Vision Plan Option

Summary Plan Description (SPD) for eligible active employees

Effective January 1, 2027

To request a paper copy of this SPD, call the Lumen Health and Life Service Center at 833-925-0487, or print this document.

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Introduction

Lumen Technologies* (hereinafter "Lumen" or "Company") is pleased to provide you with this Summary Plan Description ("SPD"). This SPD presents an overview of the Benefits available under the Vision Plan benefit option of the Lumen Welfare Benefits Plan* (the "Plan"). The SPD also presents the rights and responsibilities of you and the Company under the Plan. Vision benefits are offered through EyeMed Vision Care, LLC ("EyeMed"). Claims are handled through First American Administrators, Inc. ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care, LLC.

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

The effective date of this updated SPD is January 1, 2027. If you are a Covered Person in the Vision Plan benefit option on or after January 1, 2027, this SPD supersedes and replaces, in its entirety, any other SPD describing the Vision Plan that you currently may possess. Specific details are contained in the official Plan Document and/or Trust agreements which legally govern the operation of the Plan. In the event of any discrepancy between this SPD and the official Plan Document, the Plan Document shall govern.

This SPD, together with other plan documents (such as the Summary of Material Modifications (SMMs), the General Information SPD and materials you receive at Annual Enrollment) (hereafter "Plan documents") briefly describe your Benefits as well as rights and responsibilities, under the Lumen Welfare Benefits Plan (the "Health Plan"). These documents make up your official Summary Plan Description for the Employees enrolled in the Vision Plan benefit option as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Vision Plan benefit option under the Plan is self-funded; however, certain other benefit plan options under the Plan may be insured.

Note: This SPD is for active Lumen employees who are eligible to enroll in the vision plan benefit option. The General Information SPD provides overall guidance including but not limited to: administration contacts, the Company's reservations of rights, the Company's rights and Claims and Appeals.

Reserved Rights

The Company reserves the right to amend or terminate any of the Benefits provided in the Plan – with respect to all classes of Covered Person, without prior notice to or consultation with any Covered Person, subject to applicable laws and if applicable, the collective bargaining agreement.

The Plan Administrator, the Employee Benefits Committee, and its delegates(s), has the right and discretion to determine all matters of fact or interpretation relative to the administration of this Vision Plan benefit option—including questions of eligibility, interpretations of the Vision 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. More information about the Plan Administrator and the Claims Administrator can be found in the General Information SPD. **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 "Time Deadline to File a Benefit Claim and the Time Deadline to File a Benefit-Related Lawsuit" found in this SPD.

How to use this SPD

This SPD is provided to explain how the Plan works. It is designed to provide you with a general description in non-technical language of the benefits currently offered under the Vision Plan benefit option. 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 each Covered or Eligible person in every situation. All of the specific rules governing the Plan are contained in the Plan Document and applicable insurance policies. This SPD is not the Plan Document. You and your beneficiaries/eligible dependent(s) may examine the Plan Document and other documents related to the Vision Plan benefit option during regular business hours or by appointment at a mutually agreed upon convenient time in the office of the Plan Administrator. You may also request to receive copies of the Plan Document and insurance policies by making a request to the Plan Administrator in writing. There is a per page charge for the copying expenses. For additional information, refer to the A Statement of Your ERISA Rights in the General Information SPD. If any terms of the Plan Document conflict with the contents of the SPD, the Plan Document will always govern.

Capitalized terms are defined throughout this SPD and in the General Information SPD. All uses of "we," "us," and "our" in this document, are references to the EyeMed/FAA Claims Administrator, or Lumen. References to "you" and "your" are references to people who are Covered Persons, also known as Participants, Individuals and Eligible Dependents as the term is defined in the General Information SPD.

You are encouraged to read and keep all the SPDs and any attachments (summary of material modifications ("SMMs"), amendments, and addendums) for future reference. Many of the sections of this SPD are related to other sections. You may not have all 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.

Health Plan Determinations are not health care advice

Please keep in mind that the sole purpose of the Plan is to provide for the payment of certain health care expenses and not to guide or direct the course of treatment of any Employee, or eligible Dependent(s). Just because your health care Provider recommends a course of treatment does not mean it is approved and payable under the Plan. A determination by the Claims Administrator or the Plan Administrator that a particular course of treatment is not eligible for payment or is not covered under the Vision Plan does not mean that the recommended course of treatments, services, supplies, or procedures should not be provided to Covered Persons or that they should not be provided in the setting or facility proposed. Only you and your health care Provider can decide what is the right health care decision for you. Decisions by the Claims Administrator or the Plan Administrator are solely decisions with respect to Plan coverage and do not constitute health care recommendations or advice.

You may not assign your health care Benefits to your provider or any third party

Employees/Individuals and Eligible Dependents may not voluntarily or involuntarily assign to a physician, hospital, pharmacy or other health care Provider or any third party (your "Providers") any right you have (or may have) to:

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

The Health Plan prohibits Employees/Individuals 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 Health Plan, or to file a lawsuit against the Health Plan, the Company, the Plan Administrator, the Claims Administrator, the Appeals Administrator or any other Plan fiduciary, administrator or sponsor with respect to Health Plan benefits or any rights relating to or arising from participation in the Health Plan. If Employees/Individuals and Eligible Dependents attempt to assign any rights in violation of the Health Plan terms, such attempt will not be effective. It will be void or otherwise treated as invalid and unenforceable.

This Health Plan provision will not interfere with the Health Plan's rights 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 Employees/Individuals' and Eligible Dependents' rights to the Provider or waive the Health Plan's rights to enforce the Health Plan's anti-assignment terms. Any such direct payment to a Provider shall be treated as though paid directly to the Employees/Individuals and Eligible Dependents and shall satisfy the Health Plan's obligations under the Health Plan.

Similarly, you may not assign your disability benefits to your provider or any Third Party.

Lumen's rights to use your Social Security number for Administration of Benefits

Lumen retains the right to use your Social Security Number (including any Social Security Number of your eligible dependents' enrolled in a benefit plan) for benefit administration purposes, including tax reporting. If a state law restricts the use of Social Security Numbers for benefit administration purposes, the Company generally takes the position that ERISA preempts such state laws.

General Plan information

The Vision Plan benefit option is just one benefit option offered under the Plan. This SPD must be read in conjunction with the General Information SPD which explains details of your coverage and provides a listing of the other benefit options under the Plan.

Refer to the General Information SPD for important and general Plan information including, but not limited to, the following sections:

- Eligibility
- When Coverage Begins
- When Coverage Ends
- How to Appeal a Claim
- Circumstances that May Affect Your Plan Benefits
- The Plan's Right to Restitution
- Plan Information (e.g. Plan Sponsor and EIN, administration, contact information, Plan Number, etc.)
- A statement of your ERISA Rights
- Notice of HIPAA Rights
- Your Rights to COBRA and Continuation Coverage
- General Administrative Provisions
- Required Notice and Disclosure
- Glossary of Defined Terms
- Qualified Medical Child Support Order (QMSCO)

You can go online to lumen.com/healthandlife (if actively working) or lumen.com/healthbenefits to obtain an electronic copy or call the Service Center at 833-925-0487 or 800-729-7526, option 1 and option 1 to request a paper copy of the General Information SPD that can be mailed to you at no cost.

You must follow 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 at the Company 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.

Keep the Plan Administrator updated with information of all address changes

In order to receive benefit communications timely, you should keep your mailing address updated through SuccessFactors available on the Intranet. You should also go onto the Plan Administrator's website and enter how you wish to receive benefit communications. Lumen strongly recommends you do not list your work email address but instead list your personal email address. Lumen nor the Plan Administrator can guarantee your privacy when using your work email address and some communications will purposely not be sent to your work email address.

Plan year

The Plan year shall start January 1 and end December 31. The Benefits and Payroll Schedule may have more than 26 pay periods in a Plan year and is not based on the calendar year. You can review the schedule on the Intranet.

Benefits under the Plan are furnished in accordance with the Plan Document issued by the Lumen Employee Benefits Committee (EBC), including this SPD. Participants' rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA) and the procedures to be followed in regard to denied claims or other complaints relating to the Plan are set forth in the body of this SPD.

Plan Number

The Plan Number for the Vision Plan is 513. Vision benefits are offered through EyeMed Vision Care, LLC ("EyeMed"). Claims are handled through First American Administrators, Inc. ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care, LLC.

Claims & Plan Administrators and contact information

Claims Administrator:	EyeMed/FAA Customer Care Center P.O. Box 8504 Mason, OH 45040-7111 855-874-4744 lumen.com/eyemed Group Number: 1061657
Plan Administrator:	Lumen Health and Life Service Center at Businessolver (aka Service Center) P.O. Box 850552 Minneapolis, MN 55485-0552 833-925-0487 or 800-729-7526 option 1, option 1
Website Address:	lumen.com/healthandlife (if actively working) or lumen.com/healthbenefits

Consequences of falsification and misrepresentation

You will be given advance written notice that coverage for you or your Dependent(s) will be terminated if you or your Dependent(s) are determined to falsify or intentionally omit information, submit false, altered, or duplicate billings for personal gain, allow another party not eligible for coverage to be covered under the Plan or obtain Plan Benefits, or allow improper use of you or your Dependent's coverage. Continued coverage of an ineligible person is considered to be a misrepresentation of eligibility and falsification of, or omission to, update information to the Plan, which is in violation of the Code of Conduct and may result in disciplinary action, up to and including termination of employment. This misrepresentation/omission is also a violation of the Plan document, Section 8.3 which allows the Plan Administrator to determine how to remedy this situation. For example, if you divorce, your former spouse is no longer eligible for Plan coverage and this must be timely reported to the Service Center within 45 days, regardless if you have an obligation to provide health insurance coverage to your ex-spouse through a Court Order. Lumen does not allow ex-spouse's to be covered.

- You and your Dependent(s) will not be permitted to benefit under the Plan from your own misrepresentation. If an individual is found to have falsified any document in support of a claim for Benefits or coverage under the Plan, the Plan Administrator may, without anyone's consent, terminate coverage, possibly retroactively, if permitted by law (called "rescission"), depending on the circumstances, and may seek reimbursement for Benefits that should not have been paid out. Additionally, the Claims Administrator may refuse to honor any claim under the Plan or to refund premiums.
- While a court may order that health (vision) coverage must be maintained for an ex-spouse/domestic partner, that is not the responsibility of the Company and is not a covered eligibility under the Plan.
- You are also advised that by participating in the Plan, you agree that suspected incidents of this nature may be turned over to Plan Administrator and/or Corporate Security to investigate and to address the possible consequences of such actions under the Plan. You may be periodically asked to submit proof of eligibility and to verify claims.

Note: All Individuals by their participation in the Plan authorize validation investigations of their eligibility for Benefits and are required to cooperate with requests to validate eligibility by the Plan and its delegates.

Questions?

If you are an Employee/Individual or an eligible Dependent of an Employee/Individual who has questions or needs information about your Plan benefits, you first should call the telephone number on your ID card during regular business hours. Alternatively, and for information regarding other Plan benefits, you can call the telephone numbers listed on the Contact Information Chart within the General Information SPD. However, if the Claims Administrator is unable to answer your questions, contact the Service Center at 833-925-0487 or 800-729-7526 option 1, option 1 for further assistance.

Dual Coverage

Lumen benefit plan provisions prohibit any individual from being enrolled in dual coverage in the Company's vision benefit plan option. These provisions mean that:

- Lumen Employee/Individual cannot elect coverage for themselves while being enrolled as a qualified Dependent under another Lumen Employee's coverage; and
- Two Lumen Employees whether active or on a type of leave but still eligible for Vision coverage cannot enroll the same qualified Dependent in coverage separately.
- If you elect coverage during Annual Enrollment and are also covered under the same Plan(s) as a Dependent on another Employee's coverage, your coverage will be corrected once the enrollment period ends. You will remain in coverage under your own record but will be removed as a Dependent from the other Employee's coverage.

Choosing your coverage level

Active Employees: If you are a Full-Time Eligible Employee, you have the following coverage categories to choose from when enrolling in medical, dental and vision coverage under the Health Plan:

- Individual only
- Individual and Spouse/Domestic Partner
- Individual and Child(ren)
- Individual and Family (consisting of a Spouse/Domestic Partner and one or more dependent Children)
- Waive (no coverage)

You can change your coverage level during the year, subject to the limits on when coverage begins (see the Qualified Life Events section for more information).

Health Plan

Your contribution level, also know as "premium deductions" for the vision coverage available to you and your eligible Dependents is based on 2 things: your status on the payroll system and what coverage level you elect for the vision plan.

Benefits under the Plan are paid from the general assets of the Plan Sponsor. Any required Employee contributions (also known as "Premiums from your Paycheck") are used to partially reimburse the Plan Sponsor for Benefits under the Plan.

Tax Status of Health Care contributions

If you are an active Employee receiving a regular salary, your contribution will be deemed to be a salary reduction election (pre-tax or before-tax), and any such contributions will be deducted from your pay before taxes, as long as your pay is sufficient.

Tax implications of enrolling your Domestic Partner under the Health Plan

When adding a Domestic Partner or a Child/ren of a Domestic Partner to one or more of your healthcare plans (medical, dental and vision), you will have imputed income calculated on the value of the Company premium paid for your Domestic Partner or Child(ren) of your Domestic Partner. If you wish to enroll your Domestic Partner there are federal and possibly state tax implications. The federal Internal Revenue Code considers the fair market value of this health care coverage to be imputed income to you, which means you will be taxed according to state and federal laws. The Company will report the annual amount of this imputed income on your W-2 Form at the end of each year. It is also listed on your paycheck reflected in Current and YTD contributions. Before enrolling your Domestic Partner, you should talk with your tax advisor about the tax implications for you.

Payment of contributions

If you are an active Eligible Employee, you are responsible for paying your portion of the contributions/premiums each pay period that you are receiving covered benefits. If you work or receive pay even one day within a pay period, you will have the full/total premium amount deducted from your paycheck.

If at any time you experience a payroll adjustment for health and/or life benefits coverage, the payroll adjustment will process in accordance with the Benefits and Payroll schedule or as soon as administratively possible. Employees will be responsible for any retroactive deductions including missed deductions on subsequent pay periods.

If at any time you are eligible for a credit of a health care premium adjustment, the credit will process as a lump sum payment for the retroactive premium credit in accordance with the next payroll schedule.

Reminder to review your paycheck

- Review your paycheck along with the Lumen Benefits and Payroll schedule (available on the Intranet) to confirm your benefit premium costs for Health & Life including Savings and Spending Accounts. Any questions related to benefit premiums should be directed to the Lumen Health and Life Service Center 833-925-0487 or 317-671-8494 (International callers) or 800-729-7526, option 1, option 1. Do not contact the Lumen Payroll Department as the Payroll staff will be unable to assist you.
- If your benefit premium deductions are not correct or not what you expect, you must make a claim to the Plan Administrator in accordance with the claim's procedures as soon as possible after the year's payroll deductions begin.

Vision Plan Benefit features

Procedures for using the Vision Plan Benefits

If you choose to receive plan benefits from a member provider, contact EyeMed or an EyeMed member provider directly. A list of names, addresses and phone numbers of member providers in your geographic location can be obtained from EyeMed at lumen.com/eyemed or 855-874-4744. For the TTY, the caller should dial 711 and ask the relay operator to call 844-230-6498.

EyeMed will provide benefit authorization directly to the EyeMed member provider. If you contact the EyeMed member provider directly, you must identify yourself as an EyeMed member, so the provider knows to obtain benefit authorization from EyeMed.

When such benefit authorization is provided by EyeMed and services are performed prior to the expiration of the benefit authorization, this will constitute a claim against the Plan in spite of your termination of coverage or the termination of the Plan. Should you receive services from a member provider without such benefit authorization or obtain services from a provider who is an Out-of-Network provider, you are responsible for payment in full to the provider.

You will initially pay only the copayment to an EyeMed member provider for services covered by the Plan. EyeMed will pay the member provider directly according to their agreement with the provider.

When you use an Out-of-Network provider, you pay the provider his/her payment in full. You will be reimbursed by EyeMed up to the maximums as outlined in the Summary of Vision Benefits. Refer to the chart in this SPD.

In emergency conditions, when immediate vision care is necessary, you can obtain covered services by contacting an EyeMed member provider directly. Emergency vision care is subject to the same benefit frequencies, plan allowances, copayments, limitations and exclusions.

In the event of termination of a member provider's membership with EyeMed, EyeMed will remain liable to the member provider for services rendered to you at the time of termination and permit the member provider to continue to provide with plan benefits until the services are completed or until EyeMed makes reasonable and appropriate arrangements for the provision of such services by another member provider.

Benefit Authorization Process

EyeMed authorizes plan benefits in accordance with the latest eligibility information furnished to EyeMed by Lumen and/or the Service Center. When you request services under the Plan, your prior utilization of plan benefits will be reviewed by EyeMed to determine if you are eligible for new services based upon the Plan's level of coverage.

Payment of Vision Plan Benefits

The EyeMed Vision Plan will make a benefit determination as set forth in the contractual agreement. Benefits will be paid to the EyeMed member provider. Benefits will be paid to you when using an Out-of-Network Provider, except when noted.

Note: If you are enrolled in the Health Care Flexible Spending Account, you may be able to pay your portion of the Vision expense with your Health Care Spending Card and avoid the need to file for a claim reimbursement. See the Traditional/ Limited and Dependent Day Care Flexible Spending Accounts (FSAs) SPD for more information.

Timely filing of Out-of-Network Claims

All claim forms for Out-of-Network services must be submitted within 15 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by the Claims Administrator.

Coordination with Vision Benefit Options

The Vision Benefit plan does not use the standard COB process. Regardless if you or your eligible dependent have other vision coverage elsewhere, EyeMed only processes as “primary” plan coverage. They do not process as “secondary” plan coverage.

Covered Vision Plan Benefits

This section is a summary of expenses covered by the EyeMed Vision Plan Option.

Plan Information

Lumen (hereinafter, "Employer") has selected EyeMed Vision Care, LLC ("EyeMed") as your vision care services provider (the "Plan"). The Plan, underwritten by Fidelity Security Life Insurance, provides coverage for routine vision exams, as well as eyeglasses and contact lenses.

This Summary reflects the Plan that will be in effect beginning January 1, 2027.

This Summary is based on the filed insurance documents. If there is a disagreement between the information contained in this Summary and the insurance documents, the insurance documents will govern. This Summary does not address Plan eligibility. Eligibility decisions are solely and exclusively determined by Employer.

The Insured benefits are underwritten by Fidelity Security Life Insurance Co. Discounts are provided by EyeMed Vision Care. If you have any questions or concerns, please contact EyeMed Vision Care at eyemed.com or 1-855-874-4744.

All claims are processed through First American Administrators ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care, LLC.

The EyeMed Network

EyeMed's network of providers includes private practitioners, as well as the nation's premier retailers, LensCrafters®, Target Optical, and most Pearle Vision locations. To locate EyeMed Vision Care providers near you, visit eyemed.com and choose the Insight Network. You may also call EyeMed's Customer Care Center at 1-855-874-4744. EyeMed's Customer Care Center can be reached Monday through Friday from 8:00 am to 11:00 pm, on Saturdays from 8:00 am until 11:00 pm and on Sundays from 11:00 am to 8:00 pm EST.

Online options

You can also use your in-network benefits to purchase glasses, contacts and prescription sunglasses online. Simply visit eyemed.com to see a list of participating online options where you can instantly apply your benefits at checkout.

PLUS Providers

You can choose to visit an in-network PLUS Provider for access to enhanced benefits to help you save even more:

- $0 exam copay
- $25 additional frame allowance
- $25 additional contact lens allowance

PLUS Providers are located nationwide and easy to find – just look for them using our Provider Locator at eyemed.com.

Using In-Network Providers

When making an appointment with the provider of your choice, identify yourself as an EyeMed member and provide your name and the name of your organization or Group number, located on the front of your ID card. Confirm the provider is an in-network provider for the Network. While your ID card is not necessary to receive services, it is helpful to present your EyeMed Vision Care ID card to identify your membership in the Plan.

When you receive services at a participating EyeMed Network Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

Using Out-of-Network Providers

If you receive services from an out-of-network Provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the Summary of Vision Benefits. To receive your out-of-network reimbursement, complete and sign an out-of- network claim form and attach your itemized receipts. For your convenience, you may submit your claim form in one of the three (3) following options:

- **Online:** FAA/EyeMed out-of-network claims can be completed online. To access the out-of-network form or to check the status of a claim, log in to Member Web and navigate to the Claims tab. Remember to upload an itemized paid receipt with your name included.
- **Mail:** First American Administrators, Inc., ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care:
  FAA/EyeMed Vision Care Attn: OON Claims
  P.O. Box 8504
  Mason, OH 45040-7111
- **Email:** You may also print a claim form and email it to us at oonclaims@eyemed.com or call the EyeMed's Customer Care Center at 1-855-874-4744.

Summary of Vision Benefits

	Your In-Network Cost at PLUS Providers	Your In-Network Cost	Your Out-of-Network Reimbursement*
EXAM SERVICES			
Exam	$0 copay	$10 copay	Up to $40
Retinal Imaging	$0 copay	$0 copay	Up to $20
CONTACT LENS FIT AND FOLLOW-UP			
Fit and Follow-Up - Standard	Up to $40	Up to $40	Not covered
Fit and Follow-Up - Premium	10% off retail price	10% off retail price	Not covered
FRAME			
Frame	20% off balance over $205 allowance	20% off balance over $180 allowance	Up to $126
STANDARD PLASTIC LENSES			
Single Vision	$25 copay	$25 copay	Up to $30
Bifocal	$25 copay	$25 copay	Up to $50
Trifocal	$25 copay	$25 copay	Up to $70
Lenticular	$25 copay	$25 copay	Up to $70
Progressive - Standard	$25 copay	$25 copay	Up to $50
Progressive – Premium Tier 1	$110 copay	$110 copay	Up to $50
Progressive – Premium Tier 2	$120 copay	$120 copay	Up to $50
Progressive – Premium Tier 3	$135 copay	$135 copay	Up to $50
Progressive – Premium Tier 4	$200 copay	$200 copay	Up to $50
LENS OPTIONS			
Anti-Reflective Coating - Standard	$45 copay	$45 copay	Up to $5
Anti-Reflective Coating – Premium Tier 1	$57 copay	$57 copay	Up to $5
Anti-Reflective Coating – Premium Tier 2	$68 copay	$68 copay	Up to $5
Anti-Reflective Coating – Premium Tier 3	$85 copay	$85 copay	Up to $5

	Your In-Network Cost at PLUS Providers	Your In-Network Cost	Your Out-of-Network Reimbursement*
Photochromic – Plastic	$0	$0	Up to $5
Polycarbonate – Standard	$40	$40	Not covered
Polycarbonate – Standard – Dependent Children	$0	$0	Up to $5
Scratch Coating – Standard Plastic	$15	$15	Not covered
Tint – Solid or Gradient	$0	$0	Up to $5
UV Treatment	$15	$15	Not covered
All Other Lens Options	20% off retail price	20% off retail price	Not covered
CONTACT LENSES			
Contacts - Conventional	15% off balance over $195 allowance	15% off balance over $170 allowance	Up to $119
Contacts-Disposable	100% of balance over $195	100% of balance over $170	Up to $119
Contacts - Medically Necessary	$0 copay; paid in full	$0 copay; paid in full	Up to $210
LOW VISION SERVICES			
Low Vision Supplemental Examination	$0 copay	$0 copay	Up to $125
Low Vision Aids	25% copay up to $1,000	25% copay up to $1,000	25% copay up to $1,000
OTHER			
Hearing Care from Amplifon Network	Discounts on hearing aids	Discounts on hearing aids	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	15% off retail price or 5% off promotional price	Not covered
FREQUENCY (Based on calendar year)			
Exam	Once every 12 months	Once every 12 months	Once every 12 months
Frame (in lieu of Contact Lenses)	Once every 12 months	Once every 12 months	Once every 12 months
Lenses (in lieu of Contact Lenses)	Once every 12 months	Once every 12 months	Once every 12 months
Contact Lenses (in lieu of Frames and Lenses)	Once every 12 months	Once every 12 months	Once every 12 months
Low Vision	Once every 24 months	Once every 24 months	Once every 24 months

Additional Discounts

Under the Plan, you may receive benefits for eyeglasses (frame and lenses) or contact lenses as outlined on the Summary of Vision Benefits. In addition, EyeMed provides an in- network discount on products and services once your in-network benefits for the applicable benefit period have been used. The in-network discounts are as follows:

- 40% off additional complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by the Plan at network providers

These in-network discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed Provider's professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy.

Discounts on services may not be available at all participating providers. Prior to your appointment, please confirm with your provider whether discounts are offered.

Definition of Contact Lens Fit

1. **Standard Contact Lens Fit -** Clear, soft, spherical, daily wear contact lenses for single vision prescriptions. Standard Contact Lens does not include extended or overnight wear lenses, which are intended to be worn during periods of sleep.

2. **Premium Contact Lens Fit -** Toric, multifocal, monovision, post-surgical, gas permeable contact lenses, and other non-Standard Contact Lenses. Premium Contact Lens includes extended and overnight wear lenses, which are intended to be worn during periods of sleep.

* You are responsible to pay the Out-of-Network provider in full at time of service and then submit an Out-of-Network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.

** For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes.

Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

Medically Necessary Contact Lenses

The Plan provides coverage for medically necessary contact lenses when one of the following conditions exists:

- **Anisometropia** of 3D in meridian powers
- **High Ametropia** exceeding -10D or +10D in meridian powers
- **Keratoconus mild/moderate -** when keratoconus is present and the member's vision is not correctable to 20/ 25 in either or both eyes using standard spectacle lenses
- **Keratoconus advanced/ectasia –** when keratoconus is present and one or more specified conditions are met
- Vision Improvement for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses

The benefit may not be expanded for other eye conditions even if you or your providers deem contact lenses necessary for other eye conditions or visual improvement.

Retinal Imaging

Retinal imaging has been provided as a $0 copay to your vision care benefit. Retinal imaging is a diagnostic tool that provides high-resolution, permanent digital records of your inner eye. Please consult with your Provider to determine if you are a candidate for retinal imaging.

Savings on Laser Vision Correction

EyeMed Vision Care, in connection with the U.S. Laser Network, owned and operated by LCA Vision, offers savings to you for LASIK and PRK. You are entitled to the following discounts:

$800 off LASIK at Featured Provider LasikPlus - or - at any other in-network provider you can receive 15% off standard price or 5% off any promotional price.

For additional information or to locate a network provider, visit eyemedlasik.com or call 1- 800-988-4221. Once you choose your provider, make sure to identify yourself as an EyeMed member to receive your discount and get further member instructions.

Hearing Discount Benefit with Amplifon Hearing Health Care

At EyeMed, we're all eyes and ears about your health and wellness. That's why we teamed up with Amplifon – the world's largest distributor of hearing aids and services to add affordable hearing care to your EyeMed vision benefits package.

Members receive a discount on hearing aids with a low-price guarantee. For additional information call 1-877-203-0675

Benefit limitations and exclusions

Your vision care plan contains several limitations and exclusions. Please see your Certificate of Insurance for a complete list.

Claims and Claims Appeals

You may authorize someone else to file and pursue a claim for benefits or an appeal on your behalf. If you do so, you must notify EyeMed Vision Care in writing of your choice of an authorized representative. Your notice must include the representative's name, address, phone number, and a statement indicating the extent to which he or she is authorized to act on your behalf. A consent form that you may use for this purpose will be provided to you upon request.

Time Frames for Processing Claims

FAA will decide claims within the time permitted by applicable state law, but generally no longer than 30 days after receipt. If FAA needs additional time to decide a claim, it will send you a written notice of the extension, which will not exceed 15 days. If FAA needs additional information from you in order to decide the claim, FAA will send you a written notice explaining the information needed. You will have 45 days to provide the information to FAA. If your claim is denied, in whole or in part, FAA will inform you of the denial in writing.

Time Frames and Procedures for Appealing Claims

If your claim is denied, in whole or in part, you may file an appeal. The appeal must be in writing and received by FAA within 180 days of your notice of the denial. If you do not receive an EOB within 30 days of submission of your claim, you may submit an appeal within 180 days after this 30-day period has expired. Your written letter of appeal should include the following:

- The applicable claim number or a copy of the written denial or a copy of the EOB, if applicable.
- The item of your vision coverage that the member feels was misinterpreted or inaccurately applied.
- Additional information from the member's eye care provider that will assist FAA in completing its review of the member's first-level appeal, such as documents, records, questions or comments.

The appeal should be mailed or faxed to the following address:
FAA/EyeMed Vision Care
Attn: Quality Assurance Dept. 4000 Luxottica Place
Mason, OH 45040
Fax: 1-513-492-3259

FAA/EyeMed will review your appeal and notify you in writing of its decision.

Complaint Procedure

If you are dissatisfied with an EyeMed Provider's quality of care, services, materials or facility or with EyeMed's Plan administration, you should first call EyeMed Customer Care Center at 1-866-939-3633 to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you may file a formal complaint with EyeMed's Quality Assurance Department at the address noted above. You may also include written comments or supporting documentation.

The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

ERISA

As a participant in the Lumen, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). For a detailed description of your rights, please refer to the Summary Plan Description ("SPD") document provided by your employer.

Enforce Your Rights

If your claim for vision benefits 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.

When you have completed all appeals mandated by ERISA, additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. You should contact the U. S. Department of Labor or the state insurance regulatory agency for details. Additionally, under ERISA (Section 502(a)(1)(B)), see, 29 U.S.C. 1132(a)(1)(B), you have the right to bring a civil (court) action when all available levels of review of denied claims, including the appeals process, have been completed, the claims were not approved in whole or in part, and you disagree with the outcome.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. Your Human Resources Department should be able to provide you with the name and contact information of your Plan Administrator...If you have any questions about this summary of vision care services or about your rights under ERISA, 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.