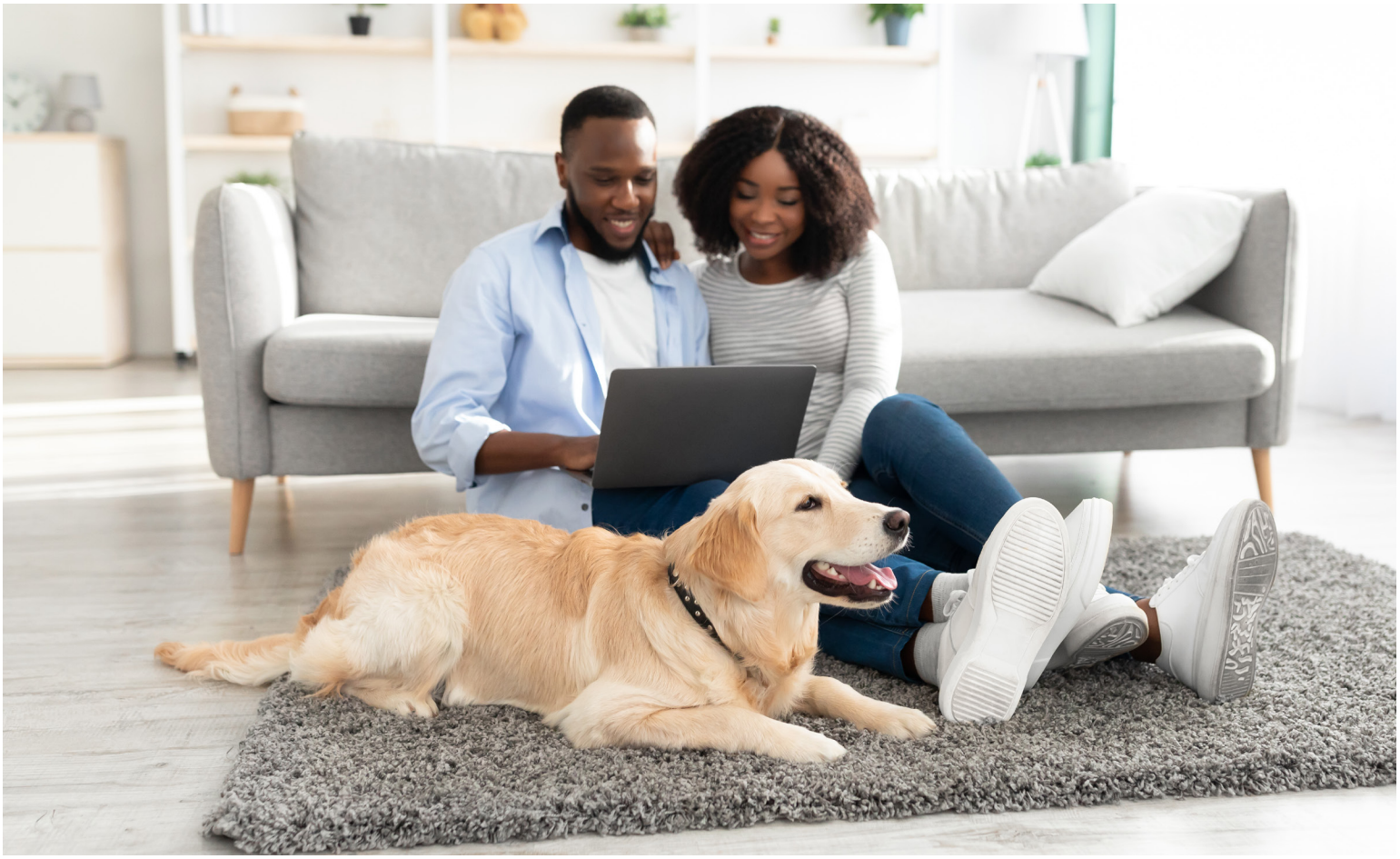
Your benefits. Your choice. Enroll now.

Nov. 8 - Nov. 22, 2023

2024 Annual Enrollment Guide

For COBRA Participants



LUMEN®

Contents

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

LUMEN®

Welcome to Annual Enrollment

Annual Enrollment is your opportunity to find the benefit options, plans and programs that are right for you and your eligible dependent(s). **We encourage you to review this guide and your available options even if you don't want to make changes.**

Go to the Health and Life website at **lumen.com/healthbenefits** to learn about your 2024 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 or make changes.

If you don't enroll by Nov. 22, you will be automatically enrolled in the plans and coverage levels displayed on your Annual Enrollment Notice and on the Health and Life website. You should save a copy of your Enrollment Notice as this will service as your Benefit Summary (Confirmation Statement).

Helpful Tip

Lumen is committed to green initiatives. Going green doesn't just benefit the planet – it also helps us all save money, time and resources. You can help us with this initiative by electing to receive communications from the Lumen Health and Life Service Center through email rather than a paper copy through the U.S. Postal Service.

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

- ☐ **Update/Confirm your Email Address**
  - Log in to **lumen.com/healthbenefits**
  - Click on the **Profile** icon in the center of the home page, or, you can click your name in the top right-hand corner and select **Profile** from the drop-down menu
  - Select **Edit** next to Contact Preferences under the Personal Preferences section
  - Choose the **Electronic Mail** radio button
  - Add your **Personal Email Address**
  - Select the **Primary** radio button
  - **Save**

What's New for 2024

The information listed below is a "Summary of Material Modifications" (this "SMM") for purposes of the Individual Retirement Income Security Act of 1974 ("ERISA"). This SMM notifies you of certain changes to the Company-sponsored plans that are subject to ERISA (collectively, the "Plan") and only summarizes certain Plan provisions. For more Plan details, refer to your Summary Plan Descriptions ("SPDs") as well as the Legal and Important Required Notices section in this guide.

Please keep this SMM with your SPDs for future reference. Note that if there is a conflict between the terms of the Plan documents and this SMM, the terms of the Plan documents will control. The Plan Administrator has the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan and the Company reserves the right to amend and/or terminate any benefits or plans.

It's important that you educate yourself before selecting your benefits.

Benefit Premiums

With costs continuing to increase across the country, premiums for most plans will also increase for 2024. Lumen continues to look for ways to control healthcare cost increases while still offering plans and programs that offer value and provide the best health outcomes.

IMPORTANT REMINDER: Account Statements are not mailed from the Service Center. If you selected to receive communication by email, you will receive an email notification when your statement is available. Refer to the reminders section of this guide for more information related to direct bill and payments.

Enrollment on the Health and Life website has been simplified

You can select from the following options when enrolling on the Health and Life website. Option 1 will provide step-by-step instructions to enroll. Option 2 will allow you to keep the same plans/programs as last year. Option 2 will take you to the Benefit Summary page for your review and approval. Review the Enroll section of this guide for more information.

Medical

The below plans will be referred to as follows:

- Consumer Driven Health Plan: CDHP
- High Deductible Health Plan: HDHP
- Doctors Plan: Doctors Plan
- Surest Health Plan: Surest PPO
- UnitedHealthcare: UHC

Note: The CDHP, HDHP and Doctors Plan are administered by UHC.

Health Savings Account (HSA)

HSA limits are determined by the IRS and are subject to change. 2024 HSA limits will increase.

Coverage Level	2024 Limits	2023 Limits
Individual	$4,150	$3,850
Individual + One or more eligible dependents enrolled	$8,300	$7,750

These changes apply to: CDHP and HDHP

Deductibles will increase.

Plan	Coverage Level	2024 Deductible		2023 Deductible	
		In-Network	Out-of-Network	In-Network	Out-of-Network
CDHP	Individual	$1,600	$3,200	$1,500	$3,000
	Individual + Spouse/Domestic Partner or Individual + Children	$2,400	$4,800	$2,250	$4,500
	Family	$3,200	$6,400	$3,000	$6,000
*HDHP	Individual	$1,600	$3,200	$1,500	$3,000
	Family	$3,200	$6,400	$3,000	$6,000

***Note:** The HDHP does not have the same coverage levels as the CDHP.

These changes apply to: CDHP, HDHP and the Doctors Plan

Child and Family Behavioral Coaching – Virtual Behavioral Coaching is a personalized, typically eight (8) week long, coach-led program that uses the principles of cognitive behavioral therapy (CBT) presented in a series of progressive weekly modules. This program is designed to help you or your child manage mild-to-moderate symptoms of stress, anxiety and depression and learn coping skills—at no cost. The program pairs virtual live coaching sessions with a digital curriculum consisting of guided content and activities. You will receive support from a dedicated behavioral health coach via 30-minute weekly audio or video calls and in-app messaging between sessions. Children receive help from a pediatric behavioral care provider. You can access modules 24/7 via smartphone, tablet, or computer. This program is available for eligible dependent(s) up to the age of 18.

Expand Acupuncture Coverage – Acupuncture has been expanded to cover all medical diagnoses. Refer to the applicable SPD for additional detail regarding percentage of coverage or co-pays. **Note:** Acupuncture Coverage is currently in place for Surest PPO for all diagnoses.

Specialist Management Solutions (SMS) - SMS offers support for specialty and outpatient surgical care needs. Whether scheduling a routine colonoscopy, orthopedic surgery, or other specialty care procedure, SMS connects members to a local Ambulatory Surgery Center (ASC) or Center of Excellence (COE). SMS offers unmatched access to high-quality, localized, and cost-effective clinical care to provide better experiences and improved health outcomes. An SMS Care Advocate or nurse will help find a specialist for your condition, schedule an appointment, and discuss options for a localized site of care. If surgery is the right path for you, a registered nurse can help find a designated provider and facility.

Enrollment in the Specialist Management Solutions (SMS) program is required to access benefit

coverage for inpatient and outpatient hip, knee, shoulder or spine surgery. If you don't enroll in SMS, the prior authorization will be denied and you could be responsible for the full cost of the surgery. You can continue to utilize 2nd.MD; however, when enrolled in SMS, a second opinion is not required for hip, knee, shoulder or spine surgery and the $500 penalty no longer applies.

Note: Surest PPO participants will continue to utilize 2nd.MD, and a second opinion is required for hip, knee, shoulder, or spine surgery. The $500 penalty applies for participants who do not seek a second opinion for the above surgeries.

Virtual Behavioral Coaching (VBC) - VBC is a personalized, adult coach-led program that uses the principles of cognitive behavioral therapy (CBT) presented in a series of progressive eight (8) weekly modules. This program is designed to help participants manage mild to moderate symptoms of stress, anxiety and depression, and learn coping skills - at no cost. VBC is available for eligible participants 18 years and older.

These changes apply to: CDHP, HDHP, Doctors Plan and Surest PPO

Expand Nutritional Counseling Visit Limits – Visits will expand from three (3) per lifetime per condition to five (5) per year. This applies to covered health services for medical education services provided by a licensed or healthcare professional when education is required for a disease that requires self-management and if there is a knowledge deficit regarding the disease. Some examples include: Congestive Heart Failure, Coronary Artery Disease, Gout, Hyperlipidemia, Obstructive Airway Disease, Phenylketonuria and Renal Failure.

Travel and Lodging Benefit for Services Not Covered (Non-Optum Services and Programs) - When services are not available for you in your state of residence due to law or regulation, and services are received in another state, as legally permissible by law, you may now be eligible for some travel and lodging expenses. Review the applicable medical SPD for more information.

Virtual Physical Therapy - Kaia will no longer be offered. Hinge Health will continue to be provided at no cost to you and your eligible dependents enrolled in a Lumen medical plan. Hinge Health provides all the tools you need to get moving again from the comfort of your home. Here are some of the ways your treatment plan could be tailored to you:

- Get a personal care team, including a physical therapist and health coach;
- Schedule personal physical therapy sessions as needed;
- Receive wearable sensors that give live feedback on your form in their app.

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

Go to **lumen.com/hingehealth** to learn more. For questions, you can call Hinge Health at 855-902-2777 or send an email to **hello@hingehealth.com**.

Note: If you are currently using Kaia, you will receive an email from Kaia in Dec. indicating that your program will end on Dec. 31, 2023.

These changes apply to: Surest PPO

Fertility Solutions - Surest members will have access to the same fertility program as UHC (CDHP and HDHP) members. Fertility Solutions provides you with helpful information, emotional support and experienced guidance as you explore options for expanding your family. A dedicated team

of experienced fertility nurses are here to help you: get information on cause of interfertility and treatment options; find doctors, clinics and facilities that meet your needs; and navigate the health care system.

If you are currently undergoing treatment with Progyny, you may be eligible to continue with your current provider. Call 866-774-4626 for more information.

Health Reimbursement Account (HRA) rollover – If you transition from the CDHP to Surest and have an HRA, your HRA funds will rollover automatically. **NEW:** You will not be required to submit a request for reimbursement.

Provider Administered Specialty Medications, Medical Infusions and Chemotherapy - Surest is continuing to drive better alignment of pricing relative to cost, frequency, and duration of provider-administered specialty medications in order to provide an equitable benefit across members with varying levels of care. If you have questions related to these benefits please contact Surest member services at 866-683-6440.

Virtual Care Capabilities - Virtual Care Capabilities are expanding to include dermatology, gastroenterologist, migraine care, speech therapy, and more. This provides flexibility and adds additional access to specialty care. Virtual Care is considered in-network. Review the Surest app, website, or the SPD for more information.

Prescription Drug

These changes apply to: CDHP, HDHP, Doctors Plan and Surest PPO

Rx Polypharmacy Value Management Program – This voluntary program can help if you take five (5) or more different medications. OptumRx will work with you, your pharmacists, and prescribing physicians to identify medications that you may no longer need and fine-tune the dosage and time period for the ones you do.

Rx Vital Medication Program - To help ensure access to affordable care, this program offers certain life-saving/emergency drugs at no additional cost to you. This means you may have no out-of-pocket costs for preferred insulins and certain other medications, including albuterol, glucagon, epinephrine, insulin, and naloxone.

These changes apply to: CDHP, HDHP and Surest PPO

Prescription Drug List (PDL) – The Lumen plans for 2024 will all have the same PDL; this new PDL is called the Essential PDL. Excluded drugs on this PDL are listed as Non-Formulary and have a pathway to coverage. If you have tried and failed on the covered alternative medications, the non-formulary drug will be covered. Prices may vary depending on which plan you enroll in. The tier of your medication may change with the new PDL. You can use the pricing tool to review costs. Refer to the Prescription Drug row in the **Reminders** section for more information.

Note: The Essential PDL is currently in place for the Doctors Plan; however, the copays differ from these plans. Refer to the Doctors Plan Overview page for copay information.

Copay Updates -

CDHP and HDHP		
	2024 Copays (after deductible)	**2023 Copays (after deductible)**
Retail		
Tier 1	15% min of $10	15%
Tier 2	20% min of $45	20%
Tier 3	30% min of $150	30%
Tier 4	40% min of $300	40%
Mail		
Tier 1	15% min of $25	15%
Tier 2	20% min of $112.50	20%
Tier 3	30% min of $375	30%
Tier 4	40% min of $750	40%
Specialty		
Tier 1	15% min of $200	15%
Tier 2	20% min of $225	20%
Tier 3	30% min of $300	30%
Tier 4	40% min of $400	40%

Surest PPO		
	2024 Copays	**2023 Copays**
Retail		
Tier 1	$10	$10
Tier 2	$45	$70
Tier 3	$150	$100
Tier 4	$300	$200
Mail		
Tier 1	$25	$25
Tier 2	$112.50	$175
Tier 3	$375	$250
Tier 4	$750	$500
Specialty		
Tier 1	$200	$200
Tier 2	$225	$225
Tier 3	$300	$300
Tier 4	$400	$400

These changes apply to: Doctors Plan and Surest PPO

Rx Specialty Coupon Management - This program allows you to potentially save money by taking advantage of pharmaceutical manufacturer coupons. OptumRx will let you know if a coupon is available on your medication and how you can sign up for coupon savings each month.

Note: The Rx Specialty Coupon Management program is currently in place for the CDHP and HDHP.

Additional Updates

Company Couples or Parent/Child Relationship - If both you and your Spouse/Domestic Partner are employed or one is inactive or a retiree of Lumen or an acquisition/subsidiary, please call the Lumen Health and Life Service Center at 833-925-0487 so your record can be updated. This ensures you receive correct benefit plans and programs information. This also applies to parents and adult children who are both employed by Lumen, or one is in an inactive status.

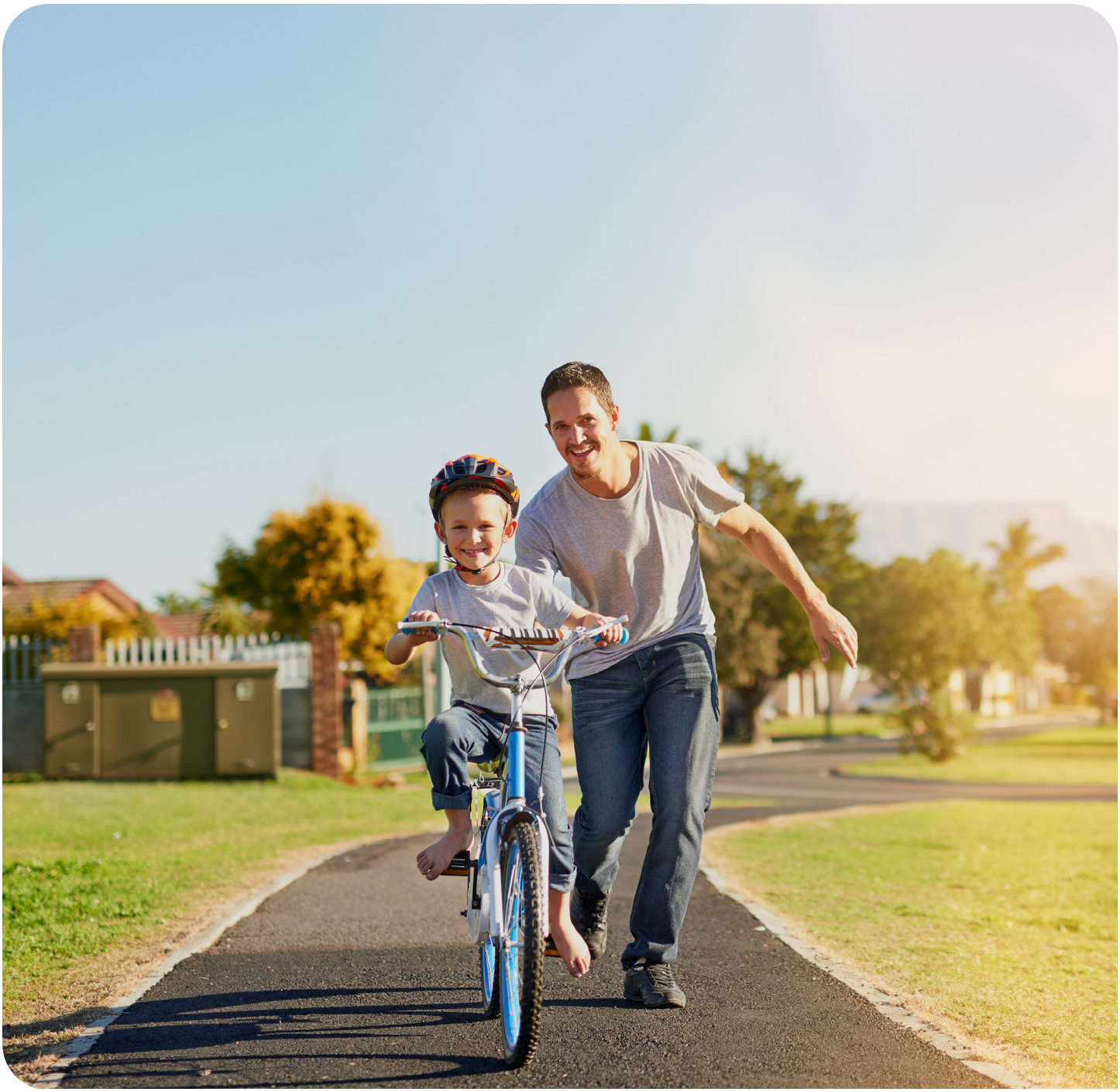
Dependent Access Features available on the Health and Life website - Spouses (SPs) and domestic partners (DPs) who are enrolled in a Lumen Health and/or Life plan can register for their own account on the Health and Life website at **lumen.com/healthbenefits**.

Select **Register** and enter the SP/DP information: last four digits of Social Security Number, date of birth, and zip code (from the mailing address).

Click **Continue** and walk through creating a username and password.

Your SP/DP can review the Benefit Summary and find helpful documents within the Reference Center such as Benefit Guides and Summary Plan Descriptions (SPDs). Also available, after registering, is the MyChoice Mobile App (available for download in the App Store and Google Play). ID cards can also be stored on the MyChoice Mobile App.

Multi Factor Authentication (MFA) – MFA adds extra security to your account on the **Health and Life website**. In addition to a username and password, you can utilize an email or SMS (text) messaging to receive a code to securely access your account. After entering your username and password, and answering security questions, if applicable, you will be prompted for your email or phone number to receive a validation code. To begin, select the Profile icon from the center of the home page on the Health and Life website. This is an optional service and is not required, but is recommended for security purposes.



Reminders

Note: If you experience a Qualified Life Event, (e.g. birth, divorce, etc.) as of Nov. 8, you will need to complete both 2023 and 2024 Annual Enrollment elections. If you don't make two elections, your benefits from 2023 will not roll over to 2024.

Benefit Details	Plan/Option Information	Prepare
Dependent Eligibility	Your dependent(s) will not be eligible for coverage until you have timely provided documentation that confirms their eligibility under the Plan or Program. If your documentation is not approved, your dependent(s) will not be enrolled.	You can upload your supporting documentation to the Health and Life website after you complete your enrollment. **IMPORTANT:** You may be asked to provide more than one supporting document to validate relationship status. Refer to the Dependent Verification page on the Intranet. Note: If you had a dependent covered under Lumen benefits at any time, the Health and Life Service Center is not able to "remove them completely" from the system as that would impact any prior benefits. To ensure your dependent is not covered going forward, when you make your elections do not select the radio button next to their name; if you do, that is adding them to coverage. Please review the Benefit Summary page to confirm they are not listed. If they are listed, you can select "edit" and go back to that specific plan to make the appropriate changes by unselecting the radio button next to their name.
Dependent Reverification	As a fiduciary responsibility under the Plan, Lumen will periodically conduct audits of covered dependents to confirm their continued eligibility for benefits under the Plan.	You will be required to provide supporting documentation (future notifications will advise you what documents to provide) that your Spouse, Domestic Partner, Common-Law Spouse, or any other dependent continues to qualify as your dependent under the Plan.
Direct Bill Payment	How to make payments.	Account Statements are not mailed. If you owe a premium for any of your benefits, you are encouraged to set up ongoing automatic payments for your direct bill account. If you choose to set up autopay, you must pay your outstanding balance in full before the autopay will begin. **Note:** If you choose to make one-time payments, you will incur a $2.00 service fee for each payment. This is not the same as autopay.

Benefit Details	Plan/Option Information	Prepare
Direct Bill Payment (continued)	How to make payments.	Follow the below steps to set up autopay on the Health and Life website or you can call the Service Center at 833-925-0487: • Log in to **lumen.com/healthbenefits**. On the lower right side of the screen, you will see **Payment Due** which provides details about your monthly premium. • Scroll down until you see **Make a Payment** and **View Account**. Select **Make a Payment**. • A pop-up window will appear. • Enter Account Type, Routing Number and Account Number. • Confirm the billing and email address. • Select **Yes** to set this account up as your primary payment method. • Select **Yes** to set up auto pay. Funds are automatically deducted on the fifth of each month. • Next, click **Pay**. • This will return you to the Billing Information page where you can view your account summary, payment history and account premium information. **You can also mail-in a payment to:** Businesssolver PO Box 850512 Minneapolis, MN 55485-0512 **Note:** You must include your **account number** and **Lumen** on the Memo line of the check.
Medicare Eligible	Contact the Service Center at 833-925-0487 if you or your dependent(s) become Medicare eligible.	If you have questions regarding Medicare, you can visit medicare.gov or contact Medicare at 800-medicare. If you or your dependent(s) become eligible for Medicare, while on COBRA, you will no longer be eligible for COBRA medical coverage.
Prescription Drugs	The Prescription Drug List (PDL) is updated periodically throughout the year.	You can use the pricing tool on the following websites based on the medical plan you are enrolling in for 2024: • CDHP and HDHP – **myuhc.com** • Doctors Plan – **lumen.com/whyuhc** • Surest PPO - **lumen.com/joinsurest**, Access Code: ENROLL2024

Benefit Details	Plan/Option Information	Prepare
Tobacco-Free Discount (The Tobacco-Free Discount applies if you are enrolled and eligible for subsidized medical coverage)	**Medical/Prescription Drug -** The amount you pay for your medical/prescription drug coverage is determined by your base pay, the medical plan elected, coverage level and tobacco use. If your base pay increases or decreases during the year, you may see a change to your premiums. The discount is calculated off the total cost of coverage. If you and your eligible dependent(s), if applicable, enroll in a Lumen medical plan and are non-tobacco users or are enrolled in a Company-recognized tobacco cessation program, you are eligible for discounted rates. If you are tobacco users, you are not eligible for discounted rates but are still eligible to enroll. **What is a Tobacco Product?** Tobacco products include but are not limited to the following: chewing tobacco, cigarettes, cigars, e-cigarettes, hookahs, nicotine gels/ dissolvables, pipe tobacco, tobacco snuff, vapors and other products associated with tobacco.	Answer the Tobacco-Free Discount questions during your enrollment. **What is a Company-recognized Tobacco Cessation Program?** Quit For Life is a Wellness Coaching Program available to you and your covered dependent(s) over the age of 18 at no cost. You can find more information related to the Program at Quitnow.net or call 866-QUIT-4-Life TTY 711. You can alternatively enroll in a tobacco cessation program of your choice, such as one sponsored by a local hospital, the American Lung Association or one recommended by your doctor. The Plan will accommodate the recommendation of an individual's personal doctor, if needed.
Working Spouse/ Domestic Partner Surcharge (The Working Spouse/ Domestic Partner Surcharge applies if you are enrolled and eligible for subsidized medical coverage)	If you are subject to the Working Spouse/ Domestic surcharge, the amount will be added to your monthly medical cost and will therefore, not reflect separately on your Benefit Summary.	Answer the Working Spouse/Domestic Partner question during your enrollment.
Zip Code Updates	Review your Annual Enrollment Worksheet	Medical provider networks are determined by ZIP code area, and those ZIP codes are reviewed each Annual Enrollment as providers go in-and out-of-network. Be sure to review the medical plans available to you on the Health and Life website or on your Enrollment Notice as options may change (based on your mailing address on file).

Enroll

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

When can I enroll? Annual Enrollment is from Nov. 8 through Nov. 22, 11:59 p.m. .

How to enroll:

Mobile Device Enrollment

- Download the free MyChoice Mobile App for iOS or Android from the App Store or Google Play
- Enter or set up a username and password (you can register using your Health and Life website Username and Password) and open the MyChoice Mobile App.
- Tap the menu in the upper left corner and select **Benefits Portal Home Page**. Then, click the Enrollment link to review your options and make your Annual Enrollment elections.

Enrollment on the Health and Life website

1. Navigate to the **Health and Life website** and log in. If you have not accessed the Health and Life website, continue to step 2. If you have, go to step 4.
2. Review the **Getting Started Details** to agree to the electronic disclosure agreement and select **Continue**.
3. Enter your **Personal Preference** on how you wish to receive benefit communications. Click **Continue**.
4. Select **Start Here** at the top of the screen to begin your 2024 Annual Enrollment elections.
5. Read the opening message and select **Start Enrollment**.
6. Read information introducing Sofia, your personal benefits assistant. Select **Start Enrollment**.
7. Review your personal information and update an alternate address, if applicable, click **Next.**
8. Read the Tobacco Free Discount information and confirm response, click **Next. This applies if you are eligible for subsidized COBRA coverage during the subsidy period.**
9. Confirm all applicable dependents are on file. Add any new dependents. Review dependent demographic information.
10. You have two options when enrolling. Option 1 will provide step-by-step instructions. If you select this option, continue to step 11. Option 2 will allow you to keep the same plans/programs. This option will take you to the Benefit Summary page for your review. If you select this option, continue to step 12.
11. Elect all healthcare (medical, dental, vision) plans. If you are enrolling in the Doctors Plan, you will be asked to identify your Primary Care Physician (PCP) during enrollment. **Note:** If you enroll a spouse/domestic partner in medical coverage and you are eligible for subsidized COBRA **(this applies during the subsidy period)**, you may be subject a working spouse/domestic partner surcharge based on how you answer the surcharge questions.
12. Review Your Elections, including plans, coverage levels and pricing in their entirety and select **Approve** to authorize your transaction.
13. Read the Confirmation pop up and select **I Agree**.
14. On the Transaction Complete page, print your Benefit Summary (formerly known as Confirmation Statement) as this is your confirmation of enrollment. Take note of the Confirmation Number for your records.
15. If an election has been made that requires Statement of Health/Evidence of Insurability (EOI), you will be provided information on how to complete the application.
16. If you added new dependent(s) to coverage, you will see information regarding the requirements for dependent verification. Read the requirements carefully. After you complete your enrollment, you can go back to the homepage to review the next steps to validate your dependent(s).

Note: If you are unable to enroll on the Health and Life website, be sure to review/update the above information with the Service Center advocate.

Phone Enrollment (longer than normal wait times usually occur on the first and last day of Annual Enrollment)

- 833-925-0487; we suggest you call in the mornings, Tuesdays - Fridays **Note:** Virtual Hold may be an option if you call during peak hours. You will not lose your place in line if you select this option. An advocate will call you back; however, it may not occur until the next business day.

Plan Overviews

Doctors Plan in Arizona and Colorado

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

In Arizona, this plan is available if your address on file is Maricopa and Pinal County.

In Colorado, this plan is available if your address on file is Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso or Jefferson County.

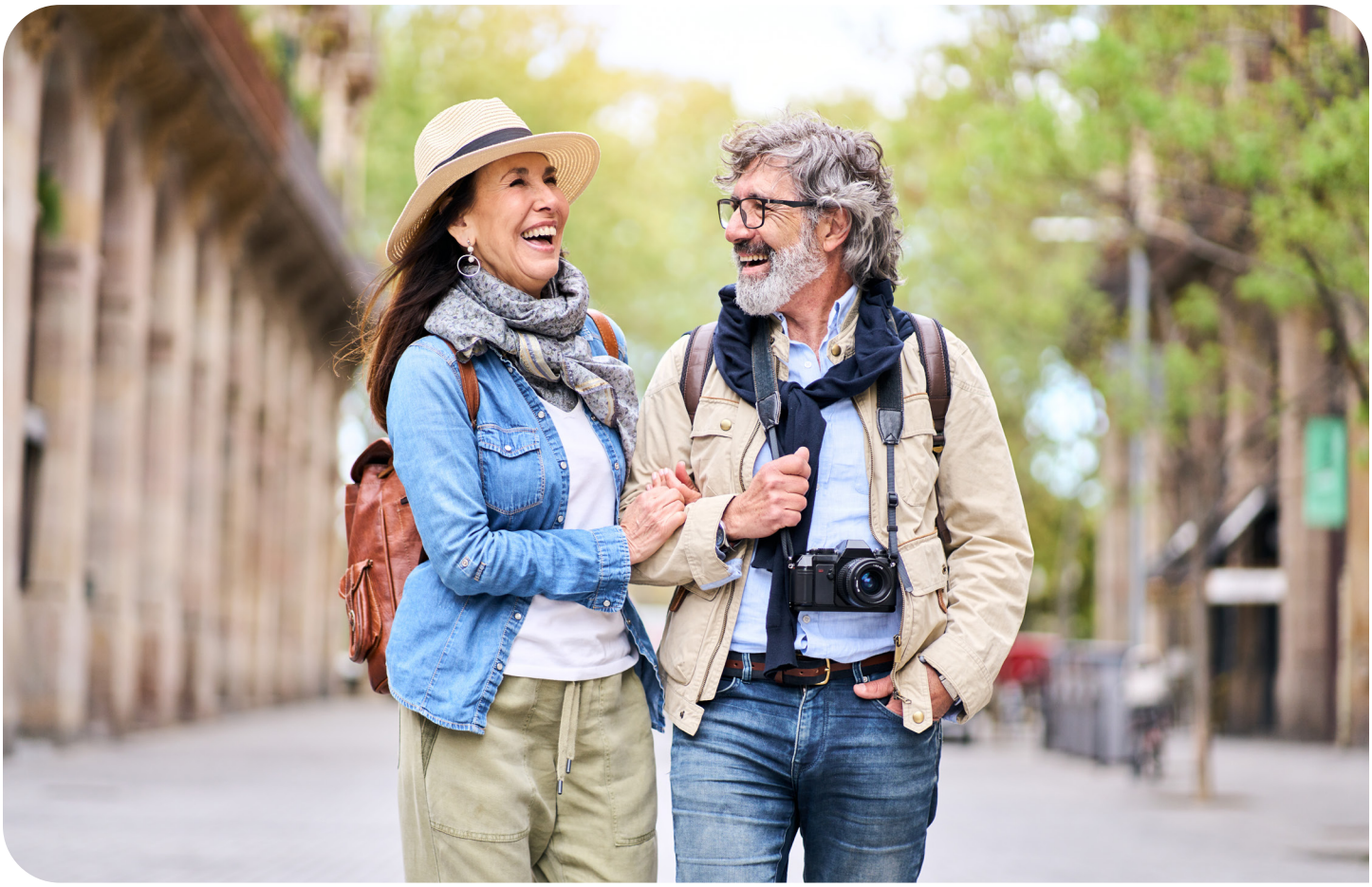
Action Required: Choose, review or update your Primary Care Physician (PCP) during Annual Enrollment for you and each covered dependent(s). If you don't, UHC will assign a PCP. In order to receive plan benefits, the Doctors Plan requires you to use In-Network providers.

Note: You pay a flat amount for prescription drug expenses based on the Tier of the medication. The amount you pay can be as low as ten dollars. This plan has a customized drug list covering the most effective drugs at the lowest cost; clinical review is available for coverage of non-formulary drugs.

	UHC Doctors Plan
You Pay	**In-Network**
	Annual Deductible (The Deductibles are separate for In-Network and Out-of-Network providers and are not combined)
	Individual
	$1,500
	Family
	$3,000 (deductible must be satisfied before coinsurance applies; no individual limits)
	Annual Out-of-Pocket Maximum (The Out-of-Pocket Maximums are separate for In-Network and Out-of-Network providers and are not combined)
	Individual
	$3,600
	Family
	$6,850 (Entire family out of pocket must be satisfied before eligible expenses are 100% covered)
Coinsurance	**In-Network**
	80% covered (Network Provider)
Primary care visit to treat an injury or illness	$0 Copay 100% covered
Specialist Visit	$75 Copay 100% covered
	Preventive Care: (No Deductible)

	UHC Doctors Plan	
Preventive care/screening/ immunization	100%	
Outpatient Lab and Pathology	80% after deductible	
Outpatient Surgery	**In-Network**	
	80% after deductible	
Emergency Room Services	$500 copay plus deductible and coinsurance	
Inpatient Hospital Care	80% covered after deductible	Out of Network / Not Covered
Prescription Drugs (Copays shown are for up to a 30 day supply of medication)	**Tier 1 Drugs**	
	• $10 copay	
	Tier 2 Drugs	
	• $25 copay	
	Tier 3 Drugs	
	• $100 copay	
	Tier 4 Specialty	
	• $400 copay	

Note: If you were previously enrolled in the CDHP and have an HRA balance, your balance will be moved to a spend down only account after the claim runout period of 90 days in 2024.



Medical Plan Comparisons - Surest PPO, High Deductible Health Plan and the Consumer Driven Health Plan

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

	Surest PPO		UHC HDHP		UHC CDHP	
HSA/HRA Contributions	Not Applicable		With Individual-Funded HSA (maximum contribution): • $4,150 Individual • $8,300 Individual + One or more dependent(s) enrolled **Note:** If you are 55 or older, you can contribute an extra $1,000 "catch-up" contribution.		With Company-Funded HRA Contribution: • $500 Individual • $750 Individual + Spouse/Domestic Partner (DP) • $750 Individual + Child/ren • $1,000 Individual + Family	
You Pay	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
	Annual Deductible (The Deductibles are separate for In-Network and Out-of-Network providers and are not combined)					
	Individual		**Individual**		**Individual**	
	$0	$0	$1,600	$3,200	$1,600	$3,200
					Individual + Spouse/DP	
					$2,400	$4,800
	Individual + Child/ren		**Family**		**Individual + Child/ren**	
	$0	$0	$3,200	$6,400 (deductible must be satisfied before coinsurance applies; no individual limits)	$2,400	$4,800
					Family	
					$3,200	$6,400 (deductible must be satisfied before coinsurance applies; no individual limits)
	Annual Out-of-Pocket Maximum (The Out-of-Pocket Maximums are separate for In-Network and Out-of-Network providers and are not combined)					
	Individual		**Individual**		**Individual**	
	$3,600	$7,200	$3,600	$7,200	$3,200	$6,400
	Individual + Spouse/Domestic Partner				**Individual + Spouse/Domestic Partner**	
	$5,400	$10,800			$4,800	$9,600
	Individual + Child/ren				**Individual + Child/ren**	
	$5,400	$10,800			$4,800	$9,600
	Family		**Family**		**Family**	
	$6,850	$14,400 (Entire family out of pocket must be satisfied before eligible expenses are 100% covered)	$6,850	$14,400 (Entire family out of pocket must be satisfied before eligible expenses are 100% covered)	$6,400	$12,800 (Entire family out of pocket must be satisfied before eligible expenses are 100% covered)

	Surest PPO		UHC HDHP		UHC CDHP	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Coinsurance	100% covered		85% covered (Tier 1 Premium Provider) 80% covered (Network Provider)	50% covered (you may be responsible for any amount over the eligible expense)	85% covered (Tier 1 Premium Provider) 80% covered (Network Provider)	50% covered (you may be responsible for any amount over the eligible expense)
Primary care visit to treat an injury or illness	$20-$90	$180	85% covered (Tier 1 Premium Provider) 80% covered (Network Provider)	50% covered (you may be responsible for any amount over the eligible expense)	85% covered (Tier 1 Premium Provider) 80% covered (Network Provider)	50% covered (you may be responsible for any amount over the eligible expense)
Specialist Visit	$20-$90	$180	85% covered (Tier 1 Premium Provider) 80% covered (Network Provider)	50% covered (you may be responsible for any amount over the eligible expense)	85% covered (Tier 1 Premium Provider) 80% covered (Network Provider)	50% covered (you may be responsible for any amount over the eligible expense)
Preventive Care: (No Deductible)						
Preventive care/ screening/ immunization	100% covered	100% covered	100%	Not covered	100%	Not covered
Inpatient (Facility), Office Visit, Outpatient (Facility), Prescriptions, Urgent Care						
Outpatient Lab and Pathology	$0	$0	85% covered	50% covered (after deductible is met)	85% covered	50% covered (you may be subject to balances over the eligible expense)
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Outpatient Surgery	Up to $3,000	Up to $7,200	85% covered (when performed at an Ambulatory Surgery Center) 80% covered (if performed as outpatient in a hospital)	Not covered	85% covered (when performed at an Ambulatory Surgery Center) 80% covered (if performed as outpatient in a hospital)	Not covered
Emergency Room Services	$500	$500	• 80% covered after deductible is met		• 80% covered after deductible is met	

	Surest PPO		UHC HDHP	UHC CDHP	
Inpatient Hospital Care	Up to $3,000 $1,400 for Inpatient Emergency Admit	$7,200 $2,800 for Inpatient Emergency Admit	80% covered (after deductible is met) 50% covered for Out-of-Network services	80% covered (after deductible is met)	50% covered (after deductible is met)
Prescription Drugs					
Tier 1 Drugs	• $10 for a 31 day retail supply • $25 for a 90 day retail/mail supply • $200 (In-Network) for Specialty Retail Pharmacy • Specialty medications are limited to a 31 day supply.		• 85% covered; minimum copay of $10 for retail, $25 for mail, $200 for Specialty; after deductible is met • Mandatory mail after two prescriptions for maintenance Rx • Up to 31-day supply/90 day if mail order (In-Network) • For certain preventive medications the deductible is waived. • Specialty medications are limited to a 31 day supply.	• 85% covered; minimum copay of $10 for retail, $25 for mail, $200 for Specialty; after deductible is met • Mandatory mail after two prescriptions for maintenance Rx • Up to 31-day supply/90 day if mail order (In-Network) • Specialty medications are limited to a 31 day supply.	
Tier 2 Drugs	• $45 for a 31 day retail supply • $112.50 for a 90 day retail/mail supply • $225 (In-Network) for Specialty Retail Pharmacy • Specialty medications are limited to a 31 day supply.		• 80% covered; minimum copay of $45 for retail, $112.50 for mail, $225 for Specialty; after deductible is met • Mandatory mail after two prescriptions for maintenance Rx • Up to 31-day supply/90 day if mail order (In-Network • For certain preventive medications the deductible is waived. • Specialty medications are limited to a 31 day supply.	• 80% covered; minimum copay of $45 for retail, $112.50 for mail, $225 for Specialty; after deductible is met • Mandatory mail after two prescriptions for maintenance Rx • Up to 31-day supply/90 day if mail order (In-Network) • Specialty medications are limited to a 31 day supply.	
Tier 3 Drugs	• $150 for a 31 day retail supply • $375 for a 90 day retail/mail supply • $300 (In-Network) for Specialty Retail Pharmacy • Specialty medications are limited to a 31 day supply.		• 70% covered; minimum copay of $150 for retail, $375 for mail, $300 for Specialty; after deductible is met • Mandatory mail after two prescriptions for maintenance Rx • Up to 31-day supply/90 day if mail order (In-Network) • For certain preventive medications the deductible is waived. • Specialty medications are limited to a 31 day supply.	• 70% covered; minimum copay of $150 for retail, $375 for mail, $300 for Specialty; after deductible is met • Mandatory mail after two prescriptions for maintenance Rx • Up to 31-day supply/90 day if mail order (In-Network) • Specialty medications are limited to a 31 day supply.	
Tier 4 Drugs	• $300 for a 31 day retail supply • $750 for a 90 day retail/mail supply • $400 (In-Network) for Specialty Retail Pharmacy • Specialty medications are limited to a 31 day supply.		• 60% covered; minimum copay of $300 for retail, $750 for mail, $400 for Specialty; after deductible is met • Mandatory mail after two prescriptions for maintenance Rx • Up to 31-day supply retail and Specialty/90 day if mail order (In-Network) • For certain preventive medications the deductible is waived. • Specialty medications are limited to a 31 day supply.	• 60% covered; minimum copay of $300 for retail, $750 for mail, $400 for Specialty; after deductible is met • Mandatory mail after two prescriptions for maintenance Rx • Up to 31-day supply retail and Specialty/90 day if mail order (In-Network) • Specialty medications are limited to a 31 day supply.	
	Tier 1, 2, 3 and 4 - Certain life saving/emergency medications on the Vital Medication list are covered at no cost share by you.				
Specialty Medications					
	No Out-of-Network prescription coverage for Specialty Medications.				

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

CDHP – If you enroll in this plan, the Company provides a subsidized Health Reimbursement Account (HRA). You can choose your healthcare providers; however, the Plan pays a greater benefit when you use providers that are in the network.

The HRA, participant responsibility (your out-of-pocket portion of the deductible) and out-of-pocket maximum are all based on the coverage level you elect (Individual Only, Individual & Spouse/Domestic Partner etc.), even if only one covered person uses the entire HRA benefit. You incur medical expenses and pay the full cost of the medical expenses with money in your HRA first, then you pay out-of-pocket until your deductible is met. You will be responsible for the cost of the prescription drugs until you have met your deductible. You can fill your prescription up to two times at retail pharmacy, after that, it will not be covered and you will pay the full retail price.

What happens to your HRA if you change medical plans as a result of a Qualified Life Event or during Annual Enrollment?

- Any CDHP HRA balance may also roll over if you change from the CDHP to the HDHP with Optional HSA. After the run-out period, any rollover balances will be deposited into a post deductible HRA account. The balance would be available once you have met your HDHP deductible.
- If you elect the Doctors Plan or the Surest PPO and have a prior CDHP HRA balance, these dollars will follow you. Your prior HRA dollars will not be available until after the run-out period (for claims from your prior coverage to clear under the CDHP HRA. This typically takes 90 days.

HDHP - You can choose your healthcare providers; however, the Plan pays a greater benefit when you use providers that are in the network.

You pay the full cost of the medical expenses until your deductible is met. You can also pay for covered services with money you have set aside in your HSA, if applicable. If you are Medicare eligible, you should review the "Medicare and You" handbook at medicare.gov.

Surest – You can review treatment options and costs before receiving treatment or choosing a provider. Here's how it works:

- Coverage starts at your first visit or prescription fill because this is a $0 deductible plan.
- Clear, upfront prices for treatments, doctors and prescription drugs. Know before you go what your healthcare choices will cost.
- Get the coverage you would expect from the broad, UHC Choice Plus national provider network.
- Shop by quality – copays are lower as an indication of higher-value care, based on quality, efficiency and overall effectiveness.

With this information, you can make informed decisions and find savings opportunities. For an overview, visit **lumen.com/joinsurest**, Access code: Enroll2024.

Dental

You can choose between two dental plan options; Option 1 or Option 2 or, you can waive this coverage. These plan options differ in terms of the amount of the annual benefit maximum, annual deductibles, orthodontia coverage, and your share of the cost of coverage. Both Dental Plan options are administered by MetLife.

This chart is only a snapshot summary of dental benefits. For specific details on how services are covered or excluded, please contact MetLife or refer to the Dental Summary Plan Description (SPD) on the **lumen.com/healthbenefits**.

Option 1	Option 2 (with orthodontia)
Passive PPO In and Out-of-Network (Your Dental PPO plan is passive, meaning that you will pay the same coinsurance levels, have the same deductible requirements and be allotted the same Annual Maximum value regardless of going In or Out-of-Network. In-Network services are subject to MetLife's negotiated Plus network rates. Out-of-Network services will be subject to the reasonable and customary charges. You may have additional out of pocket costs for services received from Out-of-Network providers.)	
Plan Year Benefit Maximum (per person)	
$1,000 (does not include oral surgery)	$2,000 (does not include oral surgery or orthodontia)
Orthodontia Lifetime Benefit Maximum	
N/A	$1,500 (separate from annual individual benefit maximum)
Plan Year Deductible (per person)	
$25 for general care and major and restorative; no deductible for diagnostic, preventive or oral surgery	$50 for general care and major and restorative (does not include orthodontia); no deductible for diagnostic, preventive or oral surgery
Lifetime Orthodontia Deductible (per person)	
N/A	$50
Plan Pays (after deductible)	**Plan Pays (after deductible)**
Diagnostic and Preventive (cleanings and exams) — No deductible	
100%* up to maximum allowable amount; two visits per year	100%* up to maximum allowable amount; two visits per year
X-rays	
Full mouth X-rays covered once every 60 months; bitewing X-rays covered once per year, except for dependent children under age 26. Children are eligible for bitewing X-rays twice per year.	Full mouth X-rays covered once every 60 months; bitewing X-rays covered once per year, except for dependent children under age 26. Children are eligible for bitewing X-rays twice per year.
General Care (fillings, root canals and periodontics)	
50%* up to maximum allowable amount	80%* up to maximum allowable amount
Major and Restorative (crowns, dentures and bridges)	
50%* up to maximum allowable amount	50%* up to maximum allowable amount
Oral Surgery — No deductible	
80%* no limit	80%* no limit
Orthodontia (adults and children)	
Not covered	50%* up to the maximum allowable amount after the $50 lifetime orthodontia deductible, per person (separate from annual deductible)

Administrator: MetLife **Group number:** 148069 **Phone number: 866-832-5756**

*Up to the plan maximum allowable amount. Subject to MetLife Preferred Dental Provider pre-negotiated fees or reasonable and customary charges if you see an Out-of-Network provider.

Vision

The vision care benefit has one option offered by EyeMed (aka EyeMed Vision Care/First American Administrators). **NOTE:** You also have the option to waive this coverage. Staying In-Network helps you save money on eye exams, contact lenses, and frames and lenses with a variety of options through the Insight (name of the in-network benefit) network to help save you even more. Since PLUS Providers are already through the Insight network, the additional perks are built right into your vision benefits. No promo codes, no coupons, no paperwork but you still have the same vision benefits, plus a little more savings.

Find plenty of In-Network optometrists, including PLUS Providers by going online to **lumen.com/visionfair** regardless if enrolled or not yet. You may also call EyeMed at **855-874-4744**. EyeMed's retail stores include but not limited to: **LensCrafters, Target Optical** and most **Pearle Vision** locations. EyeMed offers In-Network online options at: **ContactsDirect.com**, **Glasses.com**, **lenscrafters.com**, **ray-ban.com** and **targetoptical.com**. You must not only enroll but also register on EyeMed's site to become eligible for additional and special offers as an "EyeMed member."

This chart is only a snapshot summary of the available vision benefits. For specific details on how services are covered or excluded, please refer to the Vision Summary Plan Description (SPD) on the **Health and Life website**, or contact EyeMed.

Summary of Benefits

Vision Care Services	In-Network Cost Using PLUS Providers. PLUS Providers are distinguished on EyeMed's website when looking for a provider in a specified area.	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
Low Vision Supplemental Exam/Testing	$0 copay	$0 copay	Up to $125
Low Vision Aids	25% copay up to a maximum of $1,000	25% copay up to a maximum of $1,000	25% copay up to a maximum of $1,000
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)			

Summary of Benefits

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

Summary of Benefits

Vision Care Services	In-Network Cost Using PLUS Providers. PLUS Providers are distinguished on EyeMed's website when looking for a provider in a specified area.	In-Network Cost	Out-of-Network Reimbursement
LASIK or PRK from U.S. Laser Network (Call **800-988-4221**)	15% off retail or 5% off promotional price	15% off retail or 5% off promotional price	Not covered
Frequency (Adults and Children)			
Exam	Once every plan year		
Frame	Once every plan year		
Lenses (in lieu on Contact Lenses)	Once every plan year		
Contact Lenses (in lieu of Lenses)	Once every plan year		
Low Vision	Once every other plan year		

Definition of Contact Lens Fit

1. **Standard Contact Lens Fit** - Clear, soft, spherical, daily wear contact lenses for single vision prescriptions. Standard Contact Lens does not include extended or overnight wear lenses, which are intended to be worn during periods of sleep.

2. **Premium Contact Lens Fit** - Toric, multifocal, monovision, post-surgical, gas permeable contact lenses, and other non-Standard Contact Lenses. Premium Contact Lens includes extended and overnight wear lenses, which are intended to be worn during periods of sleep.

You are responsible to pay the Out-of-Network provider in full at the time of service and then submit an Out-of-Network claim for reimbursement. You will be reimbursed up to the amount shown within the Summary of Benefits section of this Guide. For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes. The benefit does not cover Safety eyewear, solutions, cleaning products or frame cases. For other Limitations and Exclusions, refer to the Vision SPD.

Offered by: EyeMed **Group number:** 1029819 **Phone number: 855-874-4744**

1) In certain states, Members may be required to pay the full retail rate and not the negotiated discount rate with certain participating Providers. Please refer to EyeMed's website and search Providers to determine which participating Providers have agreed to the discounted rate.
2) Discounts on vision materials may not be applicable to certain manufacturers' products.

Who Do I Contact - Helpful Resources

When you need more detailed information about Plan specifics, review your SPDs and SMMs located on the Health and Life website at **lumen.com/healthbenefits**. If you would like a paper copy of these materials, contact the Service Center at **833-925-0487**. Please be advised that mailing time is based on the USPS schedule. Lumen and the Service Center is unable to overnight forms, documents, letters, etc. **Note:** You may not receive these documents prior to the Annual Enrollment deadline.

Administrator - Plan - Program	Website/Group Number	Phone Number
Health Care		
Health and Life Service Center	**lumen.com/healthbenefits** Search: **MyChoice™ Mobile App**, available for Free in the App Store and Google Play	**833-925-0487** **317-671-8494** (International callers) Mon-Fri, 7 a.m. - 7 p.m. (CST)
Health Care Advocacy Services • For issues with your Health Care claims that you are unable to resolve on your own through the Claims Administrator or your Health Care provider.	**lumen.com/healthbenefits**	**833-925-0487** **317-671-8494** (International callers) Mon-Fri, 7 a.m. - 7 p.m. (CST)
Medical and Prescription Drug		
CDHP **Doctors Plan** **HDHP**	**UHC: myuhc.com** **Group Number:** 192086 Search: **UHC App**, available for Free in the App Store and Google Play	**800-842-1219** Mon-Fri, 8 a.m. - 10 p.m. (CST)
Surest PPO	If you are currently enrolled in the Surest PPO or want more informtion, visit **lumen.com/joinsurest**, access code: Enroll2024, to review updates for the 2024 Plan year. Search: **Surest**, available for Free in the App Store and Google Play **Group Number:** 78800186	**866-683-6440** Mon-Fri, 6 a.m. - 9 p.m. (CST)
Additional Medical Programs and Plans		
2nd.MD Lumen provides access to 2nd.MD services free for eligible participants and dependent(s) enrolled in a Lumen UHC or Surest PPO Plan.	**lumen.com/2ndmd** Search: **2nd.MD**, available for Free in the App Store and Google Play	**866-842-1151** Mon-Fri, 7 a.m. – 7 p.m. (CST)

Administrator - Plan - Program	Website/Group Number	Phone Number
Telemedicine **Doctors Plan:** MDLIVE **Surest:** Doctor on Demand, K Health and MDLIVE **UHC:** MDLIVE and Virtual Visits	patient.doctorondemand.com lumen.com/MDLIVE Search: **MDLIVE**, available for free in the App Store and Google Play myuhc.com/virtualvisits Search: **MyChoice™ Mobile App**, available for Free in the App Store and Google Play	**866-683-6440** Mon-Fri, 6 a.m. – 9 p.m. (CST) **800-842-1219** Mon-Fri, 8 a.m. - 10 p.m. (CST)
Dental		
Dental	metlife.com/mybenefits Search: **MetLife**, available for Free in the App Store and Google Play	**866-832-5756** Mon-Fri, 6 a.m. - 10 p.m. (CST)
Vision		
Vision	eyemed.com Search: **EyeMed**, available for free in the App Store and Google Play	**855-874-4744** Mon-Fri, 8 a.m. - 11 p.m. (CST)

Change of Address Update

Follow the steps below to update your address and/or phone number.

Administrator	Website/Email	Mail/Fax/Phone Number
Health and Life Benefits	lumen.com/healthbenefits • Click your name in the top right-hand corner and select **Profile** from the drop-down menu • Select **Your Information** under **Profile** • Update your address • **Save**	833-925-0487 317-671-8494 (Local DNIS for international callers) Mon-Fri, 7 a.m. – 7 p.m. (CST)

Summary of benefits and coverage availability

We offer an array of resources to help you understand and choose your medical benefits options. This section notifies you of an additional resource required by Health Care Reform — a Summary of Benefits and Coverage Availability (SBC) — that summarizes important information about any medical coverage options in a standard format, to help you compare features across Plan options. SBC's are available in the Reference Center on the **Health and Life website** throughout the year.

Legal and Important Required Notices

A note about privacy

Keeping your personal information secure is of primary importance. That's why we, along with the benefits administrators, have implemented various security measures and policies to help reduce the risk of unauthorized processing or disclosure of your personal information. You can also help by keeping 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. We encourage you add your personal email address as your contact preference on the Health and Life website at **lumen.com/healthbenefits**. Please be advised that using an email that is not secured may increase your risk of unauthorized disclosure.

The Company's reserved rights

This document summarizes certain provisions of the Disability Plan, the Life Insurance Plan and the Individual 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.

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 life events (QLEs) such as marriage, divorce, etc. Certain QLEs, or a second QLE during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Coverage is not advice

Health Plan coverage is not healthcare advice. Please keep in mind that the sole purpose of the Plan is to provide payment for certain eligible healthcare expenses – not to guide or direct the course of treatment for any Individual or eligible dependent. If your healthcare 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 healthcare provider can decide what the right healthcare 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 healthcare recommendations or advice.

Health Insurance Portability and Accountability Act (HIPAA)

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

- Termination of employer contribution toward other coverage;
- Moving out of a service area if the other plan does not offer other coverage;
- Ceasing to be a dependent, as defined in the other plan;
- Loss of coverage to a class of similarly situated

individuals under the other plan (for example, when the other plan does not cover temporary/ contractors).

If your 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 life 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.

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 healthcare coverage under the federal law known as COBRA. Eligibility for COBRA continuation coverage occurs only in cases of QLEs. For more information on what is a QLE, refer to the General Information Summary Plan Description.

Important note regarding your Annual Enrollment elections

By electing to participate in the Plans, by your submission of information, you have agreed to be bound to and by the provisions of each of the Plans and their administrative practices, including, but not limited to with respect to the recovery of over and underpayments, terms and conditions for eligibility and benefits. You certify that the submission of information by you in this enrollment process is true and accurate to the best of your knowledge, 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, plan or program 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. This excludes dependents who turn age 26, as they are automatically removed from coverage.

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

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. 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**).

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**.

Right to Amend and/or discontinue and make rules

The Company and its delegate, the Plan Design Committee, each has reserved the right, in its sole discretion, to change, modify, discontinue or terminate the Plan and/ or any of the benefits under the Plan and/ or contribution levels, with respect to all participants classes, retired or otherwise, and their beneficiaries at any time without prior notice or consultation, subject to applicable law, specific written agreement and the terms of the Plan Document and with respect to the Health Plan, the written agreement specific to Pre-1991 Individuals. 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.

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.