Lumen Retiree and Inactive Health Care Plan

Retiree Dental Plan 3

(administered by MetLife)

Summary Plan Description (SPD)
For Eligible Retired and Inactive Former Employee

(Qwest Pre-1991 Retirees)

Effective January 1, 2024

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

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

Issued Jan. 1, 2024

LUMEN®

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Special Note: This Summary Plan Description (SPD) provides information regarding the Lumen Retiree and Inactive Health Plan*, specifically Legacy Qwest Pre-1991 Retiree Dental Plan 3 ("Dental Plan 3"), which is a benefit option of coverage for certain Legacy Qwest Retirees and certain of their Dependents, as described in the "Who is Eligible" section of this SPD. This program is a part of the umbrella Lumen Retiree and Inactive Health Plan*, which covers Pre-91 Retirees of Legacy Qwest which is now a part of Lumen, Inc.* Unless otherwise specified, the word "Plan" as used in this booklet refers to the program of dental coverage explained in this Summary Plan Description.

Certain sections in your Health Care Plan benefit option SPD should be referenced for additional information as noted throughout this booklet. For example, see the "General Information" section in your Health Care Plan benefit option SPD for more information regarding: "Health Plan Enrollment, Additional Special Enrollment Rights, Notice of HIPAA Rights, Miscellaneous Information and Time Limitation on Civil Actions". Also see other sections such as "Legal Notices."

I. ADMINISTRATOR'S CONTACT LIST

The following is a list of toll-free numbers for your use should you need to contact any of the administrators below for assistance:

1.	**Lumen Health and Life Service Center:** For any questions about your or your Dependents' eligibility for medical coverage	**833-925-0487 or 317-671-8494 (International callers) or 800-729-7526**
2.	**COBRA/Direct Bill:** For questions on "COBRA" or Direct Bill Benefits call the Lumen Health and Life Service Center and select the COBRA option.	**833-925-0487 or 317-671-8494 (International callers) or 800-729-7526**
3.	**MetLife Dental Claims:**	**866-832-5756**
4.	**United HealthCare Insurance Company:** To request a claim form or PPO directory or for any medical plan questions about claims, eligibility, benefits.	**800-842-1219**
5.	**UnitedHealthcare Pharmacy Management:** For any questions about your Home Delivery Prescription Drug Program (long-term maintenance drugs by mail) or mail order refills – call **Optum Rx** (UHC Pharmacy Management)	**800-842-1219**

II. INTRODUCTION

The Retiree Dental Plan 3 is designed to encourage preventive dental care and help pay for dental care for you and each of your eligible Dependents.

The Retiree Dental Plan 3 was established January 1, 1991. The effective date of this revised Summary Plan Description is January 1, 2024. This SPD is typically updated or restated every 5-10 years, as Benefits do not change.

Lumen, Inc.* (hereinafter “Lumen” or “Company”) is pleased to provide you with this Summary Plan Description (“SPD”). This SPD and the other plan documents (such as the Plan Document, the Summary of Material Modifications (SMMs) and materials you receive at Annual Enrollment and other times of the year including the United Health Care (UHC) Group Medicare Advantage PPO Option SPD) (hereafter collectively the “Plan documents”) briefly describe your Benefits as well as rights and responsibilities, under the Lumen Retiree and Inactive Health Plan (the “Health Plan”), which includes your dental Benefits. These documents make up the official Summary Plan Description for Legacy Qwest Pre-91 Retirees under the Employee Retirement Income Security Act of 1974, as amended, and the regulations thereunder (“ERISA”). The Plan’s Pre-91Retiree Dental benefit options 1 through 5 are self-funded benefit options; however, certain other benefit plan options under the Health Plan are insured, such as the UHC Medicare Advantage PPO.

As a standalone retiree health care plan, the Plan is exempt from the requirements of the Patient Protection and Affordable Care Act (“PPACA”). While Lumen has decided to voluntarily comply with certain provisions of PPACA, this voluntary compliance is separate from and not a part of the health care coverage commitment to Legacy Qwest Pre-1991 Retirees. This voluntary compliance with certain provisions of PPACA also does not waive the Plan’s exempt status. The Company may choose in its sole discretion to no longer apply these provisions at any time.

COMPANY’S RESERVED RIGHTS

This document summarizes the provisions of Retiree Dental Plan 3 of the Lumen Retiree and Inactive Health Plan* that is made available by Lumen for Legacy Qwest Pre-91 Retirees and certain LTD participants. If there is any conflict between the terms of the Plan Document and this document, the terms of the Plan Document will govern.

The Plan Administrator, the Lumen Employee Benefits Committee, and its delegate(s), has the right and discretion to determine all matters of fact or interpretation relative to the administration of the Plan and all benefit options—including questions of eligibility, interpretations of the Plan provision and any other matter. The decisions of the Plan Administrator and any other person or group to whom such discretion has been delegated, including the Claims Administrator, shall be conclusive and binding on all persons.

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 Lumen -sponsored plans, including the Lumen Retiree and Inactive Health Plan. Lumen reserves the right to amend or terminate all of the Plans and the Benefits it sponsors and provides - with respect to all classes of Participants, retired or otherwise - and their beneficiaries, without prior notice to or consultation with any Participants and beneficiaries - subject to, applicable law, collective bargaining if applicable, the terms of the respective Plan documents, and with respect to the Health Plan, subject to the terms of the written agreement specific to Legacy Qwest Pre-1991 Retirees and Legacy Qwest ERO’92 Retirees.

Note: While the Plan has processes in place to prevent errors and mistakes, if a clerical error or mistake happens (however occurring) such error or mistake does not create a right to a Benefit or level of contribution rate under the Plan. You have an obligation to correct any errors or omissions that come to your attention by calling the Service Center to correct the error or omission. There are deadlines to file claims and benefit related actions; please refer to the section titled Claims Benefits Denial and Appeal and the Time Deadline to File a Benefit-Related Lawsuit in this SPD and in the General SPD for more information about the timing of these deadlines.

The Required Forum for Legal Disputes. After the claims and appeals procedures are exhausted as explained above, and a final decision has been made by the Plan Administrator, if an Eligible Employee wishes to pursue other legal proceedings, the action must be brought in the United States District Court in Denver, Colorado.

HEALTH PLAN COVERAGE IS NOT HEALTH CARE ADVICE

Please keep in mind that the sole purpose of the Lumen Retiree and Inactive Health Plan (including its health, prescription, and dental benefit options) is to provide for the payment of certain health care expenses and not to guide or direct the course of treatment of any Retiree, or eligible Dependent. Just because your health care/dental provider recommends a course of treatment does not mean it is payable under the Health Plan. A determination by the Plan Administrator or Claims Administrator that a particular course of treatment is not eligible for payment or is not covered under the Health Plan does not mean that the recommended course of treatments, services or procedures should not be provided to the individual or that they should not be provided in the setting or facility proposed. ***Only you and your healthcare/dental provider can decide what is the right health care decision for you.*** *Decisions by the Plan Administrator or Claims Administrator are solely decisions with respect to Health Plan coverage and do not constitute health care recommendations or advice.*

FOLLOWING PLAN PROCEDURES

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

YOU MAY NOT ASSIGN YOUR BENEFITS TO YOUR PROVIDER

Participants and Eligible Dependents may not voluntarily or involuntarily assign to a physician, hospital, pharmacy or other health care provider (your "Providers") any right you have (or may have) to:

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

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

This Plan provision will not interfere with the Plan's right to make direct payments to a Provider. However, any direct payment to a Provider is provided as a courtesy to the Provider and does not effectuate an assignment of Participants' and Eligible Dependents' rights to the Provider or waive the Plan's rights to enforce the Plan's anti- assignment terms. Any such direct payment to a Provider shall be treated as though paid directly to Participants and Eligible Dependents and shall satisfy the Plan's obligations under the Plan.

HOW TO USE THIS DOCUMENT

Capitalized terms are defined in the “Definitions” section, throughout this SPD or in the Pre-91 Medical SPDs. All uses of “we,” “us,” and “our” in this document, are references to the Claims Administrator or the Plan Administrator which is the Lumen Employee Benefits Committee or Lumen. References to “you and “your” are references to people who are eligible and covered under the Plan. **Note:** Additional information may need to be referenced in your Lumen Health Care benefit option SPD that also applies to your Dental benefit option. For example, see the “General Information” section in your Health Care benefit option SPD for more information regarding: “Health Plan Enrollment, Additional Special Enrollment Rights, Notice of HIPAA Rights and Time Limitation on Civil Actions”. Also see other sections such as “Legal Notices.”

This SPD is provided to explain how the Plan works. It describes your Benefits and rights as well as your obligations under the Plan. It is important for you to understand that because this SPD is only a **summary**, it cannot cover all of the details of the Plan or how the rules will apply to every person in every situation. All of the specific rules governing the Plan are contained in the official Plan Document. You and your beneficiaries may examine the official Plan Document and other documents relating to the Plan during regular business hours or by appointment at a mutually convenient time in the office of the Plan Administrator. For additional information, refer to “Your Rights as A Plan Participant” section.

You are encouraged to keep this SPD and any attachments and updates (SMM, Annual Enrollment materials, etc.) for future reference. Many of the sections of this SPD are related to other sections. You may not have all of the information you need by reading just one section.

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

III. HIGHLIGHTS OF RETIREE DENTAL PLAN 3 BENEFIT OPTION

The following table highlights how the dental Plan pays for various services.

DENTAL SERVICE	THE DENTAL PLAN PAYS
1. Diagnostic and Preventive Services - Type A • Pit and fissure sealant treatment • Routine oral examinations • Prophylaxis • Fluoride treatments • Space Maintainers • X-rays	100% of the Reasonable and Customary charges but no more than the dentist’s charges.
Other Covered Services - Type B • Restorations • Oral Surgery • Endodontics • Periodontics • Prosthodontics • Orthodontics • General Anesthesia	According to a schedule but no more than the dentist’s charges.

IV. DEFINITIONS

Calendar Year – A period of one year commencing on January 1 and ending December 31 - also known as "Claim Determination Period."

Lumen Health Care Plan – Health care (medical and dental) coverage under Plan No. 537 as amended and sponsored by Lumen, Inc. for Employees and retired Employees of Lumen and certain Lumen subsidiaries.

Claims Administrator – Metropolitan Life Insurance Company (MetLife)

Dependent – means a family member who qualifies for coverage under the Plan. This includes your:

Class 1 Dependents – your legal Spouse and your biological children, step- children, adopted children, foster children until the end of the calendar month in which they reach age 26, unless such child becomes ineligible earlier due to eligibility for other group health plan coverage, including but not limited to, her/his employer's group health plan coverage. Or any never married child, regardless of age, who is medically certified as Disabled prior to the limiting age by the Plan Administrator and determined to be indefinitely incapable of self-support and fully dependent on you for support (with the understanding that this status is reviewed every 2 years). Once the Disabled child is ever determined to no longer be Disabled or is removed from the plan, the child is no longer eligible to be re- enrolled at any later date (unless you are rehired at a later date and enroll as a new hire).

The term "Child" also includes your Children (excluding stepchildren or grandchildren) for whom there is a Qualified Medical Child Support Order (QMSCO) requiring coverage under the Plan. The term "Child" does not include those minors for whom you are awarded temporary custody, or who are wards of the State.

*See the Pre-91 Medical Plan Option SPDs for more information on Class I Dependents.

Domestic Partner and Children of a Domestic Partner – an adult same-sex Domestic Partner who is mutually responsible with you for basic living expenses, provided that neither of you may be married to anyone else. Unless otherwise subsequently changed by federal tax law or the Code, for purposes of the federal and state income tax treatment for this Plan coverage, a Domestic Partner is not a "dependent". Any child of a Domestic Partner may become a participant in the Plan, provided he/she satisfies the eligibility requirements the same as a Class I Dependent as described above (**Note:** this does not confer the rights of a Class I Dependent upon an eligible Domestic Partner child).

See **DEPENDENT VALIDATION—VERIFYING ELIGIBLE DEPENDENTS** in this SPD and the Pre-91 Medical Plan option SPDs for more information.

Plan Year – A period of one year commencing on January 1 and ending on December 31.

Pre-'91 Retirees – Former Legacy Qwest Employees who retired on a service or disability pension under either the Qwest Management Pension Plan or the Qwest Pension Plan prior to January 1, 1991. Effective January 1, 1991, non-HMO medical and dental expense coverage for these Pre-91 Retirees has been available to these eligible Retirees under a Qwest Retiree Health Care Medical Plan option (Nos. 1, 2, 3 or 4) and a Qwest Retiree Health Care Dental Plan option (Nos. 1, 2, 3, 4, or 5). Currently Benefits for Pre-91 Retirees are provided under these same Medical/Dental Plan benefit options under the Lumen Retiree and Inactive Health Plan.

Predecessor Plan – Mountain Bell Dental Expense Plan (Covers all Employees who retired prior to 1-1-90). See the listing at the end of the SPD, under **XXVII. PREDECESSOR DENTAL PLANS.**

See the "Definitions" section in your Health Care benefit option SPD for more definitions that may apply.

V. GLOSSARY OF COMMON DENTAL TERMS

Abutment – terminal tooth or root that retains or supports a bridge or a fixed or removable prosthesis.

Anesthesia:

Local – the condition produced by the administration of specific agents to achieve the loss of conscious pain response in a specific location or area of the body.

General – the condition produced by the administration of specific agents to render the patient completely unconscious and completely without conscious pain response. "General anesthesia" does not include Intravenous Drip.

Anesthetic – a drug that produces loss of feeling or sensation either generally or locally.

Appliance – a device used to provide functional or therapeutic (healing) effect.

Fixed – one that is cemented to the teeth or attached by adhesive materials.

Prosthetic – used to provide replacement for missing tooth

Bitewing – dental x-ray showing approximately the coronal (crown) halves of the upper and lower jaw.

Bridgework:

Fixed Bridge – a prosthesis which replaces one or several teeth and which is cemented in place in the mouth. It consists of one or more pontics held in place by one or more retainers on the abutment teeth.

Fixed-removable – one, which the dentist can remove but the patient cannot.

Removable – a partial denture retained by attachments which permit removal of the denture. Normally held by clasps.

Crown – the portion of a tooth covered by enamel.

Dental Hygienist – a person who has been trained to remove calcareous deposits and stains from the surfaces of the teeth, and in providing additional services and information on the prevention of oral disease.

Dentist – a person duly licensed to practice dentistry by the governmental authorities having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered. As used in this Plan, the term "dentist" also includes a licensed physician authorized to perform the particular dental service rendered.

Denture – a full or partial prosthesis that replaces one or more, but less than all, of the natural teeth and associated structures and that is supported by the teeth and/or gums; may be removable or fixed, one side or two sides.

Fillings:

Silver Amalgam – material used to fill cavities which is usually placed on the tooth surface(s) used for chewing because it is a particularly durable material.

Porcelain, Silicate, Acrylic, Plastic or Composite Fillings – materials which have less durability, and thus are used to fill cavities on the non- stress bearing surfaces of front teeth. These materials more closely resemble the natural tooth color than does Silver Amalgam.

Fluoride – a solution of fluorine which is applied topically to the teeth for the purpose of preventing dental decay.

Gingivectomy – the cutting away of the diseased gums when the underlying bone is not yet affected.

Impression – a negative reproduction of a given area. Example, in bridgework, an impression of a tooth (abutment) which has been prepared for an inlay or crown.

Inlay – a restoration made to fit a prepared tooth cavity and then cemented into place.

Malocclusion – an abnormal relation of the opposing teeth when brought into habitual opposition.

Onlay – an occlusal rest or restoration that is extended to cover the entire surface of the tooth. It often is used to restore lost structure and increase the height of a tooth.

Orthodontics – the branch of dentistry primarily concerned with the detection, prevention, and correction of abnormalities in the positioning of the teeth in their relationship to the jaw. Commonly, straightening teeth.

Periapical – enclosing or surrounding the tissues and bony sockets of the teeth.

Periodontal Disease – a disease which weakens and destroys the gums, bone, and membrane surrounding the teeth. This disease is sometimes called Vincent's Disease, Gingivitis, or Pyorrhea.

Pontic – the part of a fixed bridge which is suspended between the abutments and which replaces a missing tooth or teeth.

Prophylaxis – the removal of tartar and stains from the teeth. The cleaning of the teeth by a dentist or dental hygienist.

Prosthesis – an artificial replacement of one or more natural teeth and/or associated structures.

Restoration – a broad term applied to any inlay, crown, bridge, partial dentures, or complete denture that restores or replaces loss of tooth structure, teeth, or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape, form, and function of part or all of a tooth or teeth.

Root Canal Therapy – (Endodontic Therapy) treatment of a tooth having a damaged pulp. Usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with sealing material.

Scale – to remove calculus (tartar) and stains from teeth with special instruments.

Topical – painting the surface of teeth as in fluoride treatment, or application of a cream-like anesthetic formula to the surface of the gum.

VI. WHO IS ELIGIBLE?

The following describes who is eligible to participate in this Plan:

- You, as a retired Legacy Qwest Employee on a service or disability pension covered by a Predecessor Plan prior to January 1, 1991 and known as Pre-91 Retirees.
- Your Class 1 Dependents and Domestic Partner and Children of a Domestic Partner all as described above in the "Definitions" section of this SPD. Any other Dependent or child is not eligible for coverage under the Plan.
- Participants of the Plan who become eligible for continued coverage under COBRA (see **XIV. CONTINUATION OF DENTAL COVERAGE (UNDER COBRA)**) on or after January 1, 1991.

Dual Coverage. No individual can be covered as both a retired Employee and as a Dependent or as a Dependent of more than one retired Employee under this Plan (Dental Plan 3). If you and your Spouse or Domestic Partner both are retired Employees under this Plan as Pre-91 Retirees, each of you is covered only as a retired Employee. Either retired Employee may cover eligible Dependent children, but not both.

Rehired as Active. What Happens to Your Benefits if You Return to Work Directly for the Company as an Active Employee or Work for a Supplier on Assignment to the Company After You Retire or Leave Employment:

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

If you are rehired in a status that is eligible for active benefits, you will be offered the same benefits as other similarly situated company 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 Lumen retiree health care benefits, so this means that while you are working for the supplier, your retiree health care benefits will be suspended; however, you will be offered the opportunity to continue your retiree medical and/or dental options under COBRA. Your retiree basic and supplemental life coverage, if applicable, will continue under the terms of the Lumen 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 Lumen 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 Lumen Service Center to get 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 Lumen Health and Life Service Center at **833-925-0487** or **317-671-8494** (International callers) or **800-729-7526**. If you returned to work for a supplier on assignment to the Company, Lumen will validate that your assignment has ended before you will be allowed to resume your retiree health care coverage.

Note: If you are Medicare eligible and have enrolled in an individual Medicare policy, you may need to complete a disenrollment process to be released by that carrier from the individual plan (which can take up to 60 days).

Contact the Lumen Health and Life Service Center for the latest rules if you are returning to work for Lumen as an active employee or through a supplier or contractor as stated above.

DEPENDENT VALIDATION—VERIFYING ELIGIBLE DEPENDENTS

You are required to validate your Dependent's eligibility under the Plan. A Dependent Verification packet will be mailed to your address on file **after** you enroll the Dependent. Follow the instructions outlined in the packet closely and **make sure to respond no later than the deadline.** You will need to complete a separate Dependent Verification Form for each Dependent. (**Note:** Coverage may not be approved if you do not provide all the required information or fail to meet the deadline.) See "Qualified Life Events-- Changing Your Health Care Coverage" in the "Additional Enrollment Information " section for more information.

Dependent Verification

To assure compliance with Plan terms, the Company will periodically conduct audits of covered Dependents to determine their continued eligibility for Benefits under the Plan. Legacy Qwest Pre-91 Retirees will be required to timely provide supporting documentation to verify the eligibility of their Dependents covered under the Plan. Dependents must establish relationship, residency, and financial support. This documentation may include, but is not limited to, birth and marriage certificates, tax returns, court orders, and/or proof of residence. Any individuals who are determined to be ineligible, or for whom proof of coverage is not received timely, will be removed from the Plan.

Domestic Partner Validation and Coverage Begin Dates. Coverage begins the first of the month following receipt and approval of an affidavit of domestic partnership and proof of joint ownership. For children of a

Domestic Partner, coverage begins the first of the month following receipt and approval of an affidavit of domestic partnership and the applicable dependent verification documents if the enrollment is submitted together with the domestic partner affidavit. Otherwise, coverage begins the date a child of a Domestic Partner is acquired (birth or adoption) provided the child is enrolled within 45 days. If not enrolled within this 45-day period, the child cannot be added until the next Annual Enrollment period or next applicable change in family status. Children of a Domestic Partner are eligible only so long as the Domestic Partner is covered under the Plan, and they must qualify as the Domestic Partner's Dependent for federal tax purposes.

See the "Additional Enrollment Information" section in this SPD and the Pre-91 Medical Plan option SPDs for more information.

VII. WHEN COVERAGE STARTS

Coverage begins January 1, 1991 if you were covered under a Predecessor Plan prior to January 1, 1991.

If your family status changes, you can change your coverage, for example, from individual to family or vice versa. A newly acquired (birth or adoption) eligible Dependent may be enrolled for coverage effective the date the Dependent is acquired. A newly eligible Spouse will have coverage effective the first of the month following enrollment provided that you request enrollment within 45 days after a life event.

Enrollment may be completed by calling the Lumen Health and Life Service Center at **833-925-0487 or 317-671-8494 (International callers)** or **800-729-7526**. A Dependent Verification packet will be mailed to your address on file **after** you enroll the Dependent. Follow the instructions outlined in the packet closely and **make sure to respond no later than the deadline.** You will need to complete a separate Dependent Verification Form for each Dependent. (**Note:** Coverage may not be approved if you do not provide all the required information or fail to meet the deadline.)

See the "**DEPENDENT VALIDATION—VERIFYING ELIGIBLE DEPENDENTS**" section above and the "Qualified Life Events--Changing Your Health Care Coverage" in the "Additional Enrollment Information" section of the Pre-91 Medical plan option SPD for more information.

If you are declining enrollment for yourself (if applicable) or your Dependents, including your Spouse, because of other health insurance coverage, you may in the future be able to enroll yourself and your Dependents in this Plan, provided that you request enrollment within 45 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, or adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 45 days after the marriage, birth, adoption, or placement for adoption. See "Changing Your Health Care Coverage--Qualified Life Events" in the "General Information" section of your Health Care SPD for additional information.

Enrollment changes can be made by calling the Lumen Health and Life Service Center at **833-925-0487** or **317-671-8494** (International callers) or **800-729-7526**.

VIII. COST—WHO PAYS FOR COVERAGE

The Company pays the full cost (100%) of your coverage as a retired Employee, including your eligible Dependents. See **XIV. CONTINUATION OF DENTAL COVERAGE (UNDER COBRA)** for more information about your costs.

IX. HOW THE PLAN WORKS

For covered dental expenses (other than orthodontia) charged by a dentist, this Plan will pay a maximum of **$750** in benefits in a Calendar Year for you and **$750** in a Calendar Year for each eligible member of your family, with no lifetime maximum. This maximum includes both Type A and B services combined.

For orthodontia treatment, a maximum lifetime benefit of **$1,000** for each eligible individual is also payable under the Plan. This maximum is separate and distinct from the Plan's **$750** Calendar Year maximum payable for non-orthodontic services.

The Plan pays 100% of Reasonable and Customary charges for certain preventive and diagnostic care, called **Type A**.

No more than the "Reasonable and Customary" charge for dental services, as determined by the Claims Administrator; will be covered under the Plan.

The Reasonable and Customary charge is the lowest of:

- The usual charge by the Dentist or other provider of the services or supplies for the same or similar service or supplies; or
- The usual charge of most other Dentists or other providers of similar training or experience in the same geographical area for the same or similar service or supplies; or
- The actual charge for the service or supplies.

For other kinds of care, called **Type B**, the Plan pays according to a schedule. The dollar amounts in the schedule are what the Plan will pay for a particular procedure, but not more than what the dentist charges. Before the **Type B** benefits are paid for a covered person, you pay the first $50 of the scheduled allowances for that covered person. This is a one-time Deductible for each covered person.

PREFERRED DENTIST PROGRAM

You are free to visit any licensed dental provider, but you may lower your out-of-pocket costs if you choose to visit a dentist belonging to MetLife's Preferred Dentist Program (PDP).

The MetLife PDP is a Preferred Provider Organization (PPO) consisting of a nationwide network of over 44,500 carefully credentialed general and specialty participating dentists. All participating dentists in the network agree to provide services at fees that are typically 10-30% lower than the fees charged by other dentists in your community. This lowers the amount you have to pay because your share of the cost is based on reduced charges.

For a list of PDP network dentists in your area, call MetLife's automated system at **800-474-7371** or visit MetLife's website at metlife.com/dental. The website also includes maps and driving instructions.

PREDETERMINATION OF BENEFITS

Predetermination allows you to know what services are covered and what payments will be made for treatment performed before the work is done. If you or one of your family is likely to incur dental expenses over **$200** (such as expenses for dentures, crowns, root canals and therapy or orthodontia), you should ask your dentist to file for Predetermination of Benefits.

This feature of the Plan assures that both you and the dentist will know in advance just what part of the dentist's charges the Plan will pay. Here's how it works:

- The dentist informs the Claims Administrator of the proposed course of treatment by itemizing the services and charges on the claim form which you provide.
- The Claims Administrator then determines the amount the Plan will pay and informs you and the dentist of its payment decision. You and your dentist should discuss the result before the work is done.

Predetermination of Benefits will help you avoid surprises. Most dentists are familiar with predetermination procedures.

If your dentist submits a treatment plan for Predetermination of Benefits and then changes the treatment plan, the Claims Administrator will adjust its payments accordingly. If the dentist makes a major change in the treatment plan, the dentist should send in a revised plan.

If you do not request Predetermination of Benefits, the Claims Administrator will pay the claim based on whatever information it has about your case. Predetermination of Benefits could save you money (read the following description of Alternate Procedures).

ALTERNATE PROCEDURES

Often there is more than one way to treat a particular dental problem. For example, either a crown or a filling can perform equally well in certain situations. The same holds true in decisions about the use of precious metals versus plastic. The Claims Administrator will base its payment on the most economical method of treatment that does the job properly and meets acceptable dental standards. This is why Predetermination of Benefits is important. By using predetermination, both the patient and the dentist can find out in advance what procedures the Plan will cover and what benefits will be paid. Whenever the Alternate Procedures provision is applied, the Claims Administrator's dental consultant reviews the claim.

If you and the dentist decide upon the more costly treatment, you are responsible for the charges beyond those for the less costly appropriate treatment paid under the Plan.

X. WHAT IS COVERED

TYPE A SERVICES - DIAGNOSTIC AND PREVENTIVE SERVICES

TYPE A services, for which the Plan pays 100% of the Reasonable and Customary charges, are:

- **Pit and fissure sealant treatment** provided that the treatment is in accordance with American Dental Association guidelines, as amended from time to time. These guidelines limit treatment to the following:
  - Covered Dependents under age 16
  - 1st and 2nd molars only, and
  - Treatment once every four years.
- **Routine oral examination** but not more than two examinations in a Calendar Year. These examinations are for diagnosing the oral health of the patient and determining the dental care required.
- **Prophylaxis** (cleaning and scaling of teeth), but not more than twice in a Calendar Year, when performed by a dentist or dental hygienist.
- **Fluoride treatments** (excluding prophylaxis) when performed by a dentist or dental hygienist, including:
  - Topical (local) application of sodium fluoride, but not more than one course of treatment in a Calendar Year, or
  - Topical application of stannous fluoride, but not more than one treatment in a Calendar Year, or
  - Topical application of acid fluoride phosphate, but not more than once in a Calendar Year.
- **Space Maintainers** (for Dependent children under age 19 only)
  - Installation of fixed or removable appliances designed to maintain existing space by preventing adjacent or opposing teeth from moving, only when these appliances replace prematurely lost or extracted teeth.
  - Subsequent adjustment of these appliances when required because of a relative change in the condition of the mouth.
- **X-Rays** (dental x-rays, radiographs) include:
  - Full mouth x-rays, but not more than once in three consecutive Calendar Years.
  - Supplementary bitewing x-rays, but not more than twice in a Calendar Year, and
  - Any dental x-ray required to diagnose a specific condition that needs treatment except x-rays in conjunction with orthodontia.

TYPE B SERVICES - OTHER COVERED SERVICES

Type B services, for which the Plan pays according to a schedule, are:

- **Restorations** - (including fillings, inlays, onlays, crowns and temporary or provisional restorations) treatment necessary to restore the structure of a tooth or teeth.
  - If the preparation of a crown begins in one Calendar Year and ends in another Calendar Year, all charges will be applied to your annual benefit maximums based on the date your tooth is cut down.
- **Oral Surgery** - surgical procedures in and about the mouth excluding procedures covered by your Medical Plan.
- **Endodontics** - (such as root canal work) procedures used for the prevention and treatment of diseases of the dental pulp.
  - If your root canal begins in one Calendar Year and ends in another Calendar Year, all charges will be applied to your annual benefit maximums based on the date your tooth is opened.
- **Periodontics** - non-surgical and surgical procedures for treatment of the supporting area around the teeth.
  - Generally, if you have received periodontal treatment, you are eligible for as many as four periodontal cleaning visits during the year.
- **Prosthodontics** - services to replace one or more teeth except third molars (wisdom teeth), extracted while the patient is covered under the Plan. Congenitally missing teeth are covered as if they were removed while the Plan was in effect.
- Installation of a permanent full denture that replaces and is installed within twelve months of a temporary denture is covered.
- Replacement of an existing partial denture, full removable denture, or fixed bridgework is covered provided the existing denture or bridge is at least five years old and cannot be made serviceable. But the five-year limitation is waived if additional extractions require the replacement.

If you need bridgework to replace teeth removed before you were covered by the Plan, the following benefits apply:

- If the teeth acting as the base for the bridgework or dentures would need crowns because of dental disease, you are eligible for your scheduled crown restoration benefit.
- If no crowns were needed unless the bridgework was being done, no benefits will be paid.

If work begins on your dentures or bridgework in one Calendar Year and ends in another Calendar Year, all charges will be applied to your annual benefits maximums based on the date your teeth were cut down and/or impressions were taken.

- **Temporomandibular Joint Dysfunction (TMJ)** – Dental treatment of the improper alignment of your jaw joints is covered according to the major restorative care Benefit. Treatment can include:
  - Biofeedback
  - Diagnostic casts
  - Exams
  - Hotpacks
  - Injections
  - Occlusal adjustments
  - Orthodontia (applies to lifetime maximum)
  - Physical therapy
  - Transcutaneous nerve stimulation
  - X-rays

Please Note: These are some examples. This list is not exhaustive and may be changed from time to time without advance notice.

Medical TMJ Treatments: Please contact your medical plan Provider to determine if Benefits for surgical treatments and follow-up physical therapy are covered under your medical plan benefit option.

No Benefits Paid: If your TMJ treatment requires bridgework or dentures to replace teeth that were missing before your Dental Plan coverage began under the Plan, no benefit will be paid.

- **Orthodontics** - services for the prevention and correction of malocclusion of teeth and associated facial problems.
  - One visit per month is covered as long as you are undergoing active treatment. Non-orthodontic procedures performed for orthodontic purposes (extractions, for example) will not be applied against your orthodontic maximum.
- **General anesthesia** - when medically necessary and administered in connection with oral surgery. Apprehension is not considered a medical necessity. “General anesthesia” does not include Intravenous Drip.

XI. WHAT IS NOT COVERED

- Work done for appearance (cosmetic) purposes
- Work done while not covered under this Plan, except as provided under the Extension of Benefits provision - see **XII. WHEN COVERAGE ENDS/EXTENSION OF BENEFITS**
- Replacement of teeth removed before coverage is effective
- Amounts which are in excess of Reasonable and Customary charges
- Replacing lost or stolen prosthetic appliances
- Extra set of dentures or other appliance
- Work for which a charge would not be made if no Plan coverage existed, or that is otherwise free of charge to patient
- Bridges or crowns started or underway before coverage is effective
- Work that is furnished or payable by the armed forces of any government
- Work that is furnished or payable by any civil unit of any government
- Services or supplies not necessary for proper dental care
- Missed appointments
- Completion of claim forms or filing of forms
- Educational or training programs, literary instructions, plaque control programs
- Home fluoride treatments
- Implantology (implants)
- Treatment resulting from insurrection, participation in a riot, or service in the armed forces of any government
- Work which is payable under Worker’s Compensation or similar laws
- Periodontal splinting
- Appliances, restorations, and procedures to alter vertical dimension
- Services covered by any other health plan of this Company
- Late claims (submitted more than 15 months after services were rendered)
- Auto accident injuries to the extent auto insurance coverage is available
- Experimental procedures
- Drugs or their administration
- Anesthesia, except general anesthesia when medically necessary in connection with oral surgery. “General anesthesia” does not include Intravenous Drip.
- Treatment by other than a dentist, except cleaning or scaling of teeth and fluoride treatments performed by a dental hygienist under the supervision and direction of a dentist, and
- Acupuncture

XII. WHEN COVERAGE ENDS/EXTENSION OF BENEFITS

Coverage typically ends at the end of the month in which you are no longer eligible under the Plan as described in the next section.

The Plan will not pay for services or supplies furnished after the date coverage stops even if the Claims Administrator has predetermined the payments for a treatment plan submitted before then. But under the Extension of Benefits provisions, the Plan will pay the scheduled amounts for:

- A prosthetic device (such as full or partial dentures) if the dentist took the impressions and prepared the abutment teeth while the patient was covered and delivers or installs the device within two calendar months after Plan coverage ends
- A crown if the dentist prepared the tooth for the crown while the patient was covered by the Plan and installs the crown within two calendar months after Plan coverage ends, and
- Root canal therapy if the dentist opened the tooth while the patient was insured and completes the treatment within two calendar months after Plan coverage ends.

XIII. TERMINATION OF DENTAL COVERAGE

There are several situations that will cause your covered Dependents' dental care coverage to end. However, your Dependents may be eligible to continue the coverage, at a cost. For more information, see the **XIV. CONTINUATION OF DENTAL COVERAGE (UNDER COBRA)** section following this section.

Please Note - *the information for termination of and continuation of MEDICAL coverage is different than the information for DENTAL coverage.* Please see these sections in your *Retiree Health Care Medical Plan SPD* for details.

Dental coverage will end as described below:

Death of Retiree ("primary participant"): All coverage ends for the Surviving Spouse and other Class I Dependents on the last day of the month in which the primary participant dies. However, continued coverage under the provisions of The Consolidated Omnibus Reconciliation Act of 1985 ("COBRA") may be elected. See the next section for more information.

Class I Dependents: Coverage for these Dependents also ends:

- For a Spouse, on the last day of the month in which your marriage ends. (This date would also apply to any of your Dependent stepchildren who are children of the spouse, and to any children for whom the Spouse, but not you, remains legal guardian.)
- For a Domestic Partner, on the last day of the month of the termination of the relationship.
- On the last day of the month in which a child reaches age 26.
- On the last day of the month when a disabled child ceases to be fully dependent on you for support or is determined by the Claims Administrator to be no longer disabled.

XIV. CONTINUATION OF DENTAL COVERAGE (UNDER COBRA)

Certain of your Dependents have the option of continuing their dental care coverage, at their own cost, beyond the date that it would otherwise cease.

COBRA and its amendments require continuation of health care benefits in certain situations where coverage would otherwise end. In general, the Company must offer certain of your Dependents continued participation in the dental coverage they were in at the time of certain "Qualifying Events" (see below).

Lumen and its subsidiaries (hereinafter referred to as Lumen) have retained a vendor to act as COBRA compliance administrator for the Lumen Retiree and Inactive Health Care Plan and the dental benefit options known as the "Pre-1991 Dental Plan (options 1,2,3,4 and 5)". It is important for Plan participants to understand their ongoing rights and obligations under the continuation of coverage provisions of COBRA. This summary of rights should be reviewed by both you and your Spouse (if applicable) and referred to in the event that any action is required on your (or your Dependents') part.

If your Spouse or Dependent children should lose dental coverage under the Plan due to a "Qualifying Event" listed below, COBRA provides an opportunity to elect temporary continuation of such dental coverage on a self-pay basis at group rates ("continuation coverage"). Following is a summary of information concerning COBRA and the procedures which should be followed if or when a Qualifying Event occurs.

If you are the covered Spouse of a Company Retiree, you have the right to elect continuation coverage for yourself and your covered Dependent children, **if** you or your covered Dependent children lose Plan coverage for any of the following Qualifying Events:

1. The death of your Spouse,
2. Divorce from your Spouse,
3. Your Spouse becoming entitled to Medicare; or
4. The commencement of certain bankruptcy proceedings involving the Company.

If you are the covered Dependent child of a Company Retiree, you have the right to elect continuation coverage if Plan coverage is lost for any of the following Qualifying Events:

1. The death of the Retiree,
2. Parents' divorce; or
3. You cease to be a "Dependent child" under the terms of the Plan. (Example: child reaching his/her age limitation, or any other change in status which affects eligibility for Class I Dependent coverage.)

You also have a right to elect continuation coverage if you are covered under the Plan as a Spouse or Dependent child of a Retiree and lose coverage within one year before or after commencement of proceedings under Title 11 (bankruptcy), United States Code.

The covered Retiree, Spouse, or Dependent child has the responsibility to directly inform the Lumen Health and Life Service Center of a divorce or a child losing Dependent status under the Plan, both of which are "Qualifying Events." Notice to the Lumen Health and Life Service Center must be made within 60 days after the later of the date of the Qualifying Event, or the date your Qualified Beneficiaries would lose coverage due to a Qualifying Event.

Contact the Lumen Health and Life Service Center at **833-925-0487 or 317-671-8494 (International callers)** or **800-729-7526** for assistance.

When the Lumen Health and Life Service Center is notified that a Qualifying Event has happened, they will subsequently notify the Qualified Beneficiary(ies) losing coverage of the right to elect continuation coverage. A "Qualified Beneficiary" is any Spouse or Dependent child who is covered under the Plan on the day before the Qualifying Event occurs. If they do not elect continuation coverage, their Plan coverage will end in accordance with the provisions outlined in this Summary Plan Description or other applicable Plan documents.

If your Qualified Beneficiaries elect continuation coverage, the Company is required to give them coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated Employees or Retirees or family members. Under the law, the Qualified Beneficiary(ies) losing coverage has 60 days from either the date of loss of coverage or from the date of the notice, whichever is later, to elect continuation coverage. They then have 45 days from the date of the initial election to make their first premium payment and any other premium payments that are due during those first 45 days. Subsequent premiums must be paid in full within

31 days of each premium due date. **Please Note:** Some states offer financial aid to help certain individuals pay for COBRA coverage. Contact your appropriate state agency regarding availability and eligibility requirements.

If continuation coverage is elected, the law requires that your Qualified Beneficiaries be afforded the opportunity to maintain continuation coverage for 36 months, measured from the Qualifying Event date. Additional Qualifying Events can occur while continuation coverage is in effect, but coverage will not exceed 36 months from the initial Qualifying Event.

The law provides that your Qualified Beneficiaries' continuation coverage may end sooner for any of the following reasons:

1. The Company no longer provides group health or dental coverage for any of its Employees or Retirees;
2. The premium for their continuation coverage is not paid in a timely manner;
3. They become, after the date of the election, covered under any other group dental plan which does not contain a pre-existing condition exclusion or limitation that would apply to them; or
4. They become, after the date of election, entitled to Medicare.

Your Qualified Beneficiaries will not have to show that they are insurable to choose continuation coverage. However, under the COBRA law, they will have to pay the group rate premium for their continuation coverage plus an administration fee, if applicable.

DOMESTIC PARTNER CONTINUATION COVERAGE

If you are a Domestic Partner of a Retiree, you will have the right to elect continuation coverage for yourself and your covered Dependent children, if you or the covered children lose Plan coverage for either of the following Continuation Events.

1. The death of the Retiree, or
2. Termination of the Domestic Partner relationship between the Eligible Retiree and Domestic Partner.

The covered Retiree or Domestic Partner has the responsibility to notify the Lumen Health and Life Service Center of a termination of relationship between a Retiree and a Domestic Partner. Coverage will end at the end of the month in which the Continuation Event occurs. Notice to the Lumen Health and Life Service Center must be made within 60 days after the later of the date of the Continuation Event or the date you would have lost coverage. If notice is not received or postmarked within 60 days, rights to continue coverage will terminate. Participants should call the Lumen Health and Life Service Center at **833-925-0487 or 317-671-8494 (International callers)** or **800-729-7526**, *0 and talk to a Service Representative.

When the Lumen Health and Life Service Center is notified of a Continuation Event, they will notify the Continuation Beneficiaries losing coverage of the right to elect continuation coverage.

If the Continuation Beneficiary elects continuation coverage, the Company will give them coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated Retirees. The Continuation Beneficiary(ies) losing coverage has 60 days from either the date of loss of coverage or from the date of the notice, whichever is later, to elect continuation coverage. They then have 45 days from the date of the initial election to make their first premium payment and any other premium payments that are due during those first 45 days.

Subsequent premiums must be paid in full within 31 days of each premium due date.

If the Continuation Beneficiary elects continuation coverage, the Company will give them coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated Retirees. The Continuation Beneficiary(ies) losing coverage has 60 days from either the date of loss of coverage or from the date of the notice, whichever is later, to elect continuation coverage. They then have 45 days from the date of the initial election to make their first premium payment and any other premium payments that are due during those first 45 days. Subsequent premiums must be paid in full within 31 days of each premium due date.

If continuation coverage is elected, the Continuation Beneficiary(ies) will be given the opportunity to maintain coverage for 36 months, measured from the Continuation date.

Continuation coverage may end sooner for any of the following reasons:

1. The Company no longer provides group health coverage for any of its Employees or Retirees.
2. The premium for continuation coverage is not paid in a timely manner.
3. They first become, after the date of the election, covered under another group health plan which does not contain a pre-existing condition exclusion or limitation that would apply to them; or
4. They first become, after the date of election, entitled to Medicare.

Continuation Beneficiaries will not have to show that they are insurable to choose continuation coverage. They will have to pay the group rate premium for their continuation coverage plus any administration fee.

Children of a Domestic Partner will not be eligible to be a Continuation Beneficiary under their own right. They are only eligible for continuation coverage if the Domestic Partner is a Continuation Beneficiary.

COBRA COVERAGE COST

The cost of COBRA coverage for your Qualified Beneficiaries will be the applicable group rate plus a 2% administration fee.

COVERAGE CONVERSION (NOT AVAILABLE FOR DENTAL COVERAGE)

Unlike medical coverage, dental coverage for your Surviving Spouse and/or your Dependents cannot be converted to an individual policy at the expiration of COBRA benefits

If you have any questions about COBRA, please contact the Lumen Health and Life Service Center.

XV. WHAT ELSE YOU SHOULD KNOW

COORDINATION OF BENEFITS

This Plan has a Coordination of Benefits (COB) feature. This means that if you or other eligible members of your family are covered by another group plan, payments from all the plans combined will not exceed 100% of the allowable expenses.

An allowable expense, for this purpose, means any necessary, Reasonable and Customary charge for dental services or treatment covered in whole or in part under this Plan. Any items contained in the list of exclusions of this Plan will not be considered an allowable expense even if they are covered under another plan.

When claims are made under this Plan and the patient is also covered by another group plan, it must first be determined which plan has primary responsibility and which plan has secondary responsibility. The Claims Administrator will determine which plan has primary responsibility and that plan always pays first.

- The following guidelines are used to determine the relationship between plans: Any plan which has no coordination of benefits provisions will be primary
- The plan covering the patient directly, rather than as a Dependent, will be primary
- If a Dependent child is covered under both parents' plans, the parent whose birthday comes earliest during the calendar year will provide the primary coverage. If both parents have the same birthday, the parent who has been covered the longest will provide primary coverage
- In the case of a divorce or separation, any court decree establishing financial responsibility for the child's health care expenses will determine the primary plan. If there is no decree, plans will pay in this order:
  - The plan of the custodial parent will pay first.
  - If the custodial parent has not remarried, the plan of the non- custodial parent will pay second.

    - If the custodial parent has remarried, the plan of the stepparent will pay second, and the plan of the non-custodial parent will pay third.
    - If one person is an active Employee and the other person is laid-off or retired, the active Employee's plan will be primary.
- If none of these situations apply, the plan covering the patient the longest will be primary.

In order to administer this coordination of benefits, the Claims Administrator has the right to:

- Provide or receive information needed to determine Benefits.
- Recover excess payments, including payments made because of a third party's wrongful act or negligence.

When the Company Plan does not have to pay full Benefits due to Coordination of Benefits, the savings will automatically be credited to you to pay for unpaid allowable expenses of the same type in the same calendar year. For example, if the Plan saves $100 on your expenses due to Coordination of Benefits, you will be credited with that $100 to use toward a Deductible or your portion of a coinsurance payment.

SUBROGATION

The Plan has all rights to recovery from Participants, Dependents and Third Parties to the extent of any payments made by the Plan with respect to all rights of recovery by a Participant or his Dependent against any third party, including an individual, organization or entity in connection with any injury, disease, sickness or condition to which the Plan makes payments. The Participant or his Dependent shall do nothing after the loss to prejudice the rights of the Plan and shall do everything necessary to secure such rights. Your refusal or failure to help with the subrogation process will not limit the Company's rights, but it can be grounds for denial of your claims. The Plan shall be reimbursed first by the Participant or his Dependent, to the extent of payments made by the Plan, from the proceeds of any settlement, judgment or payments made by any individual, organization or other entity to the Participant or his Dependent.

Any amounts recovered in connection with an injury, disease, sickness or condition to which the Plan makes payments shall be apportioned as follows:

1. The Plan shall receive the first dollars of any recovery to the extent of the Plan's payments, and
2. The remaining balance of any recovery shall be apportioned to the Participant or his/her Dependent and any other Plan or insurer providing benefits to the Participant or his/her Dependent.

In the event a Participant or Dependent receives monies as the result of injury, sickness, accident or condition, and the Plan is entitled to such monies and is not reimbursed the full amount it has paid for such injury, sickness, accident or condition, the Plan shall have the right to reduce future payments due to such Participant or his Dependent, by the amount of benefits paid by the Plan. This right of offset shall not, however, limit the rights of the Plan to recover such monies in any other manner as may be specified in the official Plan Document.

RIGHTS OF RECOVERY

If a Benefit is paid - **for any reason** - which is larger than the amount allowed by the Plan, the Claims Administrator has a right to recover the excess amount from you by requesting repayment directly from you or by deducting the excess from any future Benefit payments, if necessary. You are also responsible for repaying any excess Benefits received by Dependent minors.

PLAN FUNDING AND PAYMENT OF BENEFITS

This Plan is self-insured by the Company. MetLife provides claims processing services for the Company and administers the payment of Benefits. All Plan benefits are paid through the claims processing system established with the Claims Administrator. The Company pays for your Plan Benefits from its general assets. However, the Company may choose to fund a portion of your health care coverage by making contributions to one or more trusts established by the Plan sponsor or its affiliates. These trust funds would then be available for payment of your Plan Benefits in lieu of payment directly from the Company's general funds. The Company's contributions, if any, to the trust funds may be in the form of the Company's common stock in accordance with the requirements of ERISA. If the Plan is terminated, any Plan assets will be applied to the payment of Benefits, insurance premiums, or administrative expenses incurred in the provision of Benefits, and in no event will trust assets be returned to the Company.

PLAN CONTINUANCE

Information Regarding Benefit Commitments by The Company to Pre-91 Plan Participants.

The Company is pleased to provide further information regarding the commitments communicated previously to Pre-'91 Retirees. Language has been added to the formal Plan documents to specify the following:

Pre-'91 Retirees:

(See definition of "Pre-'91 Retirees" in the **IV. DEFINITIONS** section of this SPD)

As a Pre-'91 Retiree of Lumen, you will be covered for your lifetime by a program of medical and dental coverage that meets at least the following minimum requirements:

1. The same premium requirements that were in place under your Plan effective January 1, 1996, will be continued without change. This means no premiums will be charged for coverage on you and your Class 1 Dependents, and 100% of Medicare Part B premiums will continue to be reimbursed as they have in the past. (Premiums for COBRA, Surviving Spouse, Class II Dependents, and Sponsored Child coverage will be charged and adjusted on the same basis as they have in the past.)
2. You will not be required to obtain medical and/or dental care under your Plan from a limited network of health care providers selected by the Company or Plan Administrator.
3. Your Plan* will maintain all the same schedules for medical and dental expense coverage as were in effect under your Plan on January 1, 1996, and which are reflected in this updated Summary Plan Description. This means the reimbursement schedules, covered services and treatments, Deductibles, Surviving Spouse and Dependent coverage (including provisions for survivor medical coverage after the death of the Pre'91 Retiree) and other terms under which your Plan Benefits are calculated will remain the same as they were on January 1, 1996, and as they are described in this updated Summary Plan Description.
4. To the extent that changes in the health care industry or markets, or new governmental mandates prevent the Company from meeting the three commitments described above, the Company will use reasonable efforts to maintain an equivalent program of medical and dental coverage. (An example of a change beyond the Company's control might be, for example, if by future legislation, all medical care in a given state is required to be provided only through a network of providers. This would make it necessary for all Pre-'91 Retirees, along with all others in that state, to use a network provider.)

Any medical and/or dental coverage that meets the minimum commitments described for "Pre-'91 Retirees" above may only be changed by the Company in a manner that keeps your Plan in compliance with those commitments. An example of a permissible change would be the selection of a new Claims Administrator (as has occurred in the past.) No change may be made if the Plan Administrator (acting in the best interest of the Pre-'91 Retirees as a whole) determines that the change violates any of the commitments described earlier in this section. As previously stated by the Company, these commitments are binding on Lumen, the sponsor of the Plan, and cannot be revoked. In all events, however, the Company has the obligation to conform its Plans to the requirements of applicable laws.

Please note however, that as a standalone retiree health care plan, the Plan is exempt from the requirements of the Patient Protection and Affordable Care Act ("PPACA").

While Lumen has decided to voluntarily comply with certain provisions of PPACA, this voluntary compliance is separate from and not a part of the health care coverage commitment to Legacy Qwest Pre-1991 Retirees. This voluntary compliance with certain provisions of PPACA also does not waive the Plan's exempt status. The Company may choose in its sole discretion to no longer apply these provisions at any time.

* "Your Plan" means the Company Guaranteed Coverage for medical and dental expense Plan that has been provided to you by the Company.

XVI. CLAIMING DENTAL PLAN BENEFITS

When you or a covered member of your family plans to visit the dentist, be sure to complete Part I of the claim form according to the instructions on the form. The dentist is to complete Part II.

Part I is completed by you and includes:

- Authorization for the dentist to release necessary information to the Claims Administrator so it may process your claim. This authorization must be signed as described on the form.
- Authorization for the Claims Administrator to pay the dentist directly for work performed for you and eligible members of your family.
- You, the Plan participant must sign the claim form to certify the accuracy of the information given in Part I.

Part II is completed by the dentist

A claim should be filed when a course of treatment is complete. Send the completed claim form to the address on the form, or: **MetLife, Lumen Dental Unit, P.O. Box 981282, El Paso, TX, 79998**.

You will receive a new claim form and return envelope for future use every time the Claims Administrator pays a claim. If you need additional forms, contact MetLife Customer Service at 866-832-5756, Monday through Friday, 7 a.m. to 12 p.m., and Saturday, 7 a.m. to 5 p.m., Mountain Time.

QUESTIONS ON DENTAL CLAIMS

If you have a question about your claim, contact MetLife Customer Service at 866-832-5756. When discussing your claim, please refer to your Explanation of Benefits, your claim form or other correspondence you may have received from MetLife. **Note:** On limited occasions, you may believe you have a claim relating to the Plan that cannot be handled by MetLife. In such cases, you should submit your claim in writing to the Plan Administrator. You will be contacted about your concern, and, if appropriate, your claim will be considered by the Plan Administrator under the same type of process as described below under "Claims Benefits Denial and Appeal".

XVII. FALSE OR FRAUDULENT CLAIMS

The Company, the Plan, and its Administrators require complete and correct information with regard to all Benefits claimed under this Plan. False information, intentional misrepresentation of any kind or any failure to provide accurate information will be cause for denial of the affected Benefits.

XVIII. CLAIMS BENEFITS DENIAL AND APPEAL

If a claim for Plan Benefits is denied, either in whole or in part, you or your Dependents will receive written notification from MetLife. This written notification will include:

- The specific reason or reasons for the denial
- Specific reference to pertinent Plan provisions on which the denial is based
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary
- Appropriate information as to the steps to be taken if you, your Dependent or a duly authorized person representing you or your Dependent wish to submit the claim for review.

If a written denial is received by you or your Dependents, the denial date will be the date you receive the denial letter from MetLife. However, if you do not hear from MetLife within 90 days of your claim submission, you should consider your claim denied as of that date. In this case, the denial date is 90 days after claim submission.

If a claim for benefits is denied, you, your Dependent or other duly authorized persons may appeal the denial or other action within 60 days of the denial date by sending a written letter of appeal to:

MetLife Group Claims Review
P.O. Box 14589
Lexington, KY 40512
-or-
Fax: 859-389-6505

The person sending the request has the right to:

- Review pertinent Plan documents which may be obtained by following the procedures described in the section entitled "Your Rights as a Plan Participant"
- Send to the Claims Appeal Unit a written statement of the issues plus any other documents in support of the claim for benefits or other matter under review.

MetLife will generally provide a written response to the appeal within 60 days after it is received. In some cases, more than 60 days may be needed to decide your appeal; in that instance, you will be notified that additional time (up to another 60 days, or a total of 120 days) is necessary and the reasons for the additional time. MetLife, on behalf of the Company, shall exercise the discretion to determine all matters of fact or interpretation relating to any claims.

If your initial appeal is denied, you may request a second appeal by following the same procedure as required for filing the initial appeal.

The Right to File a Benefit-Related Lawsuit. The Health Plan provides that no person has the right to file a civil action, proceeding or lawsuit against the Health Plan or any person acting with respect to the Health Plan, including, but not limited to, the Company, any Participating Company, the Committee or any other fiduciary, or any third party service provider, after the last day of the 12th month following the later of (a) the 60th day after receipt by the claimant of written notification of the Adverse Benefit Determination or (b) the date on which the Adverse Benefit Determination on appeal was issued with respect to such Plan Benefit claim.

The Required Forum for Legal Disputes. After the claims and appeals procedures are exhausted as explained above, and a final decision has been made by the Plan Administrator, if an Eligible Employee wishes to pursue other legal proceedings, the action must be brought in the United States District Court in Denver, Colorado.

XIX. YOUR RIGHTS AS A PLAN PARTICIPANT

As a participant in the Lumen Retiree and Inactive Health Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union if applicable, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to

$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these cost and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

A Word About Your Privacy

The Plan will use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. Please see the *Notice of HIPAA Rights* section for more information.

XX. PLAN DOCUMENTS

The information included in this SPD describes only the highlights of your Dental Plan. These descriptions do not attempt to cover all details of the Plan. Specific details are contained in the master contracts or the official Plan documents, prospectuses and/or the Trust agreement which legally govern the operation of the Plans and govern any questions arising under the Plans. Master contracts exist between the Company and MetLife. All questions concerning Plan benefits and any conflicts between this summary and the official Plan Document will be governed by the terms of the official Plan Document.

Company's Reserved Rights

This document summarizes the provisions of Retiree Dental Plan 3 of the Lumen Retiree and Inactive Health Plan that is made available by Lumen for Legacy Qwest Pre-91 Retirees and certain Disability participants. If there is any conflict between the terms of the Plan Document and this document, the terms of the Plan Document will govern. The Company reserves the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan. The Plan Administrator has the right and discretion to determine all matters of fact or interpretation relative to the administration of the Plan—including questions of eligibility, interpretations of the Plan provisions and any other matter. The decisions of the Plan Administrator and any other person or group to whom such discretion has been delegated, including the Claims Administrator, shall be conclusive and binding on all persons.

The Company, 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 Lumen-sponsored plans, including the Lumen Retiree and Inactive Health Plan. The Company reserves the right to amend or terminate all of the Plans and the Benefits it sponsors and provides - with respect to all classes of Participants, retired or otherwise - and their beneficiaries, without prior notice to or consultation with any Participants and beneficiaries -subject to, applicable law, collective bargaining if applicable, the terms of the respective Plan documents, and with respect to the Health Plan, subject to the terms of the written agreement specific to Legacy Qwest Pre-1991 Retirees and Legacy Qwest ERO'92 Retirees.

Invalid Provisions

In the event any provisions of the Plan Documents may be held illegal or invalid for any reason, such illegality or invalidity will not affect remaining sections of the Plan and the Plan will be construed and enforced as if said illegal or invalid provisions had never been inserted therein.

Participating Companies

Participants and beneficiaries may obtain, upon written request to the Plan Administrator, information as to whether a particular subsidiary or affiliate of the Company is a participating employer in the Plan.

Participating Providers and Employers

Participants and beneficiaries under the Plan may obtain Participating Provider Lists upon request to the Claims Administrator(s) listed above, or upon written request to the Plan Administrator.

XXI. PLAN ADMINISTRATOR

The Plan Administrator for the Lumen Retiree and Inactive Health Plan (which includes your Pre-91 dental benefit options) is:

Lumen Employees' Benefit Committee
c/o Corporate Benefit Office
214 E 24th St
Vancouver, WA 98663
360-905-7972

Discretionary Authority. The Plan Administrator has the right and discretion to determine all matters of fact or interpretation relative to the administration of the Plan - including questions of eligibility, interpretation of Plan provisions and all other matters. The decisions of the Plan Administrator, and any other person or group to whom such discretion is delegated, shall be conclusive and binding on all persons.

XXII. CLAIMS ADMINISTRATOR

Claims under the Plan are processed and paid by:

Metropolitan Life Insurance Company
One Madison Avenue
New York, New York 10010-3690

Note: The Plan Document governs the operation of the Plan at all times.

XXIII. PLAN SPONSOR AND EMPLOYER IDENTIFICATION NUMBER

The Plan Sponsor is identified by the following numbers under Internal Revenue Service (IRS) rules:

Plan Sponsor	**Employer Identification Number of Plan Sponsor** (assigned by the IRS)	**Plan Identification Number** (assigned by the Company)
Lumen, inc 100 CenturyLink Dr. Monroe, LA 71203-2041	**84-1339282**	**537**

The Plan Sponsor is Lumen, Inc. The Plan Sponsor provides certain administrative services in connection with the Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of Benefits and subrogation or recovery; care coordination; and complaint resolution assistance. These external administrators are referred to as the Claims Administrators. The Plan Sponsor also has selected MetLife Insurance Co.

The Lumen Employee Benefits Committee is the Plan Administrator and a named fiduciary for the Plan. The Lumen Employee Benefits Committee has also designated the Claims Administrator of each plan benefit option under the Plan as the claim fiduciary and delegated to each the authority and discretion to administer the Plan benefit option.

XXIV. LEGAL SERVICES

Process in legal actions with respect to the provisions of the Plan should be directed to the Plan Administrator-Lumen Associate General Counsel/ERISA, 100 CenturyLink Drive, Monroe, LA 71203 or on the Plan Sponsor's agent for service of legal process — CT Corporation System, 1675 Broadway, Suite 1200, Denver, Colorado 80202.

XXV. PLAN TYPE

The Plan is classified under the definition of the Employee Retirement Income Security Act of 1974 (ERISA) as a group health plan.

XXVI. SCHEDULE OF ALLOWANCES FOR SOME OF THE MORE COMMON TYPE B DENTAL PROCEDURES

To find out what your scheduled allowances are, follow these steps:

- Consult the location list below to find out which schedule applies to you. It is keyed to the dentist's location. Then:
- Refer to the Schedule of Allowances, on the pages following the location list, to determine benefits payable.

This is a representative listing. Payments for covered procedures where you have a procedure code or for a procedure not listed can be provided by the Claims Administrator.

Any procedure over $200 should always be filed for Predetermination of Benefits.

SCHEDULE OF ALLOWANCES, PART 1 - GEOGRAPHIC REGIONS

DENTIST'S LOCATION	SCHEDULE NO.
Alabama	
City of Montgomery (Zip Codes beginning with 361 only)	II
Remainder of State	I
Alaska	II
Arizona	II
Arkansas	
City of Little Rock (Zip Codes beginning with 722 only)	II
Remainder of State	I
California	
Greater Los Angeles Area (Zip Codes beginning with 900-918 and 926-931 only)	IV
Greater San Francisco Area (Zip Codes beginning with 940-951 only)	IV
Remainder of State	III
Colorado	
Greater Denver Area (Zip Codes beginning with 800-803 only)	III
Remainder of State	II
Connecticut	
New London Area (Zip codes beginning with 063 only)	II
Waterbury Area (Zip Codes beginning with 067 only)	II
Remainder of State	III
Delaware	

DENTIST'S LOCATION	SCHEDULE NO.
City of Wilmington (Zip Codes beginning with 198 only)	III
Remainder of State	II
District of Columbia	III
Florida	
Pensacola Area (Zip Codes beginning with 324-325 only)	II
Orlando Area (Zip Codes beginning with 327-329 only)	II
Tampa/St. Petersburg Area (Zip Codes beginning with 335-337 only)	II
Remainder of State	III
Georgia	
City of Atlanta (Zip Codes beginning with 303 only)	III
Atlanta Area (Zip Codes beginning with 300-302 only)	II
Greater Savannah Area (Zip Codes beginning with 313-314 only)	II
Remainder of State	I
Hawaii	III
Idaho	II
Illinois	
Chicago Area (Zip Codes beginning with 600-606 only)	III
Remainder of State	II
Indiana	
Indianapolis Area (Zip Codes beginning with 460-462 only)	II
Gary, South Bend, Ft. Wayne and surrounding areas (Zip Codes beginning with 463-469, and 473 only)	II
Remainder of State	I
Iowa	I
Kansas	II
Kentucky	I
Louisiana	
City of Baton Rouge (Zip Codes beginning with 708 only)	III
Remainder of State	II
Maine	I
Maryland	III
Massachusetts	II
Michigan	
Flint (Zip Codes beginning with 485 only)	III
Lansing (Zip Codes beginning with 489 only)	III
Grand Rapids (Zip Codes beginning with 495 only)	III
Remainder of State	II
Minnesota	
Minneapolis-St. Paul (Zip Codes beginning with 551, 553 and 554 only)	II

DENTIST’S LOCATION	SCHEDULE NO.
Remainder of State	I
Mississippi	
City of Jackson (Zip Codes beginning with 392 only)	II
Remainder of State	I
Missouri	
Greater St. Louis Area (Zip Codes beginning with 630-633 only)	II
Greater Kansas City Area (Zip Codes beginning with 640-641 only)	II
Remainder of State	I
Montana	II
Nebraska	
City of Omaha (Zip Codes beginning with 681 only)	II
Remainder of State	I
Nevada	IV
New Hampshire	II
New Jersey	
Southern New Jersey (Zip Codes beginning with 080-084 only)	II
Remainder of State	III
New Mexico	II
New York	
Westchester and Putnam Counties (Zip Codes beginning with 105-108 only)	III
Northern NY State (Zip Codes beginning with 128, 129 and 136 only)	I
Southern NY State (Zip Codes beginning with 127, 137-139, and 147-149 only)	I
Remainder of State	II
North Carolina	II
North Dakota	I
Ohio	
Greater Cleveland area (Zip Codes beginning with 440-441 only)	III
Greater Cincinnati Area (Zip Codes beginning with 450-452 only)	I
Remainder of State	II
Oklahoma	
Oklahoma City Area (Zip Codes beginning with 730-731 only)	II
Tulsa Area (Zip Codes beginning with 740-741 only)	II
Remainder of State	I
Oregon	II
Pennsylvania	
City of Pittsburgh (Zip Codes beginning with 152 only)	III
Remainder of State	II
Puerto Rico	III

DENTIST'S LOCATION	SCHEDULE NO.
Rhode Island	II
South Carolina	
Charleston Area (Zip Codes beginning with 249 only)	II
Remainder of State	I
South Dakota	I
Tennessee	
City of Nashville (Zip Codes beginning with 372 only)	II
City of Memphis (Zip Codes beginning with 381 only)	II
Remainder of State	I
Texas	`
City of Houston (Zip Codes beginning with 770-772 only)	IV
Houston Area, including Beaumont (Zip Codes beginning with 773-777 only)	III
Dallas, Fort Worth and Waco Areas (Zip Codes beginning with 750-752 and 760-761 and 766-767 only)	III
Corpus Christi Area (Zip Codes beginning with 783-785 only)	III
City of Austin (Zip Codes beginning with 787 only)	III
Lubbock Area (Zip Codes beginning with 793-794 only)	III
Remainder of State	II
Utah	I
Vermont	I
Virginia	
Washington, D.C. Area (Zip Codes beginning with 220-223 only) `	III
Remainder of State	II
Washington	
Seattle, Tacoma Area (Zip Codes beginning with 980-984 only)	III
Remainder of State	II
West Virginia	
Charleston Area (Zip Codes beginning with 250-253 only)	II
Wheeling Area (Zip Codes beginning with 260 only)	II
Remainder of State	I
Wisconsin	II
Wyoming	II
Outside of USA	II

Note: Schedules reflect differences in dental charges by geographic area.

SCHEDULE OF ALLOWANCES FOR TYPE B SERVICES

Services	Schedules		
	I	II	III
Restorations			
Amalgam one surface primary—ADA *codes discontinued**	$19	$22	$23
Amalgam two surfaces primary—ADA *codes discontinued**	31	32	39
Amalgam three surfaces primary—ADA *codes discontinued**	37	42	51
Amalgam one surface permanent	21	23	30
Amalgam two surfaces permanent	29	31	39
Amalgam three surfaces permanent	36	39	52
Silicate Cement — per restoration—ADA *code discontinued**	18	21	23
Composite Resin — one surface	24	30	34
Composite Resin — two surfaces	36	40	46
Composite Resin — three surfaces	51	60	68
Inlay, Gold — two surfaces	165	187	225
Inlay, Gold — three surfaces	219	248	298
Crowns			
Plastic with semiprecious Metal Crown	286	323	389
Porcelain Crown	227	257	308
Porcelain with semiprecious Crown	258	292	311
Gold Full Cast Crown	267	270	300
Gold Cast Crown	264	299	359
Stainless Steel Crown	52	59	71
Pulp Cap—Direct	13	15	17
Root Canal Therapy			
Root Canal Therapy — Anterior	144	158	195
Root Canal Therapy — Bicuspid	178	202	214
Root Canal Therapy — Molar	235	236	266
Periodontics			
Gingival Curettage — per quadrant—ADA *codes discontinued**	37	45	65
Gingivectomy — per quadrant	90	103	117
Osseous Surgery—including flap entry and closure per quadrant	228	233	311
Osseous Graft — Single Site	121	137	165
Complete dentures including 6 months' post-delivery care:			
Complete Upper	313	355	426
Complete Lower	303	343	412
Immediate Upper	323	372	437
Immediate Lower	329	372	447
Partial dentures including 6 months' post- delivery care:			

Services	Schedules		
	I	II	III
Upper with Acrylic Base Without Clasps	355	402	484
Lower with Acrylic Base Without Clasps	349	396	476
Upper Acrylic Base with Clasps	364	412	495
Lower Acrylic Base with Clasps	371	420	505
Bridge Pontics			
Cast Gold	241	273	328
Porcelain Fused to Semiprecious Metal	247	280	337
Plastic Processed to Semiprecious Metal	188	213	257
Oral Surgery			
Simple extractions:			
Single Tooth	23	28	34
Each Additional Tooth—ADA *codes discontinued**	21	26	31
Surgical extractions:			
Extraction of tooth, erupted	42	45	75
Extraction of tooth, partial bony impaction	87	94	110
Extraction of tooth, complete bony impaction	106	113	127
Orthodontics			
Appliances for tooth guidance or to control harmful habits:			
Fixed or removable	112	129	146
Comprehensive full banded treatment:			
Preliminary Study including x-rays, etc. & treatment plan	79	89	128
First month of treatment, including appliances	544	589	641
Active treatment per month after first month	56	65	75

*American Dental Association code no longer in use—service provided under new code

XXVII. PREDECESSOR DENTAL PLANS

QWEST RETIREE HEALTH CARE DENTAL PLANS

The five Retiree Health Care Dental Plans cover the following groups of eligible people who were covered under one of the Predecessor Plans listed below:

- All retired Employees on a service or disability pension covered by a Predecessor Plan prior to January l, 1991;
- Spouses and other Class I Dependents of those Retirees described above.

QWEST RETIREE HEALTH CARE DENTAL Plan 1 PREDECESSOR PLAN:

Pacific Northwest Bell Dental Expense Plan (covers all Employees who retired prior to January 1, 1990).

QWEST RETIREE HEALTH CARE DENTAL Plan 2 PREDECESSOR PLAN:

Mountain Bell Dental Expense Plan (covers all Employees who retired prior to January 1, 1990).

QWEST RETIREE HEALTH CARE DENTAL PLAN 3 PREDECESSOR PLAN:

Choice Plus Dental Expense Plan (covers all management and non-bargained Employees who retired prior to January 1, 1991 at the following non-regulated U S WEST companies: U S WEST Advanced Technologies, U S WEST Strategic Marketing, U S WEST Corporate Information Strategies, U S WEST Business Resources, Inc., U S WEST Financial Services, U S WEST Inc., U S WEST Educational Foundation, U S WEST Inc. (DE), U S WEST International, U S WEST Information Systems, U S WEST Knowledge Engineering, U S WEST New Vector Group, U S WEST Cellular, U S WEST Paging, U S WEST Marketing Resources Group, U S WEST Direct, U S WEST Network Systems, U S WEST Communications Federal Services, U S WEST Enterprises, U S WEST Corporate Communications, Inc.)

QWEST RETIREE HEALTH CARE DENTAL PLAN 4 PREDECESSOR PLANS:

US WEST Dental Expense Plan (covers all CWA craft Employees who retired prior to January 1, 1990 at U S WEST Direct, U S WEST Enterprises, U S WEST Business Resources, Inc., and U S WEST Corporate Communications), and covers all IBEW craft Employees who retired prior to January 1, 1990 at U S WEST Direct.

Northwestern Bell Dental Expense Plan (covers occupational and management Employees who retired prior to January 1, 1990.)

QWEST RETIREE HEALTH CARE DENTAL PLAN 5 PREDECESSOR PLANS:

All Dental Expense Plans covering all Employees who retired during 1990 from the following subsidiaries: Pacific Northwest Bell, Mountain Bell, Northwestern Bell, U S WEST Direct (CWA), U S WEST Enterprises (CWA), U S WEST Business Resources, Inc. (CWA), and U S WEST Direct (IBEW), and any other Employees not covered by the Choice Plus Dental Plan.

Note: *See your health care benefit option SPD for information about health care Benefits.*