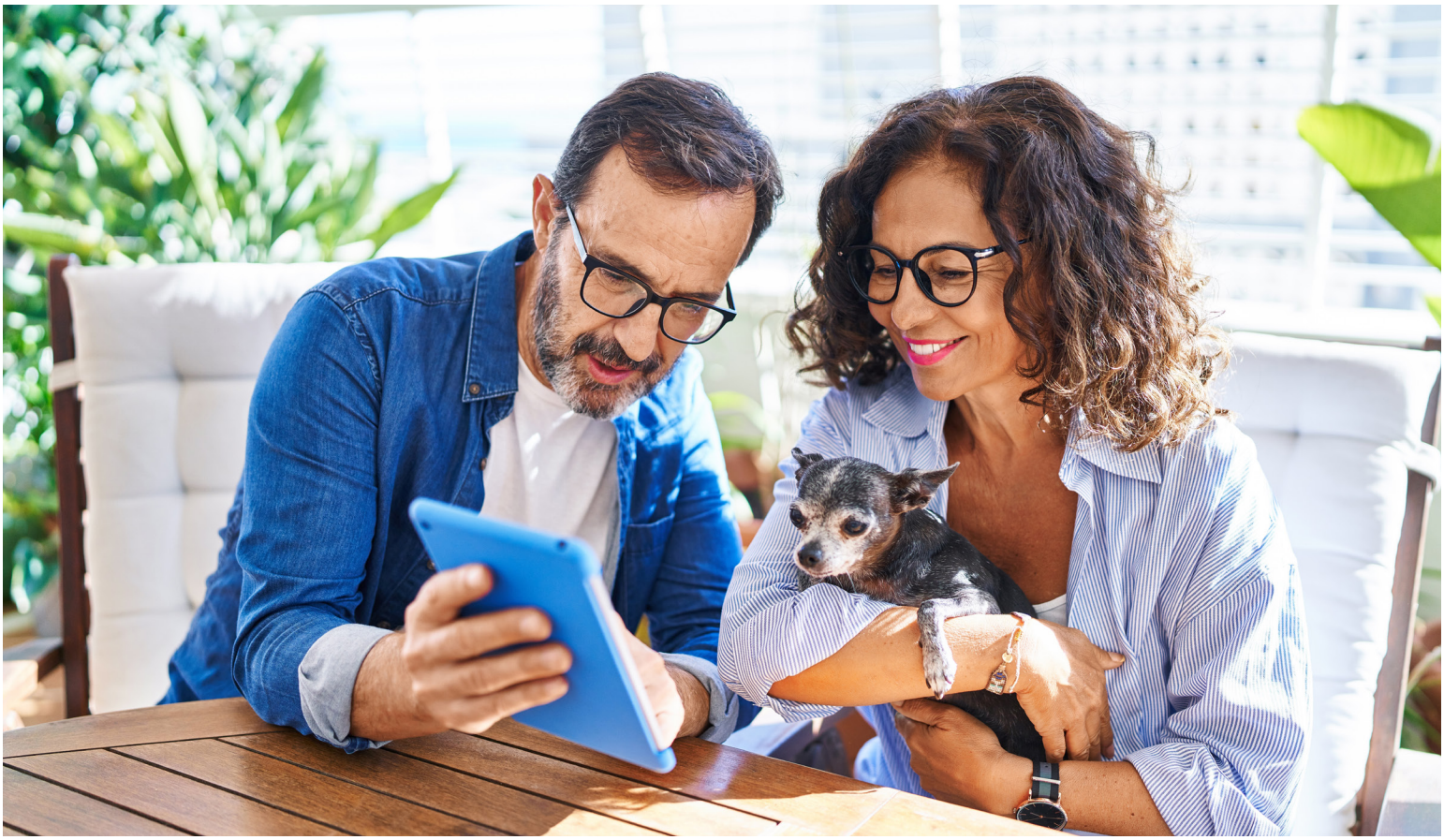
Your benefits. Your choice. Enroll now.

Nov. 8 - Nov. 22, 2023

2024 Annual Enrollment Guide

For CenturyLink Retirees with Executive Medical

Including Inactive and COBRA Participants



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Contents

- **Some references and benefit options in this guide apply only to CenturyLink Retirees with Executive Medical. The Lumen Health and Life Service Center will be referred to hereafter as "the Service Center".**
- **Lumen will be referred to hereafter as "the Company".**

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Welcome to Annual Enrollment

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

We encourage you to review this guide and your available options even if you don't want to make changes.

Go to the Health and Life website at **lumen.com/healthbenefits** to learn about your 2024 benefits. On the website, you'll find helpful information in the **Reference Center** located next to your name at the top of the screen as well as a calendar that tells you how many days you have to enroll or make changes.

This guide pertains to BOTH non-Medicare and Medicare eligible participants and eligible dependents. If you make changes during Annual Enrollment, your new coverage will begin on the first day of the new calendar year.

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

Helpful Tips

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

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

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

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

- ☐ In addition to enrolling in your retiree benefits, we recommend you view the Voluntary Lifestyle Benefits available to you.

  You will need to enroll directly with the applicable carrier using the websites provided on the Transaction Complete page if you enroll on the Health and Life website, or by selecting the Voluntary Lifestyle Benefit you are interested in under Security and Other Benefits from the main menu on the home page of the Health and Life website.

What's New for 2024

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

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

Benefit Premiums

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

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

COBRA

COBRA coverage is limited to medical, dental and/or vision coverage, as applicable. **COBRA rates have changed.** Refer to your enrollment options on the **Health and Life website** for more information.

Enrollment on the Health and Life website has been simplified

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

Medical - Non-Medicare Eligible

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: CDHP and HDHP

Deductibles will increase.

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

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 - Non-Medicare Eligible

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

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

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

These changes apply to: CDHP, HDHP and Surest PPO

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

Copay Updates -

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

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

These changes apply to: Doctors Plan and Surest PPO

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

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

Additional Updates - Applies to all

Company Couples or Parent/Child Relationship - If your Spouse/Domestic Partner is employed, 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 or retiree status.

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

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

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

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

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

Reminders

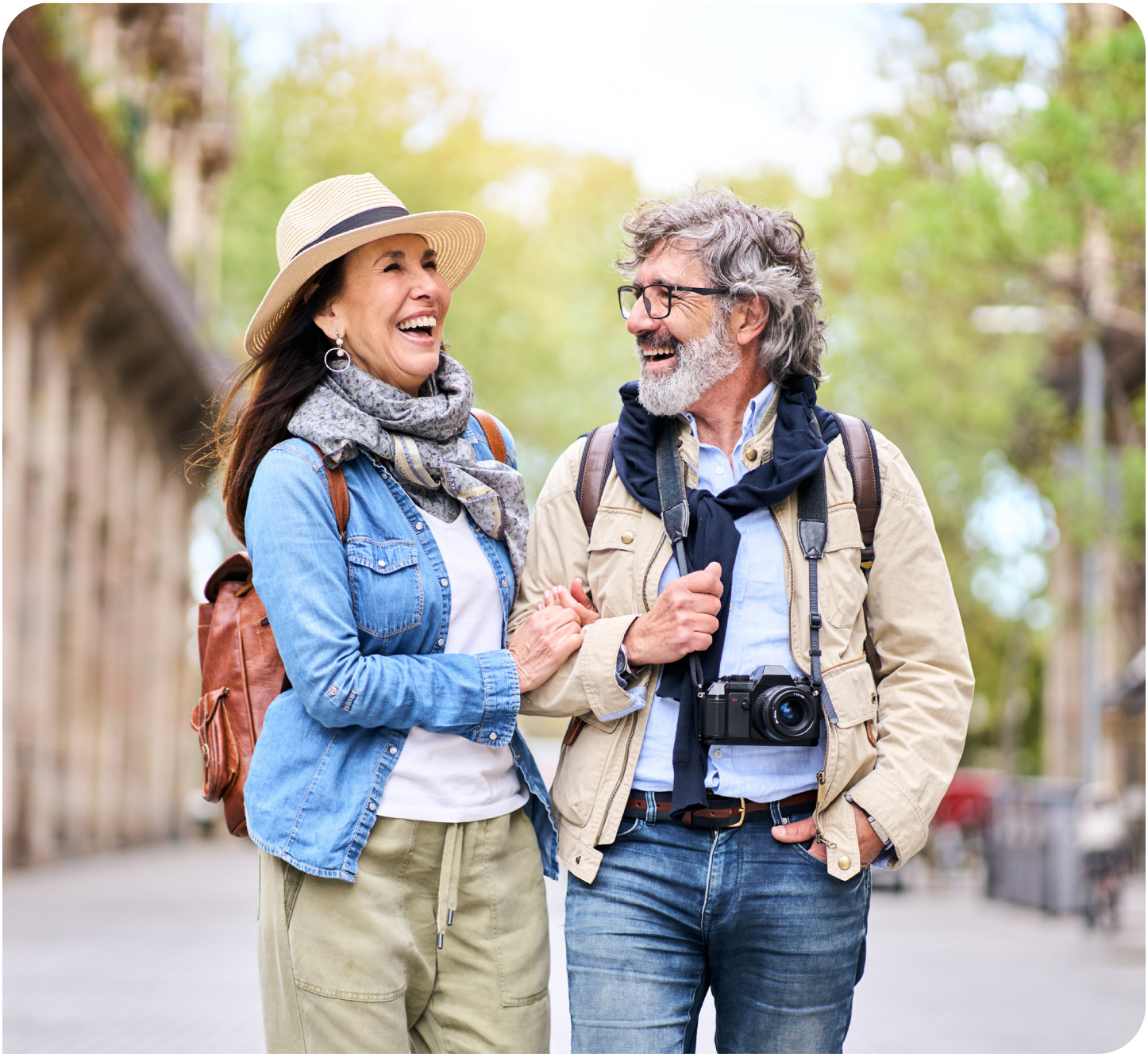
Note: If you experience a Qualified Life Event, (e.g. removing a suspended dependent, divorce, etc.) as of Nov. 8, you will need to complete both 2023 and 2024 Annual Enrollment elections. If you don't make two elections, your benefits from 2023 will not roll over to 2024.

Benefit Details	Medicare/Non-Medicare Eligible Participants	Important Information
Deductibles and Co-Insurance Accumulators reset on Jan. 1	Non-Medicare Eligible	If you elect to move from the CDHP to the HDHP or the Surest PPO, any Health Reibursement Account (HRA) dollars will be transferred to your post-deductible HRA after a run-out period of **90** days. Keep in mind that Surest PPO and UHC are unable to process prior to 90 days. If you enroll as a dependent under your spouses Lumen group plan (you are a Company couple), any HRA dollars will be moved after a run-out period of **90** days. It will be necessary for you to contact the Advocacy Services team at the Service Center, 833-925-0487 to assist you with the transfer process. The Advocacy Services team will work with UHC or the Surest PPO to have the HRA dollars moved to the applicable plan option after the **90**-day run-out period.
Dependent Re-Verification	Medicare and Non-Medicare Eligible	Lumen will periodically conduct audits of covered dependents under the Plan. Lumen has a fiduciary responsibility to ensure that benefits under the Plan are provided to those who are eligible to receive them. You will be required to provide supporting documentation (future notifications will advise you what documents to provide) that your Spouse, Domestic Partner, Common-Law Spouse, or any other dependent continues to qualify as your dependent under the Plan.
Direct Bill Payment	Medicare and Non-Medicare Eligible	Account Statements are not mailed. If you owe a premium for any of your benefits, you are encouraged to set up ongoing automatic payments for your direct bill account (e.g., for retiree dental coverage). If you choose to set up autopay, you must pay your outstanding balance in full before the autopay will begin. **Note:** If you choose to make one-time payments, you will incur a $2.00 service fee for each payment. This is not the same as autopay. Follow the below steps to set up autopay on the Health and Life website or you can call the Service Center at 833-925-0487: • Log in to **lumen.com/healthbenefits**. On the lower right side of the screen, you will see **Payment Due** which provides details about your monthly premium. • Scroll down until you see **Make a Payment** and **View Account**. Select **Make a Payment**. • A pop-up window will appear. – Enter Account Type, Routing Number and Account Number. – Confirm the billing and email address. – Select **Yes** to set this account up as your primary payment method. – Select **Yes** to set up auto pay. Funds are automatically deducted on the fifth of each month. – Next, click **Pay**. – This will return you to the Billing Information page where you can view your account summary, payment history and account premium information.

Benefit Details	Medicare/Non-Medicare Eligible Participants	Important Information
Direct Bill Payment	Medicare and Non-Medicare Eligible	**You can also mail-in a payment to:** **Businesssolver** PO Box 850512 Minneapolis, MN 55485-0512 **Note:** You must include your **account number** and **Lumen** on the Memo line of the check.
Dual Coverage	Non-Medicare Eligible	Company retirees are prohibited from being enrolled in more than one Company medical/prescription drug or dental Plan benefit option (except as noted below). • **If you elect coverage during Annual Enrollment, and are also covered as a dependent on another employee's/ retiree's coverage,** you will remain covered under your own record. You will be removed as a dependent from the other employees/retiree's coverage once the enrollment period ends. • **If you retired and enrolled as a dependent through a Qwest Pre-1991 retiree's coverage,** you will be allowed to remain enrolled as both a dependent and as a retiree, and you may also cover the Pre-1991 retiree as your dependent. **Note:** Pre-1991 retirees must be enrolled in the Company Guaranteed Plan; otherwise, dual coverage does not apply.
Medical and Dental Company Cap	Non-Medicare Eligible	**Medical and Dental Premiums - excluding Embarq Retirees** Review your Enrollment Notice as your premiums may change for 2024. Retirees are responsible for the portion of the cost of medical premium that exceeds the monthly company contribution Cap, as applicable. Be sure to review your medical plan options and premium costs carefully. The Retiree and Inactive Health Plan includes a Cap on the dollar amount of the premium subsidy provided by the Company. Cap amounts vary depending on your legacy company and whether you are enrolling yourself and/or any eligible declared dependents. Once the cost of healthcare coverage exceeds the specified Cap amount, you pay 100% of the remaining balance above the Cap amount, in addition to your percenage amount due. **Reminder:** Your contribution was capped at the 2020 amounts and will not increase in the future.
Pharmacy	Non-Medicare Eligible	The Prescription Drug List (PDL) is updated periodically throughout the year. You can use the pricing tool on the following websites based on the 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
Returning to Work?	Medicare and Non-Medicare Eligible	If you are eligible for retiree healthcare or life insurance from the company, refer to the applicable section to see how your retiree benefits may be impacted. **Note:** If you have Retiree CTT Life Benefit insurance, that coverage will not be impacted. **If you are rehired in a status that is eligible for active employee benefits**, you will be offered the same benefits as other similarly situated employees based on your employee classification. If you have retiree supplemental life insurance coverage, you will be eligible to elect active supplemental life insurance coverage. If there is a loss of supplemental life coverage between what you previously had prior to your rehire date and the amount as an active employee, you may convert the difference with Metropolitan Life Insurance Company. If you continued supplemental life coverage through Metropolitan Life Insurance Company, you will be required to surrender this policy when you return to retiree status in order to resume your retiree supplemental life coverage, if applicable.

Benefit Details	Medicare/Non-Medicare Eligible Participants	Important Information
Returning to Work?	Medicare and Non-Medicare Eligible	**If you return to work for a supplier on assignment to the company, you are not eligible to continue your Company retiree healthcare benefits. This means that while you are working for the supplier, your retiree healthcare benefits will be suspended.** However, you will be offered the opportunity to continue your retiree medical and/or dental options under COBRA. Your retiree basic and/or retiree supplemental life coverage, if applicable, will continue under the terms of the Life Insurance Plan (the Plan). In addition, please be advised that as a worker for a supplier or company contractor, you are not eligible for active employee healthcare benefits. Retiree healthcare 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 healthcare, basic and supplemental life insurance coverage, if applicable, in accordance with the terms of the Plan by calling the Service Center at **833-925-0487 (The local DNIS for international callers is 317-671-8494)** If you returned to work for a supplier on assignment, the Company, will validate that your assignment has ended before you will be allowed to resume your retiree healthcare 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).
Retiree Articles	Medicare and Non-Medicare Eligible	Stay up-to-date, visit **lumenbenefits.com** or **lumen.com/healthbenefits** to get the latest retiree news. These articles are designed to share information about benefits, the Company and other topics.
Suspended Dependents	Medicare and Non-Medicare Eligible	To cover a previously suspended dependent during Annual Enrollment, **action is required**. • To add previously suspendend dependents, follow the directions during your online enrollment or contact the Service Center. • Plan coverage for your previously suspendend dependents will become effective Jan. 1, 2024 providing supporting documentation to verify eligibility for your dependent is received timely. You can upload your supporting documentation after you complete your enrollment.
Suspending Coverage	Medicare and Non-Medicare Eligible	You can suspend medical/prescription drug or dental retiree coverage for you and/or your dependents when you first retire (which does not count towards your one-time suspend option) and if you do not make an affirmative election during Annual Enrollment, your coverage will remain in a suspended status. If you later wish to participate in the medical/prescription drug or dental Plan benefit options, you must make an affirmative election during Annual Enrollment. You can suspend your coverage one time and re-enroll at a later date. **Note**: This one-time rule does not apply with respect to Retiree/Inactive Participants who become re-employed directly with the Company as an active employee or who work for a supplier for the company.
Zip Code Updates	Non-Medicare Eligible	Medical provider networks are determined by ZIP code area, and those ZIP codes are reviewed each Annual Enrollment as providers go in-and out-of-network. Be sure to review the medical plans available to you on the Health and Life website or on your Enrollment Notice as options may change (based on your mailing address on file).
Waiving Coverage	Medicare and Non-Medicare Eligible	You can waive medical/prescription drug and/or dental retiree coverage for you and/or your dependents. If you do, you or your dependents will **NOT** be eligible to enroll in that coverage at any time in the future for any reason. "Waiving" coverage is a permanent election and different from 'suspending' coverage.

Benefit Details	Medicare/Non-Medicare Eligible Participants	Important Information
Voluntary Lifestyle Benefits	Medicare and Non-Medicare Eligible	Make sure you review these programs at lumen.com/healthbenefits. Go to the **Reference Center** located at the top right-hand side of the home page by your name. You can search for the Voluntary Benefits folder and review each benefit plan.
1095-C	Non-Medicare Eligible	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**.



Enroll

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

When can I enroll?

Annual Enrollment is from Nov. 8 through Nov. 22, 11:59 p.m. .

How to enroll:

Mobile Device Enrollment

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

Enrollment on the Health and Life website

1. Navigate to **lumen.com/healthbenefits** and log in. If you have not registered or logged into your account, go to step 2 to register. If you have previously logged in, skip to step 5.
2. Create your account following the steps to input your information, create your username and password and security questions. Once registered, log in to your account.
3. Review the **Getting Started Details** to agree to the electronic disclosure agreement and select **Continue**.
4. Enter your **Personal Preference** on how you wish to receive benefit communications. Click **Continue**.
5. Select **Start Here** at the top of the screen to begin your 2024 Annual Enrollment elections.
6. Read the opening message and select **Start Enrollment**.
7. Review your personal information and update your alternate address if applicable, click **Next**.
8. Confirm Medicare Eligibility of you and dependent(s).
9. Review dependents on file and confirm demographic details are accurate, click **Looks Good**.
10. Review your Medicare information, if applicable, for effective dates, and add your Medicare Number as that is required to enroll in a Medicare Plan. Answer the Race and Ethnicity questions.
11. You have two options when enrolling. Option 1 will provide step-by-step instructions. If you select this option, continue to step 12. Option 2 will allow you to keep the same plans/programs. This option will take you to the Benefit Summary page for your review. If you select this option, continue to step 15.
12. Elect all healthcare (medical, dental) plans. If you are enrolling in the Doctors Plan, you will be asked to identify your Primary Care Physician (PCP) during enrollment. **Note:** If you want to suspend/unsuspend or waive coverage, you will be able to do so on the medical and dental plan screens. If you waive coverage, you may not re-elect coverage in the future. Suspend rules will apply.
13. Review Health Reimbursement Accounts (HRA).
14. Review Life Insurance plans and confirm/update beneficiary information.
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 (Confirmation Statement) as this is your confirmation of enrollment.
18. If a declared dependent has been newly enrolled in coverage, you will see information regarding the requirement for dependent verification. Read through the requirements carefully.

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

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

Plan Overview

Non-Medicare Eligible Participants Doctors Plan in Arizona and Colorado.

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

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

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

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

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

	UHC Doctors Plan
You Pay	**In-Network**
	Annual Deductible (The Deductibles are separate for In-Network and Out-of-Network providers and are not combined)
	Retiree
	$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)
	Retiree
	$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

	UHC Doctors Plan	
	Preventive Care: (No Deductible)	
Preventive care/screening/ immunization	100%	
Outpatient Lab and Pathology	80% after deductible	
Outpatient Surgery	**In-Network**	
	80% after deductible	
Emergency Room Services	$500 copay plus deductible and coinsurance	
Inpatient Hospital Care	80% covered after deductible	Out of Network / Not Covered

	UHC Doctors Plan
Prescription Drugs (Copays shown are for up to a 30 day supply of medication)	**Tier 1 Drugs**
	• $10 copay
	Tier 2 Drugs
	• $25 copay
	Tier 3 Drugs
	• $100 copay
	Tier 4 Specialty
	• $400 copay

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

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

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

	Surest PPO		UHC HDHP		UHC CDHP	
HSA/HRA Contributions	Not Applicable		With Retiree-Funded HSA (maximum contribution): • $4,150 Retiree • $8,300 Retiree + 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 Retiree • $750 Retiree + Spouse/Domestic Partner (DP) • $750 Retiree + Child/ren • $1,000 Retiree + 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)					
	Retiree		**Retiree**		**Retiree**	
	$0	$0	$1,600	$3,200	$1,600	$3,200
					Retiree + Spouse/DP	
					$2,400	$4,800
	Retiree + Child/ren		**Family**		**Retiree + 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)					
	Retiree		**Retiree**		**Retiree**	
	$3,600	$7,200	$3,600	$7,200	$3,200	$6,400
	Retiree + Spouse/Domestic Partner				**Retiree + Spouse/Domestic Partner**	
	$5,400	$10,800			$4,800	$9,600
	Retiree + Child/ren				**Retiree + Child/ren**	
	$5,400	$10,800			$4,800	$9,600
	Family		**Family**		**Family**	
	$6,850	$14,400 (Entire family out of pocket must be satisfied before eligible expenses are 100% covered)	$6,850	$14,400 (Entire family out of pocket must be satisfied before eligible expenses are 100% covered)	$6,400	$12,800 (Entire family out of pocket must be satisfied before eligible expenses are 100% covered)

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

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

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

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

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

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

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

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

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

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

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

Medicare Eligible Participants

To continue benefits once you or your eligible dependent(s) become Medicare eligible and avoid a gap between your group and individual coverage, you must enroll in Medicare Part A and Part B. You should contact the Service Center as soon as you have your Medicare Number and effective date as you will not be able to enroll in a Medicare plan without this information. It is your responsibility to notify the Service Center if you or your dependent(s) become Medicare eligible prior to age 65 (for example, if disabled). If you don't advise the Service Center when you become Medicare eligible due to a disability, Medicare may assess penalties, or you may experience a gap in your coverage. Below are the options available once you and your dependent(s) become Medicare eligible:

Lumen Retiree Medicare Advantage PPO Plus Dental Plan offered through UHC

This plan includes original Medicare (Part A and Part B), Part D Prescription Drug coverage and additional benefits like dental, vision and more. Refer to the Medical Plan overview in this guide and the Summary Plan Description for additional information.

Note: If you enroll in this plan, you and/or your dependent(s) must have Part D (Medicare drug coverage) for a continuous period of 63 days or more after the end of your Initial Enrollment Period for Part D coverage or you will be subject to a Medicare Part D late enrollment penalty. The late enrollment penalty (also called "LEP" or "penalty") is an amount that may be added to the monthly premium. If you were enrolled in Lumen medical coverage, this is considered continuous drug coverage.

- When enrolling in the Lumen Medicare Advantage PPO Plus Dental Plan option, this plan replaces both the Retiree HRA and Lumen Dental Plan for the plan year and cannot be changed until the next annual enrollment period.
- The monthly cost of the plan is determined by your retiree group and retiree medical subsidy cap - refer to your Enrollment Worksheet.

What Happens to my Health Reimbursement Account (HRA) if I enroll in the Retiree Medicare Advantage PPO Plus Dental Plan?

- **CS HRA (CenturyLink):** Your CS HRA will be suspended, and you will not receive 2024 HRA funding. You can submit claims for reimbursement from any remaining 2023 HRA funds for claims/premiums incurred through Dec. 31, 2023. The deadline to submit these claims is March 31, 2024.

Health Reimbursement Account (HRA) Plan Combined with an Individual Medicare Policy

You must purchase an individual Medicare and/or prescription drug policy and pay the insurance premium directly to the carrier.

In order for your individual Medicare medical policy to be effective Jan. 1, you must enroll with Medicare between Oct. 15 and Dec. 7. Via Benefits will contact you approximately 90-120 days prior to the month your turn 65. You can contact them within 90 days of your Medicare enrollment deadline at 888-825-4252 to help you select a medical and/or prescription drug policy. Enrollment through Via Benefits is not a requirement, you can enroll through a Financial Institution, Broker of your choice or directly on **medicare.gov**. Please do not contact the Service Center to enroll in an individual Medicare policy as they will be unable to assist you. Starting Nov. 8, you will need to contact the Service Center letting them know you enrolled in an individual Medicare and/or prescription drug policy.

Note: For additional information, review the Navigation Guide on the Health and Life website at **lumen.com/healthbenefits**. The guide is located in the Reference Center next to your name at the top of the screen in the General Information folder and then the Retiree sub folder.

CenturyLink

- The HRA provides you with Company-subsidized dollars to help you purchase individual Medicare policies.
- The HRA is funded annually, on Jan. 1 of each year by the Company. Unused dollars are forfeited at the end of each year.
- Your annual Company-funded medical HRA amounts are capped and remain the same for 2024 and will not increase in the future.

Lumen Retiree Medicare Advantage PPO Plus Dental - Medicare Eligible Participants

This chart is only a snapshot summary of medical benefits. For specific details on how services are covered or excluded, please contact UHC Customer Service at **844-588-5873**, or refer to the Summary Plan Description on the **Health and Life website**, or call the Service Center.

Note: If you enroll in this plan, it replaces both the Retiree HRA and Lumen Dental Plan for the plan year and cannot be changed until the next annual enrollment period.

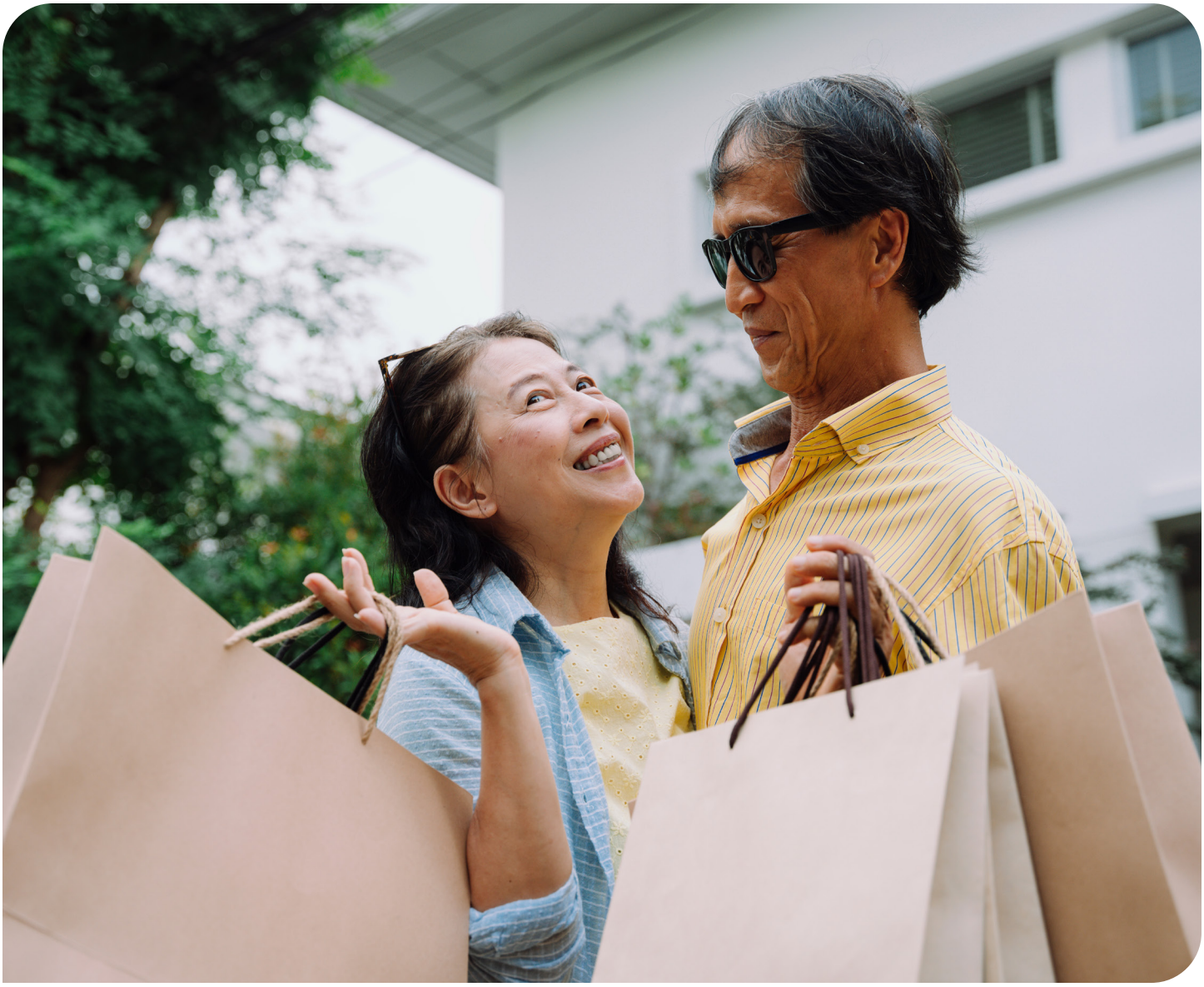
Plan comparison Medical Benefits	Lumen Retiree Medicare Advantage (PPO) + Dental Plan In-Network	Lumen Retiree Medicare Advantage (PPO) + Dental Plan Out-of-Network	Individual Medicare Advantage Plan	Medicare Supplement Plan G	Medicare Supplement Plan N
Monthly premium	**$0-$140**		$21	$143-$235	$120-$180
Annual deductible	**$0**		$150	$203	$203
Out-of-pocket maximum	**$950**		$4,750	N/A	N/A
Primary care physician/specialist visit	**$5/$35**	**$5/$35**	$2/$33	Covered	$20
Hospital stay	**$250/day 1-4**	**$250/day 1-4**	$290/day 1-5	Covered	$0
Emergency room visit	**$90**	**$90**	$90	Covered	$50/$20
Prescription drug benefits				**Individual Prescription Drug Plans**	
Monthly premium	**Included in medical**	**Included in medical**	Included in medical	$45	$45
Deductible *Tiers 3-5	**$50**	**$50**	$150	$320	$320
Tier 1: Preferred generic	**$0**	**$0**	$2	$1	$1
Tier 2: Generic	**$8**	**$8**	$9	$5	$5
Tier 3: Preferred brand	**$40**	**$40**	$40	$30	$30
Tier 4: Non-preferred drug	**$90**	**$90**	$90	41%	41%
Tier 5: Specialty	**30%**	**30%**	30%	27%	27%
Percent of Part D drugs covered	**97%**	**N/A**	50%-60%	50%-60%	50%-60%
Catastrophic Coverage	**$0**	**$0**	Greater of 5% or small copay	Greater of 5% or small copay	Greater of 5% or small copay

Note: You can save money by utilizing mail order. You can receive a 90 day supply from Optum Rx for the cost of a 60 day retail supply. To find out how your drugs are covered, contact UHC Customer Service at 844-588-5873 or log on to **lumen.com/MAPD**.

Dental Coverage included with the Medicare Advantage PPO Plus Dental

PPO Plan Design

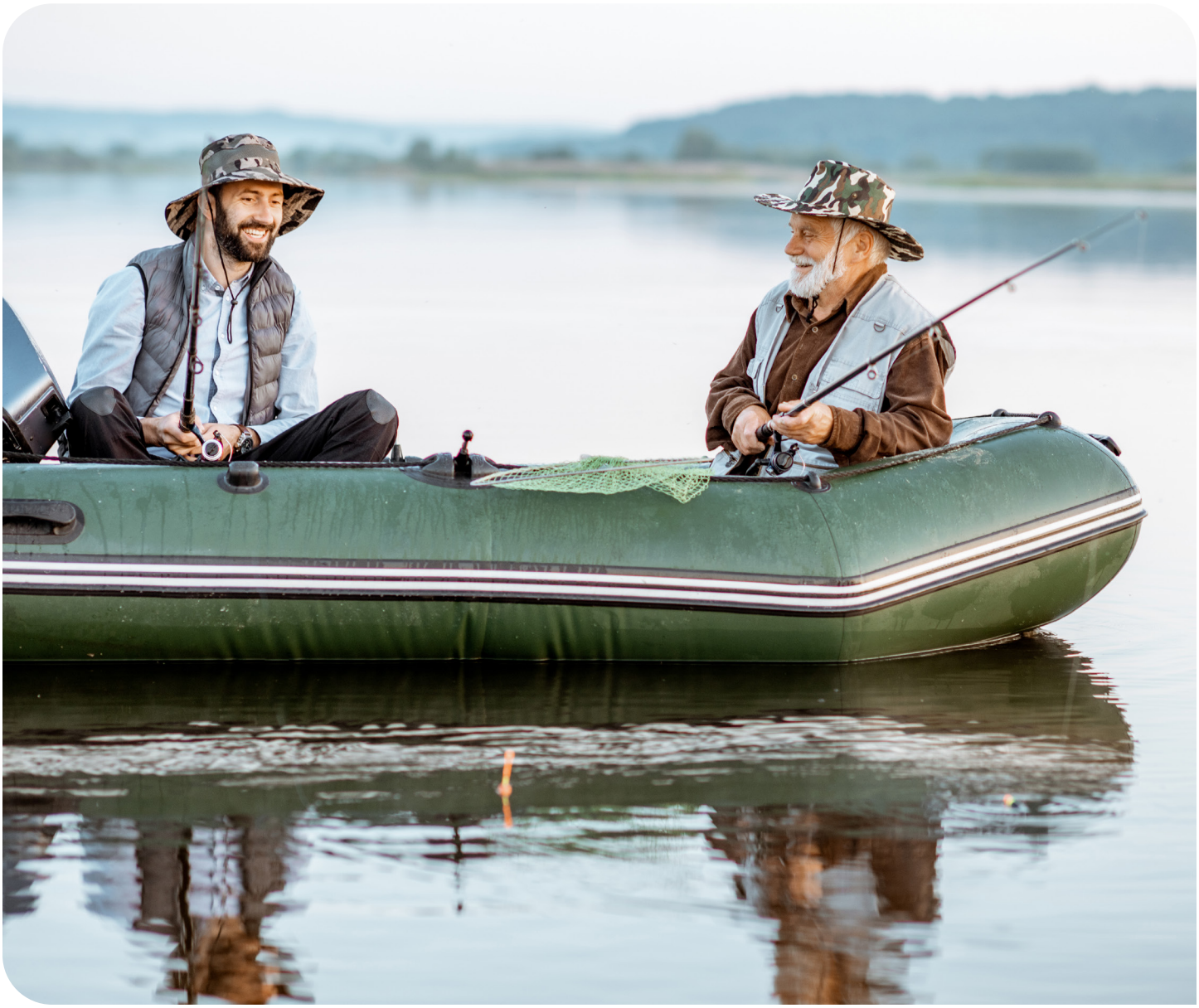
Annual Benefit Maximum (per person)	**$1,000**
You Pay	
Annual Deductible (P&D not Included)	$50
Plan Pays (after deductible)	
Diagnostic and Preventive (no deductible) Cleanings, exams, x-rays	100%
Minor Services Fillings, root canals, periodontics	80%
Major Services Crowns, dentures and bridges	50%
Oral Surgery	Not Covered
Passive PPO Network	When you use network providers, you pay a percentage of discounted fees.
Administrator	UHC, **800-445-9090**



Executive Medical

In addition to your other medical options, you are eligible for the Executive Medical option. Enrollment is automatic, and there is no cost to you.

Percentage of Covered Expenses Payable	100%
Lifetime Maximum Benefit for Orthodontia for Each Covered Person	$4,000
Calendar Year Maximum Benefit for Basic and Major Dental Services for Each Covered Person	$1,500
Services Not Covered	• Any service or supply not allowable as a tax deduction under the Internal Revenue Code • Custodial care • Vision care • See your Executive Medical Summary Plan Description for other services not covered.



Dental

Basic Dental Plan - Passive PPO

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 PDP 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.

For specific details on how services are covered or excluded, please contact MetLife or refer to the Summary Plan Description available on the Health and Life website or request a copy through the Service Center.

Annual Benefit Maximum (per person)	**$1,000 (not including oral surgery)**
You Pay	
Annual Deductible (per person)	$25 for General Care and Major and Restorative; no deductible for Diagnostic, Preventive or Oral Surgery
Plan Pays (after deductible)	
Diagnostic and Preventive (no deductible) Cleanings, exams, x-rays	100% up to maximum allowable amount
General Care Fillings, root canals, periodontics	50% up to maximum allowable amount
Major Restorative Crowns, dentures and bridges	50% up to maximum allowable amount
Oral Surgery (no deductible)	80% no limit
Passive PPO Network	When you use network dentists, you pay a percentage of discounted fees
Administrator	MetLife Group Number: 148096 Phone Number: **866-832-5756**

If you and all of your dependents are Medicare eligible

- If you choose to waive your group dental coverage, you will not be eligible to enroll at Annual Enrollment or if you experience a Qualified Life Event (QLE).
- If you waive or suspend coverage, you can enroll in an individual dental policy of your choice outside of the Company.
- You may enroll in an individual dental policy through Via Benefits (**lumen.com/Via Benefits**) or on your own directly with a dental insurance carrier or a local broker of your choice.
- **If you elect to enroll in the Lumen Retiree Medicare Advantage PPO Plus Dental, your dental coverage will be placed in a suspended status as this plan includes dental coverage.**

Who Do I Contact - Helpful Resources

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

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

Administrator - Plan - Program	Website/Group Number	Phone Number
Telemedicine **Doctors Plan:** MDLIVE **Surest:** Doctor on Demand, K Health and MDLIVE **UHC:** MDLIVE and Virtual Visits	**patient.doctorondemand.com** **lumen.com/MDLIVE** Search: **MDLIVE**, available for free in the App Store and Google Play **myuhc.com/virtualvisits** Search: **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)
Via Benefits	**lumen.com/viabenefits**	**888-825-4252**
Voluntary Lifestyle Benefits	**lumen.com/healthbenefits**	**833-925-0487** 317-671-8494 (International callers) Mon-Fri, 7 a.m. - 7 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)

Change of Address Updates

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

Administrator	Website/Email	Mail/Fax/Phone Number
Health and Life Benefits	**lumen.com/healthbenefits** • Click your name in the top right-hand corner and select **Profile** from the drop-down menu • Select **Your Information** under **Profile** • Update your address • **Save**	833-925-0487 317-671-8494 (Local DNIS for international callers) Mon-Fri, 7 a.m. – 7 p.m. (CST)
Lumen Pension Service Center	**lumen.pension.ehr.com**	Mail to: Lumen Pension Service Center DEPT: LUM P.O. Box 981909 El Paso, TX 79998 Fax: 844-286-1282 **Note:** Your written request must include your full name, last four digits of your Social Security number, complete old and new address, signature and date. If your pension is being paid by **Athene**, call 877-813-4240 to update your address. If your pension is being paid by **Brightspeed**, call 844-516-7870 to update your address.

Legal and Important Required Notices

A note about privacy

Keeping your personal information secure is of primary importance. That's why we, along with the benefits administrators, have implemented various security measures and policies to help reduce the risk of unauthorized processing or disclosure of your personal information. You can also help by keeping confidential your User ID and password for accessing the Health and Life website. Please keep this information safe and don't share it with anyone. Never use your Social Security number as your password. Together, we can make sure your personal information stays safe and secure. We encourage you add your personal email address as your contact preference on the Health and Life website at **lumen.com/healthbenefits**. Please be advised that using an email that is not secured may increase your risk of unauthorized disclosure.

The Company's reserved rights

This document summarizes certain provisions of the Disability Plan, the Life Insurance Plan and the Retiree and Inactive Health Plan (collectively referred to as the "Plan"). For specific employee benefit plan information, refer to the respective official Plan documents, and the applicable Summary Plan Description and Summaries of Material Modifications, if any. If there is any conflict between the terms of the official Plan documents and this document, the terms of the official Plan documents will govern. The Plan Administrator has the authority, discretion and the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan, to supply omissions and resolve conflicts. Benefits and contribution obligations, if any, are determined by the Company in its sole discretion or by collective bargaining, if applicable.

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

Continuation of Coverage

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

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

Coverage is not advice

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

Health Insurance Portability and Accountability Act (HIPAA)

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

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

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

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

If You Voluntarily Elect to Drop Coverage

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

Important note regarding your Annual Enrollment elections

By electing to participate in the Plans, by your submission of information, you have agreed to be bound to and by the provisions of each of the Plans and their administrative practices, including, but not limited to with respect to the recovery of over and underpayments, terms and conditions for eligibility and benefits. You certify that the submission of information by you in this enrollment process is true and accurate to the best of your knowledge, unless you submit changes as instructed; you agree that you'll submit new information timely as changes occur. You understand that if you are found to have falsified any document in support of a claim for eligibility or reimbursement, the Plan Administrator may, subject to and as may be permitted under the requirements of law, without anyone's consent, terminate your and/or your dependent(s) coverage, and the Claims Administrator may refuse to honor any claim you or your dependent(s) may have made or will make under the Plans, if applicable. You understand that you are liable and bear the full financial responsibility for the misappropriation of Plan funds through the filing of false documentation under any of the Plans; you certify that you or your dependent(s) are eligible to enroll in a benefit option, including voluntary or supplemental coverages. Please refer to the applicable Plan document or SPD available on the Health and Life website or by requesting a copy through the Service Center for details about eligibility for coverage, or call the Claims Administrator – limitations may apply including, but not limited to, being actively at work in order to be eligible for coverage. You understand that it is your responsibility to confirm your eligibility to enroll in a benefit option, plan or program including voluntary or supplemental coverages; enrolling in and paying for coverage for which you are ineligible will not entitle you to benefits; you understand that it is your responsibility to terminate benefit coverage once you or your dependent(s) become ineligible, for example, due to death, divorce. This excludes dependents who turn age 26, as they are automatically removed from coverage.

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

Notice of "Exempt" Retiree Medical Plan status

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

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. You can review and print the complete notice at **lumen.com/healthbenefits**. You may obtain a paper copy upon request by calling the Service Center at **833-925-0487** (The local DNIS for international callers is **317-671-8494**).

Other coverage options

There may be other, more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period," even if the plan generally doesn't accept late enrollees. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away,

and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA doesn't limit your eligibility for coverage for a tax credit through the Marketplace.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out of pocket than you would under COBRA, because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

More information on health insurance options through the Marketplace can be found at **healthcare.gov**.

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

Note: This is an updated notice.

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

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

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

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

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

ALABAMA – Medicaid
Website: **myalhipp.com**
Phone: **1-855-692-5447**

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: **myakhipp.com**
Phone: **1-866-251-4861**
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: **dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**

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

ARKANSAS – Medicaid
Website: **myarhipp.com**
Phone: **1-855-MyARHIPP (855-692-7447)**

CALIFORNIA - Medi-Cal
Website: **medi-cal.ca.gov/**
Phone: **1-800-541-5555**

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado
Website: **healthfirstcolorado.com**
Health First Colorado Member Contact Center: **1-800-221-3943/State Relay 711**
CHP+: **colorado.gov/pacific/hcpf/child-health-plan-plus**
CHP+ Customer Service: **1-800-359-1991/State Relay 711**

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

DELAWARE - Delaware Healthy Children Program
Website: **dhss.delaware.gov/dss/dhcp.html**
Phone: **800-372-2023**

FLORIDA – Medicaid
Website: **myflfamilies.com/services/public-assistance/medicaid-redetermination**
Phone: **850-300-4323**
Florida Relay 711 or TTY 800-955-8771

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

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

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

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

INDIANA – Medicaid
Healthy Indiana Plan for Low-Income Adults 19-64
Website: **in.gov/fssa/hip/**
Phone: **1-877-438-4479**
All other Medicaid
Website: **indianamedicaid.com**
Phone **1-800-403-0864**

IOWA – Medicaid
Website: **dhs.iowa.gov/hawki**
Phone: **1-800-257-8563**

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

KENTUCKY – Medicaid
Website: **kynect.ky.gov**
Phone: **1-800-635-2570**

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

MAINE – Medicaid
Website: **maine.gov/dhhs/ofi/public-assistance/index.html**
Phone: **1-800-442-6003**
TTY: Maine relay 711

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

MASSACHUSETTS – Medicaid and CHIP
Website: **mass.gov/topics/masshealth**
Phone: **1-800-862-4840**

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

MINNESOTA – Medicaid
Website: **mn.gov/dhs**
Phone: **1-800-657-3739**

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

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

MONTANA – Medicaid
Website: **dphhs.mt.gov/montanahealthcareprograms/HIPP**
Phone: **1-800-694-3084**

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

NEVADA – Medicaid
Website: **dhcfp.nv.gov**
Phone: **1-800-992-0900**

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

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

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

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

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

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

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

OKLAHOMA – Medicaid and CHIP
Website: **insureoklahoma.org**
Phone: **1-888-365-3742**

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

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

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

SOUTH CAROLINA – Medicaid
Website: **scdhhs.gov/**
Phone: **888-549-0820**

SOUTH DAKOTA – Medicaid
Website: **dss.sd.gov**
Phone: **605-773-4678**

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

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

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

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

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

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

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

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

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

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

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

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

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

Right to Amend and/or discontinue and make rules

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

Plans or any document relating to the Plans.

Women's Health and Cancer Rights Act

This notice is provided to you in compliance with the federal law entitled the Women's Health and Cancer Rights Act of 1998 (the Act). The Plan provides medical and surgical benefits in connection with a mastectomy. In accordance with the requirements of the Act, the Plan also provides benefits for certain reconstructive surgery.

In particular, the Plan will provide, to an eligible participant who is receiving (or who presents a claim to receive) benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and treatment of physical complications associated with all the stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

As with other benefit coverages under the Plan, this coverage is subject to each medical benefit option's annual deductible (if any), required coinsurance payments, benefit maximums, and copay provisions that may apply under each of the benefit options available under the Plan.

You should carefully review the provisions of the Plan, the medical benefit option in which you elect to participate, and its SPD and SMM available on the Health and Life website or by requesting a copy through the Service Center regarding any applicable restrictions. Contact the Claims Administrator of your medical benefit option for more information.