Your benefits. Your choice. Enroll now.

Nov. 8 - Nov. 22, 2023

2024 Annual Enrollment Guide

Qwest Pre-1991 Retirees, Including Inactive and COBRA participants

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Contents

- **Some references and benefit options in this guide apply only to Pre-1991 Retirees. For more information, refer to the Health and Life website at lumen.com/healthbenefits or contact the Lumen Health and Life Service Center. The Lumen Health and Life Service Center will be referred to hereafter as "the Service Center".**
- **Lumen will be referred to hereafter as "the Company".**

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Welcome to Annual Enrollment

Annual Enrollment is your opportunity to find the 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.

This guide pertains to BOTH non-Medicare and Medicare eligible participants and eligible dependents. If you make changes during Annual Enrollment, your new coverage will begin on the first day of the new calendar year. However, if enrolling in the UnitedHealthcare (UHC) Group Medicare Advantage PPO Plan outside of the Annual Enrollment period, please enroll at least 30 days prior to your desired plan effective date. Enrollment must be approved by Medicare prior to the plan effective date. For example, if approved by UHC in Dec., coverage under the UHC Group Medicare Advantage PPO Plan would become effective Jan 1. Please have your Medicare Number ready as you will be required to provide this to the Service Center during your enrollment.

If you don't enroll by Nov. 22, you will be automatically enrolled in the plans and coverage levels displayed 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 Tips

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 communication from the 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 (you can also Opt-In to receive text messages)
  - Choose the **Electronic Mail** radio button
  - Add your Personal Email Address
  - Select the **Primary** radio button
  - **Save**

- ☐ Confirm/update your designated beneficiary information for the Life Insurance plan(s) as this information didn't transition from the prior Benefit Administrator.

What's New for 2024

The information listed below is a "Summary of Material Modifications" (this "SMM") for purposes of the Employee 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 of 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.

COBRA Participants

As a COBRA participant, coverage is limited to medical and/or, dental coverage, as applicable. COBRA rates have changed. Not all provisions of this guide apply to COBRA participants, please refer to your Enrollment Notice for further information.

Company Couples

If you are a Company Couple and the Service Center is not aware of your Company Couple status, please contact them at 833-925-0487 so that your record can be updated.

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.

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. This option will take you to the Benefit Summary page for your review and approval. Review the **Enroll** section of this guide for more information.

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

Adding dependents during enrollment

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

1. Add your newly eligible dependents by following the directions on the Health and Life website, or by contacting the Service Center.
2. Coverage for your dependents will become effective Jan. 1, 2024, provided supporting documentation to verify eligibility for your dependent is received timely and approved. You can upload your supporting documentation after you complete your enrollment. You can also elect to fax or mail the supporting documentation, but uploading will expedite the dependent verification process.

Mail: Lumen (Businessolver.com, Inc.)
PO BOX 850552
Minneapolis, MN 55485-0552

Email: dv@businessolver.com

Fax: 515-273-1545

Dependent Reverification

Lumen will periodically conduct audits of covered dependents under the Plan. Lumen has a fiduciary responsibility to ensure that benefits under the Plan are provided to those who are eligible to receive them.

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.

Ending coverage for dependents during Annual Enrollment

If you voluntarily end coverage for yourself or a dependent during Annual Enrollment, without a Qualified Life Event (QLE), you and/or your dependent will not be eligible for continuation of health care coverage under the federal law known as COBRA. Eligibility for COBRA continuation coverage occurs only in cases of QLEs.

Form 1095-C

Form 1095-C verifies your health insurance coverage for tax purposes. If you were eligible for or enrolled in non-Medicare health coverage in 2023, you will receive Form 1095-C based on your communication preference on the Health and Life website.

Medicare-eligible and/or non-Medicare-eligible

If you and your dependent(s) are Medicare eligible, you must enroll in the same benefit plan option. If you were enrolled in the UnitedHealth Group Medicare Advantage PPO Plan in 2023 and you are not changing benefit plan options, you will not be required to re-enroll. Therefore, no action is required and your Enrollment Notice will serve as your Benefit Summary (Confirmation Statement) for 2024. If you are enrolling in an individual policy outside of the Company in the HRA Plan option, you must complete that carrier's enrollment form and follow their process.

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

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

Premium Payments

As a result of Lumen's "Going Green" initiative, montly Account Statements will only be available on the Health and Life website. If you pay for any portion of your coverage, (e.g., Supplemental Life Insurance), you can set up your communication preference as email to receive a monthly notification that your invoice is available to be viewed. Refer to Page 3 for instructions.

How do I make a payment?

Log in to the Health and Life website at: **lumen.com/healthbenefits**. You can submit a one-time payment or set up automatic monthly payments. Click your name in the top right-hand corner from the home page and choose **View Current Account Balance** to see your current amount due or set up an online payment.

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.

Make your payment payable to: Businessolver, Inc. and mail to:

Businessolver, Inc.
ATTN: Direct Bill Administration
P.O. Box 850512
Minneapolis, MN 55485-0512

Important: You must include your account number and Lumen on the check's Memo line.

Where can I find my account number?

If you have a prior monthly statement from the Lumen Health and Life Service Center, the account number is located on the top of page 1 with your Account Summary detail, as well as on the detachable coupon.

You can locate a prior statement by logging in to your account at **lumen.com/healthbenefits**. Click your name in the top right-hand corner from the home page and choose "View Current Account Balance." Scroll down to Payment Reminders and click on the blue link for a prior payment reminder.

If you have additional questions or need help locating your account number, call the Lumen Health and Life Service Center at 833-925-0487 Mon-Fri, 7 a.m. – 7 p.m. (CST) for assistance.

Qualified Life Event (QLE)

If you experience a QLE in 2024 such as marriage, death, divorce, adoption or birth, or losing other coverage, you can go to the Health and Life website at **lumen.com/healthbenefits** or contact the Service Center at **833-925-0487** within 45 days of the event in order to change your coverage elections. Be sure to gather your dependent(s) Social Security numbers and birthdates before you start the enrollment process so you can enter them into the system or provide them to the representative. You will be required to go through the Dependent Verification process if you add a new dependent who does not currently have Company coverage.

Note: If you make changes during Annual Enrollment and have a subsequent change to your coverage before the end of Dec. 2023, because of a QLE (for example, you add a spouse to your coverage), your 2023 changes/enrollment will not automatically be applied to 2024. **As a result, you will need to update BOTH your 2023 and 2024 coverage by contacting the Service Center.**

Retiree Articles

Stay up-to-date, visit **lumenbenefits.com** or **lumen.com/healthbenefits** to get the latest retiree news. These articles are designed to share information about benefits, the Company and other topics. Don't miss out!

Voluntary Lifestyle Benefits

Make sure you review these benefits at **lumen.com/healthbenefits**. Go to the Reference Center located at the top right-hand side of the home page by your name. You can search for the Voluntary Benefits folder and review each benefit plan.

Disaster Insurance - Protect your home and finances from a natural disaster.

Employee Perks/Discounts – Provides you with access to hundreds of exclusive deals from brand-name retailers and local merchants.

Identity and Fraud Protection – Protects you and your family from fraud.

Legal Services – Legal experts on your side, whenever you need them.

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

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

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

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

Once your employment or assignment ends, you may resume your retiree health care, basic and supplemental life insurance coverage, if applicable, in accordance with the terms of the Plan by calling the Service Center at 833-925-0487 (The local DNIS for international callers is 317-671-8494). If you returned to work for a supplier on assignment, the Company will validate that your assignment has ended before you will be allowed to resume your retiree health care coverage. Note: If you are Medicare eligible and have enrolled in an individual Medicare policy, you may need to complete a disenrollment process to be released by that carrier from the individual plan (which can take up to 60 days).

Enroll

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

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

Note: You will be required to enter information regarding your Race and Ethnic Identification. You can indicate you do not wish to share this information during your enrollment by checking the box stating, “I choose not to answer” for both questions.

1. Navigate to **lumen.com/healthbenefits** and log in. If you have not registered or logged into your account, go to step 2 to register. If you have previously logged in, skip to step 5.
2. Create your account following the steps to input your information, create your username and password and security questions. Once registered, log in to your account.
3. Review the **Getting Started Details** to agree to the electronic disclosure agreement and select **Continue**.
4. Enter your **Personal Preference** on how you wish to receive benefit communication. Click **Continue**.
5. Select **Start Here** at the top of the screen to begin your 2024 Annual Enrollment elections.
6. Read the opening message and select **Start Enrollment**.
7. Review your personal information and update your alternate address if applicable, click **Next**.
8. Confirm Medicare Eligibility of you and dependent(s).
9. Review dependents on file and confirm demographic details are accurate, click **Looks Good**.
10. Review Medicare information if applicable for dates, Medicare Beneficiary Identifier (MBI) information. Answer Race and Ethnicity questions.
11. You have two options when enrolling. Option 1 will provide step-by-step instructions. If you select this option, continue to step 12. 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 14.
12. Elect all healthcare (medical, dental) plans.
13. Review Life Insurance plans and confirm/update beneficiary information.
14. Review Your Elections, including plans, coverage levels and pricing in their entirety and select **Approve** to authorize your transaction.
15. Read the Confirmation pop up and select **I Agree**.
16. If a dependent has newly been enrolled in coverage, you will see information regarding the requirement for dependent verification. Read through the requirements carefully.
17. On the Transaction Complete page, click **Benefit Summary PDF** to print your Benefit Summary (Confirmation Statement) as this is your confirmation of enrollment.

Phone Enrollment: (longer than normal wait times usually occur on the first and last days 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.

More to Know About Medicare

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

Medicare Part A – Hospital Insurance

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

Medicare Part B – Medical Insurance

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

Part B covers:

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

Note: There is a cost for Medicare Part B since the health plan requires coordination with Medicare Part B. If you do not enroll in Medicare Part B, your benefits, if any, will be reduced, and you will be responsible for paying your healthcare expenses.

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

Medicare Part D – Prescription Drug Coverage

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

Important Note:

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

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

Medical Options for Medicare Eligible Participants

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

The Medical Plan (shown as the Pre-1991 Guaranteed Coverage Medical Plan on your Notice and the Health and Life website)

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

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

- If you elect to participate in this Plan option, you are waiving coverage under the Guaranteed Coverage Commitment Plan as well as the UHC Medicare Advantage PPO benefit options.
- The HRA provides you with Company-subsidized dollars to help you purchase an individual Medicare policy.
- The HRA is credited annually, on Jan. 1 of each year by the Company in the amount of $3,800. Unused dollars are forfeited at the end of each year.
- The HRA is a Plan option under the Company group retiree plan. You must purchase an individual Medicare and/or prescription drug policy directly from the insurance carrier(s) ("carrier") of your choice, pay the insurance premium directly to them, and then receive reimbursement for the premium from your HRA. For additional information, review the Navigation Guide located in the Reference Center in the General Information folder and then the Retiree sub folder.
- In order for your individual Medicare medical policy to be effective Jan. 1, you must enroll with Medicare between Oct. 15 and Dec. 7. For assistance, you can call Via Benefits at **888-825-4252**. Please do not contact the Service Center to enroll in an individual Medicare policy as they will be unable to assist you. Starting Nov. 8, you will need to contact the Service Center letting them know you enrolled in an individual Medicare and/or prescription drug policy.

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

UnitedHealthcare Group Medicare Advantage Preferred Provider Option (MA PPO) - shown as the Pre-1991 and ERO'92 UHC Group Medicare Advantage PPO Plan on your Notice and the Health and Life website

- You can see any provider (in or out-of-network) that participates in Medicare and accepts the plan, at the same cost.
- 100% coverage for preventive services.
- Care and disease management programs (e.g., diabetes, heart failure, and more).
- UHC House Calls are designed to complement your doctor's care. A licensed and knowledgeable health care practitioner will review your health history and current medications, perform a health screening, identify risks and provide health education in the comfort of your home.
- **Personal Emergency Response System (PERS)** – PERS is a wearable monitoring device at no cost to you that provides access to emergency assistance to give your family peace of mind, should you experience a fall.
- **Telephonic Support (Previously referred to as NurseLine)** – Registered nurses answer your call 24 hours a day, seven days a week.
- **Renew Active** – Free gym memberships, brain games, cooking classes, etc.
- **Healthy at Home** – Meals, transportation and in-home personal care at no charge for up to 30 days following an inpatient facility visit.

To enroll in this plan, please provide your Medicare Number to the Service Center. This can be found on your red, white, and blue Medicare ID card. Contact UnitedHealthcare for additional information regarding these benefits, services, and offerings at **877-886-7313**. You must call the Service Center to enroll in this plan.

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

Plan Overviews

Medical

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

	UnitedHealthcare Group Medicare Advantage PPO Plan*	Guaranteed Coverage Plan Options		
	Your in- and out-of-network costs	**Plan Options 1 & 2**	**Plan 3**	**Plan 4**
Annual Out-of-Pocket Maximum (Medical Only)	$150	$1,000	$1,000	$250
Deductible	$0	1% of Pension ($150 max)	1% of Pension ($150 max)	$100
Coordination of Benefits with Medicare	UnitedHealthcare (UHC) handles on your behalf	Claims must be submitted to Medicare Part A or B first, then to UHC for Coordination with Plan 1 & Plan 2	Claims must be submitted to Medicare Part A or B first, then to UHC for Coordination with Plan 3	Claims must be submitted to Medicare Part A or B first, then to UHC for Coordination with Plan 4
Medical Benefits				
Primary Care Physician Office Visit	$0	20% after deductible	20% after deductible	10% after deductible
Specialist Physician	$10	20% after deductible	20% after deductible	
Preventive Services	$0	Not covered	20% after deductible	
Emergency	$50	$0	$25	
Hospital Copay Per Admit	$0	$0	$0	
Outpatient Services	$0	$0	$0	

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

	UnitedHealthcare Group Medicare Advantage PPO Plan*	Guaranteed Coverage Plan Options		
	Your in- and out-of-network costs	**Plan Options 1 & 2**	**Plan 3**	**Plan 4**
Additional benefits and programs not covered by Medicare				
Hearing Aids	$500 allowance (every 3 years, In-Network Providers only)	Not covered	Not covered (Covered if resulting from an accidental injury or surgery)	Not covered (Covered if resulting from an accidental injury or surgery)
Telephonic Support (previously referred to as NurseLine)	Speak with a registered nurse (RN) 24 hours a day, seven days a week	Not available	Not available	Not available
Vision Services: Eye Exam	$0	Not covered	Not covered	Not covered
Routine Eyeglass or Contact Lenses Allowance (every 12 months)	$130 for eyeglasses OR $175 for Contact Lenses			
Fitness Program	Stay active with a basic membership at a participating location at no extra cost to you			
Prescription drug benefits retail (30-day supply)				
Tier 1 (Preferred Generic)	$4 copay	20% after deductible Prescription must be submitted to the medical plan for reimbursement		
Tier 2 (Preferred Brand and non-Preferred Generic)	$15 copay			
Tier 3 (non-Preferred Brand)	$40 copay			
Tier 4 (Specialty)	$40 copay			
Coverage Gap	Full coverage			
Prescription drug benefits retail (90-day supply)				
Tier 1 (Preferred Generic)	$0 copay	$3 copay	$0 copay	$2 copay
Tier 2 (Preferred Brand and non-Preferred Generic)	$0 copay			
Tier 3 (non-Preferred Brand)	$0 copay			
Tier 4 (Specialty)	$0 copay			

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

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

If you are enrolled in one of the Guaranteed Coverage Plans, (Plans 1-4, as applicable), Medicare becomes your primary coverage and the Guaranteed Coverage Plan becomes secondary. Your benefits will be reduced if you do not enroll timely in Medicare Part B coverage. Refer to your Annual Enrollment Notice to determine which plan option you are currently eligible for or enrolled in under the Guaranteed Coverage Plans, **(Plans 1-4, as applicable)**.

Dental

The dental option available to you is indicated on your **Enrollment Notice**.

It pays to use network Dentists

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

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

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

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

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

All Other Services

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

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

To enroll, you will need to log on to the Health and Life website or contact the Service Center. If you are already enrolled and would like to continue your coverage into the new year, no action is required to continue the dental plan option.

Life Insurance

Retiree Basic Life Insurance (Company-paid).

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

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

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

Important notes if you have Retiree Supplemental Life Insurance

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

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

Beneficiary reminder

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

The Service Center is the record keeper of beneficiary designations. Refer to the Retiree Life Insurance SPD for Facility of Payment to find out what happens when no beneficiaries are on file.

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

Paying for your coverage

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

Premiums are due on the first day of each month for the prior month's benefit coverage. Account Statements are not mailed. Refer to Reminders section of this guide under Direct Bill for more information. You can contact the Service Center for payment options such as:

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

Note: Your premiums may change based on you decreasing or ending your coverage, reaching age 65 or passing away.

Important: If you currently have deductions taken from your pension check, that will not change and deductions will continue.

Be sure to make timely payments!

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

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

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 **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		
The Medical Plan (Guaranteed Coverage Plan Options)/ Prescription Drug Plans	**UnitedHealthcare: myuhc.com** Search: **UHC App**, available for Free in the App Store and Google Play	**UnitedHealthcare: 800-842-1219** Do not enroll through this number. Enrollment is completed through the Service Center.
Group Medicare Advantage Preferred Provider Option (PPO) Plan	**UnitedHealthcare: retiree.uhc.com** Search: **UHC App**, available for Free in the App Store and Google Play	**UnitedHealthcare: 877-886-7313** Do not enroll through this number. Enrollment is completed through the Service Center.
Health Reimbursement Account (HRA)	**lumen.com/healthbenefits** Search: **MyChoice™ Mobile App**, available for Free in the App Store and Google Play	**833-925-0487** **317-671-8494** (Local DNIS for international callers) Mon-Fri, 7 a.m. – 7 p.m. (CST)
Dental		
Dental	**MetLife: metlife.com/mybenefits** Search: **MetLife**, available for Free in the App Store and Google Play	**MetLife: 866-832-5756** Do not enroll through this number. Enrollment is completed through the Service Center.
Life Insurance		
Health and Life Service Center	**Metropolitan Life Insurance Company** 200 Park Avenue New York, NY 10166 **800-638-6420**	**833-925-0487** **317-671-8494** (Local DNIS for international callers) Mon-Fri, 7 a.m. – 7 p.m. (CST)
Voluntary Lifestyle Benefits		
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** (Local DNIS for international callers) Mon-Fri, 7 a.m. – 7 p.m. (CST)

Additional services provided by MetLife

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

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

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

Change of Address Updates

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)
Lumen Pension Service Center	Email: **lumen.pension.ehr.com**	**Mail to:** Lumen Pension Service Center DEPT: LUM P.O. Box 981909 El Paso, TX 79998 Fax: 844-286-1282 **Note:** Your written request must include your full name, last four digits of your Social Security number, complete old and new address, signature and date. If your pension is being paid by **Athene**, call 877-813-4240 to update your address. If your pension is being paid by **Brightspeed**, call 844-516-7870 to update your address.

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

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

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

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

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

If you are enrolled in the UHC Medicare Advantage PPO Plan and your IRMAA premium has changed, you will need to provide a copy of the notification letter from the Social Security Administration which lists the premium amount in order to receive the accurate reimbursement for the IRMAA premium in 2024.

Medicare Part B reimbursement:

The Centers for Medicare & Medicaid Services (CMS) requires high-income Medicare-eligible individuals who are enrolled in the Part B program to pay a monthly Part B premium that is higher than the 2024 standard Medicare premium. The premium for high-income individuals, as defined by CMS, will vary depending upon your modified adjusted gross income and income tax filing status. The income amounts will be indexed annually by CMS for inflation.

If you are receiving the standard Medicare Part B reimbursement, your monthly reimbursement will automatically update to the standard 2024 Medicare Part B premium, as determined by Medicare. If your Medicare Part B is different than the standard amount, you will need to provide a copy of the notification letter from the Social Security Administration which lists the adjusted Medicare Part B premium amount in order to receive the accurate reimbursement for your Medicare Part B reimbursement in 2024. You will not be eligible to receive reimbursement from the Company for the updated premium amount until you notify and provide the Service Center with a copy of the notification letter from the Social Security Administration.

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

Request for reimbursement:

Mail or fax a copy of your Social Security Administration notification letter, which includes the updated 2024 Medicare Part B and/or IRMAA premium amount/s to:

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

If the notification letter is postmarked **on or before** March 31, 2024, your reimbursement amount will be effective retroactive to Jan. 1, 2024.

If the notification letter is postmarked **after** March 31, 2024, your reimbursement amount will be prospective only, meaning it would be effective the first of the month following receipt of the letter and retroactive reimbursement will **not** be approved.

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

Legal and Important Required Notices

A note about privacy

Keeping your personal information secure is of primary importance to the Company. That's why we, along with the benefits administrators, have implemented various security measures and policies to help reduce the risk of unauthorized processing or disclosure of your personal information. You can also help by keeping confidential your User ID and password for accessing the Health and Life website. Please keep this information safe and don't share it with anyone. Never use your Social Security number as your password. Together, we can make sure your personal information stays safe and secure. We encourage you to 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 Retiree and Inactive Health Plan (collectively referred to as the "Plan"). For specific employee benefit plan information, refer to the respective official Plan documents, and the applicable Summary Plan Description and Summaries of Material Modifications, if any. If there is any conflict between the terms of the official Plan documents and this document, the terms of the official Plan documents will govern. The Plan Administrator has the authority, discretion and the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan, to supply omissions and resolve conflicts. Benefits and contribution obligations, if any, are determined by the Company in its sole discretion or by collective bargaining, if applicable.

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

Continuation of Coverage

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

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

Coverage is not advice

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

Health Insurance Portability and Accountability Act (HIPAA)

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

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

- Loss of coverage to a class of similarly situated individuals under the other plan (for example, when the other plan does not cover temporary/ contractors).

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

If You Voluntarily Elect to Drop Coverage

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

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 Plan Administrator – limitations may apply including, but not limited to, being actively at work in order to be eligible for coverage. You understand that it is your responsibility to confirm your eligibility to enroll in a benefit option, including voluntary or supplemental coverages; enrolling in and paying for coverage for which you are ineligible will not entitle you to benefits; you understand that it is your responsibility to terminate benefit coverage once you or your dependent(s) become ineligible, for example, due to death, divorce. 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 "Exempt" Retiree Medical Plan status

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

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**.

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

Note: This is an updated notice.

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: myalhipp.com

Phone: **855-692-5447**

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

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

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

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

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

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

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

FLORIDA – Medicaid
Website: **myflfamilies.com/service-programs/access/medicaid/**
Phone: **877-357-3268**

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

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

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

ILLINOIS - Illinois All Kids
Website: **www2.illinois.gov/hfs/MedicalPrograms/AllKids/Pages/about.aspx**
Phone: **866-255-5437**

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

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

KANSAS – Medicaid
Website: **kancare.ks.gov/consumers/apply-for-kancare**
Phone: **800-792-4884**

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

LOUISIANA – Medicaid
Website: **dhh.louisiana.gov/index.cfm/subhome/1/n/331**
Phone: **888-342-6207**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OREGON – Medicaid
Website: **oregon.gov/oha/hsd/medicaid-policy/pages/state-plans.aspx**
Phone: **800-699-9075**

PENNSYLVANIA – Medicaid
Website: **dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx**
Phone: **800-692-7462**

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

SOUTH CAROLINA – Medicaid
Website: **scdhhs.gov**
Phone: **605-773-4678**

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

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

TEXAS – Medicaid
Website: **hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program**
Phone: **800-440-0493**

UTAH – Medicaid and CHIP
Medicaid Website: **medicaid.utah.gov**
CHIP Website: **health.utah.gov/chip**
Phone: **877-543-7669**

VERMONT – Medicaid
Website: **greenmountaincare.org**
Phone: **800-250-8427**

VIRGINIA – Medicaid and CHIP
Website: **coverva.org**
Medicaid Phone: **800-432-5924**
CHIP Phone: **855-242-8282**

WASHINGTON – Medicaid
Website: **hca.wa.gov**
Phone: **800-562-3022 ext. 15473**

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

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

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

WYOMING – Medicaid
Website: **health.wyo.gov/healthcarefin/medicaid/**
Phone: **307-777-7531**

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Right to Amend and/or discontinue and make rules

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

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.