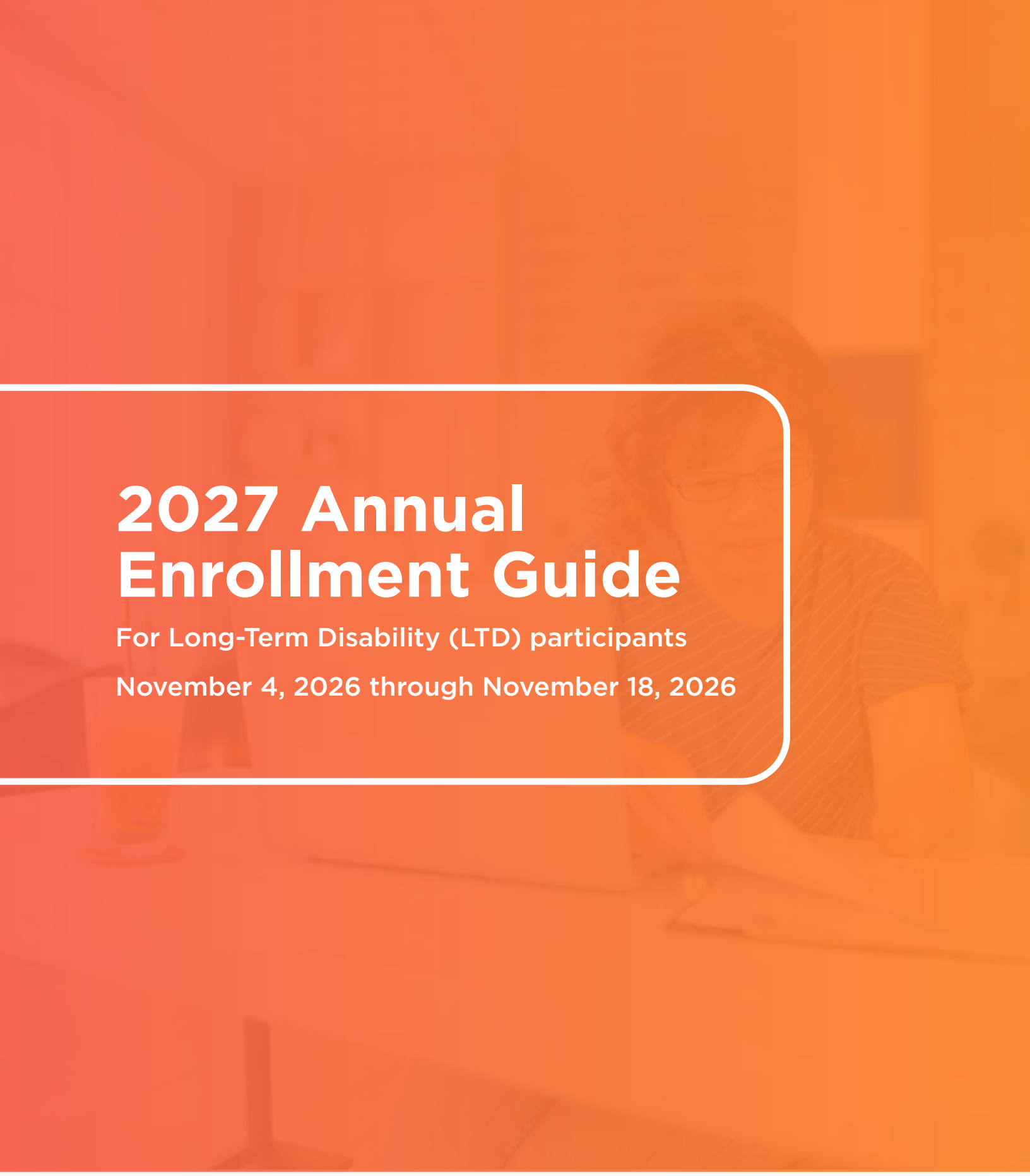


2027 Annual Enrollment Guide

For Long-Term Disability (LTD) participants

November 4, 2026 through November 18, 2026

LUMEN®

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Important benefit information

Choose well. Live well. Thrive!

Welcome to 2027 Annual Enrollment. This guide is designed to help you understand your benefit options and make confident, informed decisions for the year ahead. Please read it carefully, as it includes important details about your coverage, enrollment steps, deadlines, and resources available to support you.

Checklist

- ☑ **Read the What's new or changing for 2027** section to review any changes to your premiums or out-of-pocket costs.
- ☑ **Compare your plan options** using the charts in this guide.
- ☑ **Review your Annual Enrollment Notice** in your Personal Documents on the Health and Life website if you chose electronic delivery. If you chose paper delivery, your notice was mailed with this guide.
- ☑ If your information is correct and you don't want to make changes, your current elections will continue as shown in your Annual Enrollment Notice.

Visit the Annual Enrollment or Webinars tab on the Health and Life website to register for a Surest or UnitedHealthcare webinar.

- Tuesday, November 3 at 12 p.m. to 1:30 p.m. CST
- Tuesday, November 10 at 3:30 p.m. to 5 p.m. CST
- Tuesday, November 17 at 1 p.m. to 2:30 p.m. CST

How to log in and enroll

Be sure to review the **Enrollment enhancements** to the Health and Life website in the **What's new or changing for 2027** section in this guide.

How	Where	When
Online	lumen.com/healthbenefits	By 11:59 p.m. CST, November 18, 2026
Mobile App	MyChoice Benefits App (App Store/Google Play). Company key: **Lumen**	By 11:59 p.m. CST, November 18, 2026
Phone	Service Center: 833-925-0487	By 6:59 p.m. CST, November 18, 2026

Note: Virtual hold may be available if you call during peak hours. An advocate will call you back either the same or the next business day. Only one callback attempt will be made, whether you answer or not. The call will come from 317-981-6810, so please do not block this number.

Reminders

- **Download the free MyChoice Benefits App** available in the App Store or Google Play. Sign in or create a Username and Password — you can use the same login as the Health and Life website. The Benefits App provides access to most of the same features and functions available online.
- **Receive benefit information timely** by adding your email address on the Health and Life website: **Select Profile** (from the homepage, click your name in the top right corner and choose **Profile**). Go to **Contact Preferences** under **Personal Preferences**. Click on **Edit** and then choose the **Electronic Mail** button and enter your email address. Select the **Primary** button, then click **Save**.
- **Want to receive benefit information by text message?** We can text you certain Lumen benefit updates (data rates may apply). From the home page, click your name in the top right corner and choose **Profile**. Go to **Contact Preferences** under **Personal Preferences**. Click on **Edit** and then check the box under **Text messages (optional)**, then click **Save**.

What's new or changing for 2027

Welcome to 2027 Annual Enrollment. We know your benefits are important, and we want to make reviewing them as easy as possible. Please take a few minutes to read this guide, see what's changing that may impact your benefits, review your current coverage, and confirm whether you need to make any updates for 2027.

Enrollment enhancements to the Health and Life website

Changes at a Glance and Things to Consider

- During enrollment, a new **Changes at a Glance** screen will provide a summary of any updates you make, including changes to coverage, contributions, or dependents. The **Things to Consider** section will also include helpful reminders before you submit your elections.

Benefits App branding update

- The MyChoice Benefits app will have an updated name, refreshed design, and easier navigation to provide a more consistent experience across devices.

Dependent removal during Annual Enrollment

- During Annual Enrollment, you will have the option to remove a dependent from your coverage through the enrollment process.

Premiums will increase

Health care premiums for medical and dental coverage will increase as health care expenses continue to rise nationwide because of higher use of care, more expensive treatments, and increased prescription drug costs.

Be sure to review your Annual Enrollment Notice on the Health and Life website to confirm your benefit premiums.

Tobacco Surcharge will increase

If you and your dependents are enrolled in a Lumen medical plan and use tobacco products, the $216.67 surcharge will be added to your monthly medical premium. However, if you and your dependents are enrolled in a Company-recognized tobacco cessation program, the surcharge will not apply.

2027	2026
$216.67	$190.67

Medical, prescription drug and plan design updates

Surest Health PPO and Surest Select Health PPO

Enhancement - Clinical Advocacy Support

Members enrolled in a Surest medical plan will have access to enhanced Clinical Advocacy Support. Surest Clinical Advocates can help guide you through your health care journey by assisting with a wide range of health needs, including pregnancy, pediatric care, heart care, cancer support, and more. Advocates can help you navigate the Surest app, identify high-value in-network providers and virtual care programs, understand your care options, and make informed health care decisions.

In addition, Clinical Advocates can provide personalized support to help improve your physical and mental well-being, align care with your personal preferences, connect you with relevant health resources, and help identify programs that may offer financial assistance when needed.

Copay ranges will increase

Copay ranges	2027 – Surest Health PPO	2026 – Surest Health PPO	2027 – Surest Select Health PPO	2026 – Surest Select Health PPO
Office Visit – PCP and Specialist	$25 to $135	$20 to $105	$20 to $110	$10 to $65
Complex Imaging	$125 to $1,900	$100 to $1,400	$100 to $1,450	$75 to $950
Emergency Room	$900	$650	$650	$450
Urgent Care	$80	$60	$60	$35
Procedures (ASC, OP, IP)	Up to $3,500	Up to $3,000	Up to $3,000	Up to $2,500
Other Outpatient Hospital	$250 to $1,350	$150 to $850	$150 to $1,100	$75 to $525
Other inpatient hospital	$2,750	$2,000	$2,000	$1,600
Maternity	$1,300 to $2,750	$900 to $2,000	$900 to $2,000	$625 to $1,600

Surest Health PPO

In-network out-of-pocket maximum will increase

Coverage level	2027	2026
Individual	$5,500	$3,600
Individual + Spouse/Domestic Partner	$8,250	$5,400
Individual + Child(ren)	$8,250	$5,400
Family	$11,000	$6,850

Out-of-network out-of-pocket maximum will increase

Coverage level	2027	2026
Individual	$22,000	$10,800
Individual + Spouse/Domestic Partner	$33,000	$16,200
Individual + Children	$33,000	$16,200
Family	$44,000	$20,550

Surest Select Health PPO

In-network out-of-pocket maximum will increase

Coverage level	2027	2026
Individual	$5,000	$3,200
Individual + Spouse/Domestic Partner	$7,500	$4,800
Individual + Children	$7,500	$4,800
Family	$10,000	$6,400

Out-of-network out-of-pocket maximum will increase

Coverage level	2027	2026
Individual	$20,000	$9,600
Individual + Spouse/Domestic Partner	$30,000	$14,400
Individual + Children	$30,000	$14,400
Family	$40,000	$19,200

UnitedHealthcare High Deductible Health Plan (HDHP)

In-network deductibles will increase

Coverage level	2027	2026
Individual	$1,750	$1,700
Individual + one or more dependents	$3,500	$3,400

Out-of-network deductibles will increase

Coverage level	2027	2026
Individual	$7,000	$3,400
Individual + one or more dependents	$14,000	$6,800

In-network out of pocket maximum will increase

Coverage level	2027	2026
Individual	$5,500	$3,600
Individual + one or more dependents	$11,000	$6,850

Out-of-network out of pocket maximum will increase

Coverage level	2027	2026
Individual	$22,000	$10,800
Individual + one or more dependents	$44,000	$20,550

Prescription Drug Program

Surest Health PPO - Maintenance medications

To align with the Surest Select PPO and HDHP, beginning in 2027, the Surest Health PPO plan will require maintenance medications to be filled through Optum Rx® Home Delivery Pharmacy after two retail fills. Maintenance medications are prescriptions taken on a regular, recurring basis for long-term conditions such as diabetes or birth control. Mail order maintenance medications is currently the same requirement for the Surest Select PPO and HDHP.

You may fill a maintenance medication at a retail pharmacy up to two times. After that, the medication must be filled through Optum Rx® Home Delivery Pharmacy and may no longer be filled at a retail pharmacy or another mail-order pharmacy. Home delivery can help you receive a consistent, uninterrupted supply of maintenance medications.

Expanded health programs

Program changes at a glance

There are several programs that will be introduced, replaced, or consolidated for 2027. The chart below provides an overview of the current program and the updated program for 2027 followed by a more detailed program description.

Current program	2027 update
Weight-loss GLP-1 coverage through Optum Rx	Replaced by the eMed GLP-1 Weight Management Program
Wondr Advanced GLP-1 Support Program*	Discontinued
Solutions for Nursing Mothers	Replaced by Maven
Milk Stork	Replaced by Maven
Surest & UnitedHealthcare Maternity Support Programs	Replaced by Maven
Pacify	Replaced by Maven

Current program	2027 update
Quit4Life	Replaced by Pelago
Real Appeal	Discontinued

Note: *Wondr Health will continue to be offered. However, the Wondr Advanced GLP-1 support program will not be offered in 2027.

Plan design updates

Surest Health PPO, Surest Select Health PPO and the HDHP

GLP-1 Medication coverage and Support (does not apply to GLP-1 for diabetes)

FDA-classified weight-loss GLP-1 medications (which is Wegovy, Zepbound, Foundayo and Saxenda) will no longer be covered through the Optum Rx pharmacy benefit.

Instead, weight-loss GLP-1 medications will be available through the eMed GLP-1 Support Program, which will become the only Lumen-supported program for access to FDA-classified weight-loss GLP-1 medications. Eligible participants may have access to medications through a direct manufacturer-to-consumer pricing structure using eMed-designated pharmacies. Member contribution for a 30-day fill is expected to be on average $250. Final pricing will be available later in the year. Amounts paid through eMed do not apply toward your medical plan deductible or out-of-pocket maximum.

Participation in eMed is optional. Members may continue to work with their healthcare provider or use another program of their choice. However, weight-loss GLP-1 medications obtained outside of eMed will not be covered through Optum Rx and will not be eligible for Lumen-supported eMed pricing.

This change applies regardless of why the weight loss medication is prescribed, e.g., for sleep apnea, cardiovascular risk reduction, MASH (Metabolic Dysfunction-Associated Steatohepatitis), or another weight-related health condition.

Note: GLP-1 medications for diabetes

GLP-1 medications FDA-classified for Type 2 diabetes treatment (which is Ozempic® and Mounjaro®) are not changing. These medications remain covered through OptumRx only for members with a Type 2 diabetes diagnosis, are subject to prior authorization, and continue to follow the plan's standard tier-based pharmacy coverage. Coverage requirements and plan rules continue to apply.

eMed GLP-1 Weight Management Program

New for 2027, Lumen is introducing the eMed GLP-1 Support Program for eligible participants seeking FDA-classified weight-loss GLP-1 medications, such as Wegovy, Zepbound and Foundayo. The program combines medication access with clinical oversight and ongoing support to help participants manage their treatment journey.

The eMed program includes:

- Clinical intake and health assessment
- At-home lab testing and biometric screening
- Review by a licensed clinician to determine program eligibility
- Prescription management and medication fulfillment through designated pharmacies
- Weekly check-ins and progress monitoring
- Clinical support for medication management and side effects
- Digital tools to help track progress throughout treatment

The eMed program supports more than medication access. The program is designed to help participants better understand their health, monitor key health indicators, and receive ongoing support throughout treatment. Additional details about enrollment, eligibility requirements, and program availability will be shared before the January 1, 2027 launch.

Maven

Maternity, menopause, and midlife support: Maven will replace the current Surest and UnitedHealthcare maternity support programs, along with Solutions for Nursing Mothers and Milk Stork, creating one simplified experience for maternity, postpartum, lactation, menopause, and midlife support.

Available at no cost to LTD participants and covered partners enrolled in a UnitedHealthcare or Surest health plan, Maven provides 24/7 virtual access to providers, care advocates, on-demand classes, community support, and expert resources.

- Maternity and newborn care – Support for pregnancy, postpartum recovery, newborn care, lactation, miscarriage and loss, plus breast milk shipping for eligible health plan members.
- Menopause and midlife health – Guidance for perimenopause, menopause, post-menopause, hormone health, hormone replacement therapy, early intervention, and men's health.

Nox Sleep – Expert sleep health support

Better health begins with better sleep. Nox Sleep provides one convenient source of expert care for sleep-related conditions, with access to board-certified physicians and a dedicated care team.

The Nox Sleep program is available to Lumen LTD participants and spouses/domestic partners enrolled in a Lumen medical plan beginning January 1, 2027. Members have access to personalized sleep care, from evaluation and diagnosis through treatment and ongoing support, including a no-cost home sleep test (when appropriate) and teleconsult.

- Sleep Apnea: Expert evaluation, diagnosis, treatment, and ongoing care, including convenient at-home testing and access to sleep specialists.
- Insomnia: Personalized support and evidence-based treatment to address trouble falling asleep, staying asleep, or getting restorative sleep.
- Restless Legs Syndrome & Circadian Rhythm Disorders: Specialized care to identify and treat conditions that can disrupt sleep timing, quality, and comfort.

You may continue receiving CPAP equipment and supplies from your current DME provider through December 31, 2026.

Beginning January 1, 2027, covered CPAP equipment, supplies, and related care should go through Nox Sleep. Our Care Team can help coordinate the transition, including support for members with rented CPAP devices.

Tobacco Cessation Program

To offer a more comprehensive and streamlined experience, we are consolidating all tobacco cessation support into Pelago. If you or a covered family member is seeking assistance with quitting tobacco products, Pelago will be your single resource going forward.

Pelago is a Wellness Coaching Program available to you and your eligible dependent(s) ages 15 or older who are enrolled in a Lumen medical plan. It supports your health goals by helping you cut back, quit, or manage tobacco use, as well as alcohol, cannabis, and opioid use. Key features include virtual one-on-one support from a licensed care team of health coaches, counselors, and physicians; 24/7 online access with appointments available within 24 hours; a personalized care plan; and on-demand resources and goal tracking in the digital app. You can learn more and get started at lumen.com/pelago or by calling 877-349-7755.

The Quit4Life Tobacco Cessation program will no longer be available.

WellTheory

If you or a covered dependent (18+) are living with an autoimmune condition — or experiencing unexplained symptoms like fatigue, brain fog, joint pain, or digestive issues — WellTheory is now available to you at no cost through your medical plan. WellTheory pairs you with a Registered Dietitian who specializes in autoimmune health, offering regular video visits, unlimited messaging, and a personalized nutrition and lifestyle plan built around your unique needs. Members have reported impressive results: 92% reduced their symptoms within just four weeks, and 74% experienced a better quality of life within 20 weeks.

World Class Health – Specialty care made simple

If you or a covered dependent need surgery, imaging, or infusion care, World Class Health (WCH) is available to you through your Lumen medical plan. WCH connects you with top-rated hospitals and specialists for procedures including bariatric surgery, spine surgery along with other specialty categories such as imaging and infusion services.

A dedicated WCH nurse navigator guides you through every step, from your first questions through recovery, helping ensure you get the right care, at the right place, at the right time. Members who use the WCH network can access great savings on their care, including relief on copay costs.

The information in the What's new or changing for 2027 section is intended to serve as an SMM under the Employee Retirement Income Security Act of 1974 (ERISA) to notify you of certain changes to the Company-sponsored plans subject to ERISA. Please keep this SMM with your Summary Plan Descriptions (SPDs). For more Plan details, refer to your SPDs and the Legal and Important Required Notices section in this guide. The Plan Administrator has the right to interpret and resolve any ambiguities in the Plan, and the Company reserves the right to amend and/or terminate any benefits or plans.

Reminders

Benefit focus	Summary
Dependent reverification	Lumen reverifies dependents every five years to keep health plan costs down for everyone. If your spouse, common-law spouse or domestic partner has not been verified since 2022 and is enrolled in Lumen medical or Lumen dental (non-Medicare participants), you'll receive a reverification request in the second quarter of 2027. It's important to respond promptly. If a spouse or domestic partner is not approved during the reverification process, their coverage — and coverage for any stepchildren or domestic partner's children — will end at the close of the reverification period. They will not be eligible for COBRA.
Dependent eligibility	Newly added dependent(s) will not be eligible for coverage until you timely provide the requested supporting documentation that confirms their eligibility under the Plan and the Dependent Verification process approves your dependent(s).
Life Insurance **Note:** Optional Term Life Insurance, Spouse/ Domestic Partner Optional Term Life Insurance, and Child Optional Term Life Insurance is available for up to 36 months from your STD start date, provided all premiums are paid timely.	**Optional Term Life Insurance** **Participant paid** - You cannot elect to increase or decrease any life insurance coverage. You can only keep the current coverage amount. If you waive coverage and later return as an active employee, you may be required to complete a Statement of Health (SOH) for approval by the Claims Administrator. **Note:** If you are adding a new dependent, they are not eligible to enroll in Employee, Spouse/ Domestic Partner, or Child/ren Optional Term Life Insurance.
Direct bill payment **Note:** It is essential to pay all premiums by the due date to maintain continuous coverage. Failure to do so will result in the termination of coverage. Account Statements are **not** mailed.	You are encouraged to set up automatic payments (autopay) for your direct bill account (e.g., medical coverage). If you choose to set up autopay, you must pay any outstanding balance in full, if applicable, before the autopay will begin. If you are enrolled in Voluntary Benefits, you will be direct billed by the vendor. **Note:** If you choose to make one-time payments, each month you will incur a $2.00 service fee for each payment. This is not the same as autopay. Lumen can't waive the service fee. You can also set up autopay on the Health and Life website or you can call the Service Center at 833-925-0487 and an advocate can walk you through the set up process.
Other coverage options	There may be other, more affordable coverage options for you and your dependent(s) through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's employer's plan) through what is called a "special enrollment period," even if the Plan generally doesn't accept late enrollees. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. **Note:** Being eligible for COBRA doesn't limit your eligibility for coverage for a tax credit through the Marketplace. You should compare your other coverage options with COBRA and choose the coverage that is best for you. For example, if you move to other coverage, you may pay more out of pocket than you would under COBRA, because the new coverage may impose a new deductible. More information on health insurance options through the Marketplace can be found at healthcare.gov.
Medicare eligibility	If you or your dependent(s) become Medicare eligible, you will need to ensure you have Medicare Part A and Part B and notify UHC or Surest. If you are eligible for retiree health care, please contact the Service Center.
Prescription drugs	The Prescription Drug List (PDL) is updated periodically throughout the year. You can use the pricing tool on the following websites based on the plan you are enrolling in for 2027: • HDHP - myuhc.com • Surest Health PPO and Surest Select Health PPO - benefits.surest.com
Voluntary Benefits	You can continue the plans or programs you are currently enrolled in and the vendor will bill you directly. If you want to change or end your coverage, you must contact the vendor.
Working Spouse/Domestic Partner Surcharge	If you are subject to the Working Spouse/Domestic Partner surcharge, $216.67 will be added to your monthly medical cost. **Note:** The Working Spouse/Domestic Partner Surcharge applies if you are enrolled and eligible for subsidized medical coverage.

Helpful resources

When you need more detailed information about Plan specifics, review the Summary Plan Descriptions (SPDs) in the **Reference Center** on the Health and Life website.

Summary of benefits and coverage availability

We offer resources to help you understand and compare your non-Medicare medical benefit options. The Summary of Benefits and Coverage Availability (SBC) provides key information in a standard format so you can review Plan options side by side. You can find the SBC in the **Reference Center** on the Health and Life website home page.

Administrator/Plan/Program	Website/Group number	Phone number
To Report the passing of an LTD participant or a dependent, please contact WTW who will notify all Lumen Claims and Plan Administrators.	N/A	888-324-0689 Monday to Friday, 8 a.m. to 7 p.m. CST
Lumen Health and Life Service Center	lumen.com/healthbenefits Download the free MyChoice Benefits App for iOS or Android **Search:** MyChoice™ Benefits App, available for free in the App Store and Google Play	800-GETMET8, (800-438-6388) Monday to Friday, 7 a.m. to 7 p.m. CST 317-671-8494 (International callers) **Note:** If you receive a call from the Service Center, the number will appear as 317-981-6810. Make sure not to block calls from this area code so you don't miss calls.
Medical and Prescription Drug		
Blue Cross/Blue Shield Hawaii Medical Services Association (HMSA)	HMSA: hmsa.com/contact Group Number: 030541001	800-776-4672 Monday to Friday, 5 a.m. to 2 p.m. CST
HDHP including prescription drug through OptumRx	lumen.com/exploreuhc or, if already enrolled myuhc.com Group Number: 192086 **Search:** UHC App, available for free in the App Store and Google Play	800-842-1219 Monday to Friday, 8 a.m. to 10 p.m. CST
Surest Health PPO and Surest Select Health PPO including prescription drug through OptumRx	lumen.com/joinsurest or, if already enrolled, benefits.surest.com **Search:** Surest App, available for free in the App Store and Google Play Group Number: 78800186	800-531-6329 Monday to Friday, 6 a.m. to 9 p.m. CST
Virtual Care Surest Health PPO and Surest Select Health PPO **HDHP** **MD Live** (available for all plans)	benefits.surest.com **Search:** Surest App, available for free in the App Store and Google Play myuhc.com **Search:** UHC App, available for free in the App Store and Google Play lumen.com/mdlive	800 531-6329 Monday to Friday, 6 a.m. to 9 p.m. CST 800-842-1219 Monday to Friday, 8 a.m. to 10 p.m. CST 888-632-2738

Administrator/Plan/Program	Website/Group number	Phone number
2nd.MD Access to 2nd.MD services free for eligible participants and dependent(s) enrolled in a Lumen medical plan.	lumen.com/2ndmd **Search:** 2nd.MD, available for free in the App Store	866-842-1151 Monday to Friday, 7 a.m. to 7 p.m. CST
Dental		
Dental (MetLife) (Option 1 and Option 2)	metlife.com/mybenefits **Search:** Metlife App, available for free in the App Store and Google Play Group Number: 305521	866-832-5756 Monday to Friday, 6 a.m. to 10 p.m. CST
Vision		
Vision (EyeMed)	lumen.com/eyemed **Search:** EyeMed App, available for free in the App Store and Google Play Group Number: 1061657	855-874-4744 Monday to Friday, 8 a.m. to 11 p.m. CST
Life Insurance		
Life Insurance (MetLife)	lumen.com/healthbenefits Refer to the SPD for the policy number.	800-GETMET8, (800-438-6388) Conversion: Transition Solutions Resource Center 877-275-6387; Barnum Financial may call you regarding options for individual policies.
Voluntary Benefits		
Voluntary Benefits	For the following MetLife plans and programs, call MetLife at 800-GETMET8, (800-438-6388). – Accident Insurance, Critical Illness, Farmers Insurance, Hospital Indemnity, Identity & Fraud Protection, Legal Services, Pet Insurance. For the following plans and programs, call the Service Center a 833-925-0487. – Airvet, Liberty Mutual, PerkSpot, Recoop, Transamerica.	

Change of address update - Follow the steps below to update your information

Administrator	Website	Phone number
Health and Life Service Center	lumen.com/healthbenefits • Click on the **Change My Benefits** icon from the home page • Select **Update Demographic Information** Only under the Life Event drop-down menu • Enter the current date and select **Continue**, then **Start Change** • Continue through the screens to update your address, add an alternate address and phone number(s). • Select **Approve**, then **I Agree** to confirm your change	833-925-0487 Monday to Friday, 7 a.m. to 7 p.m. CST 317-671-8494 (International callers)

Appendix

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Medical plan overviews

Surest Health PPO, Surest Select Health PPO and HDHP

This chart is only a snapshot summary of medical benefits. For specific details on how services are covered or excluded, please contact the Claims Administrator (Surest or UnitedHealthcare) or refer to the medical Summary Plan Description (SPD) in the **Reference Center** on the home page at Health and Life website.

Note: Dependent(s) can enroll in medical coverage if the LTD participant is enrolled in medical coverage. If the LTD participant waives medical coverage, the dependent(s) can't enroll.

Annual deductibles and annual out-of-pocket maximums

	Surest Health PPO	Surest Select Health PPO	HDHP w/Optional HSA
Note: Deductibles are separate for In-network and Out-of-network providers and are not combined			
Annual deductible (Individual)	$0	$0	$1,750 In-network $7,000 Out-of-network
Surest plans - Individual + Child/ren and Family **HDHP – Individual + one or more dependents**	$0	$0	$3,500 In-network $14,000 Out-of-network
The In-network copays apply towards the In-network and Out-of-network Out-of-pocket Maximum.			The In-network and Out-of-network maximums are separate and are not combined.
In-network out-of-pocket maximums			
Individual	$5,500	$5,000	$5,500
Individual + Spouse/Domestic Partner	$8,250	$7,500	N/A
Individual + Child/ren	$8,250	$7,500	N/A
Surest plans – Family **HDHP – Individual + one or more dependents**	$11,000	$10,000	$11,000
Out-of-network out-of-pocket maximums			
Individual	$22,000	$20,000	$22,000
Individual + Spouse/Domestic Partner	$33,000	$30,000	N/A
Individual + Child/ren	$33,000	$30,000	N/A
Surest plans – Family **HDHP – Individual + one or more dependents**	$44,000 (Entire family out-of-pocket must be satisfied before eligible expenses are 100% covered)	$40,000 (Entire family out-of-pocket must be satisfied before eligible expenses are 100% covered)	$44,000 (Entire family out-of-pocket must be satisfied before eligible expenses are 100% covered)

Doctor visits and preventive care

	Surest Health PPO	Surest Select Health PPO	HDHP
In-network			
Primary care and Specialist visit	$25 – $135	$20 – $110	• 85% covered (Tier 1 premium provider) • 80% covered (network provider)
Preventive care	100% covered	100% covered	100% covered

	Surest Health PPO	Surest Select Health PPO	HDHP
Coinsurance	100% covered (for eligible services)	100% covered (for eligible services)	• 85% covered (Tier 1 premium provider) • 80% covered (network provider)
Out-of-network			
Primary care and Specialist visit	$220	$220	50% covered (you may be responsible for any amount over the eligible expense)
Preventive care	Not covered	Not covered	Not covered
Coinsurance	100% covered (for eligible services)	100% covered (for eligible services)	50% covered (you may be responsible for any amount over the eligible expense)

Hospital and emergency care

	Surest Health PPO	Surest Select Health PPO	HDHP
In and Out-of-network			
Emergency Room (copay waived if admitted)	$900	$650	80% after deductible
In-network			
Inpatient hospital	$2,750	$2,000	80% after deductible
Outpatient surgery	$250 – $1,350	$150 – $1,100	• 85% covered (when performed at an Ambulatory Surgery Center) • 80% covered (if performed as outpatient in a hospital)
Out-of-network			
Inpatient hospital	$8,250	$6,000	50% after deductible
Outpatient surgery	$3,500	$3,300	Not covered

Prescription drugs – Tier 1, 2, 3 and 4

Certain life saving/emergency medications on the Vital Medication list are covered at no cost to you.

Surest Health PPO	Surest Select Health PPO	HDHP
Tier 1		
• $15 for up to a 30 day retail supply • $37.50 for up to a 90 day home delivery supply • $260 (In-network) for Specialty Retail Pharmacy • Specialty medications are limited to a 30 day supply **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions.	• $10 for up to a 30 day retail supply • $25 for up to a 90 day supply for home delivery • $200 (In-network) for Specialty Retail Pharmacy • Specialty medications are limited to a 30 day supply **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions	• 85% covered; minimum copay of $15 for retail, $37.50 for home delivery, $260 for Specialty; after deductible is met. • Up to 31 day supply/90 day for home delivery (In-network). • For certain preventive medications the deductible is waived. • Specialty medications are limited to a 31 day supply. **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions.

Surest Health PPO	Surest Select Health PPO	HDHP
Tier 2		
• $60 for up to a 30 day retail supply • $150 for up to a 90 day home delivery supply • $285 (In-network) for Specialty Retail Pharmacy • Specialty medications are limited to a 30 day supply **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions.	• $45 for up to a 30 day retail supply • $112.50 for up to a 90 day supply for home delivery • $225 (In-network) for Specialty Retail Pharmacy • Specialty medications are limited to a 30 day supply **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions	• 80% covered; minimum copay of $60 for retail, $150 for home delivery, $285 for Specialty; after deductible is met. • Up to 31-day supply/90 day for home delivery (In-network). • For certain preventive medications the deductible is waived. • Specialty medications are limited to a 31 day supply. **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions.
Tier 3		
• $180 for up to a 30 day retail supply • $450 for up to a 90 day home delivery supply • $360 (In-network) for Specialty Retail Pharmacy • Specialty medications are limited to a 30 day supply **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions.	• $150 for up to a 30 day retail supply • $375 for up to a 90 day supply for home delivery • $300 (In-network) for Specialty Retail Pharmacy • Specialty medications are limited to a 30 day supply **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions.	• 70% covered; minimum copay of $180 for retail, $450 for home delivery, $360 for Specialty; after deductible is met. • Up to 31-day supply/90 day for home delivery (In-network). • For certain preventive medications the deductible is waived. • Specialty medications are limited to a 31 day supply. **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions
Tier 4		
• $360 for up to a 30 day retail supply • $900 for up to a 90 day home delivery supply • $460 (In-network) for Specialty Retail Pharmacy • Specialty medications are limited to a 30 day supply **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions.	• $300 for up to a 30 day retail supply • $750 for up to a 90 day supply for home delivery • $400 (In-network) for Specialty Retail Pharmacy • Specialty medications are limited to a 30 day supply **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions.	• 60% covered; minimum copay of $360 for retail, $900 for home delivery, $460 for Specialty; after deductible is met. • Up to 31-day supply retail and Specialty/90 day for home delivery (In-network). • For certain preventive medications the deductible is waived. • Specialty medications are limited to a 31 day supply. **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions.

Specialty Medications – Out-of-network coverage is not covered.

Good to know — Surest plans

- $0 deductible — coverage starts at your first visit or first prescription.
- Clear upfront prices — know what you'll pay before you go.
- Lower copays for higher-quality providers.
- If you are enrolled in a Surest health plan, you can find prices in the Surest App, or at benefits.surest.com, or, for pre-members, at lumen.com/joinsurest.

Good to know — HDHP

- You can pick any provider, but In-network costs less.
- You pay full cost until you meet your deductible.
- Lumen does not offer an HSA for COBRA participants.
- If you are enrolled in the UHC HDHP, you can find prices in the UnitedHealthcare App, or at myuhc.com, or, for pre-members, at lumen.com/exploreuhc.

Dental Plan overview

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

This chart is only a snapshot summary of dental benefits. For a Schedule of Benefits, please refer to the Dental Summary Plan Description (SPD) on InsideLumen, in the **Reference Center** on the Health and Life website or by contacting Metlife.

Dental Option 1	Dental Option 2 (with orthodontia)
Plan year benefit maximum per individual	
$1,000 (does not include oral surgery)	$2,000 (does not include oral surgery or orthodontia care)
Orthodontia lifetime benefit maximum per individual	
N/A	$1,500 (separate from Plan year benefit maximum per individual)
Plan year deductible per individual	
$25 for Type B and Type C; $0 deductible for Type A and Type B: Oral surgery only	$50 for Type B and Type C; $0 deductible for Type A and Type B: Oral surgery only
Lifetime orthodontia care deductible per individual	
N/A	$50
Type A = Diagnostic and preventive care (cleanings and exams)	
100%* up to maximum allowable amount; two visits per year	100%* up to maximum allowable amount; two visits per year
X-rays	
Full mouth X-rays covered once every 60 months; bitewing X-rays covered once per year, except for dependent children under age 26 who are eligible for bitewing X-rays twice per year.	Full mouth X-rays covered once every 60 months; bitewing X-rays covered once per year, except for dependent children under age 26 who are eligible for bitewing X-rays twice per year.
Type B = General care (fillings, root canals and periodontics)	
50%* up to maximum allowable amount	80%* up to maximum allowable amount
Type C = Major services (crowns, dentures and bridges)	
50%* up to maximum allowable amount	50%* up to maximum allowable amount
Type B = Oral surgery — No deductible	
80%* no limit	80%* no limit
Type D = Orthodontia care (adult and children)	
Not covered	50%* up to the maximum allowable amount after the lifetime orthodontia deductible, per individual (separate from Plan year deductible per individual)

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

Passive PPO In and Out-of-network Your Dental PPO plan is passive, meaning that you will pay the same coinsurance levels, have the same deductible requirements and be allotted the same benefit maximum value regardless of going In or Out-of-network. In-network services are subject to MetLife's negotiated Plus network rates. Out-of-network services will be subject to the reasonable and customary charges. You may have additional out of pocket costs for services received from Out-of-network providers.

You pay the same coinsurance, have the same deductible requirements, and receive the same benefit maximum either way.

When you use an in-network provider, services are based on MetLife's negotiated PDP Plus network rates. PDP Plus is MetLife's national dental network, where participating providers agree to charge lower rates for covered services.

You may still use an out-of-network provider, but you could have additional out-of-pocket costs. Out-of-network services are based on reasonable and customary charges.

Visit metlife.com/dental to determine if your provider is in-network or to find a provider.

Under **Dental Insurance Plan Participants**:

- Select **Find a Participating Dentist**.
- In the **Your Network** dropdown, choose **PDP Plus** (do not select **PDP**, as it is a different network).
- Enter your **ZIP code** or select **Use Current** Location.
- If you know the **Dentist or Practice Name**, enter the information. This is optional and not required.
- Click **Find**.

Look for MetLife SpotLite providers

SpotLite identifies in-network MetLife providers who focus on preventive care and strong long-term oral health outcomes. All SpotLite providers are in-network, but not all in-network providers are SpotLite providers.

To find a SpotLite provider, go to mybenefits.metlife.com and search for the **Find a Provider** tool and look for providers marked with the Spotlite designation.

If you are unable to access the website, you can contact MetLife Dental at 800-GETMET8, 800-438-6388, and let the customer service representative know you are looking for providers in the PDP Plus network.

Vision Plan overview

The vision plan is a fully insured, participant-pay-all model offered by EyeMed, (aka EyeMed Vision Care/First American Administrators). This means that you will be responsible for the full premium deduction cost. You can choose the vision plan option or elect to waive coverage. Staying In-Network helps you save money on eye exams, contact lenses, and frames and lenses with a variety of options through **Insight** (name of the In-Network benefit) to help save you more. PLUS Providers are distinguished on EyeMed's website when looking for a provider in a specified area. Since PLUS Providers are already through Insight, the additional perks are built right into your vision benefits. No promo codes, no coupons, no paperwork but you still have the same vision benefits, plus a little more savings.

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

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

Note: Dependent(s) can enroll in vision coverage if the LTD participant is enrolled in vision coverage. If the LTD participant waives vision coverage, the dependent(s) waive coverage.

Vision care services	In-network cost using Plus providers	In-network cost	Out-of-network reimbursement
Examination services			
Exam (with dilation as necessary)	$0 copay	$10 copay	Up to $40
Retinal imaging	$0 copay	$0 copay	Up to $20
Low vision supplemental exam/testing	$0 copay	$0 copay	Up to $125
Low vision aids	25% copay up to a maximum of $1,000	25% copay up to a maximum of $1,000	25% copay up to a maximum of $1,000
Contact lens (allowance includes materials only)			
Conventional	$0 copay; 15% off balance; over $195 allowance	$0 copay; 15% off balance; over $170 allowance	Up to $119
Disposable	$0 copay; 100% of balance over $195 allowance	$0 copay; 100% of balance over $170 allowance	Up to $119
Medically necessary	$0 copay; paid-in-full	$0 copay; paid-in-full	Up to $210
Contact lens fit and two follow-ups			
Fit and follow-up - standard	Up to $40 ;contact lens fit and two follow-up visits	Up to $40; contact lens fit and two follow-up visits	Not covered
Fit and follow-up - premium	10% off retail price	10% off retail price	Not covered
Frame in lieu of contacts (any available frames at Provider locations)			
Frame	$0 copay; 20% off balance over $205 allowance	$0 copay; 20% off balance over $180 allowance	Up to $126
Standard plastic lenses (in lieu of contacts)			
Single vision	$25 copay	$25 copay	Up to $30
Bifocal	$25 copay	$25 copay	Up to $50
Trifocal	$25 copay	$25 copay	Up to $70
Lenticular	$25 copay	$25 copay	Up to $70

Vision care services	In-network cost using Plus providers	In-network cost	Out-of-network reimbursement
Progressive - standard	$25 copay	$25 copay	Up to $50
Progressive - premium tier 1	$110 copay	$110 copay	Up to $50
Progressive - premium tier 2	$120 copay	$120 copay	Up to $50
Progressive - premium tier 3	$135 copay	$135 copay	Up to $50
Progressive - premium tier 4	$200 copay	$200 copay	Up to $50
Lens options			
Anti reflective coating - standard	$45 copay	$45 copay	Up to $5
Anti reflective coating – premium tier 1	$57 copay	$57 copay	Up to $5
Anti reflective coating – premium tier 2	$68 copay	$68 copay	Up to $5
Anti reflective coating – premium tier 3	$85 copay	$85 copay	Up to $5
Photochromic – non-glass (plastic)	$0 copay	$0 copay	Up to $5
Polycarbonate – standard	$40 copay	$40 copay	Not covered
Polycarbonate – standard – under 19 years of age	$0 copay	$0 copay	Up to $5
Scratch coating – standard plastic	$15 copay	$15 copay	Not covered
Tint – solid or gradient	$0 copay	$0 copay	Up to $5
UV treatment	$15 copay	$15 copay	Not covered
All other lens options	20% off retail price	20% off retail price	Not covered
Low vision			
Supplemental exam/testing	$0 copay	$0 copay	Up to $125 allowance (no reimbursement)
Aids	25% copayment up to the maximum of $1,000	25% copayment up to the maximum of $1,000	25% copayment up to the maximum of $1,000
Member savings (enrollees who register on EyeMed's website receive additional savings)			
Additional pairs of glasses, conventional lenses	40% off additional pairs of glasses.	40% off additional pairs of glasses.	Not covered
Non-prescription sunglasses and other items not covered by Plan* ***Note:** Safety glasses and Provider's professional services or contact lenses are not eligible for coverage under the Plan.	20% off	20% off	Not covered
Hearing care from Amplifon Hearing Health Care network (Call 877-203-0675)	Up to 66% off hearing aids, with an extended warranty including free batteries.	Up to 66% off hearing aids, with an extended warranty including free batteries.	Not covered
LASIK or PRK from U.S. Laser network (Call 800-988-4221)	15% off retail or 5% off promotional price	15% off retail or 5% off promotional price	Not covered

Frequency	
Exam	Once every plan year
Frame	Once every plan year
Lenses (in lieu on contact lenses)	Once every plan year
Contact lenses (in lieu of lenses)	Once every plan year
Low vision	Once every other plan year

Definition of contact lens fit

- **Standard contact lens fit -** Clear, soft, spherical, daily wear contact lenses for single vision prescriptions. Standard contact lenses does not include extended or overnight wear lenses, which are intended to be worn during periods of sleep.
- **Premium contact lens fit -** Toric, multifocal, monovision, post-surgical, gas permeable contact lenses, and other non-standard contact lenses. Premium contact lens includes extended and overnight wear lenses, which are intended to be worn during periods of sleep.

Offered by: EyeMed **Group number:** 1061657 **Phone number:** 855-874-4744

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

Claims and appeals for enrollment issues

If you wish to file a claim or appeal regarding eligibility or enrollment for you and/or your eligible dependent(s) in a benefit Plan option or change in benefit Plan options, you must submit a Claim Initiation Form which is available in the **Reference Center** on the Health and Life website.

Decisions concerning the Plan

Claims and appeals are reviewed, and decisions are made based on benefit Plan provisions. The Benefits Appeals Committee, the Claims Administrators and the Plan Administrator have each been delegated the sole and absolute discretion to make decisions with respect to questions and requests related to the benefits under the Plan. This includes but is not limited to interpreting the Plan Document and determining eligibility for benefits.

The time frame for making an initial claim for a premium payroll adjustment is the earlier of: (1) within 180 calendar days of an adverse decision by the Plan Administrator, or (2) the earlier (a) within 180 calendar days of the effective date of an election claimed to be erroneous, or (b) by the last day of the Plan year of when the election error is claimed to have occurred. If the initial claim is not filed by this deadline, it shall be deemed untimely and denied on that basis.

Important: In selecting your coverage and advising of your and your dependents' eligibility, if applicable, you are held to the standard of honesty and truthfulness. Falsifying or omitting information in enrolling for coverage under the Plan will subject you to disciplinary action, up to and including termination. If you have questions about whether your responses during the enrollment process are accurate, please call the Service Center.

Note: Each Plan has its own claims and appeal process for benefit claims. Refer to the applicable SPD for additional information regarding these procedures.

In most cases, claims and appeals are reviewed within 30 calendar days of receipt, but additional time may be required. Health care claims are reviewed sooner if they are related to pre-service or urgent claims. Call the Service Center for further assistance or to ask additional questions regarding the claims and appeals process after reviewing the SPDs.

If an appeal is approved on a retroactive basis, you may experience retroactive premium due. For example, if your appeal is approved and your medical coverage level changes from Individual Only to Individual + Family, you will be responsible for paying the retroactive benefit premium difference between the Individual Only and Individual + Family coverage amount. Review any and all premiums for accuracy.

Legal and important required notices

Review the Lumen Welfare Benefits Plan General Information Summary Plan Description (SPD) in the **Reference Center** on the Health and Life website for additional information.

A note about privacy

Keeping your personal information secure is of primary importance. That's why we, along with the Claims Administrators, have implemented various security measures and policies to help reduce the risk of unauthorized processing or disclosure of your personal information. You can also help by keeping your User ID and Password confidential for accessing websites. Please keep this information safe and don't share it with anyone. Never use your Social Security number as your password. Together, we can make sure your personal information stays safe and secure. We encourage you to add your personal email address as your **Personal Preferences** in your **Profile** on the Health and Life website. For assistance on how to add or change to a personal email address, contact the Service Center.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. You can review the complete notice, in the **Reference Center** on the Health and Life website, or by calling the Service Center at 833-925-0487 to request a copy.

California Department of Managed Health Care Notification

Grievance Process and Independent Medical Review

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

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

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

Clerical Error

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 or premium under the Plan. You have an obligation to correct any errors or omissions that come to your attention by calling the Service Center at 833-925-0487.

Company's reserved rights

The Company reserves the right to amend or terminate any of the benefits provided in the Plan. For more information, review the Lumen Welfare Benefits Plan General Information Summary Plan Description (SPD) in the **Reference Center** on the Health and Life website.

Coverage is not advice

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

Health Care Reform Requirements

Medical Plan benefit options under the Health Care Plan comply with the Health Care Reform benefit coverage and affordability requirements. As long as you are enrolled in a Medical Plan benefit option in 2026, your coverage will meet (or exceed) the mandated affordability and coverage requirements. Since the Company's Medical Plan benefit options meet Health Care Reform requirements, it is unlikely you will receive any kind of financial help (subsidy) from the government to pay for any coverage you may purchase from a public exchange.

If you voluntarily elect to end coverage

If you voluntarily end coverage for yourself or a dependent during Annual Enrollment, without there being a Qualified Life Event (QLE), you and/or your dependent(s) will not be eligible for continuation of health care coverage under the federal law known as COBRA. Eligibility for COBRA continuation coverage occurs only in cases of QLEs. For more information on what is a QLE, refer to the Lumen Welfare Benefits Plan General Information Summary Plan Description (SPD) available in the **Reference Center** on the Health and Life website.

Important note regarding enrollment elections

By electing to participate in the Plan, by your submission of information, you have agreed to be bound to and by the provisions of each of the plans and their administrative practices, including, but not limited to with respect to the recovery of over and underpayments, terms and conditions for eligibility and benefits. You certify that the submission of information by you in this enrollment process is true and accurate to the best of your knowledge; you agree that you'll submit new information timely as changes occur. You understand that if you are found to have falsified any document in support of a claim for eligibility or reimbursement, the Plan Administrator may, subject to and may be permitted under the requirements of law, without anyone's consent, terminate your and/or your dependent's coverage, and the Claims Administrator may refuse to honor any claims you or your dependent(s) may have made or will make under the Plan, if applicable. You understand that you are liable and bear the full financial responsibility for the misappropriation of Plan funds through the filing of false documentation under any of the plans; You certify that you and your dependent(s) are eligible to enroll in a benefit option, plan or program including voluntary or supplemental/optional coverages. Please refer to the applicable Plan Document or SPD in the **Reference Center** on the Health and Life website for details about eligibility for coverage or call the Claims Administrator - limitations may apply including, but not limited to, being actively at work (and if returning, working at least one full work day) in order to be eligible for coverage. You understand that it is your responsibility to confirm your eligibility to enroll in a benefit option; enrolling in and paying for coverage for which you are ineligible will not entitle you or your dependent(s) to benefits; you understand that it is your responsibility to terminate benefit coverage once you or your dependent(s) become ineligible, for example, due to death or a divorce. This excludes dependent child(ren) who turn age 26, as they are automatically removed from coverage at the end of the month they turn age 26. **Note:** In the case of a divorce, even if your court order indicates you must continue providing health care and/or life benefits for your ex-spouse, the Plan doesn't allow ex-spouse's coverage. You will need to remove your ex-spouse from all Lumen benefits.

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

Women's Health and Cancer Rights Act

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

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

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

You should carefully review the provisions of the Plan, the medical benefit option in which you elect to participate, and its SPD and SMM (if any) in the **Reference Center** on the Health and Life website regarding any applicable restrictions. Contact the Claims Administrator of your medical benefit option for more information.