Lumen Health Care Plan
Vision Plan Option

(Offered by First American Administrators/EyeMed Vision Care, LLC)

Summary Plan Description (SPD)
For Eligible Active Employees

Effective Jan 1, 2023

You can go online to obtain an electronic copy or call the Lumen Health and Life Service Center at Businessolver, **833-925-0487** or **317-671-8494** (International callers), to request a paper copy of a Summary Plan Description (SPD).

Note: When enrolling during Annual Enrollment, Nov. 7 – Nov. 18, 2022, or the 2023 Plan year, use lumen.com/healthandlife (if actively working) or lumen.com/healthbenefits.

Issued Jan. 1, 2023

LUMEN®

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INTRODUCTION

Lumen Technologies* (hereinafter "Lumen" or "Company") is pleased to provide you with this Summary Plan Description ("SPD"). This SPD presents an overview of the Benefits available under the Vision Plan benefit option of the Lumen Health Care Plan* (the "Plan"). The SPD also presents the rights and responsibilities of you and the Company under the Plan.

This SPD must be read in conjunction with the *General Information SPD* which explains many details of your coverage and provides a listing of the other benefit options under the Plan.

The effective date of this updated SPD is Jan 1, 2023. If you are a Covered Person in the Vision Plan benefit option on or after Jan. 1, 2023, this SPD supersedes and replaces, in its entirety, any other SPD describing the Vision Plan that you currently may possess. Specific details are contained in the official *Plan Document* and/or Trust agreements which legally govern the operation of the Plan. In the event of any discrepancy between this SPD and the official *Plan Document*, the *Plan Document* shall govern.

This SPD, together with other plan documents (such as the Summary of Material Modifications (SMMs), the *General Information SPD* and materials you receive at Annual Enrollment) (hereafter "Plan documents") briefly describe your Benefits as well as rights and responsibilities, under the Lumen Health Care Plan (the "Health Plan"). These documents make up your official Summary Plan Description for the Employees enrolled in the Vision Plan benefit option as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Vision Plan benefit option under the Plan is self-funded; however, certain other benefit plan options under the Plan may be insured.

Note: This SPD is for active Lumen employees who are eligible to enroll in the vision plan benefit option. The *General Information SPD* provides overall guidance including but not limited to: administration contacts, the Company's reservations of rights, the Company's rights and Claims and Appeals.

Reserved Rights

The Company reserves the right to amend or terminate any of the Benefits provided in the Plan – with respect to all classes of Covered Person, without prior notice to or consultation with any Covered Person, subject to applicable laws and if applicable, the collective bargaining agreement.

The Plan Administrator, the Employee Benefits Committee, and its delegates(s), has the right and discretion to determine all matters of fact or interpretation relative to the administration of this Vision Plan benefit option—including questions of eligibility, interpretations of the Vision Plan provisions and any other matter. The decisions of the Plan Administrator and any other person or group to whom such discretion has been delegated, including the Claims Administrator, shall be conclusive and binding on all persons. More information about the Plan Administrator and the Claims Administrator can be found in the General Information SPD.

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. There are deadlines to file claims and benefit related actions; please refer to **"Time Deadline to File a Benefit Claim and the Time Deadline to File a Benefit-Related Lawsuit"** found in this SPD.

How to Use This SPD

This SPD is provided to explain how the Plan works. It is designed to provide you with a general description in non-technical language of the benefits currently offered under the Vision Plan benefit option. It describes your benefits and rights as well as your obligations under the Plan. It is important for you to understand that because this SPD is only a summary, it cannot cover all of the details of the Plan or how the rules will apply to each Covered or Eligible person in every situation. All of the specific rules governing the Plan are contained

in the *Plan Document* and applicable insurance policies. This SPD is not the *Plan Document*. You and your beneficiaries/eligible dependent(s) may examine the *Plan Document* and other documents related to the Vision Plan benefit option during regular business hours or by appointment at a mutually agreed upon convenient time in the office of the Plan Administrator. You may also request to receive copies of the *Plan Document* and insurance policies by making a request to the Plan Administrator in writing. There is a per page charge for the copying expenses. For additional information, refer to the **A Statement of Your ERISA Rights** in the *General Information SPD*. If any terms of the *Plan Document* conflict with the contents of the SPD, the *Plan Document* will always govern.

Capitalized terms are defined throughout this SPD and in the *General Information SPD*. All uses of "we," "us," and "our" in this document, are references to the EyeMed Claims Administrator, or Lumen. References to "you" and "your" are references to people who are Covered Persons, also known as Participants, Individuals and Eligible Dependents as the term is defined in the *General Information SPD*.

You are encouraged to read and keep all the SPDs and any attachments (summary of material modifications ("SMMs"), amendments, and addendums) for future reference. Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.

Please note that your health care Provider does not have a copy of the SPD and is not responsible for knowing or communicating your Benefits.

Health Plan Determinations Are Not Health Care Advice

Please keep in mind that the sole purpose of the Plan is to provide for the payment of certain health care expenses and not to guide or direct the course of treatment of any Employee, or eligible Dependent(s). Just because your health care Provider recommends a course of treatment does not mean it is approved and payable under the Plan. A determination by the Claims Administrator or the Plan Administrator that a particular course of treatment is not eligible for payment or is not covered under the Vision Plan does not mean that the recommended course of treatments, services, supplies, or procedures should not be provided to Covered Persons or that they should not be provided in the setting or facility proposed. ***Only you and your health care Provider can decide what is the right health care decision for you.*** *Decisions by the Claims Administrator or the Plan Administrator are solely decisions with respect to Plan coverage and do not constitute health care recommendations or advice.*

You May Not Assign Your Health Care Benefits to Your Provider or any Third Party

Employees/Individuals and Eligible Dependents may not voluntarily or involuntarily assign to a physician, hospital, pharmacy or other health care Provider or any third party (your "Providers") any right you have (or may have) to:

1. receive any benefit under the Health Plan,
2. receive any reimbursement for amounts paid for services rendered by Providers, or
3. request any payment for services rendered by Providers

The Health Plan prohibits Employees/Individuals and Eligible Dependents from voluntarily or involuntarily assigning to Providers any right you have (or may have) to submit a claim for benefits to the Health Plan, or to file a lawsuit against the Health Plan, the Company, the Plan Administrator, the Claims Administrator, the Appeals Administrator or any other Plan fiduciary, administrator or sponsor with respect to Health Plan benefits or any rights relating to or arising from participation in the Health Plan. If Employees/Individuals and Eligible Dependents attempt to assign any rights in violation of the Health Plan terms, such attempt will not be effective. It will be void or otherwise treated as invalid and unenforceable.

This Health Plan provision will not interfere with the Health Plan's rights to make direct payments to a Provider. However, any direct payment to a Provider is provided as a courtesy to the Provider and does not effectuate

an assignment of Employees/Individuals' and Eligible Dependents' rights to the Provider or waive the Health Plan's rights to enforce the Health Plan's anti-assignment terms. Any such direct payment to a Provider shall be treated as though paid directly to the Employees/Individuals and Eligible Dependents and shall satisfy the Health Plan's obligations under the Health Plan.

Similarly, you may not assign your disability benefits to your provider or any Third Party.

Lumen's Rights to Use Your Social Security Number for Administration of Benefits

Lumen retains the right to use your Social Security Number (including any Social Security Number of your eligible dependents' enrolled in a benefit plan) for benefit administration purposes, including tax reporting. If a state law restricts the use of Social Security Numbers for benefit administration purposes, the Company generally takes the position that ERISA preempts such state laws.

GENERAL PLAN INFORMATION

The Vision Plan benefit option is just one benefit option offered under the Plan. This SPD must be read in conjunction with the *General Information SPD* which explains details of your coverage and provides a listing of the other benefit options under the Plan.

Refer to the *General Information SPD* for important and general Plan information including, but not limited to, the following sections:

- Eligibility
- When Coverage Begins
- When Coverage Ends
- How to Appeal a Claim
- Circumstances that May Affect Your Plan Benefits
- The Plan's Right to Restitution
- Plan Information (e.g. Plan Sponsor and EIN, administration, contact information, Plan Number, etc.)
- A statement of your ERISA Rights
- Notice of HIPAA Rights
- Your Rights to COBRA and Continuation Coverage
- General Administrative Provisions
- Required Notice and Disclosure
- Glossary of Defined Terms
- Qualified Medical Child Support Order (QMSCO)

You can go online to lumen.com/healthandlife (if actively working) or lumen.com/healthbenefits to obtain an electronic copy or call the Service Center at 833-925-0487 or 800-729-7526, option 1 and option 1 to request a paper copy of the *General Information SPD* that can be mailed to you at no cost.

You Must Follow Plan Procedures

Please keep in mind that it is very important for you to follow the Plan's procedures, as summarized in this SPD, in order to obtain Plan Benefits and to help keep your personal health information private and protected. For example, contacting someone at the Company other than the Claims Administrator or Plan Administrator (or their duly authorized delegates) in order to try to get a Benefit claim issue resolved is not following the Plan's procedures. If you do **not** follow the Plan's procedures for claiming a Benefit or resolving an issue involving Plan Benefits, there is no guarantee that the Plan Benefits for which you may be eligible will be paid to you on a timely basis, or paid at all, and there can be no guarantee that your personal health information will remain private and protected

Keep the Plan Administrator Updated with Information of All Address Changes

In order to receive benefit communications timely, you should keep your mailing address updated through SuccessFactors available on the Intranet. You should also go onto the Plan Administrator's website and enter how you wish to receive benefit communications. Lumen strongly recommends you do not list your work email address but instead list your personal email address. Lumen nor the Plan Administrator can guarantee your privacy when using your work email address and some communications will purposely not be sent to your work email address.

Plan Year

The Plan year shall start January 1 and end December 31. The Benefits and Payroll Schedule may have more than 26 pay periods in a Plan year and is not based on the calendar year. You can review the schedule on the Intranet.

Benefits under the Plan are furnished in accordance with the *Plan Document* issued by the Lumen Employee Benefits Committee (EBC), including this SPD. Participants' rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA) and the procedures to be followed in regard to denied claims or other complaints relating to the Plan are set forth in the body of this SPD.

Plan Number

The Plan Number for the Vision Plan is 512.

CLAIMS & PLAN ADMINISTRATORS AND CONTACT INFORMATION

Claims Administrator:	EyeMed Customer Care Center 4000 Luxottica Place Mason, OH 45040 855-874-4744 lumen.com/visioncare
Group Number:	1029819
Plan Administrator:	Lumen Health and Life Service Center at Businessolver (aka Service Center) P.O. Box 850552 Minneapolis, MN 55485-0552 833-925-0487 or 800-729-7526 option 1, option 1
Website Address:	lumen.com/healthandlife (if actively working) or lumen.com/healthbenefits

Consequences of Falsification and Misrepresentation.

You will be given advance written notice that coverage for you or your Dependent(s) will be terminated if you or your Dependent(s) are determined to falsify or intentionally omit information, submit false, altered, or duplicate billings for personal gain, allow another party not eligible for coverage to be covered under the Plan or obtain Plan Benefits, or allow improper use of you or your Dependent's coverage.

Continued coverage of an ineligible person is considered to be a misrepresentation of eligibility and falsification

of, or omission to, update information to the Plan, which is in violation of the Code of Conduct and may result in disciplinary action, up to and including termination of employment. This misrepresentation/omission is also a violation of the Plan document, Section 8.3 which allows the Plan Administrator to determine how to remedy this situation. For example, if you divorce, your former spouse is no longer eligible for Plan coverage and this must be timely reported to the Service Center within 45 days, regardless if you have an obligation to provide health insurance coverage to your ex-spouse through a Court Order. Lumen does not allow ex-spouse's to be covered.

- You and your Dependent(s) will not be permitted to benefit under the Plan from your own misrepresentation. If an individual is found to have falsified any document in support of a claim for Benefits or coverage under the Plan, the Plan Administrator may, without anyone's consent, terminate coverage, possibly retroactively, if permitted by law (called "rescission"), depending on the circumstances, and may seek reimbursement for Benefits that should not have been paid out. Additionally, the Claims Administrator may refuse to honor any claim under the Plan or to refund premiums
- While a court may order that health (vision) coverage must be maintained for an ex-spouse/domestic partner, that is not the responsibility of the Company and is not a covered eligibility under the Plan.
- You are also advised that by participating in the Plan, you agree that suspected incidents of this nature may be turned over to Plan Administrator and/or Corporate Security to investigate and to address the possible consequences of such actions under the Plan. You may be periodically asked to submit proof of eligibility and to verify claims.

Note: All Individuals by their participation in the Plan authorize validation investigations of their eligibility for Benefits and are required to cooperate with requests to validate eligibility by the Plan and its delegates.

Questions?

If you are an Employee/Individual or an eligible Dependent of an Employee/Individual who has questions or needs information about your Plan benefits, you first should call the telephone number on your ID card during regular business hours. Alternatively, and for information regarding other Plan benefits, you can call the telephone numbers listed on the Contact Information Chart within the *General Information SPD*. However, if the Claims Administrator is unable to answer your questions, contact the Service Center at 833-925-0487 or 800-729-7526 option 1, option 1 for further assistance.

Dual Coverage

Lumen benefit plan provisions prohibit any individual from being enrolled in dual coverage in the Company's vision benefit plan option. These provisions mean that:

- Lumen Employee/Individual cannot elect coverage for themselves while being enrolled as a qualified Dependent under another Lumen Employee's coverage; and
- Two Lumen Employees whether active or on a type of leave but still eligible for Vision coverage cannot enroll the same qualified Dependent in coverage separately.
- If you elect coverage during Annual Enrollment and are also covered under the same Plan(s) as a Dependent on another Employee's coverage, your coverage will be corrected once the enrollment period ends. You will remain in coverage under your own record but will be removed as a Dependent from the other Employee's coverage.

Choosing Your Coverage Level

Active Employees: If you are a Full-Time Eligible Employee, you have the following coverage categories to choose from when enrolling in medical, dental and vision coverage under the Health Plan:

- Individual only
- Individual and Spouse/Domestic Partner
- Individual and Child(ren)
- Individual and Family (consisting of a Spouse/Domestic Partner and one or more dependent Children)
- Waive (no coverage)

You can change your coverage level during the year, subject to the limits on when coverage begins (see the **Qualified Life Events** section for more information).

Health Plan

Your contribution level, also know as “premium deductions” for the vision coverage available to you and your eligible Dependents is based on 2 things: your status on the payroll system and what coverage level you elect for the vision plan.

Benefits under the Plan are paid from the general assets of the Plan Sponsor. Any required Employee contributions (also known as “Premiums from your Paycheck”) are used to partially reimburse the Plan Sponsor for Benefits under the Plan.

Tax Status of Health Care Contributions

If you are an active Employee receiving a regular salary, your contribution will be deemed to be a salary reduction election (pre-tax or before-tax), and any such contributions will be deducted from your pay before taxes, as long as your pay is sufficient.

Tax Implications of Enrolling Your Domestic Partner under the Health Plan

When adding a Domestic Partner or a Child/ren of a Domestic Partner to one or more of your healthcare plans (medical, dental and vision), you will have imputed income calculated on the value of the Company premium paid for your Domestic Partner or Child(ren) of your Domestic Partner. If you wish to enroll your Domestic Partner there are federal and possibly state tax implications. The federal Internal Revenue Code considers the fair market value of this health care coverage to be imputed income to you, which means you will be taxed according to state and federal laws. The Company will report the annual amount of this imputed income on your W-2 Form at the end of each year. It is also listed on your paycheck reflected in Current and YTD contributions. Before enrolling your Domestic Partner, you should talk with your tax advisor about the tax implications for you.

Payment of Contributions

If you are an active Eligible Employee, you are responsible for paying your portion of the contributions/ premiums each pay period that you are receiving covered benefits. If you work or receive pay even one day within a pay period, you will have the full/total premium amount deducted from your paycheck.

If at any time you experience a payroll adjustment for health and/or life benefits coverage, the payroll adjustment will process in accordance with the Benefits and Payroll schedule or as soon as administratively possible. Employees will be responsible for any retroactive deductions including missed deductions on subsequent pay periods.

If at any time you are eligible for a credit of a health care premium adjustment, the credit will process as a lump sum payment for the retroactive premium credit in accordance with the next payroll schedule.

Reminder to Review Your Paycheck

- Review your paycheck along with the Lumen Benefits and Payroll schedule (available on the Intranet) to confirm your benefit premium costs for Health & Life including Savings and Spending Accounts. Any questions related to benefit premiums should be directed to the Lumen Health and Life Service Center 833-925-0487 or 317-671-8494 (International callers) or 800-729-7526, option 1, option 1. Do not contact the Lumen Payroll Department as the Payroll staff will be unable to assist you.
- If your benefit premium deductions are not correct or not what you expect, you must make a claim to the Plan Administrator in accordance with the claim’s procedures as soon as possible after the year’s payroll deductions begin.

VISION PLAN BENEFIT FEATURES

Procedures for Using the Vision Plan Benefits

If you choose to receive plan benefits from a member provider, contact EyeMed or an EyeMed member provider directly. A list of names, addresses and phone numbers of member providers in your geographic location can be obtained from EyeMed at lumen.com/visioncare or **855-874-4744**. For the TTY, the caller should dial 711 and ask the relay operator to call 844-230-6498.

EyeMed will provide benefit authorization directly to the EyeMed member provider. If you contact the EyeMed member provider directly, you must identify yourself as an EyeMed member, so the provider knows to obtain benefit authorization from EyeMed.

When such benefit authorization is provided by EyeMed and services are performed prior to the expiration of the benefit authorization, this will constitute a claim against the Plan in spite of your termination of coverage or the termination of the Plan. Should you receive services from a member provider without such benefit authorization or obtain services from a provider who is an Out-of-Network provider, you are responsible for payment in full to the provider.

You will initially pay only the copayment to an EyeMed member provider for services covered by the Plan. EyeMed will pay the member provider directly according to their agreement with the provider.

When you use an Out-of-Network provider, you pay the provider his/her payment in full. You will be reimbursed by EyeMed up to the maximums as outlined in the **Summary of Vision Benefits**. Refer to the chart in this SPD.

In emergency conditions, when immediate vision care is necessary, you can obtain covered services by contacting an EyeMed member provider directly. Emergency vision care is subject to the same benefit frequencies, plan allowances, copayments, limitations and exclusions.

In the event of termination of a member provider's membership with EyeMed, EyeMed will remain liable to the member provider for services rendered to you at the time of termination and permit the member provider to continue to provide with plan benefits until the services are completed or until EyeMed makes reasonable and appropriate arrangements for the provision of such services by another member provider.

Benefit Authorization Process

EyeMed authorizes plan benefits in accordance with the latest eligibility information furnished to EyeMed by Lumen and/or the Service Center. When you request services under the Plan, your prior utilization of plan benefits will be reviewed by EyeMed to determine if you are eligible for new services based upon the Plan's level of coverage.

HOW TO FILE A BENEFIT CLAIM FOR SERVICES

This section provides you with information about how and when to file a claim. This information is for services. If you wish to file a benefit claim related to eligibility, the instructions are further within this SPD.

If You Receive Covered Health Services from an EyeMed Member Provider

When you obtain services from an EyeMed member provider, the EyeMed member provider will file the claim on your behalf. You are responsible for paying the co-payments to the EyeMed member provider at the time you receive care. If an In-network provider or PLUS provider bills you for any Covered Health Services other than your co-payments and coinsurance, please contact the provider or call EyeMed at 855-874-4744.

If You Receive Covered Vision Services from an Out-of-Network Provider

Typically, when you obtain services from an Out-of-Network Provider, you are responsible for paying the provider in full. You are also responsible for requesting reimbursement from EyeMed, the Claims Administrator.

Members are required to complete an Out-of-Network Claim Form, and provide copies of itemized receipts. Required information is noted on the form, which can be submitted online, through email or via regular postal mail. Reimbursement will be sent directly to the member. To ensure there is no delay in processing claims, make sure you promptly and accurately complete the claim form and attach the requested information.

Make sure you sign the claim form.If you need assistance completing the form, please contact EyeMed at 855-874-4744.

Submit claim forms online at:	lumen.com/visioncare
Submit claim forms through email at:	oonclaims@eyemed.com
Send claim forms through mail to:	FAA/EyeMed Vision Care Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111

Note: Regardless of how you file your claims, you should keep track of all your expenses as backup for substantiation. You must submit a request for reimbursement no later than 12 months after the date of service.

Payment of Vision Plan Benefits

The EyeMed Vision Plan will make a benefit determination as set forth in the contractual agreement. Benefits will be paid to the EyeMed member provider. Benefits will be paid to you when using an Out-of-Network Provider, except when noted.

Note: If you are enrolled in the Health Care Flexible Spending Account, you may be able to pay your portion of the Vision expense with your Health Care Spending Card and avoid the need to file for a claim reimbursement. See the *Traditional/Limited and Dependent Day Care Flexible Spending Accounts (FSAs) SPD* for more information.

Timely Filing of Out-of-Network Claims

All claim forms for Out-of-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by the Claims Administrator. This 12-month requirement does not apply if you are legally incapacitated.

Benefit Determinations

Post service claims: Post service claims are those claims that are filed for payment of benefits after care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim.

The Claims Administrator will notify you within this 30-day period if additional information is needed to process the claim and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the

denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for the denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures. See the *"***CLAIMS AND APPEALS***"* section within this SPD and the *General Information SPD* for more information on appeal procedures.

Coordination with Vision Benefit Options

The Vision Benefit plan does not use the standard COB process. Regardless if you or your eligible dependent have other vision coverage elsewhere, EyeMed only processes as "primary" plan coverage. They do not process as "secondary" plan coverage.

COVERED VISION PLAN BENEFITS

This section is a summary of expenses covered by the EyeMed Vision Plan Option.

EyeMed Provider Benefits

If you use the services of an EyeMed member provider, the Vision Plan Option will pay covered vision care services as follows:

Eye Exam

One eye examination each plan year, paid in full after your $10 co-payment for In-Network providers or $0 co-payment if you visit a PLUS provider. If you see an Out-of-Network provider, you may be reimbursed up to $40. This includes a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities. This does not include exams needed to evaluate medical symptoms (i.e. eye pain) or contact lens fitting and evaluation.

Retinal Imaging/Screening

The Retinal Screening enhancement allows members to have retinal screening done with their routine exam. Retinal screening uses high-resolution imaging systems to take pictures of the inside of the eye. This enhancement helps increase pathology detection and documentation of suspicious cases of glaucoma through retinal images. It does not replace pupil dilation as that is still considered the gold standard. Please note retinal screening technology may not be available in all EyeMed provider locations as it is dependent upon whether the provider has purchased the necessary equipment to do the imaging. Please contact the provider prior to your appointment. One screening each Plan year with a PLUS provider and In-network provider is a $0 co-payment. If you see an Out-of-Network provider, you may be reimbursed up to $20.

Glasses

Lenses and frames are covered each Plan year and are paid in full after your co-payment.

The EyeMed member provider will order lenses, if needed. The provider also verifies the accuracy of the finished lenses.

There is a $0 co-payment with a PLUS provider and In-network provider when ordering polycarbonate lenses for children up to age 19.

There will be an additional charge if you select special lenses, including but not limited to contact lenses (except as noted), oversize lenses, premium or custom progressive multi focal lenses, and certain coating for lenses. For specific details about each service, review the **Summary of Vision Benefits** in this SPD.

A frame is available once every Plan year. If you select a frame that costs more than the amount allowed by the Plan, there will be an additional charge. If you see an In-network provider, you will receive a $160 allowance towards any frame of your choice plus 20% off any amount over the allowance. If you see a PLUS

provider, you receive a $185 allowance towards any frame of your choice plus 20% off any amount over the frame allowance.

Contact Lenses

Benefits for contact lenses are available in lieu of lenses for glasses. The Vision Plan benefit option pays 100% for routine eye exam with an In-network provider after a $10 copayment ($0 copayment if you see a PLUS provider) plus 15% off balance over the $150 allowance for Conventional contact lenses. If you purchase Disposable contact lenses, the Plan pays 100% for routine eye exam with $0 co-payment plus 100% of balance over $150 allowance. Contact Lens Fit and Follow-Up (Standard) is up to $40 co-payment whether you see an In-network provider or a PLUS provider. Contact lens Fit and Follow-Up (Premium) is 10% off retail price whether you see an In-network provider or a PLUS provider. There is no reimbursement if you see an Out-of-Network provider for either Standard or Premium Contact Lens Fit and Follow-Up.

Contact lenses that are classified as “medically necessary” contact lenses are covered at 100% with $0 co-payment when an EyeMed provider secures proper approval. If you see an Out-of-Network provider, your reimbursement may be up to $210. Medically necessary contact lenses may be prescribed by an EyeMed provider for certain conditions. An EyeMed provider will determine eligibility for these types of lenses at the time of service.

Vision Correction

Lasik or PRK from U.S. Laser Network offers a discount for EyeMed registered members. You will receive a 15% discount off retail or 5% off of a promotional price when using U.S. Laser Network. Please call 800-988-4221 for more information.

To Request Benefits

Once you have made an appointment with a member provider, the provider will verify benefit coverage on your behalf prior to rendering service. If you need to locate a member provider in your area or wish to verify your level of coverage prior to your appointment, call EyeMed at **855-874-4744** or visit the web site at lumen.com/visioncare.

1. **Lenses and Frames**
   - Single vision lenses, co-payment of $25
   - Bifocal lenses, co-payment of $25
   - Trifocal lenses, co-payment of $25
   - Lenticular lenses, co-payment of $25
   - Progressive lenses Standard, co-payment of $25
   - Progressive lenses Premium, co-payment up to $200 (depending on level)
   - Frames, up to $160 allowance with 20% off balance over the allowance

2. **Contact Lenses**
   - Contact lens Fit and Follow-up Standard, copayment up to $40.
   - Contact lens Fit and Follow-up Premium, 10% off retail price.
   - Medically Necessary, up to $210

3. **Low Vision**
   - One supplemental exam and testing every two Plan years with a 25% co-payment and up to $1,000 maximum benefit. If low vision exam/supplemental testing is approved by EyeMed, it will be covered at 100% when using an In-Network provider or PLUS provider. If you see an Out-of-Network provider, your allowance is up to $125 every two Plan years. You will not be reimbursed. If low vision aids are approved by EyeMed, your co-payment will be 25% up to a maximum of $1,000 per covered member every two Plan years. The covered member is responsible for the remaining 25% of the approved amount plus any amount over the maximum.

PLUS Providers

You can choose to visit a PLUS provider (automatically an In-network provider). Services through a PLUS provider allows for access to enhanced benefits to help you save even more. Seeing PLUS providers, you'll receive an eye exam at $0 co-payment, plus an additional $25 frame allowance (on top of your base frame allowance of $160). PLUS providers are located nationwide and easy to find – just look for them using our Provider Locator at lumen.com/visioncare.

Summary of Vision Benefits

Summary of Benefits

Vision Care Services	In-Network Cost Using PLUS Providers	In-Network Cost	Out-of-Network Reimbursement
Examination Services			
Exam (with Dilation as necessary)	$0 copay	$10 copay	Up to $40
Retinal Imaging	$0 copay	$0 copay	Up to $20
Contact Lens (allowance includes materials only)			
Conventional	$0 copay; 15% off balance; over $150 allowance	$0 copay; 15% off balance; over $150 allowance	Up to $105
Disposable	$0 copay; 100% of balance over $150 allowance	$0 copay; 100% of balance over $150 allowance	Up to $105
Medically Necessary	$0 copay; paid-in-full	$0 copay; paid-in-full	Up to $210
Contact Lens Fit And Two (2) Follow-Ups (in lieu of lenses)			
Fit and Follow-Up - Standard	Up to $40	Up to $40	Not covered
Fit and Follow-Up - Premium	10% off retail price	10% off retail price	Not covered
Frame (any available frames at Provider locations)			
Frame	$0 copay; 20% off balance over $185 allowance	$0 copay; 20% off balance over $160 allowance	Up to $112
Standard Plastic Lenses (in lieu of contacts)			
Single Vision	$25 copay	$25 copay	Up to $30
Bifocal	$25 copay	$25 copay	Up to $50
Trifocal	$25 copay	$25 copay	Up to $70
Lenticular	$25 copay	$25 copay	Up to $70
Progressive - Standard	$25 copay	$25 copay	Up to $50
Progressive - Premium Tier 1	$110 copay	$110 copay	Up to $50
Progressive - Premium Tier 2	$120 copay	$120 copay	Up to $50
Progressive - Premium Tier 3	$135 copay	$135 copay	Up to $50
Progressive - Premium Tier 4	$200 copay	$200 copay	Up to $50
Lens Options			
Anti Reflective Coating - Standard	$45 copay	$45 copay	Up to $5
Anti Reflective Coating – Premium Tier 1	$57 copay	$57 copay	Up to $5
Anti Reflective Coating – Premium Tier 2	$68 copay	$68 copay	Up to $5
Anti Reflective Coating – Premium Tier 3	$85 copay	$85 copay	Up to $5
Photochromic – Non-Glass (Plastic)	$0 copay	$0 copay	Up to $5

Summary of Benefits

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

Definition of Contact Lens Fit

1. **Standard Contact Lens Fit** - Clear, soft, spherical, daily wear contact lenses for single vision prescriptions. Standard Contact Lens does not include extended or overnight wear lenses, which are intended to be worn during periods of sleep.
2. **Premium Contact Lens Fit** - Toric, multifocal, monovision, post-surgical, gas permeable contact lenses, and other non-Standard Contact Lenses. Premium Contact Lens includes extended and overnight wear lenses, which are intended to be worn during periods of sleep.

* You are responsible to pay the Out-of-Network provider in full at time of service and then submit an Out-of-Network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.

** For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes.

Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

LIMITATIONS AND EXCLUSIONS FOR BENEFITS AND SERVICES NOT COVERED

The Plan does not pay Benefits for the following services, supplies (products) or treatments even if they are recommended or prescribed by a provider or are the only available treatment for your condition. This section is subject to change from time to time and over time. Please note that in listing services, supplies (products) or treatments as examples, when the SPD says "this includes," or "including but not limiting to," it is not the Claims Administrator's (EyeMed's) intent to limit the description to that specific list. When the Plan does intend to limit a list of services, supplies and treatments for example, the SPD specifically states that the list "is limited to."

To assure that services, supplies (products) or treatments is a Covered Expense, contact the number on the back of your ID card for EyeMed approval.

- No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures.
- Refraction, when not provided as part of a Comprehensive Eye Examination.
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing.
- Aniseikonic lenses
- Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment.
- Safety eyewear: solutions, cleaning products or frame cases.
- Non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices.
- Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.
  - Fees charged by a provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the provider. Such fees, taxes or materials are not covered under the Policy.
- Allowances provide no remaining balance for future use within the same Benefit Frequency.
- Some provisions, benefits, exclusions or limitations listed herein may vary by state.
- Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers.

CLAIMS AND APPEALS

Questions and Appeals – What to Do First

The Plan Administrator believes that most claim issues, such as a denied claim, can be addressed informally if promptly and objectively raised with the appropriate Claims Administrator, and that the best time to solve a problem or answer a question is when it first arises, not days, weeks or months later. In no event should it be more than a year after you have been notified and are aware of the issue. There is a separate claims process if you dispute the deductions from your paycheck for your Plan Benefits. Refer to **"Claim for Payroll Adjustments and Deadlines"**within this SPD.

Covered Persons who have had a claim denied, have questions or complaints, etc., may informally contact the Claims Administrator before requesting a formal appeal. If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination, you may appeal it without first informally contacting the Claims Administrator.

How to Appeal a Denied "Service" Claim

Time Frames and Procedures for Appealing Claims – First Level

If your claim is denied, in whole or in part, you may file a first-level appeal. The first-level appeal must be in writing and received by FAA /EyeMed Vision Care within 180 days of your notice of the denial. If you do not receive an EOB within 30 days of submission of your claim, you may submit a first-level appeal within 180 days after this 30-day period has expired. Your written letter of appeal should include the following:

* the applicable claim number or a copy of the written denial or a copy of the EOB, if applicable.

* member's name and ID number as show on the ID card,

* Provider's name,

* the date of vision service,

• the vision coverage that the member feels was misinterpreted or inaccurately applied,

• additional information from the provider that will assist FAA /EyeMed Vision Care in completing its review of the first-level appeal, such as documents, records, questions or comments.

You and your authorized representative may send a written request for an appeal.

Mail:

FAA/EyeMed Vision Care
Attn: Quality Assurance Dept
4000 Luxottica Place
Mason, OH 45040

Fax: 513-492-3259

FAA/EyeMed Vision Care will review your first-level appeal, **providing acknowledgment within 3 business days after receipt**, and notify you in writing of its decision **within thirty (30) days**.

Complaint Procedure

If you are dissatisfied with an EyeMed provider's quality of care, services, materials or facility or with EyeMed's administration, you should first call EyeMed Member/Patient Services at **855-874-4744** to request resolution. Member/Patient Services will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Member/Patient Services, you may file a formal complaint with EyeMed's Quality Assurance Department at the address noted above. You may include written comments or supporting documentation along with dates and who you spoke to when calling EyeMed Member/Patient Services.

If you wish to include your Explanation of Benefits (EOB), you can print your EOB by going online to lumen.com/visioncare or calling EyeMed to request your EOB is mailed to your attention at 855-874-4744.

The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

Timing of Benefit Determinations on Vision Claims and Appeals

Most of these are typically medical related claims, vision services are typically only post-service claims. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- **post-service claim**; or
- concurrent claim.

Urgent Care requests for Benefits – a request for Benefits provided in connection with Urgent Care services, as defined in the Glossary section of the *General Information SPD*.

Review of an Appeal

The Claims Administrator will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if the Claims Administrator upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Time Frames for and Procedures for Appealing Claims – Second Level

If your first-level appeal is denied, in whole or in part, you may file a second-level appeal. The second-level appeal must be in writing and received by FAA /EyeMed Vision Care within 60 days after the denial of your first-level appeal. If you do not receive the first-level appeal decision within 60 days after it was filed, you may still submit a second-level appeal within 60 days. Your written letter of appeal should include the same items from your level-one appeal, plus any new information that you believe supports your position.

The appeal should be mailed or faxed to the following address:

Mail:

FAA/EyeMed Vision Care
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040

Fax: 513-492-3259

FAA/EyeMed Vision Care will review your second-level appeal, **providing acknowledgment within 3 business days after receipt**, and notify you in writing of its decision **within 30 days**.

Note: Upon written request at no cost, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. The Claims Administrator will review all claims in accordance with the rules established by the U.S. Department of Labor.

Federal External Review Program

If, after exhausting your internal appeals under First and Second-Level, you are not satisfied with the determination made by the Claims Administrator, or if the Claims Administrator fails to respond to your appeal

in accordance with applicable regulations regarding timing, you may be entitled to request an external review of the Claims Administrator's determination.

You may request an external review of an adverse benefit determination if the denial is based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your representative may request an expedited external review, in urgent situations, by calling EyeMed. This is the External Review a participant can request after an appeal is denied, or by sending a written request to the address listed in the determination letter. **Please Note this Deadline**: A request must be made within four (4) months after the date you received the Claims Administrator's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and SSN;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). The Claims Administrator has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by the Claims Administrator of the request;
- a referral of the request by the Claims Administrator to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, the Claims Administrator will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the vision service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the preliminary review, the Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Claims Administrator will assign an IRO to conduct such review. The Claims Administrator will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten (10) business days following the date of receipt of the notice additional

information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten (10) business days.

The Claims Administrator will provide to the assigned IRO the documents and information considered in making the Claims Administrator's determination. The documents include:

- all relevant vision records;
- all other documents relied upon by the Claims Administrator; and
- all other information or evidence that you or your provider submitted. If there is any information or evidence you or your provider wish to submit that was not previously provided, you may include this information with your external review request and the Claims Administrator will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Claims Administrator. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and the Claims Administrator, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing the Claims Administrator's determination, the Plan will immediately (as soon as administratively possible) provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the vision service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, the Claims Administrator will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the review, the Claims Administrator will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Claims Administrator will assign an IRO in the same manner the Claims Administrator utilizes to assign standard external reviews to IROs. The Claims Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions

reached by the Claims Administrator. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to the Claims Administrator.

You may contact the Claims Administrator at the number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined by the medical benefit option; (**Urgent Care claims do not apply to vision services**) and
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify before non-Urgent Care is provided; (**Pre-Service claims do not apply to vision services**) and
- Post-Service- a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and the Claims Administrator are required to follow for Post-Service Claims. If you wish to review the Urgent Care or Pre-Service chart, refer to the *General Information SPD*.

Post Service Claims

Types of Claim or Appeal	Timing
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
if the initial claim in complete, within	30 days
after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal in adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
you must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment,

the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

How to Appeal a Denied Eligibility/Participation Claim (not for Services)

If you or your dependent(s) are initially denied services when you are making an appointment or at the Provider's office and they are indicating you and/or your dependent(s) are not showing covered/eligible, or if after you receive an initial denial of a submitted claim, there are **two** levels of appeal you may be able to pursue. Both the first level and second level appeals should be submitted to the Plan Administrator. You will need to reach out to the Plan Administrator to start the process as there is a specific form, Claim Initiation Form (CIF) that will need to be completed and submitted along with any supporting documentation you feel would be appropriate to include with your appeal request.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Plan Administrator within 180 days from the receipt of the first level appeal determination. The below chart outlines both the timeline for filing an appeal by you and for receiving responses from the Plan Administrator.

Eligibility/Participation Claims

Type of Appeal	Timing
Complete, sign and return the Claim Initiation Form (CIF) for a Level One Appeal review. The form is available in the Reference Center on the Health and Life website. You may also include with your CIF, any additional documentation that you feel supports your claim.	
The Plan Administrator must notify you of the determination:	
The Plan Administrator must notify you of the Level One appeal decision within:	**30 days** upon receipt
If your Level One appeal is denied and you want to submit a Level Two (instructions are within your Level One decision notice), you must do so within:	***180 days** after receiving the Level One appeal decision
The Employee Benefits Committee (EBC) must notify you of the Level Two appeal decision within:	**60 days** upon receipt (up to an additional 30 days may be required to fully review your claim, if necessary). If an additional 30 days is needed, you will be notified.

*__180 days__ after receiving the Level One Decision

If your claim impacts premiums (owed credits or charged premium deductions through Direct Bill & Payment, Payroll or Pension), the timeline to file a Level Two appeal is 180 days but no later than the end of the Plan year. In other words if the 180 days goes into the following year, you only have until the end of the current year to file.

Claim for Payroll Adjustments and Deadlines

If your benefit premium contributions/deductions are not correct or not what you expect you must make a claim to the Plan

Administrator in accordance with the claim's procedures as soon as possible after the year's payroll deductions begin.

► If your claim is denied, be advised that there is a deadline to file an appeal and if you miss the deadline, your contributions/deductions remain in place for the Plan year. The time period to make an appeal is the earlier of:

- (1) within 180 days of an adverse 1st level decision by the Plan Administrator, or
- (2) the earlier of
  a. within 180 days of the effective date of an election that is later claimed to be erroneous, or
  b. by the last day of the Plan year of when the election error is claimed to have occurred.

Note: If the appeal is not filed by this deadline it shall be deemed untimely and denied on that basis.

Time Deadline to File a Benefit Claim and the Time Deadline to File a Benefit-Related Lawsuit

The Health Plan provides that no person has the right to file a civil action, proceeding or lawsuit against the Health Plan, including, but not limited to, the Company, any Participating Company, the Committee or any other fiduciary, or any third party service provider unless it is filed within the timing explained as follows below:

Initial Claim: The time frame for filing an initial claim for a premium Payroll Adjustment is the earlier of:

1. Within 180 days of an adverse decision by the Plan Administrator, or
2. The earlier of:
   a. Within 180 days of the effective date of an election that is later claimed to be erroneous, or
   b. By the last day of the Plan Year of when the election error is claimed to have occurred. If the initial claim is not filed by this deadline, it shall be deemed untimely and denied on that basis. Appeals from a claim denial must also be timely filed as described in this SPD.

Legal Action Deadline: After you have exhausted or completed the claims and appeals procedures as explained, you may pursue any other legal remedy, such as bringing a lawsuit or civil action in court provided, that you file a civil action, proceeding or lawsuit against the Plan or the Plan Administrator or the Claims Administration no later than the last day of the twelfth month following the later of (1) the deadline for filing an appeal under the Plan or (2) the date on which an adverse benefit determination on appeal was issued to you with respect to your Plan benefit claim.

This means that you cannot bring any legal action against the Plan, the Employee Benefits Committee or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described. After completing that process, if you want to bring a legal action, you must do so no later than the last day of the 12th month from the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan or the Claims Administrator.

Agent for Service of Legal Process

Lumen
Attn: Associate General Counsel
100 CenturyLink Drive
Monroe, LA 71203

Legal Process May Also Be Serviced:

The Corporation Company (a.k.a. CT Corp)
1675 Broadway, Suite 1200
Denver, CO 80202

GENERAL ADMINISTRATIVE PROVISIONS

This section summarizes the legal information about the Plan. For more information, refer to the *General Information SPD*.

Plan Document

This Benefits Summary presents an overview of your Benefits. In the event of any discrepancy between this summary and the official *Plan Document*, the *Plan Document* shall govern.

Right to Amend and Right to Adopt Rules of Administration

The Plan Administrator, the Employee Benefits Committee, may adopt, at any time, rules and procedures that it determines to be necessary or desirable with respect to the operation of the Plan. Lumen, in its separate and distinct role as the Plan Sponsor has the right, within its sole discretion and authority, at any time to amend, modify, or eliminate any benefit or provision of the Plan or to not amend the Plan at all, to change contribution levels and/or to terminate the Plan, subject to all applicable laws. Lumen has delegated this discretion and authority to amend, modify or terminate the Plan to the Plan Design Committee.

Interpretation of Plan

The Plan Administrator, and to the extent it has delegated to the Claims Administrator, have sole and exclusive authority and discretion in:

- Interpreting Benefits under the Plan
- Interpreting the other terms, conditions, limitations, and exclusions set out in the Plan, including this SPD
- Determining the eligibility, rights, and status of all individuals and dependents under the Plan
- Making factual determinations, finding and determining all facts related to the Plan and its Benefits
- Having the power to decide all disputes and questions arising under the Plan

The Plan Administrator and to the extent it has delegated to the Claims Administrator may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Plan Administrator, or its authorized delegate, may, in its sole discretion, offer Benefits for services that would not otherwise be Covered Health Services. The fact that the Plan Administrator does so in any particular case shall not in any way be deemed to require them to do so in other similar cases.

Circumstances that May Affect Your Benefit

There are limitations that may apply to your Benefit under the Vision Plan benefit option. Some of these are listed in this SPD, but there may be other circumstances that are listed in the *General Information SPD* and you are encouraged to review that document to fully understand your benefit coverage.

Records and Information and Your Obligation to Furnish Information

At times, the Plan or the Claims Administrator may need information from you. You agree to furnish the Plan and/or the Claims Administrator with all information and proofs that are reasonably required regarding any matters pertaining to the Plan including eligibility and Benefits. If you do not provide this information when requested, it may delay or result in the denial of your claim.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you, to furnish the Plan or the Claims Administrator with all information or copies of records relating to the services provided to you. The Plan or the Claims Administrator has the right to request this information at any reasonable time as well as other information concerning your eligibility and Benefits. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed an enrollment form, if

applicable. The Plan agrees that such information and records will be considered confidential.

We and the Claims Administrator have the right to release any and all records concerning dental care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required by law or regulation. For complete listings of your dental records or billing statements, we recommend that you contact your Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms. If you request dental forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records. In some cases, we and the Claims Administrator will designate other persons or entities to request records or information from or related to you and will release those records as necessary. Our designees have the same rights to this information as we have. During and after the term of the Plan, we and our related entities may use and transfer the information gathered under the Plan, including claim information for research, database creation, and other analytic purposes.

Clerical Error

If a clerical error or other mistake occurs, however occurring, that error does not create a right to Benefits. Clerical errors include, but are not limited to: providing misinformation on eligibility or benefit coverages or entitlements or relating to information transmittal and/or communications, perfunctory or ministerial in nature, involving claims processing, and recordkeeping. Although every effort is and will be made to administer the Plan in a fully accurate manner, any inadvertent error, misstatement or omission will be disregarded, and the actual Plan provisions will be controlling. A clerical error will not void coverage to which a Participant is entitled under the terms of the Plan, nor will it continue coverage that should have ended under the terms of the Plan. When an error is found, it will be corrected or adjusted appropriately as soon as practicable. Interest shall not be payable with respect to a Benefit corrected or adjusted. It is your responsibility to confirm the accuracy of statements made by the Plan or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan Documents.

Administrative Services

The Plan may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing and utilization management services. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion and over time. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Workers' Compensation Not Affected

Benefits provided under the Health Plan do not substitute for and do not affect any requirements for coverage by Worker's Compensation insurance.

Conformity with Statutes

Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered), is hereby amended to conform to the minimum requirements of such statutes and regulations. As a self-funded plan, the Plan generally is not subject to State laws and regulations including, but not limited to, State law benefit mandates. This benefit option is an "excepted benefit" not subject to the mandated requirements of the Affordable Care Act.

Refund of Benefit Overpayment to You or an Eligible Dependent

If the Plan pays Benefits for expenses incurred by a Covered Person, that Covered Person, or any other person or organization that was paid, must refund the overpayment if either of the following apply:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the

Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person

- All or some of the payment we made exceeded the cost of Benefits under the Plan
- All or some of the payment was made in error.

The refund equals the amount the Plan paid in excess of the amount the Plan should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future Benefits including adding the amount of the overpayment to your W-2 income.

Additionally, if the Covered Person was determined not to be eligible for the Benefits under the Plan, that individual must refund the amount of the excess Benefit payment and the Plan may undertake collection actions, subject to the requirements of applicable law.

This SPD must be read in conjunction with the *General Information SPD*, which explains many details of your coverage and provides a listing of the other benefit options under the Plan.