a copy of the notification letter from the Social Security Administration which lists the adjusted Medicare Part B premium amount in order to receive the accurate reimbursement for your Medicare Part B reimbursement in 2023. You will not be eligible to receive reimbursement from the Company for the updated premium amount until you notify and provide the Service Center with a copy of the notification letter from the Social Security Administration.

The Social Security Administration will directly notify each high-income beneficiary regarding his/her obligation to pay a higher Medicare Part B premium. If you are one of these affected individuals, it will be your responsibility to notify the Service Center each Plan year, refer to the below for further information.

Request for reimbursement:

Mail or fax a copy of your Social Security Administration notification letter, which includes the updated 2023 Medicare Part B and/or IRMAA premium amount/s to:

Lumen Health and Life Service Center at Businessolver
P.O. Box 850552
Minneapolis, MN 55485-0552
Fax: 515-273-1545

If the notification letter is postmarked **on or before** March 31, 2023, your reimbursement amount will be effective retroactive to January 1, 2023.

If the notification letter is postmarked **after** March 31, 2023, your reimbursement amount will be prospective only, meaning it would be effective the first of the

month following receipt of the letter and retroactive reimbursement will **not** be approved.

Questions: Contact the Service Center at **833-925-0487**, Mon. - Fri. 7 a.m. - 7 p.m., (CST)

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, and 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 ERO'92 or 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; and
- 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 Individual 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 under 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, 2022. 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: myflfamilies.com/service-programs/access/medicaid/
Phone: **1-877-357-3268**

GEORGIA – Medicaid
Website: medicaid.georgia.gov/programs/third-party-liability/health-insurance-premium-payment-program-hipp
Click on Health Insurance Premium Payment (HIPP)
Phone: **678-564-1162**, Press 1

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: illinois.gov/hfs/MedicalPrograms/AllKids/Pages/about.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: kancare.ks.gov/consumers/apply-for-kancare
Phone: **1-785-296-3512**

KENTUCKY – Medicaid
Website: kynect.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/assistance-programs/healthcare/childrenteens/michild
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/montanahealthcareprograms/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/programs-services/medicaid
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: oregon.gov/oha/hsd/medicaid-policy/pages/state-plans.aspx
Phone: **800-699-9075**

PENNSYLVANIA – Medicaid
Website: dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx
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: health.wyo.gov/healthcarefin/medicaid/
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.

Qualifying events for spouses/domestic partners or dependent children include those events above, plus, the covered retiree's becoming entitled to Medicare, divorce of the covered retiree, death of the covered retiree, 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. 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.

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