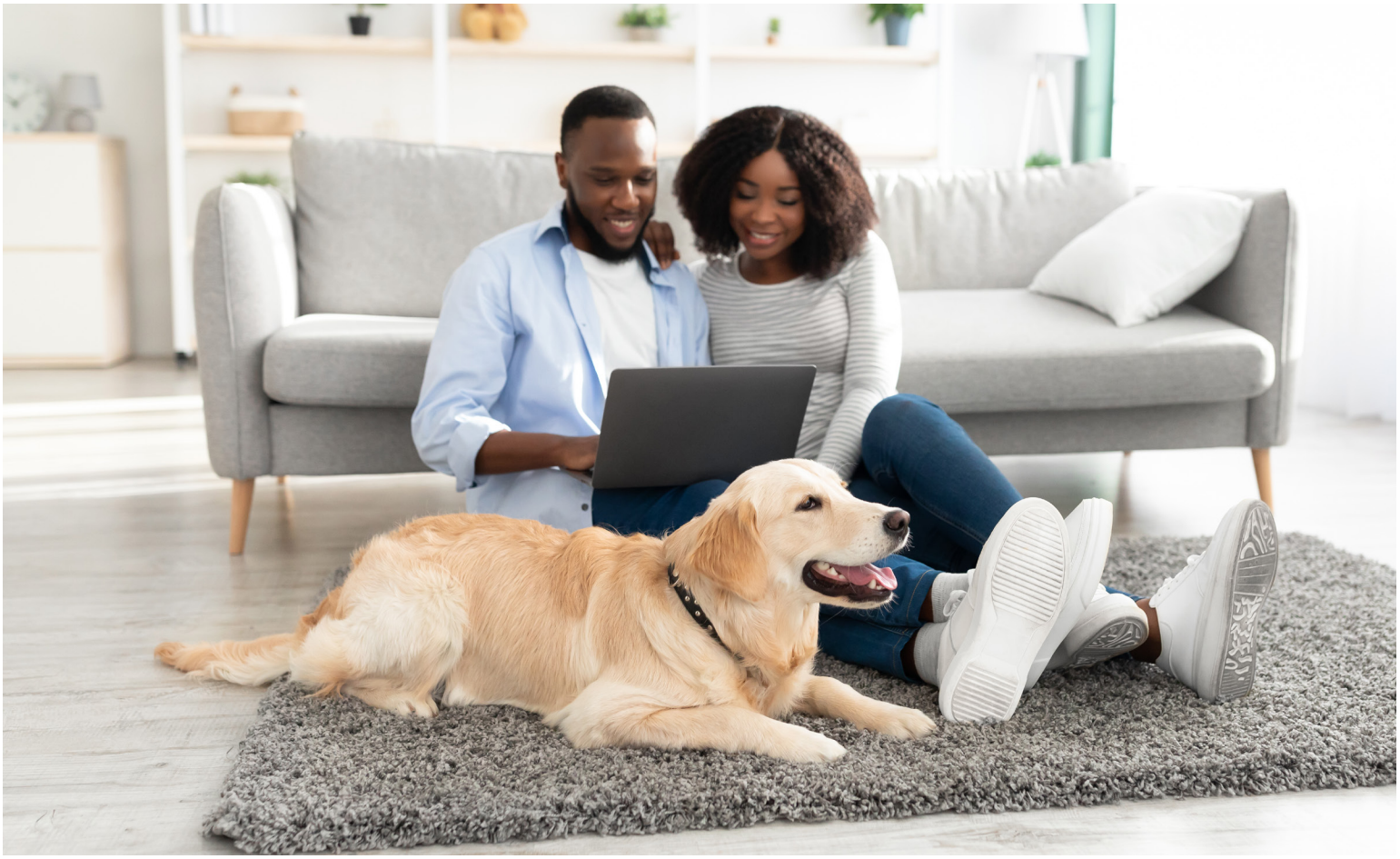
Your benefits. Your choice. Enroll now.

Nov. 8 - Nov. 22, 2023

2024 Annual Enrollment Guide

For Active Employees



LUMEN®

Contents

Lumen (referred to hereafter as the Company) is committed to green initiatives. You can help by saving this guide as a PDF instead of printing. However, if you would like a paper copy and don't have access to a printer, contact the Lumen Health and Life Service Center (referred to hereafter as the "Service Center") at **833-925-0487** to request one to be mailed to you. Please be advised that mail time is based on the USPS schedule. Lumen and the Service Center is unable to overnight forms, documents, letters, etc.

Note: If you leave the Company before the end of the year, you should review the Benefits Resource Guide for Departing Employees on the Intranet for more information.

LUMEN®

Welcome to Annual Enrollment

Well-being is the state of feeling good and functioning well and is crucial to the success of every employee and the company. Lumen is committed to creating a supportive culture that prioritizes financial, mental, physical, and social well-being through benefits to empower you and eligible dependent(s) to be your best selves.

Annual Enrollment is your opportunity to find the plans and programs that are right for you. You can add, change or waive your health and life benefits for you and/or your eligible dependent(s). If you don't enroll by Nov. 22, you will be automatically enrolled in the same plans with the same coverage levels listed on the Health and Life website, **lumen.com/healthandlife**, with the exception of FSAs and/or HSA. You must enroll in these accounts each year as current elections and goal amounts DO NOT roll over. Refer to the **Eligibility** section of this guide to determine what plans you are eligible to enroll in based on your employment status, e.g., full-time, part-time, etc.

Get ready:

- ☐ **Ask ALEX.** ALEX is an interactive tool that can help you learn about your health and life benefit options including: medical plans, Health Savings Account (HSA), Flexible Spending Accounts (FSAs), Voluntary Lifestyle Benefits and more. Keep in mind, even if you use ALEX, you must enroll through the Health and Life website.

- ☐ **Watch** a benefit video that provides you with a high-level summary of What's New in 2024. You can find the video on the Annual Enrollment home page on the Intranet.
- ☐ **Read** #LiveWellatLumen and visit the Annual Enrollment home page on the Intranet to learn more about Annual Enrollment.
- ☐ **Review/Add** your personal information on the Health and Life website. You are strongly encouraged to use a personal email address as your preferred method to receive benefit communications. The company email does not guarantee privacy and does not comply with company policy. Benefit communications will not be sent to your company email address unless approved by Management and only on certain directives. Log in to **lumen.com/healthandlife**:
  - 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**
- ☐ **Answer** the Tobacco-Free Discount, and the Working Spouse/Domestic Partner Surcharge questions each Annual Enrollment. Your answer can impact medical plan premiums and certain Voluntary Lifestyle Benefit plan premiums.
- ☐ **Chat** with Sofia on the Health and Life website. Sofia is your personal benefits assistant and can answer questions and guide you as you enroll.
- ☐ **Register** for MyEvive at **lumen.com/myevive** if you have not already done so. MyEvive is a customized benefit portal that puts control of your health, wealth and well-being at your fingertips.

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 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.

A Message from Ana White, Chief People Officer

It is so rewarding when we get the opportunity to make a difference, either large or small, in the lives of our employees and their loved ones. The Benefits team worked hard this year, and we are thrilled to bring you the news that, benefit premiums will not increase if you and your eligible dependents live a smoke-free or tobacco-free lifestyle.*

Lumen has made a significant financial commitment for your well-being

Our 2024 Healthcare costs are projected to increase 12.6 percent, which is more than $35 million annually. As a further investment in our people, Lumen will absorb nearly $25.5 million in these additional costs, rather than pass on premium increases to employees. A few benefit changes will be implemented in 2024 to offset the remainder of the costs. Please review this guide to understand these changes and all of our 2024 benefit plans and programs, designed to support and improve the lives of you and your eligible dependents.

Each of us, and our dependents, can impact rising costs by making our health and well-being a priority. Get your annual preventive screenings, manage chronic illnesses and, if needed, engage in cessation and care management support programs. These steps will help Lumen keep health cost increases down in future years and give Lumen the opportunity to make additional investments in other areas for our people.

Everyone has different circumstances and needs when it comes to benefits coverage, and Lumen provides benefits to support you and your family in various life stages. These are **Your benefits**. It is **Your choice**.

Enroll, and let's live well together!

*If you and/or your eligible dependents are tobacco users and not enrolled in a company-sponsored tobacco cessation program, you are not eligible for the 15 percent discount for non-tobacco users, and you will see a slight increase in your medical premiums.

Note: Coverage amounts and benefit costs may increase or decrease throughout the year, in certain situations. Refer to the General Information Summary Plan Description (SPD) and the Life Insurance SPD, on the Intranet.

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 (excluding a Health Saving Account (HSA) and Flexible Spending Accounts (FSAs), you must enroll in these each Plan 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.

Employee Assistance Program (Emotional Wellbeing Solutions)

Employee Assistance Program (EAP) – EAP has a new name, Emotional Wellbeing Solutions. All active Lumen employees and their household family members are eligible for the Employee Assistance Program (EAP) through Optum Emotional Wellbeing Solutions. You are automatically enrolled in the EAP at no cost even if you elect to waive medical coverage.

Solutions for Nursing Mothers – This program will be offered through the Emotional Wellbeing Solutions at no cost to all employees and dependents who live in the household. Worklife advisors help expectant mothers address prenatal care, consultations on a variety of topics, referrals and more. A Nursing Mothers Kit will be provided along with ongoing communication material and phone support.

Life Insurance

The Employee Basic Life and Employee Supplemental Life insurance coverage amounts currently reduce by 50% effective the first of the following month after your 70th birth date. This age reduction rule will be eliminated. The age 70 reduction rules will also be eliminated for Spouse/Domestic Partner Supplemental Life insurance coverage.

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.

These changes apply to: HDHP

Limited Purpose Flexible Spending Account (FSA)

If you enroll in the HDHP with Optional HSA and also enroll in the Health Care Flexible Spending Account, you will be automatically enrolled in the Limited Purpose FSA. **NEW:** Your FSA can now be used for medical and pharmacy expenses **once your deductible has been satisfied**. This is in addition to eligible dental and vision expenses.

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
Employee	$4,150	$3,850
Employee + 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	Employee	$1,600	$3,200	$1,500	$3,000
	Employee + Spouse/Domestic Partner or Employee + Children	$2,400	$4,800	$2,250	$4,500
	Family	$3,200	$6,400	$3,000	$6,000
*HDHP	Employee	$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

Real Appeal and GLP-1 Weight Loss Medication Program -

- If you are taking a GLP-1 weight loss medication, you will receive an outreach from UnitedHealthcare or Surest PPO to encourage enrollment in Real Appeal.
- Real Appeal can help support participants who are on or seeking GLP-1 weight loss medication coverage with a wrap-around behavior change program. Real Appeal works in tandem with your GLP-1 weight loss medication to help you develop sustainable habits with 1:1 personal coaching, live group sessions, nutritional support, online resources, and on-demand fitness classes.

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.

Voluntary Lifestyle Benefits

Airvet - Airvet is a 24/7 veterinary telehealth company that can help with anything from urgent health questions to routine pet care. Airvet offers visits with licensed veterinary professionals and has no deductibles, co-pays, and pet restrictions (number of pets, age, breed, etc.)

Additional Updates

Actively Employed and 65? – If you leave the company (for any reason), are age 65 and are eligible for Lumen retiree healthcare benefits, you will need to notify the Service Center at 833-925-0487 the first of the month following your termination date. You will need to provide them your Medicare Part A and Part B coverage start dates and your Medicare Number as indicated our your Medicare Health Insurance card. Please do not call prior to the first of the month as the Service Center will not be able to process the information.

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.

Health Care Flexible Spending Account - If you are enrolled in the CDHP, Doctors Plan or the Surest PPO and move to the HDHP during the 2024 Annual Enrollment period and have unused Traditional Health Care FSA (HCFSA) funds at the end of the year, you MUST use your remaining HCFSA dollars for eligible medical, dental and vision expenses by Dec. 31, 2023. If you do not use the funds by Dec. 31, 2023 they will be forfeited.

Lifestyle Reimbursement - To promote employee health and well-being, the Fitness Reimbursement Policy will be updated to include additional activities that promote and support financial, mental, physical, and occupational well-being and renamed to Lifestyle Reimbursement.

Update Your Beneficiary Information - As part of the transition to the new Health and Life Administrator at Businessolver in 2022, not all beneficiary contact information transferred from the prior Health and Life Administrator.

Action Required

Please update your beneficiary contact information. Follow the steps below:

1. Go to the **Health and Life website** and select the icon, **Change my Benefits** and then click on **BASIC INFO** and **Change of Beneficiary**.
2. The system will prepopulate the day you are online. Select **Continue** and then **Start Change**.
3. Acknowledge Sofia by selecting **Start Enrollment**.
4. **Review Your Dependents** will appear first. Select **Looks Good** as this is not the Beneficiary Information screen.
5. On the Beneficiary Information screen, select **Edit** to review or update existing information such as: relationship status, first name and last name. The below fields are optional; however, we recommend you complete them to prevent any delay when processing a claim.
   - Social Security Number
   - Date of Birth
   - Address (mailing)
   - City, State, Zip Code
   - Primary Phone
   - Secondary Phone
6. If you want to add a new beneficiary, scroll down to the bottom of the screen and select **+Add New Beneficiary** making sure you enter relationship, first name and last name.
7. Confirm all beneficiary contact information and select **Next** until you reach the **Benefit Summary** page. Complete your enrollment by clicking **Approve** and then **I Agree**. Make note of your confirmation number listed on the Thank You! Page. If you don't receive a confirmation number, your changes and updates were not saved.

If you are unable to make updates on the **Health and Life website**, you can call the Service Center at 833-925-0487 at anytime and an advocate can assist you.

Reminders

If you are a new hire or experience a Qualified Life Event, (e.g. marriage, divorce, birth) 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. If you are a new hire Dec. 2 or later, you do not need to complete 2024 Annual Enrollment elections, your benefit elections from 2023 will roll over to 2024.

Benefit Details	Plan/Option Information	Prepare
Amazing Benefits	Beyond the comprehensive benefits package, employees are eligible for additional benefits and perks (such as 401(k), Advocacy Services, Employee Concessions, and more).	Visit the U.S. Benefits Home Page on the intranet.
Commuter Spending Account	This is a pre-tax qualified transportation benefit account that can be used to pay for mass transit and/or parking expenses.	To enroll, visit the Health and Life website at **lumen.com/healthandlife**. You can enroll at any time.
Dependent Day Care Flexible Spending Account (DCFSA)	You have the option each Annual Enrollment to elect to contribute to the DCFSA.	Contribution elections do not roll over into the new year, you must enroll.
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.

Benefit Details	Plan/Option Information	Prepare
Health Care Flexible Spending Account (HCFSA - General Purpose and Limited Purpose)	You have the option each Annual Enrollment to elect to contribute to the HCFSA. **Note:** If you enroll in the HDHP and elect a HCFSA, you will be automatically enrolled in the Limited Purpose FSA which covers eligible out-of-pocket dental and vision care expenses. Medical and prescription drug expenses are not eligible for reimbursement until you have satisfied your annual deductible.	Contribution elections do not roll over into the new year, you must enroll. **IMPORTANT:** If you elect the HCFSA but do not elect to contribute to an HSA, you will still be automatically enrolled in the Limited Purpose FSA.
Health Savings Account (HSA)	You have the option each Annual Enrollment to elect to contribute to an HSA as well as anytime throughout the year if you are enrolled in the HDHP medical option. **Note:** If you enroll in the HDHP and elect an HCFSA, you will be automatically enrolled in the Limited Purpose FSA which covers eligible out-of-pocket dental and vision care expenses. Medical and prescription drug expenses are not eligible for reimbursement until you have satisfied your annual deductible. You can also elect to contribute to an HSA for eligible medical expense reimbursement.	Contribution elections do not roll over into the new year, you must enroll. If you contribute to an HSA through Optum Bank, payroll contributions will occur bi-weekly. Optum Bank must first approve (vet) your record before your account can be set up and contributions deposited. A welcome kit and debit card will be mailed by Optum Bank after you are approved. **IMPORTANT**: If you elect not to contribute to an HSA, but you elect to contribute to a HCFSA and are enrolled in the HDHP medical option, you will still be automatically enrolled in the Limited Purpose FSA.
Imputed Income	Imputed income is income that the IRS required you to be taxed on, e.g. Basic Life insurance over $50,000, Post-Tax Short-Term Disability, Domestic Partner and or Domestic Partner child/ren covered under the Medical/ Prescription drug, Dental and/or Vision plan.	Be sure to review your bi-weekly paycheck. Calculations of imputed income are based on the effective date and may adjust your taxable amount as a lump sum if the effective date is retroactive.
Payroll Deductions	If you work one or more days in a pay period and are enrolled in healthcare (e.g., Medical/ Prescription Drug, Dental and Vision), you are responsible for paying the full cost of your benefit premiums during that pay period. Premiums are not prorated and are based on the payroll schedule, not the calendar year. Therefore, premiums could cross over from one calendar year to the next calendar year.	Review your paychecks on Success Factors.
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 **Note:** If you are enrolled in the Hawaii Medical Services Association (HMSA) Plan, you will automatically receive the Tobacco-Free discount.	**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, not the actual medical bi-weekly premium amount. 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. **Voluntary Lifestyle Benefits -** Your answer may also impact your rate if you enroll in the Critical Illness Insurance or Universal Life Insurance with Long-Term Care through the Voluntary Lifestyle Benefits Program.	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, or enroll through Rally at **lumen.com/wellconnected**. 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	If you are subject to the Working Spouse/ Domestic Partner Surcharge, $100 will be added to your bi-weekly medical cost.	Answer the Working Spouse/Domestic Partner question during your enrollment.
1095-C	The IRS requires individuals to report on their healthcare coverage. Lumen is required to supply this information on a standard form. You will use this form when preparing your taxes. You will receive this form generally in Feb.	You can choose to receive this form electronically or via mail. You can review your status on your **Account Profile** on the Health and Life website or by calling the Service Center at 833-925-0487.

Post Annual Enrollment Checklist (not all will apply):

1. **ID Cards:** If you enroll in a new Plan, watch for your healthcare ID cards towards the middle/end of December.
2. **Paycheck:** Review your Pay Period 1 paycheck dated Jan. 12, 2024 confirming your 2024 Health, Life, FSAs and HSA premium deductions.
3. **Dependent Verification:** Provide supporting documentation for any dependents you add to Lumen plan(s).
4. **Statement of Health/Evidence of Insurability (EOI)** Complete and submit the Statement of Health/Evidence of Insurability (EOI) for Supplemental Life Insurance and/or Supplemental Long-Term Disability (LTD).
5. **Benefit Summary:** At the end of your enrollment, print your Benefit Summary (formerly referred to as Confirmation Statement) from the Health and Life website and keep for your records.

Eligibility

Businessolver administers eligibility for the Lumen Health Care Plan, Lumen Surest Health Plan, Lumen Disability Plan, Lumen Business Travel Accident Insurance Plan, Lumen Life Insurance Plan, Lumen Survivor Benefit Plan and Lumen Qualified Transportation Plan.

Employee Classification	Eligibility	Premiums
Full-time or **Term Full-time** employees	As a Full-time employee, you and your eligible dependent(s) may enroll in: • Medical/prescription drug • Dental • Vision • Employee Assistance Program (Emotional Wellbeing Solutions) - EAP (no enrollment required, EAP is automatic) • Flexible Spending Accounts (Health Care, Limited Purpose Health Care, and Dependent Day Care). Employees who elect an FSA will default to the Limited Purpose Health Care FSA if enrolling in the HDHP with Optional Health Savings Account (HSA) medical plan even if not electing an HSA amount. • HSA when enrolled in the HDHP with Optional HSA • Well Connected Wellness Program (employees do not need to be enrolled in the medical/prescription drug plan to participate in the Wellness Program) • Fitness Reimbursement Program (Lifestyle Reimbursement) • Disability (STD and LTD) • Life Insurance including Accidental Death & Dismemberment and Business Travel Accident (BTA) • Commuter Spending Accounts (Parking and Mass Transit) • Voluntary Lifestyle Benefits	Medical premiums are determined based on how you answer questions during your enrollment. • Tobacco-Free Discount • Working Spouse/Domestic Partner (SP/DP) Surcharge when enrolling your SP/DP in a Lumen medical plan **Note:** Your medical premium may change throughout the year if your base pay increases or decreases. If your base pay is less than $30,000 regardless of how your answer the Working Spouse/Domestic Partner Surcharge question, you will not be subject to the surcharge. If your base pay changes mid-year and is $30,000 or over, your benefits will be reviewed and a surcharge applied, if applicable.
Part-time, Term Part-time or **Qwest Union Represented Seasonal** employees	As a Part-time, Term Part-time or Qwest Union Represented Seasonal employee, you and your eligible dependent(s) may enroll in: • Medical/prescription drug • Employee Assistance Program (Emotional Wellbeing Solutions) - EAP (no enrollment required, EAP is automatic) • Flexible Spending Accounts (Health Care, Limited Purpose Health Care, and Dependent Day Care). Employees who elect an FSA will default to the Limited Purpose Health Care FSA if enrolling in the HDHP with Optional HSA medical plan even if not electing an HSA amount. • Health Savings Account (HSA) when enrolled in the HDHP with Optional Health Savings Account (HSA) • Well Connected Wellness Program (employees do not need to be enrolled in the medical/prescription drug plan to participate in the Wellness Program) • Disability (only available to Part-time Seasonal Qwest Union Represented employees if hired before Jan. 1, 2018 and Part-time Non-Union Employees)	Premiums are 150% of the Full-time rates and are determined based on how you answer the questions during your enrollment: • Tobacco-Free Discount • Working Spouse/Domestic Partner (SP/DP) Surcharge when enrolling your SP/DP in a Lumen medical plan **Note:** Your medical premium may change throughout the year if your base pay increases or decreases. If your base pay is less than $30,000 regardless of how your answer the Working Spouse/Domestic Partner Surcharge question, you will not be subject to the surcharge. If your base pay changes mid-year and is $30,000 or over, your benefits will be reviewed and a surcharge applied, if applicable.
Temporary Full-time, Temporary Part-time and **Qwest Union Represented Incidental** employees **Note:** > or = 20 hours but <30 hours per week	As a Temporary Full-time, Temporary Part-time or a Qwest Union Represented Incidental employee, you and your eligible dependent(s) may enroll in: • Medical/prescription drug • Employee Assistance Program (Emotional Wellbeing Solutions) - EAP (no enrollment required, EAP is automatic) • Well Connected Wellness Program (employees do not need to be enrolled in the medical/prescription drug plan to participate in the Wellness Program)	Premiums are 100% of the total cost **Note:** The Tobacco-Free Discount and Working Spouse/Domestic Partner Surcharge does not apply.

Enroll

Before deciding whether you need to enroll, review your current elections. You must positively elect to contribute to a Dependent Day Care and/or Health Care Flexible Spending Account (FSA) or a Health Savings Account (HSA), as those contributions do not roll over.

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

How to enroll:

Mobile Device Enrollment

1. Download the free MyChoice Mobile App for iOS or Android from the App Store or Google Play
2. 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.
3. 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.**
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 15.
11. Elect all healthcare (medical, dental, vision) plans, spending account plans (Health Care Flexible Spending Account (FSA), Dependent Day Care FSA and/or Health Savings Account (HSA)). 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, you may be subject to a bi-weekly working spouse/domestic partner surcharge based on how you answer the surcharge questions.
12. Review Disability and Life insurance plans. Confirm/update beneficiaries.
13. Elect Voluntary Lifestyle benefits.
14. Elect Commuter Spending Account (Mass Transit and/or Parking).
15. Review Your Elections, including plans, coverage levels and pricing in their entirety and select **Approve** to authorize your transaction.
16. Read the Confirmation pop up and select **I Agree**.
17. 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.
18. 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.
19. 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 UnitedHealthcare or refer to the Summary Plan Description (SPD) on the Intranet.

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

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

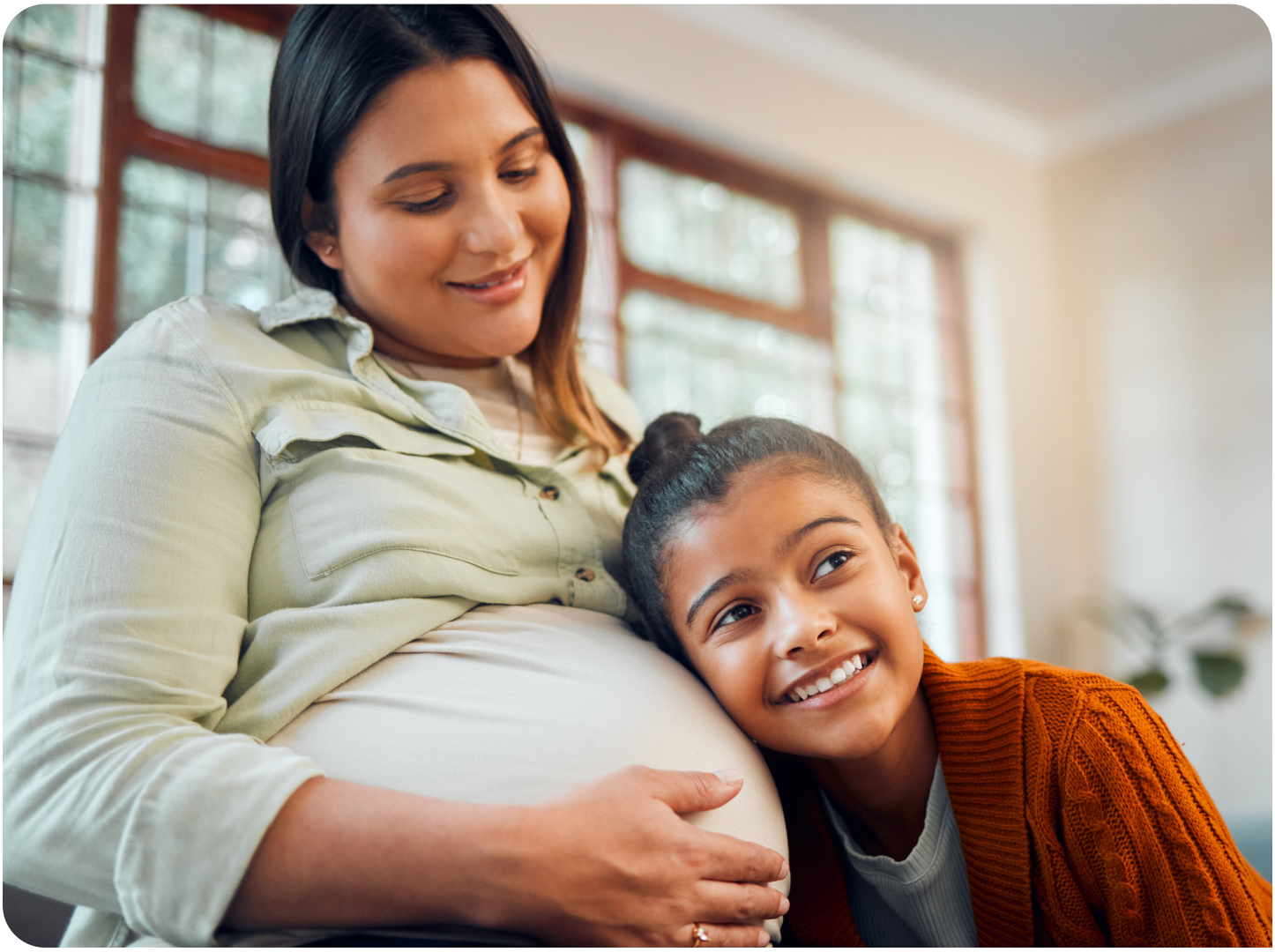
Action Required: Choose, review or update your Primary Care Physician (PCP) during Annual Enrollment for you and each covered dependent(s). If you don't, UHC will assign a PCP. In order to receive benefits, the Doctors Plan requires you to use In-Network providers.

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.

	UnitedHealthcare Doctors Plan
You Pay	**In-Network**
	Annual Deductible (The Deductibles are separate for In-Network and Out-of-Network providers and are not combined)
	Employee
	$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)
	Employee
	$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)
Preventive care/screening/ immunization	100%

	UnitedHealthcare Doctors Plan	
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 Drugs	
	• $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 Comparison - Surest PPO, High Deductible Health Plan with Optional HSA 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 (SPD) on the Intranet.

	Surest PPO		UHC HDHP with Optional HSA		UHC CDHP	
HSA/HRA Contributions	Not Applicable - See Flexible Spending Account Options for more information		With Employee-Funded HSA (maximum contribution): • $4,150 Employee • $8,300 Employee + 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 Employee • $750 Employee + Spouse/Domestic Partner (DP) • $750 Employee + Child/ren • $1,000 Employee + 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)					
	Employee		**Employee**		**Employee**	
	$0	$0	$1,600	$3,200	$1,600	$3,200
					Employee + Spouse/DP	
					$2,400	$4,800
	Employee + Child/ren		**Family**		**Employee + 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)					
	Employee		**Employee**		**Employee**	
	$3,600	$7,200	$3,600	$7,200	$3,200	$6,400
	Employee + Spouse/Domestic Partner				**Employee + Spouse/Domestic Partner**	
	$5,400	$10,800			$4,800	$9,600
	Employee + Child/ren				**Employee + 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 with Optional HSA		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 with Optional HSA	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 coverage for Specialty Medications.				

UnitedHealthcare 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 (Employee Only, Employee & 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 prescription drugs until you have met your deductible. You can fill your prescriptions up to two times at retail pharmacy, after that, it will not be covered and you will pay the full retail price.

Note: If you elect a Health Care Flexible Spending Account (HCFSA), funds will be taken from your HRA first and then once exhausted, will be taken from your HCFSA. You do not have the option to have your HCFSA pay first as the HRA is a component of the medical plan. In addition, you receive the full allocation on Jan. 1st.

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 - If you enroll in this plan, you can choose your healthcare providers; however, the Plan pays a greater benefit when you use providers that are in the network. You can elect a Health Savings Account (HSA) to help you save for qualified medical expenses, including prescription drugs and eligible dental and vision expenses. An HSA allows you to set aside pre-tax dollars from your paycheck. This account rolls over from year to year and the money in the account is 100% yours even if you leave the company. You can enroll in an HSA any time throughout the year but do not need to contribute when you elect the HDHP medical plan.

If you elect a Health Care Flexible Spending Account (FSA), it will automatically be a Limited Purpose FSA and can only be used for eligible out-of-pocket dental and vision care expenses until your medical deductible has been satisfied. After your deductible has been satisfied, you can use the FSA for eligible medical and prescription drug expenses as well as dental and vision expenses. Refer to the FSA and HSA page in this guide for more information.

Note: The HSA is not a Company-sponsored plan or benefit and is not covered uner ERISA. The Company has chosen to allow Optum Bank to make its program available to Lumen employees, but this is a voluntary program and only you can decide whether the benefits provided by this program are appropriate for you and your eligible dependent(s). You are encouraged to research all suitable alternatives and consult with your personal advisors. The company is not able to provide you with advice regarding this program.

Surest PPO - 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.

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 Intranet.

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 Intranet, 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.

Flexible Spending Accounts (FSAs) and Health Savings Account (HSA)

To participate in FSAs or an HSA, you must enroll each year. Your FSA and/or HSA contribution elections will not roll over from one year to the next. HSA and FSA contributions are fully funded by you and your contributions are pre-tax, meaning, free from federal taxes.

Traditional (General Purpose) Health Care FSA	Limited Purpose Health Care FSA (for HDHP with Optional HSA)	Dependent Day Care FSA (for child/elder care services)	Health Savings Account (HSA) (for HDHP with Optional HSA)
How much can you contribute?			
Between $150–$3,050 per plan year **Note:** FSA limits are determined by the IRS and subject to change.	Between $150–$3,050 per plan year **Note:** FSA limits are determined by the IRS and subject to change.	Between $150–$5,000 per plan year **Note:** If you are determined to be a highly compensated employee, the Plan Administrator may need to adjust your contribution election, at which time you will be notified.	Up to $4,150 Employee-only Up to $8,300 Employee + one or more enrolled **Note:** If you are age 55 or older, you can contribute an extra $1,000 "catch-up" contribution per plan year.
What types of expenses can you use it for?			
A range of eligible out-of-pocket health care expenses not covered by a medical, prescription drug, dental or vision plan can be used for any eligible dependent, even those not covered by a Company health care plan.	Only eligible out-of-pocket dental and vision care expenses, including deductibles, copayments and coinsurance not covered by other plans. Medical and prescription drug expenses are not eligible for reimbursement until you have satisfied your annual deductible.	Eligible out-of-pocket child/elder care expenses for eligible dependents so you (and your Spouse, if married) can work or attend school Full-time.	Eligible medical, prescription, over-the-counter drugs, dental and vision expenses.
How does it work?			
The plan year amount you elect to contribute is available for you to use on Jan. 1, 2024. **Note:** If you enroll in the HDHP with Optional HSA and elect an FSA, you will automatically be enrolled in the Limited Purpose FSA whether or not you contribute to the HSA.		FSA money is available as contributions are deducted from your paycheck and loaded to UHC's system.	• You can open an HSA with Optum Bank (through payroll deductions), a bank of your choice, or an insurance Company or other IRS-approved trustee. • Optum Bank must first approve (vet) your account before an account can be set up and contributions deposited. • There are no federal taxes on contributions, interest earned or expenses paid from the HSA (except for Alabama, California and New Jersey).

Reminder: Pay period 1 includes 2024 healthcare (medical, dental and vision), life, disability (imputed income calculated for STD post-tax election), FSAs and HSA premium deductions.

FSA Enrollment Rules

- FSA limits are determined by the IRS and are subject to change. FSA premiums are deducted over 26 pay periods. To ensure employees do not contribute over the IRS maximum allowed amount, the calculation per pay period will always round-down which may result in under contribution between $.01 to $.26 at the end of the Plan year. Refer to the example below:

Contribution Election Amount: $5,000

- Per pay period deduction: $5,000/26 = $192.30 (rounded down). Your total deduction for the Plan year is $192.30 x 26 = $4,999.80 which is $.20 under your $5,000 contribution amount.
- If an FSA deduction is missed or the full amount is not deducted, an adjustment is made. The adjustment is taken in subsequent pay periods, in addition to the regular deduction amount.
- 2024 FSA funds can be used for eligible expenses incurred from Jan. 1, 2024, to March 15, 2025. You have until March 31, 2025, to file claims, or remaining funds are forfeited. The Internal Revenue Service (IRS) does not allow

expenses incurred by Domestic Partners or their dependents to be reimbursed through an FSA unless you claim your Domestic Partner or their dependents on your income tax return. *If you have additional FSA dollars, you can check out the OptumStore (store.optum.com) that offers all FSA eligible items for purchase.*

- If you are currently enrolled in the traditional/general purpose Health Care FSA, keep your Health Care Spending Card (HCSC) from 2023, as 2024 elections will be added to your existing card. If your HCSC has expired, you will automatically be mailed a new card in December. HCSC are not issued for the Limited Purpose Health Care FSA.

HSA Enrollment Rules

- If you are newly enrolling in an HSA, the effective date is the first of the month following the eligibility effective date. Changes in contribution election amounts (including stopping contributions) will be effective based on the payroll cutoff date. If an HSA deduction is missed or the full amount is not deducted, the system may adjust the amount taken on subsequent pay periods depending on your election of either a Total For Plan Year amount or a per pay period amount.

Life Insurance and Accident

Automatic and Company-Paid Plan Benefits	
Employee Basic Life Insurance	Eligible employees have a benefit of 1x eligible pay (Base Pay + anticipated Short-Term Incentive) rounded up to the next higher $1,000 up to $2,000,000 maximum benefit. If your Employee Basic Life Insurance is more than $50,000, the IRS requires you pay taxes on imputed income, which is the cost of Company-provided Employee Basic Life Insurance over $50,000. **To avoid paying taxes on imputed income, you have the option to choose the $50,000 in coverage.** If you are in this category, you will see $50,000 as an option when you go online to enroll, as well as your 1x Base Pay + anticipated Short-Term Incentive. You have the option to change your Basic Life Insurance coverage amount to $50,000 at any time and, therefore, you would not be subject to imputed income.
Employee Basic Accidental Death & Dismemberment Insurance (AD&D)	Eligible employees have a benefit of 1x eligible pay (Base Pay + anticipated Short-Term Incentive) rounded up to the next higher $1,000 up to $2,000,000 maximum benefit.
Business Travel Accident	Eligible employees have a benefit of 3x eligible pay (Base Pay + anticipated Short-Term Incentive) rounded up to the next higher $1,000 up to $500,000 maximum benefit.
You Pay the Cost	
Employee Supplemental Life Insurance (Statement of Health/Evidence of Insurability (EOI) may be required.)	1x, 2x, 3x, 4x, 5x, 6x, 7x or 8x Base Pay rounded up to the next higher $1,000 up to $2,000,000 maximum benefit.
Employee Supplemental Accidental Death & Dismemberment Insurance (AD&D)	1x, 2x, 3x, 4x, 5x, 6x, 7x or 8x eligible (Base Pay + anticipated Short-Term Incentive) rounded up to the next higher $1,000 up to $2,000,000 maximum.
Spouse/Domestic Partner Supplemental Life Insurance (Statement of Health/Evidence of Insurability (EOI) may be required.)	$5,000, $10,000, $25,000, $50,000, $75,000, $100,000 or $200,000 (cannot elect more than 100% of Employee Basic Life + Employee Supplemental Life coverage).
Child Supplemental Life Insurance (Can be for more than one child)	Each child: $3,000, $5,000, $10,000 or $20,000 (cannot elect more than 100% of Employee Basic Life + Employee Supplemental Life coverage).
Spouse/Domestic Partner Supplemental Accidental Death & Dismemberment Insurance (AD&D)	50% of Employee Supplemental AD&D Coverage up to $750,000 maximum benefit.
Child Supplemental Accidental Death & Dismemberment Insurance (AD&D)	25% of Employee Supplemental AD&D Coverage up to $100,000 maximum benefit.

Reminders:

- Please confirm that you have current and up-to-date beneficiaries for all of your Life Insurance plan options by going to **lumen.com/healthandlife**. The Service Center is the record keeper of beneficiary designations. Refer to the Life Insurance and AD&D Summary Plan Description (SPD) on the Intranet for Facility of Payment to find out what happens when no beneficiaries are on file.
- Coverage amount and benefit premium deductions may increase or decrease throughout the Plan year in certain situations (for example, if you have a change in pay or change age brackets; age brackets are every 5 years, i.e., 30, 35, 40, 45, etc.). If your benefit costs increase or decrease, you will receive a notification from the Service Center. You can view your updated Benefit Summary (formerly known as Confirmation Statement) on the Health and LIfe website. Refer to the Life Insurance and AD&D Summary Plan Description (SPD) on the Intranet.
- If both you and your Spouse/Domestic Partner are employed by the Company, or on Long-Term Disability, or in a parent/child relationship, you cannot be covered for Supplemental Life Insurance as an employee, Long-Term Disability participant and a dependent on each other's benefit coverage. If both you and your Spouse/Domestic Partner are employed by the Company and one of you is not enrolled in the Employee Supplemental Life plan, you may enroll under the Spouse/Domestic Partner Supplemental Life plan of the other Spouse/Domestic Partner. You cannot be covered for both Employee Supplemental Life and Spouse/Domestic Partner Supplemental Life. Also, you cannot both purchase Child Supplemental Life and AD&D Insurance coverage for the same dependent children. You must decide which parent will cover the child/ren.

Short-Term Disability (STD) - Qwest Union Represented Employees

A brief overview of your STD benefits.

You must be a Regular Full-time or Term Full-time employee to be eligible for Short-Term Disability benefits. Qwest Union Represented Seasonal employees are eligible if hired, rehired or transferred prior to Jan. 1, 2018.

Qwest Union Represented Hired Before Jan. 1, 2009	Qwest Union Represented Hired, Rehired Or Transferred On Or After Jan. 1, 2009	Qwest Union Represented Hired, Rehired Or Transferred On Or After Jan. 1, 2018
Note: Qwest Union Represented Employees who are in a part-time classification as of Dec. 31, 2017 and have an Equivalent Work Week (EWW) of 21 or more hours and have satisfied a one year eligibility period, will be eligible for coverage under the Disability Plan.	You must have one year of service to be eligible for this benefit and have an Equivalent Work Week (EWW) of at least 20 hours.	You must have one year of service to be eligible for this benefit, classified as being in a full-time position.
Maximum Benefit Period (Duration of Benefits)		
39 weeks	39 weeks	26 weeks
Benefit Election Options		
You are automatically enrolled.	You may elect to have STD benefits paid on a pre-tax basis, which means STD benefits would be subject to tax. If an election is not made, you will default to the post-tax option, which means STD benefit payments are not subject to tax. Changing from pre-tax to post-tax or vice versa can only be done during Annual Enrollment.	
Benefit Amount		
After completing your Eligibility Period, you will receive an allowance of 100% to 60% of your Normal Take Home Pay, based on your years of service. See the STD Summary Plan Description (SPD) for Qwest Union Represented employees on the Intranet for more information.	70% Base Pay post- or pre-tax option If you choose the **post-tax** option, your STD benefit amount is not taxed if/when the benefit is paid. Imputed income* is added to your taxable pay so that you will not have to pay taxes on benefits you may receive from the Plan. • The post-tax option will appear as imputed income on your paycheck. If you choose the **pre-tax** option, your STD benefit amount is taxed if/when the benefit is paid. When selecting the STD **pre-tax** option, there will not be a line item on your paycheck as the cost and credit amounts offset. **Note for Qwest Union Represented Hired Before Jan. 1, 2009 and Qwest Union Represented Hired, Rehired Or Transferred On Or After Jan. 1, 2009:** If you are eligible and on STD for longer than 6 months, and enrolled in the **pre-tax** option, your STD benefit becomes FICA Free due to IRS regulations.	

*Imputed income is the term the IRS applies to the value of any benefit or service that should be considered income for the purposes of calculating your federal, state and local taxes. On your paycheck, the post-tax in the "Imputed Income" section is the taxable amount that reflects the value of the STD benefit. This line item on your check does not mean you are on STD but that you elected the post-tax option.

This chart is only a snapshot summary of STD benefits. For specific details refer to the STD Summary Plan Description (SPD) and the collective bargaining agreement (CBA), on the Intranet.

Short-Term Disability (STD) - Non-Union and Union Represented Employees

A brief overview of your STD benefits.

Union Represented	Non-Union and Qwest Union Represented Outside Sales Representatives
Eligibility	
You must have one year of service to be eligible for this benefit.	You must have one year of service to be eligible for this benefit.
Benefit Election Options	
For employees in CenturyLink unions, refer to your collective bargaining agreement (CBA) for more information.	You may elect to have STD benefits paid on a pre-tax basis, which means STD benefits would be subject to tax. If an election is not made, you will default to the post-tax option, which means STD benefit payments are not subject to tax. Changing from pre-tax to post-tax or vice versa can only be done during Annual Enrollment.
Maximum Benefit Period (Duration of Benefits)	
26 weeks	26 weeks
Maximum Benefit Period (Duration of Benefits)	
Tier level ranges from 100% to 60% based on years of service. **Note:** You are not eligible to supplement your STD with accrued Paid Time Off (PTO) or vacation time.	70% of your base pay If you choose the **post-tax** option, your STD benefit amount is not taxed if/when the benefit is paid. You are not eligible to supplement your STD with accrued Paid Time Off (PTO) or Flexible Time Off (FTO). Imputed income* is added to your taxable pay so that you will not have to pay taxes on benefits you may receive from the Plan. • The post-tax option will appear as imputed income on your paycheck. If you choose to elect the **pre-tax** option, your STD benefit amount is taxed if/when the benefit is paid. You are eligible to supplement your STD with accrued PTO or FTO only if you elect the pre-tax option. When selecting the pre-tax option, there will not be a line item on your paycheck as the cost and credit amounts offset.

*Imputed income is the term the IRS applies to the value of any benefit or service that should be considered income for the purposes of calculating your federal, state and local taxes. On your paycheck, the STD post-tax option in the "Imputed Income" section is the taxable amount that reflects the value of the STD benefit. This line item on your check does not mean you are on STD but that you elected the post-tax option.

This chart is only a snapshot summary of STD benefits. For specific details refer to the STD Summary Plan Description (SPD) and the collective bargaining agreement (CBA), on the Intranet.

Long-Term Disability (LTD)

A brief overview of your LTD benefits.

Basic LTD (Fully paid by the Company, basic level of LTD coverage)	Supplemental LTD (Employee-paid, higher level of LTD coverage)
Eligibility	
You are eligible for Basic LTD after you have completed one year of service.	You are eligible to enroll in the Supplemental LTD Plan the first Annual Enrollment after completing one year of service. For example, if you were hired in 2023, you are not eligible to enroll in Supplemental LTD until 2025 Annual Enrollment. If you are eligible for Supplemental LTD for the first time and do not enroll during your first Annual Enrollment opportunity, but want to enroll later, you will be required to complete the Statement of Health/Evidence of Insurability (EOI). Refer to the LTD Summary Plan Description (SPD) for more information.
Benefit Amount	
Maximum of 50% of Pre-disability earnings up to $12,000 maximum per month.	Maximum of 65% of Pre-disability earnings up to $25,000 maximum per month.
Rates	
If you elect Supplemental LTD, calculate your bi-weekly premium rate by using the table below. Benefit premiums cost for Supplemental LTD will be deducted bi-weekly directly from your paycheck. If you do not enroll in Supplemental LTD, subject to eligibility requirements, you will automatically be enrolled in Basic LTD at no cost to you. If you have questions regarding how to determine your earnings, please review the Basic & Supplemental LTD Highlights found on the Intranet.	
1. Enter your bi-weekly pre-disability Earnings, not to exceed $17,752.	**Line 1:** $___
2. Your bi-weekly premium rate: • .00233 for Qwest Union Represented employees hired, rehired, or transferred prior to Jan. 1, 2018 • .00291 for Qwest Union Represented employees hired, rehired, or transferred on or after Jan. 1, 2018; Non-Union; Union Represented; Qwest Represented Outside Sales Representatives	**Line 2:** $___
3. Multiply the amount on **Line 1** by the amount on **Line 2**, and enter the total here. The amount on Line 3 is your estimated bi-weekly premium for coverage under Supplemental LTD.	**Line 3:** $___

Note: If you are on STD as of Jan. 1, 2024, and enroll in Supplemental LTD, your Supplemental LTD will not become effective until the day you return and complete one full day of Active work or until your Supplemental LTD is approved. Refer to the actively at work provisions in the LTD Summary Plan Description (SPD) on the Intranet.

This chart is only a snapshot summary of LTD benefits. For specific details refer to the LTD SPD and the collective bargaining agreement (CBA), if applicable, on the Intranet.

Voluntary Lifestyle Benefits

You must be a Full-time employee to enroll in Voluntary Lifestyle Benefits. Information on these plans can be found on the Intranet.

Accident Insurance, Critical Illness Insurance and Hospital Indemnity Insurance are the only Voluntary Lifestyle Benefits that are company-sponsored and are covered under the federal law known as "ERISA." All other Voluntary Lifestyle Benefits are not Company-Sponsored.

Important Note: The Voluntary Lifestyle Benefits are not Company-sponsored plans or benefits (excluding: Accident Insurance, Critical Illness Insurance and Hospital Indemnity Insurance) and are not plans covered by the Employee Retirement Income Security Act (ERISA). The Company allows these vendors to make these benefits available to employees as a mere convenience. Please note that the Company is not sponsoring or otherwise endorsing the benefits and is not responsible for any of the program products, services or practices. Your rights and remedies under the program are addressed solely and exclusively with the benefits vendor and not with the Company. These are voluntary benefits and you enroll at your own expense. Only you can decide whether the benefits provided by the program are appropriate for you and your family. The Company is not able to provide you with advice regarding the program.

Access to the Voluntary Lifestyle Benefits Program is provided through the Health and Life website at **lumen.com/healthandlife**. You can review the Voluntary Lifestyle Guide by going to the Reference Center on the top right-hand side of the home page and then select the Voluntary Lifestyle Benefits folder. **Lumen does not benefit from your participation in these plans and no commissions or incentives are paid to Lumen as a result of the products or services you may choose to purchase.**

Enroll only during Annual Enrollment, Nov. 8 - Nov. 22, 2023

Subject to the policy terms:

Accident Insurance

Accidents can happen when you least expect them. And while you can't always prevent them, you can help lessen the financial impact and try to make your recovery less stressful. Even the best medical plans may leave you with unexpected expenses like deductibles, copays, extra costs for out-of-network care, and non-covered services.

Airvet

Airvet is a 24/7 veterinary telehealth company that can help with anything from urgent health questions to routine pet care. Airvet offers visits with licensed veterinary professionals and has no deductibles, co-pays, and pet restrictions (number of pets, age, breed, etc.)

Critical Illness Insurance

Medical insurance may only cover a portion of the expenses associated with treating a serious illness. Plus, additional costs that often come with recovering, like childcare, transportation, and grocery delivery, may be left up to you. Critical Illness Insurance can provide you with a benefit that can help you pay for unexpected costs, such as those that your existing medical insurance may not cover.

Hospital Indemnity Insurance

Hospital stays can be pricey and are often unexpected. Since most healthcare plans don't cover all expenses, taking steps to help protect yourself can make a big difference. Hospital stay services can add up and result in out-of-pocket costs beyond what your medical plan may cover in addition to deductibles, copays, and expenses that come with out-of-network care.

Enroll at any time

Disaster Insurance through Recoop

Recoop is the first and only multi-peril disaster coverage that quickly pays you a lump sum benefit (up to $25,000) after a disaster: disaster: dust storm, earthquake, gas explosion, hurricane (with storm surge), tornado, or wildfire. Disaster Insurance is not available in the following states: CA, CT, FL, ID, LA, MA, ME, NH, NJ, NY, SC and WA.

Employee Perks

PerkSpot is a members-only discount site that provides you with access to hundreds of exclusive deals from brand-name retailers and local merchants. It offers travel deals, great gifts, and practical everyday necessities — all at specially negotiated prices.

Home and Auto Insurance Program*

Like health insurance, premiums and out-of-pocket expenses for home and auto insurance are going up. From auto accidents to natural disasters, there has been an increase in both severity and frequency of incidents. And without the right coverage, an accident or storm can be devastating to your family's financial security. Now, with **Farmers Insurance** and **Liberty Mutual**, you can save money on the right coverage for you and your family, without sifting through dozens of quotes.

Enroll only during Annual Enrollment, Nov. 8 - Nov. 22, 2023	Enroll at any time
Legal Services Like health insurance, legal assistance is there to help you when the unexpected happens. This can include helping you with matters such as divorce, identity theft, traffic citations, and more. Other times, legal assistance can help you avoid issues ahead of time, such as credit monitoring or preparing a will or trust. **Universal Life with Long-Term Care through TransAmerica** TransElite® is universal life insurance that helps provide financial protection at a competitive cost, going beyond traditional life insurance to meet challenging situations. If you need to borrow against the cash value, you can pay it back when times get better. If you're diagnosed with a terminal illness, you can use a portion of the policy's death benefit to make a difficult time easier. If you're laid off, monthly deductions are waived for up to six months, so you maintain your policy.	**Identity & Fraud Protection Program** Keep your identity secure with extensive monitoring of your personal information, like your accounts, credit, SSNs, IDs, and more. You'll also get near real-time alerts on suspicious credit inquiries, like if someone was opening a loan or credit card in your name. Live with peace of mind that your online personal and financial information is secure. **Pet Insurance** Pet Insurance is there to help with the cost of seeing a vet for those moments when your cats and dogs are feeling less than well. For a small premium per pet each month, this coverage will pay out a certain amount when you need to make an urgent or emergency vet visit. **Purchasing Power Program** Purchasing Power provides you with an affordable way to buy today and pay over time, right from your paycheck. Sign up for free and shop thousands of name-brand products, such as computers, electronics, furniture, appliances, vacation packages, and online education services.

You may have the option for payroll deductions from the programs listed above.

*The Home and Auto Insurance Program may not be part of the benefit offering in Florida and Massachusetts.

Who Do I Contact - Helpful Resources

When you need more detailed information about Plan specifics, review your SPDs and SMMs located on the Intranet, or in the Reference Center located on the top right-hand side of the home page on the **Health and Life website**. If you would like a paper copy of these materials, contact the Service Center. Please be advised that mail 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/healthandlife 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/healthandlife	**833-925-0487** **317-671-8494** (International callers) Mon-Fri, 7 a.m. - 7 p.m. (CST)
Medical and Prescription Drug		
Blue Cross/Blue Shield Hawaii Medical Services Association (HMSA)	HMSA: hmsa.com/contact **Group Number:** 030541001	**800-776-4672** Mon-Fri, 5 a.m. – 2 p.m. (CST)
CDHP **Doctors Plan** **HDHP**	**UnitedHealthcare:** 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)
Flexible Spending Accounts (FSAs) and Health Savings Account (HSA)		
Flexible Spending Accounts	**UnitedHealthcare:** myuhc.com **Policy Number:** 199383 Search: **UHC App**, available for free in the App Store and Google Play	**800-842-1219** Mon-Fri, 7:30 a.m. - 8 p.m. (CST) **Note:** For help with card reissues or lost/stolen cards, call FSA Support/Card Services at **866-755-2648**.
Optum Bank	OptumBank.com Search: **Optum Bank App**, available for Free in the App Store and Google Play	**866-234-8913** Available 24/7

Administrator - Plan - Program	Website/Group Number	Phone Number
Additional Medical Programs and Plans		
Bright Horizons Family Solutions Provides high-quality care for your entire family including infants, toddlers, preschoolers, school-age children, teens, adults and elderly family members.	lumen.com/brighthorizons	**888-874-0420** Available 24/7
2nd.MD Lumen provides access to 2nd.MD services free for eligible employees 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)
Maternity Support Program	surest.com Search: **Surest**, available for Free in the App Store and Google Play myuhc.com Search: **UHC 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)
Telemedicine **Doctors Plan:** MDLIVE **Surest:** Doctor on Demand, K Health and MDLIVE **UnitedHealthcare:** 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: **UHC 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 Group Number: 148069	**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 Group Number: 1029819	**855-874-4744** Mon-Fri, 8 a.m. - 11 p.m. (CST)

Administrator - Plan - Program	Website/Group Number	Phone Number
Disability and Life Insurance		
Short-Term Disability Sedgwick	lumen.com/disability	**844-223-7153** Mon-Fri, 7 a.m. - 4 p.m. (CST)
Long-Term Disability MetLife	metlife.com/mybenefits	**833-622-0135** Mon-Fri, 8 a.m. - 11 p.m. (CST)
Life, Accident, and Business Travel Accident (BTA)	lumen.com/healthandlife 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)
Retirement		
401(k) Savings Plan Principal	lumen.com/401k	**800-547-7754** Mon-Fri, 7 a.m. – 9 p.m. (CST)
Combined Pension Plan	lumen.com/pension	**888-324-0689** Mon-Fri, 8 a.m. – 7 p.m. (CST)
Wellness		
Employee Assistance Program (Emotional Wellbeing Solutions)	lumen.com/EAP	**866-270-0033** Available 24/7
Real Appeal	lumen.com/realappeal	**844-344-7324** Mon-Fri, 7 a.m. – 7 p.m. (CST)
Wondr™	lumen.com/wondrhealth	**N/A**
Well Connected, Rally, and Coaching Programs	lumen.com/wellconnected Search: **Rally Coach™** available for Free in the App Store and Google Play	**877-818-5826** Mon-Fri, 8 a.m. – 8 p.m. (CST)
Lifestyle Reimbursement	lumen.com/wellconnected	**N/A**
Voluntary Lifestyle Benefits		
Voluntary Lifestyle Benefits - Health and Life Service Center	lumen.com/healthandlife	**833-925-0487** **317-671-8494** (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.

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 your User ID and password confidential 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 information on the **Health and Life Website**. Please be advised that using an email that is not secured, such as your work email address, may increase your risk of unauthorized disclosure.

California Department of Managed Health Care Notification

Grievance Process and Independent Medical Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your behavioral health care service plan, you should first telephone your plan at **800-999-9585** or 711 for TTY (at operator request say "1-800-999-9585") and use the plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance.

You may also be eligible for an independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

- The department also has a toll-free telephone number (**888-466-2219**) and a TDD line (**877-688-9891**) for the hearing and speech impaired.
- The department's internet website: **dmhc.ca.gov** has compliant forms IMR application forms and instructions online.

Company's reserved rights

The Company reserves the right to amend or terminate any of the Benefits provided in the Plan. For more information, review the Lumen Health Care Plan General Information for Active Employees Summary Plan Description on the Intranet or the Health and Life website at lumen.com/healthandlife in the Reference Center located on the top right hand side of the home page.

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) due to employment termination or reduction of hours of employment. Certain QLEs, or a second during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. Upon termination, or other COBRA qualifying event, the former employee and any other Qualified Beneficiaries (QBs) will receive COBRA enrollment information. QLEs for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment. QLEs for Spouses/Domestic Partners or dependent children include those events above, plus, the covered employee's becoming entitled to Medicare, divorce of the covered employee, death of the covered employee, and the loss of dependent status under the plan rules. If a QB chooses to continue group benefits under COBRA, they must timely enroll and make their premium payment by the due date before eligibility is sent to the Claims Administrators. Upon receipt of premium payment, the 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.**

Coverage is not advice

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

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 life event. For example, if you have Employee Only coverage in a 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 benefit options available to you, provided you verify your Spouse's/Domestic Partner's eligibility for the Plan.

Honesty is the Best Policy

As an employee, you are held to the Code of Conduct's standard of honesty and truthfulness. Falsifying or omitting information when enrolling for coverage under the Plan will be cause for disciplinary action, up to and including termination. If you have questions about whether your responses in the enrollment process are accurate, please call the Service Center.

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.

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 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; 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, plan or program including voluntary or supplemental coverages. Please refer to the applicable Plan document or SPD on the Intranet 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 or a 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 the complete notice on the Intranet, the Health and Life website at **lumen.com/healthandlife**, or by calling the Service Center at **833-925-0487** to request a copy.

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. For more information, review the Lumen Health Care Plan General

Information for Active Employees Summary Plan Description on the Intranet or the Health and Life website at lumen.com/healthandlife in the Reference Center located on the top right hand side of the home page.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Lumen may use aggregate information it collects to design a program based on identified health risks in the workplace, Rally will never disclose any of your personal information either publicly or to your employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and never used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) a registered nurse or a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

Right to amend and/or discontinue

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. 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.

Wellness Program Notice

Lumen's Well Connected program is a voluntary wellness program available to all employees and eligible spouses/domestic partners enrolled in a Lumen medical plan. The program is administered according to federal rules permitting Company sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health survey through Rally, our wellness platform, that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., diabetes, heart disease, or COPD). You will also be asked to complete a biometric screening, which will include a blood test for cardiac disease or diabetes. You are not required to complete the health survey or to participate in the biometric screening or other medical examinations.

However, employees and eligible spouses/domestic partners who choose to participate in the wellness program will receive an incentive in the form of gift cards or a deposit into a medical account for completing both the health survey and biometric screening. Although you are not required to complete the health survey or participate in the biometric screening, only those who do so will each receive the $150 each incentive.

Additional incentives of up to $600 total may be available for employees and covered spouses/domestic partners who participate in certain health-related activities such as preventive screenings, walking activities, or health coaching. **If you are unable to participate in any of the health-related activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Rally at 877-818-5826.**

The information from your health survey and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as nurse engagement or the Total Health Immersion Program. You also are encouraged to share your results or concerns with your own doctor.

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 (if any) on the Intranet regarding any applicable restrictions. Contact the Claims Administrator of your medical benefit option for more information.

Working After Retirement

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 to see how your retiree benefits may be impacted.

Note: If you had VEBA Life Insurance, that coverage will not be impacted.

If you are rehired in a status that is eligible for active benefits, you will be offered the same benefits as other similarly situated employees based on your employee classification. If you had 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 your 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 insurance coverage, if applicable.

If you return to work for a supplier on assignment to the Company, you are not eligible to continue your retiree health care benefits, so this means that while you are working for the supplier, your retiree health care benefits will be suspended. You will, however, be offered the opportunity to continue your retiree medical and/or dental options under COBRA. Your retiree basic and/or 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 terms of the Plan by calling the Service Center at **833-925-0487**. If you returned to work for a supplier on assignment to the Company, 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 the disenrollment process to be released by that carrier from the individual plan (which can take up to 60 days).