LUMEN RETIREE AND INACTIVE HEALTH PLAN

Retiree Healthcare Medical Plan 2

Summary Plan Description (SPD) for eligible retired and inactive former employees (Qwest Pre-1991 Retirees)

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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Special Note: This Summary Plan Description (SPD) provides information regarding the Lumen Retiree and Inactive Health Plan, specifically Qwest Pre-1991 Retiree Health Medical Plan 2, which is a benefit option of coverage for certain Qwest Retirees, Long-Term Disability participants and certain Dependents, as described in the "Who is Eligible" section of this SPD. This program is a part of the umbrella Lumen Retiree and Inactive Health Plan, which covers Pre-1991 (Pre-91) Retirees of Qwest which is now a part of Lumen, Inc. Unless otherwise specified, the word "Plan" as used in this SPD refers to the program of medical coverage explained in this Summary Plan Description.

The general administrative sections of this SPD also apply to the dental benefit options under the Lumen Retiree and Inactive Health Plan. See your Dental SPD for details regarding dental Benefits and plan design.

Administrator's Contact Information

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

Lumen Health and Life Service Center	833-925-0487 or 317-671-8494 (International callers) or 800-729-7526
COBRA/Direct Bill: For questions on "COBRA" or Direct Bill Benefits call the Lumen Health and Life Service Center	833-925-0487 or 317-671-8494 (International callers) or 800-729-7526 lumen.com/healthbenefits
UnitedHealthcare (UHC): To request a claim form or PPO directory or for any medical plan questions about claims, eligibility and Benefits. You are also encouraged to visit myuhc.com to take advantage of several self-service features including viewing your claim status, finding In-Network Physicians and ordering ID Cards.	800-842-1219
Care Coordination℠: Prior notification is required before you receive certain Covered Health Services. Contact Care CoordinationSM at the number shown on your UHC ID card before receiving these services. Refer to Notification Requirements later in this SPD for additional information.	800-842-1219
OptumRx (UHC Pharmacy Management): For any questions about your Retail or Home Delivery Prescription Drug Program (long-term maintenance drugs by mail).	800-842-1219
MetLife Dental Claims: Please refer to the SPD for the Dental options in which you participate for contact information.	866-832-5756
Mental Health/Substance Abuse	To arrange mental health/substance abuse pre-notification or to contact a care manager (available seven days a week, 24 hours a day), contact United Behavioral Health at 800-961-9378 (TDD line 800-842-9489).

Claim Administrator's Mailing Address	**Medical Claims:** To file medical claims, mail the claim form to: UnitedHealthcare Insurance Company Attention: Claims P. O. Box 30555 Salt Lake City, UT 84130 **Requests for Review of Denied Claims and Notice of Complaints:** **Medical Appeals/Complaints:** To file a medical appeal, mail the appeal to: UnitedHealthcare Appeals P.O. Box 30432 Salt Lake City, UT 84131 **Mental Health/Substance Abuse Appeals/Complaints:** For Covered Persons who file a formal written complaint, their advocate will be the appeals coordinator in Member Relations who will thoroughly investigate the matter and bring it to resolution. Resolution on formal complaints is communicated in writing within 30 days. You may submit written complaints to: United Behavioral Health Attn: Member Relations Department P.O. Box 30432 Salt Lake City, UT 84131

Introduction

The Retiree Health Care Medical Plan 2 is designed to provide you and your eligible Dependents with broad Hospital-surgical-medical and major medical protection against the cost of medical care. Certain provisions are also included in the Plan to encourage appropriate utilization of health care services such as the Well Connected care coordination program. This Medical Plan 2 benefit option is considered to be your "Guaranteed Coverage Commitment" benefit option under the Lumen Retiree and Inactive Health Plan (the "Health Plan").

The Retiree Health Care Medical Plan 2 was established January 1, 1991. The effective date of this revised Summary Plan Description is January 1, 2027. This SPD is typically updated or restated every 5-10 years, as Benefits do not change.

Lumen Inc. (hereinafter "Lumen" or "Company") is pleased to provide you with this Summary Plan Description ("SPD"). This SPD and the other plan documents (such as the Plan Document, the Summary of Material Modifications (SMMs) and materials you receive at Annual Enrollment, and other times of the year including the UnitedHealthcare (UHC) Group Medicare Advantage PPO option SPD) (also referred to as a Certificate of Coverage "COC" as prepared by UHC) (hereafter collectively the "Plan documents") briefly describe your Benefits as well as rights and responsibilities, under the Lumen Retiree and Inactive Health Plan (the "Health Plan"). This SPD, together with the Annual Enrollment summaries make up the official Summary Plan Description for Qwest Pre-1991 Retirees under the Employee Retirement Income Security Act of 1974, as amended, and the regulations thereunder ("ERISA").

The Plan's Retiree Medical Plans 1 through 4 are self-funded benefit options; however, certain other benefit plan options under the Health Plan are insured, such as the UnitedHealthcare Medicare Advantage PPO.

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

Company's Reserved Rights

This document summarizes the provisions of Retiree Medical Plan 2 of the Lumen Retiree and Inactive Health Plan that is made available by Lumen for Qwest Pre-91 Retirees and certain LTD participants. If there is any conflict between the terms of the Plan Document and this document, the terms of the Plan Document will govern.

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

The Plan Administrator may adopt, at any time, rules and procedures that it determines to be necessary or desirable with respect to the operation of the Lumen-sponsored plans, including the Lumen Retiree and Inactive Health Plan. Lumen reserves the right to amend or terminate all of the Plans and the Benefits it sponsors and provides - with respect to all classes of Participants, retired or otherwise - and their beneficiaries, without prior notice to or consultation with any Participants and beneficiaries - subject to, applicable law, collective bargaining if applicable, the terms of the respective Plan documents, and with respect to the Health Plan, subject to the terms of the written agreement specific to Qwest Pre-1991 Retirees and Qwest ERO'92 Retirees.

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

The Required Forum for Legal Disputes

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

Health Plan Coverage is Not Health Care Advice

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

Following Plan Procedures

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

You May Not Assign Your Benefits to Your Provider

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

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

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

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

Consequences of Falsification or 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 your 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. This misrepresentation/omission is 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.

- You and your Dependent(s) will not be permitted to benefit under the Plan from your own misrepresentation. If a person 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 coverage must be maintained for an ex-spouse/domestic partner, that is not the responsibility of the Company or 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 the Plan Administrator and or Corporate Security to investigate and to address the possible consequences of such actions under the Plan. All Covered Persons are periodically asked to submit proof of eligibility and to verify claims.

Note: All Participants 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.

How to Use this Document

Capitalized terms are defined in the "Definitions" section of this document and in the Plan Document. All uses of "we," "us," and "our" in this document, are references to the Claims Administrator or, the Plan Administrator which is the Lumen Employee Benefits Committee or Lumen. References to "you" and "your" are references to people who are eligible and covered under the Plan. **Note:** Most general sections of this SPD also refer to the Dental benefit options. See your applicable Dental benefit option SPD for more details and definitions for those Benefits.

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

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

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

Highlights of Plan Benefit Options

In addition to the medical benefit option you have available as your Guaranteed Coverage Commitment (Company Plan 2 benefit option described in this SPD), you have additional options available to you when you are Medicare eligible.

The two added options are:

1. the UnitedHealthcare Group Medicare Advantage PPO (UHC Medicare Advantage), and
2. the Health Reimbursement Account (HRA).

Information on these additional benefit options is noted as such throughout this SPD and for the Medicare Advantage benefit option, in the carrier's specific SPD. However, the Company Pre-91 Plan benefit option is described in greater detail in this SPD.

The Guaranteed Company Medical Plan 2

This benefit option is also called the "Company Medical Plan" or the "Medical Expense Plan". It is available to you and your eligible Medicare and non-Medicare eligible Dependents. **Note:** Medicare eligible participants must have their Medicare Parts A and B for this benefit option.

This benefit option pays a substantial share of the costs of the Hospital, surgical and medical care you and your family receive each year - as much as 100% of Reasonable and Customary Charges in many cases. Just how much is paid depends upon the type of care received.

The following table highlights how much the Plan pays for various medical services. These benefits are described in more detail later in this SPD.

Medical Service	Medical Expense Plan Pays
Hospital Care Inpatient Services	Retirees or their Physicians are encouraged to notify UnitedHealthcare prior to any inpatient admission by contacting UnitedHealthcare's care coordination program, referred to as "Well Connected", as described later in this SPD to avoid a penalty. Contact the number shown on your ID Card.
Semi-private room, board and services (including intensive care and cardiac units)	100% of Reasonable and Customary Hospital charges for up to: • 120 days of each separate Confinement for illnesses or injuries. This includes Confinements for mental health and substance use disorder treatments.
Outpatient Services	100% of Reasonable and Customary Hospital charges for: • Emergency treatment within 72 hours after an accident or the onset of a Sudden and Serious illness, or • Minor surgery at any time.
Preadmission testing	100% of Reasonable and Customary charges for diagnostic X-ray and laboratory tests performed under an "approved" program prior to admission for surgery.
Ambulatory Surgical Facility Care	100% of Reasonable and Customary facility charges for approved facilities.
Alternatives to Hospitalization: • Skilled Nursing Facility • Home Health Care • Hospice Care	100% of Reasonable and Customary facility charges when in lieu of hospitalization subject to certain limitations described later in this SPD.
Surgical Care, Surgery:	95% of the Physician's Reasonable and Customary charge for procedures performed on an inpatient basis. 100% of the Physician's Reasonable and Customary charges for procedures performed on an outpatient basis.
Medical Care: • Pre-arranged Second Opinions on Elective Surgery • Diagnostic X-ray and Lab Tests • Radiation Therapy • Chemotherapy • Electroshock Therapy • Hemodialysis • Cardiac Rehabilitation	100% of Reasonable and Customary charges - subject to certain limitations described later in this section.
Medical Care: • Administration of Anesthesia • In-Hospital Doctor's visits • Well-Baby Exam • In-Hospital Consultations (i.e., your doctor with a specialist)	90% of Reasonable and Customary charges - subject to certain limitations described later in this section.
Mental Health Care: • Inpatient	100% of Reasonable and Customary facility charges for inpatient treatment for up to 120 days per confinement. Treatment beyond 120 days in one confinement will be considered under "Other Covered Charges."
Mental Health Care: • Outpatient	80% of Reasonable and Customary charges. The remaining 20% is the responsibility of the patient.

Medical Service	Medical Expense Plan Pays
Substance Use Disorder Treatment: • Inpatient	100% of Reasonable and Customary facility charges for inpatient treatment for up to 120 days per confinement. Treatment beyond 120 days in one confinement will be considered under "Other Covered Charges." Physician charges payable at 90% of Reasonable and Customary.
Substance Use Disorder Treatment: • Outpatient	80% of Reasonable and Customary charges. The remaining 20% is the responsibility of the patient.
Other Covered Charges: The remainder of most services above paid in full, as well as other medical expenses, including such things as: • Prescription drugs • Doctor's office visits • Private duty nursing • Medical equipment rental • Chiropractor visits (subject to limitations)	After your meet your Deductible, the not "Other Covered Charges" portion of the Plan pays: 80% of Reasonable and Customary charges for most other Covered Expenses, and when your "Other Covered Charges" total $5,000 in a calendar year, the Plan pays: 100% of Reasonable and Customary charges for any remaining covered services received during the rest of the calendar year.
Well Connected Care Coordination:	Care Coordination, provided by the Claims Administrator, is part of the Company Well Connected program and is designed to deliver comprehensive, personalized services and efficient care for you and your Dependents. This may include: admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. **Using this program is required to avoid a penalty.** See **"Well Connected Program (Company Plan)"** later in this SPD.
Prescription Drug Programs: Mail order only available to the Mountain Bell Retiree group. See **"Prescription Drug Program (Company Plan)"** for Mountain Bell Retiree, you also have details.	**Retail:** You and your eligible Dependents may use the "Other Covered Charges" provision of the Medical Expense Plan and submit for Mail order only available to the reimbursement of Prescription Drug expenses. **Note:** If you are a Mountain Bell Retiree, you also have details. the mail order (home delivery) option below. **Available only to Retirees from Mountain Bell:** Home Delivery (Mail Order): You and your eligible Dependents may obtain prescription drugs through the Prescription Drug Program (long-term maintenance drugs delivered by mail).

Retiree Health Care Medical Plan 2

It is important to know that the way you choose your medical providers can affect whether you save money. If you are a Retiree participating in the Company Retiree Health Care Medical Plan 2, and you or your Dependents are not yet eligible for Medicare, then you and your Dependents are eligible to utilize PPO providers, if available in your area until you each reach age 65 or Medicare becomes primary. You may be able to receive additional savings by using doctors and Hospitals contracted for the UnitedHealthcare Preferred Provider Organization (PPO) under the Company Medical benefit option for non-Medicare eligible participants.

Non-Medicare participants in the Company Medical Plan may be able to receive additional savings by using doctors and Hospitals contracted for the UnitedHealthcare Preferred Provider Organization (PPO).

How the Company medical Plan PPO Works

To find out if a PPO network exists in your area, you can search the directory of PPO Providers through myuhc.com, or by calling UnitedHealthcare at 800-842-1219. At your request, UnitedHealthcare will send you a directory of the doctors and Hospitals in your PPO area. The PPO directory lists all the providers that UnitedHealthcare has selected

for its PPO network in that location. These providers have agreed to accept a negotiated fee for covered services. The UnitedHealthcare payment will be based on this negotiated fee rather than on Reasonable and Customary rates. If there is a difference between the amounts the PPO provider would usually bill a patient and the amount of the negotiated fee, the PPO will not bill you for the difference.

For example: You see one of the PPO doctors for an office visit, and that doctor's normal office visit charge is $40.00. If the negotiated fee is $30.00, you are not responsible for the $10.00 difference. If the office visit had been covered at 80% after your Deductible was satisfied, your benefit would be 80% of the negotiated fee of $30.00. You would be responsible for the remaining 20% of the $30.00, or $6.00, but not for the $10.00 difference in the earlier case. As a result, your Out-Of-Pocket expense should be less if you use the PPO providers.

Note: If your doctor makes a referral or calls in another provider that provider may or may not be part of the PPO and PPO Benefits may or may not apply as a result.

You can use the PPO providers in any location where UnitedHealthcare has the PPO network established. If you would like a PPO directory for another location, please search the online directory at myuhc.com or call UnitedHealthcare at the number given above, and a Customer Care Representative will send you the directory.

You may elect to use the PPO providers or not to use them each time you need medical care. There are no special steps required to use the PPO. You need only to show your UnitedHealthcare ID card when you receive your care from a UnitedHealthcare PPO provider. The card lets providers know that you have access to the PPO Benefits.

If you are Medicare eligible and enrolled or changed coverage to the Lumen UHC Medicare Advantage PPO benefit option, you can use any provider that accepts Medicare. See **"When You are Eligible for Medicare"** and the **"Coordination of Benefits"** sections in the SPD.

UnitedHealthcare® Group Medicare Advantage (PPO) Plan

The level and type of Benefits provided under the UHC Group Medicare Advantage PPO Plan will be as described in the UHC SPD/Evidence of Coverage. To request a copy of the SPD/Evidence of Coverage contact UnitedHealthcare at 877-886-7313.

Health Reimbursement Account (HRA)

The Health Reimbursement Account (HRA) benefit option is only available to Medicare eligible participants with Medicare Parts A and B. This benefit option is being offered to you in lieu of any medical/prescription drug benefit coverage from Lumen, which means you are waiving/suspending those benefit coverages under the Company Retiree Health Care Medical Plan 2. Instead, you are electing to use the Company subsidy dollars that will be placed in a Health Reimbursement Account (HRA) which you can access to reimburse yourself for medical premiums you have paid to a carrier of your choice for an individual Medicare policy (such as Medicare Supplemental/gap, Part D or Medicare Advantage). The Company subsidy dollars help to cover the cost you will incur, if any, when you purchase individual Medicare medical and prescription drug policies. See the "Enrolling in Medicare policies" below.

Funding. The HRA is funded on January 1 of each year with the full amount of the Company subsidy. This allows you to access the dollars as you pay your premium. For instance, if you paid your policy premium in full for the year in January or on a quarterly basis, you could access the full amount you paid up to the maximum amount of the subsidy dollars available. You must pay the carrier directly and then get reimbursement—the HRA cannot pay the carrier directly for you. HRA dollars are provided on a non-taxable basis. The HRA is not intended to reimburse you for any out- of-pocket expenses or the Medicare Part B premium that you receive separately from Lumen – this Part B reimbursement will continue as is.

The HRA account is set up as one account per family. If you are married to another Lumen employee/retiree, contact the

Lumen Health and Life Service Center for information on how your account will be managed and other Company Couple rules regarding the hierarchy of who will be primary on the account.

Note: The HRA does not reimburse you for out-of-pocket expenses such as Copays or Deductibles. The policy you obtain is an insurance arrangement between you and the carrier you selected therefore; you pay your medical policy premiums directly to the carrier. You do not pay Lumen for any medical premiums.

Forfeiture/No roll over. Any subsidy dollars that are not used by the end of the year will be forfeited. You have until March 31 of the following year to submit for reimbursement of premiums paid for the previous year. No balances will roll over for use in the next year.

Enrolling in Medicare policies. When enrolling in the individual Medicare policies, you can go directly to the carrier, use a local broker of your choice or use the enrollment vendor that the Company has arranged to help its Retirees: Via Benefits at 888-825-4252. They can help you determine what individual policy may be best for you and complete the enrollment over the phone without any necessary paperwork.

Note: Because these are individual policies, you and your Medicare eligible dependents must each go through the enrollment process and make a positive enrollment election with the carrier. This also means, you can each enroll with different carriers and policies.

The HRA is available regardless of which individual policies you select.

Reimbursement. Your HRA is administered by MyChoice Accounts (MCA). MCA can be contacted through the Lumen Health and Life Service Center at 833-925-0487 or 317-671-8494 (International callers) or 800-729-7526. If you elect the HRA, you will receive information directly from MCA notifying you that your account has been established and how to access your dollars. The HRA administrator can assist you with processes that allow you to set up your account to reimburse you automatically (on a recurring basis) once you provide proof of your Medicare policy enrollment and premium amount to MCA.

To use the Health Reimbursement Account:

1. You must elect it during Annual Enrollment.
2. You must be enrolled in an individual Medicare policy not offered by Lumen. Enrollment for these policies is set by Medicare not the Company. You must follow the Medicare rules governing these policies.
3. Your HRA will automatically be set up for you by the Company and MCA once you are enrolled.
4. You pay your premium directly to the carrier of your choice and then submit for reimbursement from your HRA.

The level and type of Benefits provided under the individual Medicare policy you purchase will be as described in that plan's SPD/Certificate of Coverage, and will differ from that which is provided under the Company Medical Plan option described throughout this Summary Plan Description.

Definitions

To help you understand how the Company Plan benefit option works, it's important that you know what the following terms mean as used in this SPD.

Ambulatory Surgical Facility - is an institution in which you can have surgery performed without an overnight stay. Many different types of surgical procedures can be performed in these facilities at less cost - and inconvenience - than if you were an inpatient in a Hospital. The facility need not be part of a Hospital, but it must be permanently equipped and operated primarily to provide outpatient surgical services. A doctor's or dentist's office is not considered such a facility.

Annual Basic Pay - (upon which your and each of your Dependents' Deductibles are based) means the amount of "annual pension" being paid as of December 31 of the preceding calendar year. For former Employees only who are covered under the terms of the Long-Term Disability provisions of the Company Disability Plan, it is the basic rate of pay in effect immediately prior to becoming entitled to receive Long-Term Disability Benefits.

Lumen Retiree and Inactive Health Plan - Health care coverage under Plan No. 511 as amended effective January 1, 2015 and sponsored by Lumen, Inc for eligible employees of Lumen and certain Lumen subsidiaries who retired having satisfied certain age and service criteria.

Coinsurance - is the percentage of Eligible Expenses you must pay for certain Covered Services after you have paid any applicable Deductibles and Copays and until you reach your Out-of-Pocket Maximum.

Copay - is the charge you are required to pay for certain Covered Health Services. A Copay may be either a set dollar amount or a percentage of Eligible Expenses. You are responsible for the payment of any Copay for Network Benefits directly to the Provider at the time of service or when billed by the Provider.

Covered Expenses - A Reasonable and Customary medical expense incurred by the Participant under the direction of a Physician while covered under this Plan. The expense must be for the treatment of an injury or illness and must not be specifically excluded or otherwise limited under this Plan. A Covered Expense must be for a health service or supply that meets each of the following criteria:

- It is supported by national medical standards of practice.
- It is consistent with conclusions of prevailing medical research that demonstrates that the health service or supply has a beneficial effect on health outcomes and are based on trials that meet the following designs:
- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
- It is the most cost–effective method and yields a similar outcome to other available alternatives.
- It is a health service or supply that is described under "Plan Benefits," and which is not excluded under "Exclusions of Benefits."
- It is not Experimental or Investigational.

Covered Facility - Any of the following:

- Ambulatory Care Center
- Ambulatory Surgical Facility
- Birthing Center
- Free-standing hemodialysis center (for hemodialysis treatment)
- Hospice
- Hospital
- Nursing home (for Hospice Care only)

- Physical/Cardiac Rehabilitation Center
- Physician's Office (for emergency care only)
- Skilled Nursing Facility.

Note: For purposes of Mental Health/Substance Use Disorder coverage, Covered Facility means only those facilities described in the "Plan Benefits" section.

Deductible - Shall mean an amount of Covered Expenses incurred during a calendar year which is not reimbursed under this Plan but which must be satisfied each year before Benefits become payable.

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

- **Class I Dependents -** your legal Spouse and your biological children, step- children, adopted children, foster children until the end of the calendar month in which they reach age 26, unless such child becomes ineligible earlier due to eligibility for other group health plan coverage, including but not limited to, her/his employer's group health plan coverage. Or any never married child, regardless of age, who is medically certified as Disabled prior to the limiting age by the Plan Administrator and determined to be indefinitely incapable of self-support and fully dependent on you for support (with the understanding that this status is reviewed every 2 years). Once the Disabled child is ever determined to no longer be Disabled or is removed from the plan, the child is no longer eligible to be re- enrolled at any later date (unless you are rehired at a later date and enroll as a new hire).
  The term "Child" also includes your Children (excluding stepchildren or grandchildren) for whom there is a Qualified Medical Child Support Order (QMSCO) requiring coverage under the Plan. The term "Child" does not include those minors for whom you are awarded temporary custody, or who are wards of the State.
- **Class II Dependents -** your children who are not Class I Dependents, your unmarried grandchildren, your brothers and sisters, parents and grandparents, and your Spouse's parents and grandparents, if they are dependent upon you for the majority of support and have lived with you or in a household provided by you in the vicinity for at least six months within the last 12 consecutive months preceding the commencement of coverage and continue to reside with the participant or in such household of the participant. In addition, to qualify for coverage, the total income of a Class II Dependent - not counting any support you provide - must be less than the annual rate specified by the Plan Administrator from all sources, including Social Security. Proof of Class II dependency is required.
- **Sponsored Child -** your "child" who does not qualify as either a Class I or Class II Dependent, but only until the end of the calendar year in which such child reaches age 26. You can enroll such a child for coverage whether the child resides with you or not and regardless of how much income he or she is receiving; however, you must pay the full cost of the coverage (single premium rate) to the Company.
- **Domestic Partner and Children of a Domestic Partner -** an adult same-sex Domestic Partner who is mutually responsible with you for basic living expenses, provided that neither of you may be married to anyone else. Unless otherwise subsequently changed by federal tax law or the Code, for purposes of the federal and state income tax treatment for this Plan coverage, a Domestic Partner is not a "dependent". Any child of a Domestic Partner may become a participant in the Plan, provided he/she satisfies the eligibility requirements the same as a Class I Dependent as described above (Note: this does not confer the rights of a Class I Dependent upon an eligible Domestic Partner child).
  See **"Dependent Validation—Verifying Eligible Dependents"** in this SPD for more information.

Elective Surgery - means a surgical procedure which is scheduled at the patient's convenience without endangering the patient's life or without causing serious impairment to the patient's normal body functions.

Home Health Care - includes paid professionals and paraprofessionals working through a licensed Home Health Care Agency that has a Quality Assurance/Utilization Review program in place. Before someone receives home care, a specific plan of care is designed for that individual by their Physician. The Plan covers expenses which are prescribed by

a licensed Physician and that would have been payable as a Covered Expense if confinement in a Hospital would have been necessary in the absence of Home Health Care.

Hospice Care - is a coordinated program of supportive care to meet the physical, psychological, and social needs of dying persons and their families in the home or in a Hospice facility. A Hospice facility provides for a short period of stay for the terminally ill in a home-like setting for either direct care or respite care (relieving the primary caregiver of their responsibilities at intermittent intervals). Although this facility may be either free-standing or affiliated with a Hospital, it must be licensed, operate as an integral part of a Hospice Care Program, and meet the standards of the National Hospice Association.

Hospital - means a legally constituted institution, which provides facilities primarily for the inpatient surgical and medical diagnosis and treatment of sick or injured people by or under the supervision of a staff of Physicians, and which furnishes 24 hour-a-day care by registered graduate nurses. Convalescent homes, nursing homes and other facilities which are primarily places for rest, for the aged, or for drug addicts or alcoholics do not qualify as "Hospitals" under the Plan. However, Hospitals classified and accredited as "Mental Health Hospitals" by the Joint Commission on Accreditation of Hospital Organizations are considered to be Hospitals under the Plan. Hospitals outside the continental United States, including those in foreign countries, are covered on the same basis as those within the continental United States.

Medically Necessary - means those services and supplies which are reasonable and necessary for the diagnosis and treatment of an illness or injury and which are given at the appropriate level of care. The fact that a procedure or level of care is prescribed by a Physician does not mean that it is Medically Necessary or that it is covered under the Plan even though it is not specifically listed as an exclusion. The final determination as to whether a service is Medically Necessary will be made by the Claims Administrator.

Medicare - is a program administered by the Social Security Administration which provides coverage for the cost of medical care. The program has three parts:

- **Part A -** which provides benefits for Hospital care; and
- **Part B -** which provides benefits toward Physicians' fees and certain other covered medical expenses; and
- **Part D –** which covers prescription drugs.

You and your Dependents each become eligible for parts A, B and D of Medicare when each participant reaches age 65 - or before reaching age 65 if disabled and 24 months of disability payments have been received from Social Security. Medicare is also available at any age if the individual has chronic kidney disease and requires dialysis or kidney transplant.

For Parts B and D, the government charges a monthly premium. You should enroll in Parts A and B as soon as you are eligible because this Plan coordinates Benefits with Medicare. Medicare will become the Primary payer once you are Medicare eligible. The Health Plan will pay on a secondary basis. **Note:** As long as the Health Plan has creditable prescription drug coverage, you do not need to take a separate Part D policy when you are enrolled under a Lumen Retiree and Inactive Health Care Plan benefit option.

Out-of-Pocket Maximum - means the total dollar amount of Covered Expenses that a Participant must pay before the Plan will reimburse 100% of the Covered Expenses for the balance of that calendar year.

Physical Rehabilitation - means the use of medical, social, educational, and vocational services to enable patients disabled by illness or injury to achieve a reasonable level of functional ability.

Physician or Surgeon - means a licensed medical doctor (M.D.) who performs a service which is covered under the Plan. Physician also includes any other licensed practitioner who:

- Is acting within the lawful scope of his or her license; and
- Performs a service which would be covered under the Plan 2 if the service had been performed by an M.D.

Note: The definition excludes "practitioners of the healing arts."

Pre-'91 Retiree - former Qwest Employees who retired on a service or disability pension under either the U S WEST Management Pension Plan or the Qwest Pension Plan prior to January 1, 1991. Effective January 1, 1991, guaranteed non-HMO medical and dental expense coverage for these Retirees has been made available to these eligible Retirees under a Retiree Health Care Medical Plan only through option (Plan 1, 2, 3 or 4) and a Retiree Health Care Dental Plan only through option (Plan 1, 2, 3, 4, or 5). Currently Benefits for Pre-91 Retirees are provided under these same Medical Plan benefit options under the Lumen Retiree and Inactive Health Plan. Other options that may be available are not considered to be guaranteed benefits.

Predecessor Plans - The Plans identified below are "Predecessor Plans" eligible for the Medical Plan 2. See **"Predecessor Health Care Plans"** at the back of this SPD for the other historical reference:

Retired From	Retirement Date	Predecessors Plan
BRI-CWA	After 1-1-86 Occupational Employees	Medical Expense Plan
CCI-CWA	Prior to 1-1-91 Occupational Employees	Medical Expense Plan
USWC - Eastern (Northwestern Bell)	After 12-31-86	Medical Expense Plan 2
Occupational Employees		
US West non-regulated companies	After 1-1-91 Management Employees Non-Bargained Employees	Choice Plus Plan
	After 1-1-87 IBEW Non-Management	Choice Plus Plan

Preferred Provider Organization (PPO) - a group of Hospitals and Physicians that have entered into an agreement with the Claims Administrator and have agreed to accept specified reimbursement rates for Covered Expenses to provide comprehensive medical service.

Reasonable and Customary (R & C) - means the lowest of:

- The fee which the particular Physician or other provider of services or supplies most frequently charges for the same or similar services or supplies;
- The fee which most other Physicians or providers of such services or supplies in the same or similar geographic areas usually charge for the same or similar service or supply; or
- The actual charge for the service or supply.

In all instances, the Claims Administrator shall make the final determination in its discretion as to the amount of any charge or expense that will qualify as Reasonable and Customary. In making this determination, the Claims Administrator may, in its discretion, consider the time, skill and experience of the provider, as well as any special circumstances or medical complications requiring additional time, skill and experience in connection with a particular service or procedure.

Note: The Claims Administrator shall determine and maintain Reasonable and Customary charge information in all cases.

Skilled Nursing Facility - means an institution or part of an institution licensed by the state where it is located which for

compensation primarily provides inpatient skilled nursing and treatment for patients convalescing from illness or injury and which provides 24 hours-a-day nursing services under the full-time supervision of a Physician or registered nurse.

Spouse - means the individual to whom an Eligible Retiree is lawfully married in accordance with the laws of the jurisdiction in which the marriage was celebrated, whether the marriage is by civil or religious ceremony or at common law.

Notwithstanding the foregoing, tax treatment of the Benefits available to a Spouse will be determined in accordance with the Code and Federal law except where State law requires otherwise for State income tax purposes.

Sudden and Serious Illness - means a condition that occurs suddenly and unexpectedly and requires immediate and urgent medical attention, such as:

- acute appendicitis
- diabetic coma
- acute asthmatic attack
- kidney stones
- choking
- convulsions
- food poisoning
- stroke
- frostbite
- severe chest pains
- hemorrhage

or any other condition of similar severity that, in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or death.

UnitedHealthcare Well Connected - is a unit of UnitedHealthcare with medically educated professionals who provide coordination of health care services, an assist with the planning of health care choices for individuals and their covered Dependents based on health benefit plan.

Who is Eligible

As a retired Qwest Employee or Long-Term Disability (LTD) Recipient covered under one of the Predecessor Plans (and retired having satisfied certain age and service criteria), you and the following Dependents are eligible for coverage under this Plan. (See **"Additional Enrollment Information"** and **"General Information"** sections for more enrollment information.) Eligible individuals include the following per Plan provisions and limitations:

- All retired Qwest Employees on a service or disability pension covered by a Predecessor Plan prior to January 1, 1991 and known as Qwest Pre-91 Retirees
- Class I Dependents of eligible Qwest Pre-91 Retirees and LTD Recipients
- Class II Dependents of eligible Qwest Pre-91 Retirees
- Qwest LTD Recipients who were eligible for a Company Long-Term Disability Plan prior to January 1, 1991

- Surviving Spouses of eligible Qwest Pre-91 Retirees
- Sponsored Children of eligible Qwest Pre-91 Retirees
- Participants of this Plan who become eligible for continued coverage under COBRA (see **"Continuation of Medical Coverage (Under COBRA)"**) on or after January 1, 1991

LTD Recipients. If you are eligible to receive Benefits under the Long-Term Disability (LTD) provisions of the Disability Plan and you are not retired, you shall be eligible for the Benefit provisions of this Plan 2 if your LTD commenced prior to January 1, 1991. Your medical Benefits are payable on the same basis as a Qwest Pre-91 Retiree provided you remain eligible as "Disabled" under the terms of the Disability Plan. However, you may not cover Class II Dependents or Sponsored Children who were not covered effective January 1, 1991.

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

- **If you are eligible for retiree health care or life insurance from the Company,** refer to the applicable section below to see how your retiree benefits may be impacted.
- **If you are rehired in a status that is eligible for active benefits,** you will be offered the same benefits as other similarly situated employees based on your employee classification. If you had retiree supplemental life insurance coverage, you will be eligible to elect active supplemental life insurance coverage. If there is a loss of supplemental life coverage between what you previously had prior to your rehire date and the amount as an active employee, you may convert the difference with Metropolitan Life Insurance Company. If you continued your supplemental life coverage through Metropolitan Life Insurance Company, you will be required to surrender this policy when you return to retiree status in order to resume your retiree supplemental life insurance coverage, if applicable.
- **If you return to work for a supplier on assignment to the Company,** you are not eligible to continue your retiree health care benefits, so this means that while you are working for the supplier, your retiree health care benefits will be suspended; however, you will be offered the opportunity to continue your retiree medical and/or dental options under COBRA. Your retiree basic and supplemental life coverage, if applicable, will continue under the terms of the Life Insurance Plan ("the Plan"). In addition, please be advised that as a worker for a supplier or Company contractor, you are not eligible for Lumen active employee health care benefits. Retiree health care benefits are reinstated once your work with the supplier/contractor for the Company has ended. You will need to call the Lumen Health and Life Service Center to get your benefits reinstated.
- **Once your employment or assignment ends,** you may resume your retiree health care, basic and supplemental life insurance coverage, if applicable, in accordance with terms of the Plan by calling the Lumen Health and Life Service Center at 866-935-5011 or 800-729-7526. If you returned to work for a supplier on assignment to the Company, Lumen will validate that your assignment has ended before you will be allowed to resume your retiree health care coverage.

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

Dual Coverage. If you and your Spouse or Domestic Partner are both covered as Pre- 91 Retirees under the Company Plan benefit option (Plan 2), each of you is covered as an individual or one of you may waive coverage and be covered as an eligible Dependent under the other. No person is eligible for coverage under this Plan 2 as both a Retiree (or LTD Recipient) and as a Dependent at the same time. Dual coverage is not allowed for either the UHC Medicare Advantage or the HRA benefit options (see **"Additional Enrollment Information"**). Either Retiree, but not both, can enroll his or her eligible Dependents for coverage.

If you are in different Lumen medical benefit option. In the event a Pre-1991 Retiree is a Dependent of another Company employee/retiree who is enrolled in a Company Plan other than the Pre-1991 Medical Plan 2, then the

Dependent may be covered both as a Primary Participant in his/her own right and as an eligible Dependent of the Qwest Pre-1991 Retiree Medical Plan 2.

Dependent Validation—Verifying Eligible Dependents

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

Dependent Verification

To assure compliance with Plan terms, the Company will periodically conduct audits of covered Dependents to determine their continued eligibility for Benefits under the Plan. Qwest Pre-91 Retirees will be required to timely provide supporting documentation to verify the eligibility of their Dependents covered under the Plan.

Dependents must establish relationship, residency, and financial support. This documentation may include, but is not limited to, birth and marriage certificates, tax returns, court orders, and/or proof of residence. Any individuals who are determined to be ineligible, or for whom proof of coverage is not received timely, will be removed from the Plan.

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

Note: To participate in the additional plan benefit options, you must be an eligible Retiree or Class 1 Dependent as described in this SPD who is Medicare eligible. Class II and Sponsored Children do not qualify for the additional benefit options.

See the **"Additional Enrollment Information"** section for more details.

Effective Date of Coverage

Effective January 1, 1991, if you were covered under one of the following Predecessor Plans, you are covered under and subject to the terms of this Plan:

- Participants covered by the Business Resources Medical Expense Plan who were CWA occupational Retirees or LTD Recipients after 1-1-86, and before 1-1-91, and Surviving Spouses of any such Pre-91 Retirees.
- Participants covered by the Northwestern Bell Medical Expense Plan II who were occupational Retirees or LTD Recipients after 12-31-86 or before 1-1-91, and Surviving Spouses of any such Pre-91 Retirees.
- Participants covered by the Qwest nonregulated companies' Choice Plus Plan who were management and

nonbargained Retirees or LTD Recipients after 1- 1-86 and before 1-1-91, and Surviving Spouses of any such Pre-91 Retirees.

- Participants covered by the Qwest Choice Plus Plan who were IBEW occupational Retirees and LTD Recipients after 1-1-87 and before 1-1-91, and Surviving Spouses of any such Pre-91 Retirees.
- Individuals who were Surviving Spouses under a Predecessor Plan and who continue their coverage as Surviving Spouses of a Pre-91 Retiree under this Plan.

If your family status changes, you can change your coverage from individual to family - or vice versa. A newly acquired (newborn or adoption) Class I Dependent may be enrolled for coverage effective the date the Dependent is acquired. All other newly eligible (e.g., Sponsored Child, Class II Dependent, or Spouse) Dependents will have coverage effective the first of the month following enrollment provided that you request enrollment within 45 days after the life event. Enrollment may be completed by calling the Lumen Health and Life Service Center at 866-935-5011 or 800-729-7526 Option 2. A Dependent Verification packet will be mailed to your address on file after you enroll the Dependent. Follow the instructions outlined in the packet closely and make sure to respond no later than the deadline. You will need to complete a separate Dependent Verification Form for each Dependent. (**Note:** Coverage may not be approved if you do not provide all the required information or fail to meet the deadline.) See **"Dependent Validation—Verifying Eligible Dependents"** above and **"Qualified Life Events — Changing Your Health Care Coverage"** in the **"Additional Enrollment Information"** section for more information.

If you are declining enrollment for yourself or your Dependents, including your Spouse, because of other health insurance coverage, you may in the future be able to enroll yourself and your Dependents again in this Plan, provided that you request enrollment within 45 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, or adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 45 days after the marriage, birth, adoption, or placement for adoption.

See **"Additional Enrollment Information"** later in this SPD.

Cost—Who Pays for Coverage

Company Medical Plan benefit option. The Company contributes up to an amount equal to 100% of the single, single plus Spouse/Domestic Partner, single plus Children or family premium, as applicable for eligible Retirees under the guaranteed Company Medical Plan benefit option. Your Annual Enrollment materials will describe how payment can be made when applicable.

Medicare Advantage PPO benefit option. The Company contributes up to an amount equal to 100% of the UHC Medicare Advantage PPO medical benefit option premium for each eligible tier of Retiree and eligible Class I Medicare eligible person enrolled in this benefit option (Class II and Sponsored Children are not eligible for this option). Your Annual Enrollment materials will describe how payment can be made when applicable.

Health Reimbursement Account benefit option. The HRA subsidy account, as described later in this SPD, is also subsidized 100% (as determined by the Company) for each eligible Retiree and eligible Dependent enrolled in this benefit option, according to the provisions and limitations of the Plan. Your Annual Enrollment materials will describe how payment can be made when applicable.

Please Note: Any premium contributions which are required beyond the Company's contribution are your responsibility (e.g., premiums must be paid by Surviving Spouses, COBRA continuant, Class II Dependent or Sponsored Child).

If Medicare eligible, you will have to pay for Medicare Part B coverage which is paid directly by you to Medicare (typically deducted from your Social Security check). You may be eligible for reimbursement from the Company for this Part B premium. See **"When You are Eligible for Medicare"** in this SPD for the reimbursement rules.

Surviving Spouse Cost. See "Surviving Spouse Medical Continuation" information in the **"Continuation of Medical Coverage (Under COBRA)"** section later in this SPD.

For consequences of late or non-timely payment of premiums, see **"Termination of Medical Coverage"** in this SPD.

Deductible and Out-of-Pocket Maximum

Company Plan Benefit Option

Your Deductible for each calendar year will be one percent (1%) of your Annual Pension. It will be no less than $25.00 per person and no more than $150 per person.

If you and your Spouse are both retired from the Company and covered under this Qwest Pre-91 guaranteed benefit option, you are covered only as individual retired Employees. However, your Deductibles will be combined to determine when the "family" Deductible has been met.

If your Spouse or Domestic Partner is covered under this Qwest Pre-91 benefit option, or any other Retiree Health Care Plan benefit option, there will be no consolidation of Deductibles. Each of you must satisfy your own Deductible and Out-of- Pocket Maximum.

Your Deductible applies separately for each participant in each calendar year, except that a maximum of three Deductibles (not to exceed $450) will apply to your family in any calendar year. No individual in your family can contribute more than one individual Deductible toward your family Deductible.

If you have Covered Expenses during the last three months of a calendar year and they were used to help satisfy your Deductible in that calendar year, you may reuse those expenses the following year to help satisfy your Deductible.

You have an annual cost sharing limit (Out-of-Pocket Maximum) which you must meet prior to the Plan paying 100% of eligible expenses. This annual limit excludes any expenses you incurred that were used to satisfy your Deductible. Your annual Out-of- Pocket Maximum is $1,000 per person per calendar year.

It is important to remember that Class II Dependents and Sponsored Children must meet their own Deductible and Out-of-Pocket Maximums. Their expenses are not included with yours when determining your family Deductible and Out-of-Pocket Maximum.

Other Benefit Plan Options

If you enroll in the UHC Medicare Advantage benefit option or an individual Medicare policy, the Deductibles and other Out-of-Pocket expenses are determined by the plan design of those specific benefit plan options and are subject to change. See the Certificate of Coverage provided by the specific carrier for more information.

Plan Benefits (Company Plan)

Benefits are subject to UnitedHealthcare Well Connected notification requirements.

Hospital Care Benefits

This part of the Plan pays benefits for inpatient and outpatient Hospital care, plus preadmission tests and the services of an Ambulatory Surgical Facility.

Hospital Care - Inpatient (for other than mental health care or substance use disorder treatment).

For each separate Hospital confinement - either for you or one of your Dependents - Hospital Care Benefits pay:

- 100% of Reasonable and Customary charges for the full cost of semi-private room, board, and "Other Hospital Services," including charges for the use of intensive care and cardiac care units for up to 120 days

If the Hospital you enter has only private rooms, you will still be covered for up to 120 days for each separate confinement. However, the benefit will be 90% of the most prevalent private room rate. You pay the difference.

For certain conditions - as explained later in this section - there are special limitations on the number of days benefits are paid under the Plan. However, for each day that is covered, benefits are also paid at 100% of the Reasonable and Customary Charges based on the Hospital semi-private room rate.

"Other Hospital Services" include:

- use of operating, delivery, recovery, treatment rooms and equipment
- all FDA-approved and recognized drugs and medicines used during hospitalization
- dressings, ordinary splints casts and necessary supply items
- X-ray examinations, X-ray therapy, radiation therapy and treatment and chemotherapy
- laboratory tests
- oxygen and oxygen therapy, including the use of equipment for administration
- electrocardiograms, electroencephalograms and basal metabolism tests
- physical therapy, occupational therapy and psychotherapy
- anesthetics and the administration thereof
- processing and administration of blood plasma, but not including the supply of blood or plasma
- the use of heart-lung and kidney machines
- special diets
- general nursing care (excluding private duty nursing care in a facility)
- **Preadmission testing -** the Plan pays 100% of the Reasonable and Customary charges for diagnostic laboratory and X-ray examinations ordered by a Physician and performed under a Preadmission Testing Program in the outpatient department of a Hospital in conjunction with a scheduled inpatient admission for surgery in the same Hospital, provided:
  - the tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is scheduled,
  - reservation for a Hospital bed and an operating room is made before the tests are performed and the date of the scheduled admission for surgery is within the time frame that permits the tests to be valid when surgery is performed,

- the patient is physically present for the tests,
- the scheduled surgery is not cancelled or postponed for any reason other than (i) the results of the preadmission tests findings, or (ii) as a result of a second surgical opinion consultation, or (iii) because of the lack of Hospital Facilities at the time of scheduled admission, and
- the tests are not repeated upon admission for the scheduled surgery.

Hospital Benefits for inpatient care are limited to 120 days for each separate confinement. However, if you enter the Hospital again after you've been out at least 90 days - or for a new condition, regardless of when you were last discharged - that next confinement is considered separately from the previous one. Benefits are payable for another 120 days. If you re-enter the Hospital within 90 days for the same or related condition, benefits will be paid only for the number of days you have left from your previous stay.

Continued inpatient care beyond 120 days is covered under **"Other Covered Charges"** provided that care is Medically Necessary as determined by the Claims Administrator.

Hospital Care - Diagnostic or Physical Therapy Admission

If you enter a Hospital as an inpatient primarily for diagnostic studies or laboratory tests, no Benefits will be paid toward your room and board charges. The tests only will be covered under "Medical Care Benefits" - see the **"Medical Care Benefits"** in this section. Benefits will not be paid toward your room and board charges during a Hospital stay or any period of a Hospital stay which is primarily for physical therapy. However, itemized charges for physical therapy will be considered for payment under **"Other Covered Charges"**

Hospital Care - Dental Admission

If a Physician, oral surgeon or dentist certifies that dental treatment must be rendered in a Hospital inpatient setting to safeguard your life or health because of a serious non- dental organic impairment, such as heart trouble, hemophilia, etc., or that hospitalization for dental work is required as the result of accidental injury, the Plan provides Benefits for the Hospital charges, but not the Physician's or dentist's fees.

Hospital Care - Outpatient (for other than mental health care or substance use disorder treatment)

Hospital Care Benefits also pay 100% of Reasonable and Customary charges for covered services you receive in a Hospital outpatient department for:

- radiation therapy
- electroshock therapy
- hemodialysis
- chemotherapy
- diagnostic X-ray and lab tests (including allergy testing)
- minor surgery
- cardiac rehabilitation
- emergency treatment within 72 hours after an accident
- medical emergencies within 72 hours after the onset of a "Sudden and Serious" illness (see the IV. DEFINITIONS section for more information).

Outpatient Facility Benefits For Surgery

The Plan pays 100% of Reasonable and Customary charges for covered services rendered in the Outpatient department or emergency room of a Hospital or an "Ambulatory Surgical Facility" on the same basis as a "Hospital." (Your Surgeon's bill will be separate and will be reimbursed under Surgical Care Benefits described below.)

Since surgery in one of these facilities doesn't require an overnight stay, the overall cost is less than if you had the surgery performed as an inpatient in a Hospital. If the surgery you need permits it and such a facility is available, your Physician will know.

Benefits For Emergency Care

The Plan pays 100% of Reasonable & Customary charges for covered services rendered in the outpatient department or emergency room of a Hospital, an urgent care treatment center, or a Physician's office. The service must be rendered within 72 hours of the date of the accident or onset of the Sudden or Serious Illness.

The following may be considered in making a determination as to whether the illness was sudden and serious:

- Hospital, urgent care facility, or Physician's office statement
- Type of transportation to Hospital or Ambulatory Surgical Facility
- Time of arrival for medical attention

Determination of Sudden and Serious Illness will be based on your individual case and circumstances as determined by the Claims Administrator.

Hospitalization Alternatives

Hospitalization alternatives include:

- Home Health Care
- Hospice Care
- Skilled Nursing Facility care

Your Benefits - paid according to your coinsurance and Out-of-Pocket Maximums - will be the same as your hospitalization Benefits.

Notification. Notification to UnitedHealthcare Well Connected is required before receiving care if this Plan is primary. In addition:

- Services must be in place of otherwise necessary hospitalization for a covered illness or injury and be generally more cost-effective than hospitalization.
- The patient's Physician must establish and approve the treatment plan, and then review it at least every 30 days.
- The Physician must examine the patient at least once every 60 days.

Because a number of conditions may be imposed on these alternatives, notification is a particularly important step that will help you avoid denied or uncovered Out-of-Pocket expenses.

Surgical Care Benefits

This part of the Plan pays 95% of Reasonable and Customary charges not subject to the Deductible for covered surgical procedures when they are performed on an inpatient basis. In addition, the Plan pays 100% of Reasonable and Customary charges not subject to the Deductible for surgical procedures which are performed on an outpatient basis.

When the surgery is performed in a Hospital, the services of an assistant Surgeon (if needed) are also paid at 95% of Reasonable and Customary charges. Your Benefit payment for surgery includes normal pre- and post-operative care. The 5% that is not paid under "Surgical Care Benefits" is automatically considered under "Other Covered Charges."

When multiple surgical procedures are performed during the same operative sessions, "Surgical Care Benefits" do not provide 95% of the Reasonable and Customary allowance for each procedure. The allowance is determined by the following:

- multiple surgical procedures during the same operative session, performed through the same incision or in the same operative field, shall be payable at 95% of Reasonable and Customary charges for the greater procedure, and 50% of the Reasonable and Customary charges for the lesser procedure(s).
- multiple surgical procedures during the same operative session performed through separate incisions and in separate operative fields shall be payable at 95% of Reasonable and Customary charges for the total procedure, but not to exceed the Reasonable and Customary charges for the greater procedure, and 50% of the Reasonable and Customary charge for the lesser procedure(s).

In addition, female employees and enrolled female Dependents are eligible to receive "Surgical Care Benefits" for maternity care providing pregnancy terminates on or after the effective date of coverage. "Surgical Care Benefits" pay 95% of Reasonable and Customary charges for services rendered on or after the effective date of coverage, including prenatal care, actual delivery and postnatal care. Please refer to the "Legal Notices" section of this SPD for more information on Care Under the Mothers' and Newborns' Act.

"Surgical Care Benefits" are not payable for dental surgery. Nor are they payable for reconstructive cosmetic surgery, except to restore features damaged by accidental injury or illness occurring while covered under the Plan - or to correct congenital deformities or anomalies.

Medical Care Benefits

In addition to surgery, the Plan pays for a wide variety of other Physician services. Services payable at 100% of Reasonable and Customary charges are:

- **Elective Surgery Second Opinions** for a second opinion consultation on covered Elective Surgery currently recommended by another Physician for you or a Dependent. The opinion must be rendered by a qualified specialist who is a board certified Physician. Benefits paid include those covered diagnostic X-ray and laboratory procedures required for a valid opinion, regardless of the findings.
- **Diagnostic X-ray Examinations and Lab Tests (including Pap Smears)** performed in the Hospital outpatient department, an Ambulatory Surgical Facility, the Physician's office, a clinic or laboratory provided they are consistent with your symptoms or diagnosis. No Benefits are paid for dental X-rays or for tests covered under the Hospital portion of the Plan. Benefits for allergy testing are provided under this portion. However, allergy "treatment" is payable under **"Other Covered Charges"**

The Plan will also pay 100% of Reasonable and Customary charges for you or a Dependent to receive a routine mammography screen. Benefits are available according to the following schedule:

Age	Benefits
35-49	One baseline mammogram
40-49	Five mammogram payable at 2 year intervals
50 and older	One mammogram annually

- Cardiac Rehabilitation
- Chemotherapy (including prescription drugs)
- Electroshock Therapy in or out of the Hospital, including the administration of anesthesia by a Physician other than the doctor who provides the treatment
- Hemodialysis
- Radiation Therapy

Doctor's office visits are not covered under **"Medical Care Benefits"** but are considered for payment under the **"Other Covered Charges"** portion of the Plan.

"Medical Care Benefits" are payable at 90% of Reasonable and Customary charges for the following services:

- **Administration of Anesthesia by a Physician other than your Surgeon or his or her assistant.** Benefits are payable for surgical procedures covered by the Plan. In addition, if the medical condition is such that hospitalization and anesthesia are required for dental surgery, the charge for the anesthesia is also covered under the Plan.
- **In-Hospital Doctors' Visits (one each day per Physician per specialty).** Benefits are payable for the first 120 days of Hospital confinement under "Medical Care Benefits" except those made in conjunction with eye examinations for eyeglasses or the fitting thereof. In addition, no Benefits are paid in surgical cases (including pregnancy termination) since the cost for pre- and post- operative care is included in your Surgeon's fee. Also, no benefits are payable when hospitalization is for dental treatment.
- Benefits for hospital confinements exceeding 120 days are available under "Other Covered Charges."
- **Well-Baby Exam Benefits** are payable for one pediatric examination of a newborn child during the mother's covered confinement.
- **In-Hospital Consultation Benefits** are payable for one consultation between your Physician and another specialist while you're in the Hospital. If your condition requires the attention of a number of specialists in different specialties, Benefits will be paid for the first consultation with each one.

Remember that most of the remaining costs for those services above which are not paid at 100% can be considered for payment under "Other Covered Charges." Amounts in excess of Reasonable and Customary are not considered for payment under "Other Covered Charges".

Mental Health Care and Substance Use Disorder Treatment Program Benefits

The Plan also provides Benefits for you and your eligible Dependents for treatment of mental and nervous disorders (mental health care), and for the treatment of alcoholism, drug addiction, chemical dependency, and detoxification (substance use disorder treatment) in a facility whose treatment programs have been accredited by the Joint Commission on Accreditation of Hospital Organizations (JCAHO).

You or your Physician should notify UnitedHealthcare Well Connected prior to (or within 72 hours of) any inpatient or partial care admission by calling the telephone number on the back of your ID card.

Inpatient Mental Health Care

Eligible participants in this Plan are provided inpatient mental health care in a Covered Facility (as described below).

- This Benefit provides 100% of Reasonable and Customary charges for up to 120 days of care per confinement.
- After you have received 120 days of Inpatient care, additional Inpatient care will be considered under the "Other Covered Charges" and subject to any Deductible and copayment/coinsurance requirements.
- Physician charges are payable at 90% of Reasonable and Customary during the inpatient stay. The remaining 10%, and all Physician charges, will be considered under "Other Covered Charges" (only for the period of approved confinement).

Outpatient Mental Health Care

Outpatient therapy (Physician's fees only) is payable at 80% of Reasonable and Customary charges after the Deductible has been satisfied. Care must be considered a Covered Expense.

The remaining 20% is your responsibility. Once you have met your Out-of- Pocket Maximum Benefits for outpatient mental health care will be paid at 100% of Reasonable and Customary charges.

Inpatient Substance Use Disorder Treatment

This portion of the Plan provides for in-Hospital or JCAHO facility treatment when required to relieve, delay, or reverse current symptoms or disorders.

The Plan pays 100% of Reasonable and Customary charges for up to 120 days of care per confinement. After you have received 120 days of Inpatient care, additional Inpatient care will be considered under the "Other Covered Charges" and subject to any Deductible and copayment/coinsurance requirements.

Physician charges will be payable at 90% of Reasonable and Customary. The remaining 10% will be considered under "Other Covered Charges" (only for the period of approved confinement).

Outpatient Substance Use Disorder Treatment

The Plan will pay 100% of Reasonable and Customary charges for the professional fees per each Plan participant.

Notification Requirement

You and your Dependents are required to notify UnitedHealthcare Care Coordination for:

- Inpatient Mental Illness Benefits
- Inpatient/Outpatient Substance Use Disorder Benefits (including detoxification)

Failure to notify will result in you having to pay an additional $125 Deductible for each admission for Inpatient Substance Use Disorder and Mental Health Treatment and each series of schedule outpatient treatments for substance use disorder. Your maximum annual additional Deductible is $250.

- This Deductible will not be used to satisfy your annual Deductible or Out-of-Pocket Maximums.

Covered Facilities. Inpatient care is covered if given in a Hospital, a mental health Hospital or a Substance Use Disorder Treatment Facility. Any facility must be state- licensed and accredited by the Joint Commission on Accreditation of Hospital Organizations (JCAHO).

Covered Providers. Covered providers (inpatient and outpatient) include state- licensed psychiatrists, psychologists, and social workers.

Other Covered Charges

While "Hospital, Surgical, and Medical Care Benefits" pay most of the costs for many different medical services, there are some charges which are not paid in full and some expenses (e.g., office calls, prescription drugs, private duty nursing, etc.) that are not paid at all under those parts of the Plan.

That's where Benefits for "Other Covered Charges" help you out.

Here's how that part of the Plan works for you: During each calendar year, a "Deductible" will be applied to Covered Expenses incurred by you and each of your eligible Dependents. After you meet the Deductible in each case (refer to "Deductible and Out-of-Pocket Maximum" section), then "Other Covered Charges" pays:

- 80% of Reasonable and Customary for all remaining covered charges until these charges total $5,000, and then the Plan pays
- 100% of Reasonable and Customary for all covered charges incurred during the rest of that calendar year.

While you are covered under this Plan, there is no limit to the total amount of Benefits payable from the "Other Covered Charges" portion of the Plan for you and your Class I Dependents - regardless of age - and for each of your other eligible Dependents under age 65.

Medical expenses payable under "Other Covered Charges" include:

- Charges for semi-private Hospital room, board and other services beyond 120 days
- Reasonable and Customary charges of Physicians and Surgeons not covered by the Surgical and Medical Care portion of the Plan (e.g., office visits)
- Outpatient skilled services of private duty registered nurses or licensed practical nurses whose services are Covered Expenses and who are not members of your immediate family, or who do not ordinarily reside in your home
- Physical therapy prescribed by a Physician and performed by a qualified physical therapist
- All FDA-approved and recognized prescription drugs and medicines used during hospitalization
- Dental work or treatment required because of accidental injury to the natural teeth
- Blood and blood plasma (if not replaced)
- Artificial limbs and eyes (but not replacements due to obsolescence and/or general use)
- Rental of durable medical equipment (DME) (e.g., wheelchairs, oxygen units, delivery pumps, Home IV needles/ syringes). Purchase will be considered if the rental cost would exceed the purchase price
- Local professional ambulance service to the first Hospital where treatment is given
- Thirty-six chiropractic visits per year

Medical expenses not covered under "Other Covered Charges" include, but are not limited to:

- Air Conditioner
- Air freshening devices

- Athletic club dues
- Autopsies
- Bed Rails (may be covered if an integral part of Hospital bed)
- Bed Tables and Trays
- Bed Boards
- Bicycle
- Blood pressure kits (except for dialysis patients)
- Child's stroller
- Dietetic Foods
- Electric Fans
- Enuresis Unit
- Escalator for patient's home
- Exercycle
- Food liquidizer
- Heating pad
- Heating unit for swimming pool
- Home Elevators or similar apparatus
- Hot tubs/spas
- Humidifier (excluding those used with oxygen equipment)
- Hypo-allergenic cosmetics or toiletries, disposable briefs/underwear
- Ice bags
- Inoculations, vaccinations, immunization shots, booster shots, preventive gammaglobulin shots, etc.
- Mattresses - except when purchased with a Hospital bed—and bed under pads
- Orthopedic mattress
- Orthopedic shoes, insoles, or arch supports
- Overbed table
- Scale (weight)
- Swimming pools
- Thermometer
- Vaporizer
- Vibrating devices
- Vitamins, food, and food supplements used as dietary supplements
- Walking cane with seat
- Wheat germ
- Wigs and Wig styling
- Wines and liquors

Well Connected Program (Company Plan)

Care Coordination, provided by the Claims Administrator, is part of the Well Connected program and is designed to deliver comprehensive, personalized services and efficient care for you and your covered Dependents. This may include: admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities. Well Connected activities are not a substitute for the medical judgment of your Physician, however, and the ultimate decision as to what medical care you or your covered Dependents receive must be made by you and your Physician.

The role of Well Connected is to provide coordination of health care services and assist with the planning of health care choices for you and your covered Dependents.

Notification is mandatory to avoid a penalty. However, notification through UnitedHealthcare is not necessary when you become eligible for Medicare.

Notification Penalty

Each time you or your Dependents fail to notify UnitedHealthcare Well Connected you will be charged a $125 Deductible per occurrence, subject to a maximum annual penalty of $250. This Deductible will not be used to satisfy your annual Deductible or Out-of-Pocket Maximums.

Notification for Benefits

Well Connected is helpful when it receives notification of an upcoming treatment or service. The notification process serves as a gateway to Well Connected activities and is an opportunity to let Well Connected know that you are planning to receive specific health care services. The services requiring for notification include:

- All Hospital admissions (Inpatient)
- All Inpatient surgical procedures
- Nursing Care to include Home Health, Skilled Nursing Facility and Hospice Care
- Selected Outpatient non-surgical procedures:
  - MRI scans (Magnetic Resonance Imaging)
  - PET scans (Positron Emission Tomography)

Note: Office procedures do not require notification.

Inpatient Hospital Admission Notification

The purpose of the Inpatient Hospital admission notification by Well Connected is to verify in advance that your recommended Hospital confinement is a Covered Expense, and that the proposed plan of care is appropriate.

Surgical Notification

Surgical notification is to help prevent unnecessary surgical procedures. The purpose of the review of all (Inpatient) surgical procedures is to evaluate if a proposed surgical procedure is a Covered Expense for Benefit payment purposes.

When surgery is planned, you or your attending Physician should call Well Connected. Once Well Connected has been notified a second opinion may be requested.

Case Evaluation

Upon notification, UnitedHealthcare Care Coordination will collect information concerning the condition of the patient, the proposed treatment, the length of any proposed Hospital stay and the name of the Physician. Discussions with the Physician will help to evaluate the appropriate type and level of care.

After discussions with the Physician are concluded, UnitedHealthcare will phone the patient (or family member) to discuss the specifics of any decision, to review treatment options and to provide education and support.

If the care is approved, you will be given an authorization number by phone. In case of denial, you and your Physician will receive a letter of explanation.

If you are hospitalized, UnitedHealthcare Care Well Connected will continue to review your case to assure that your Hospital care is appropriate and consistent with your Physician's orders. UnitedHealthcare Well Connected will also work with your Physician to plan your discharge from the Hospital.

Catastrophic Case Management

Well Connected will provide individual attention to assure that you or your Dependents receive appropriate and cost-effective care in the event of a catastrophic case, such as:

- AIDS
- Major head trauma
- Amputation
- Multiple Sclerosis
- Burns
- Multiple fractures
- Eating disorders
- Spinal cord injury
- High-risk newborns
- Strokes

Administrative Procedures

It will be your responsibility to call Well Connected. The call should be made prior to admission in the case of a planned admission, and within 48 hours of the hour of admission in the case of an Emergency. In some situations, it may be necessary for a family member or others to make the call but it is ultimately the responsibility of the Participant to see that the notification has occurred.

Well Connected is available during the following hours: 6 A.M. to 8 P.M. Mountain Time Monday through Friday and can be reached at the following phone number: 800-842-1219

For after-hours and weekend calls, call 800-842-1219, and you will be instructed to leave your name, phone number, group number and Subscriber number. Your call will be returned the next working day.

Clinical Appeal Process

Well Connected will review cases based on established UnitedHealthcare medical criteria and the terms of the Plan. If your request for notification is denied, you or your Physician can appeal the denial by making a written request to:

UnitedHealthcare Appeals
P.O. Box 30432
Salt Lake City, UT 84131

Your appeal review will be handled by a Physician chosen by UnitedHealthcare who is not involved in your care or in the decision to deny your original request. Additional reviewers in the appropriate specialty area may also be consulted. You will be responsible for any costs associated with making your medical records available for review.

See the **"Benefit Claims and Appeal Procedures"** section for more details.

Prescription Drug Program (Company Plan)

The Prescription Drug Program is administered by OptumRx through UnitedHealthcare.

- BRI Medical Expense Plan and U S WEST-nonregulated Choice Plus Plan participants prior to January 1, 1991 are eligible for both the retail prescription drug program and the mail order.
- All other retiree groups in this Plan 2 are only eligible for the retail prescription drug program.

Retail Prescription Drugs

When obtaining prescription drugs directly from the pharmacy, you are purchasing the drugs at the retail costs. Once you pay for your prescriptions, you can then submit those receipts to UHC for reimbursement under the Plan's "Other Covered Charges" benefit provision for eligible prescriptions. This covers 80% of the retail cost of the prescription drug. Your retail prescription drug expenses can be submitted to:

UnitedHealthcare
P.O. Box 30555
Salt Lake City, UT 84130

Home Delivery (mail service)

When using this service, you are purchasing maintenance drugs through the mail order program paying a copay per prescription.

This program is only available if you were participating in either the BRI Medical Expense Plan or the US WEST-nonregulated Choice Plus Plan prior to January 1, 1991, you are eligible to participate in the Home Delivery Prescription Drug Program. If you were covered by any other Predecessor Plan, you are not eligible to participate in the Home Delivery Prescription Drug Program.

The Home Delivery Prescription Drug Program is an option to the "Other Covered Charges" portion of the Retiree Health Care Medical Plan 2. The Home Delivery Prescription Drug Program provides eligible participants, required to take medication on a long-term basis, with a choice for each prescription. You may utilize either the "Other Covered Charges" portion of the Plan or the Home Delivery Prescription Drug Program.

Each prescription sent into the Home Delivery Prescription Drug Program requires a $3.00 co-payment. The medication will be sent to your home via first class mail.

The Home Delivery Prescription Drug Program is administered by OptumRx, a mail service pharmacy.

When switching to mail order (for first time users), take the following steps:

- Log on to myuhc.com
- Click on "Manage My Prescriptions" and select "Transfer Prescriptions".
- Select the current medications you would like to transfer.
- Print out the pre-populated form and take this to your doctor.

Ask your doctor to call 800-791-7658 or fax in the prescriptions with the order form to 800-491-7997. You will need to give your Physician your ID number located on your ID Card.

Once OptumRx receives your complete order for a new prescription, your medications should arrive within ten business days – completed refill orders should arrive in about seven business days.

You can also:

- Complete the OptumRx By Mail Order Form
- Enclose your prescriptions(s) and the appropriate Copay for each prescription and mail to: OptumRx, Attn: Claims Department, P.O. Box 29077, Hot Springs, AR 71903
- Or, you can ask your Physician to call 800-791-7658 with your prescriptions or fax them to 800-491-7997 on your behalf. You will need to give you Physician your ID number located on your ID Card.

Refills through mail order can be ordered online, by phone or by mail. For online refills, log on to the website at myuhc.com, then click "Prescriptions" in the main menu and follow the directions online. Have your ID number, prescription number and credit card number available for reference. For phone or by mail, follow the instructions above.

The toll-free telephone number for you to use is 800-842-1219. This number is available 24 hours a day, 7 days a week.

Unless your doctor indicates otherwise, OptumRx will dispense a generic equivalent when available and permissible under the law.

Note: Brand name drugs and their generic equivalents must, by law, meet the same standards for safety, purity, strength, and effectiveness.

Learn more about your pharmacy benefit by going to myuhc.com. After you register, log in and click on the "Prescriptions" tab and then on "Drug Pricing/Coverage." You can access:

- Copays, pricing, and coverage information about most prescription medications
- Information about lower-cost medication alternatives
- A list of participating retail pharmacies by ZIP code
- Your prescription history

Although the Prescription Drug Program covers most medications that require a prescription, some items that are excluded from the Home Delivery Prescription Drug Program are:

- drugs that do not require a prescription (i.e., over the counter drugs), other than insulin
- therapeutic appliances or durable medical equipment
- prescriptions written for a quantity of medication which exceeds 90 days (only the excess is excluded)
- drugs which an eligible participant is to receive without charge from Worker's Compensation laws or any municipal, state, or federal program
- "Investigational" or "Experimental" drugs
- contraceptive devices
- prescribed for appetite suppression and other weight loss products
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a prescription order or refill. Compounded drugs that are available as a similar commercially available Prescription Drug.
- dispensed outside of the United States, except in an Emergency

Exclusions of Benefits (Company Plan)

Although the Plan covers a broad range of services and supplies, there are some expenses - as in all plans of this type - that are not covered. These expenses include, but are not limited to:

- any services received before coverage under this Plan becomes effective
- charges for any occupational illness or injury
- care, treatment, services or supplies that are not a Covered Expense for the treatment of injury or disease (and includes supplies such as disposable supplies, except Ostomy and Catheter and diabetic supplies)
- diagnostic studies (except Pap Smears and Mammograms) which do not reveal an illness or injury unless there is satisfactory proof of a definite symptomatic condition requiring medical attention
- routine health checkups
- Hospital private room and board charges in excess of the semi-private room rate - or if an all-private room Hospital - in excess of 90% of the most prevalent private room rate
- charges paid or payable under the laws of any government except for care or service provided to a veteran for a non-service-connected disability
- all non-surgical procedures for treatment of temporomandibular joint dysfunction
- orthodontia related to an accident
- surgery that is intended to allow you to see without glasses or other vision correction including radial keratotomy, laser, LASIK, and other refractive eye surgery
- infertility treatment (i.e., artificial insemination and invitro fertilization, GIFT and related charges by any method)
- charges for weight reduction program, exercise sessions, and related nutritional therapy
- charges related to any type of automobile accident/injury
- charges for experimental drugs or medical procedures, food supplements or vitamins
- expenses incurred for services by a non-professional or unlicensed Physician
- charges for cytotoxic food testing (mental and nervous)

- charges for routine footcare
- charges resulting from injury received while in the act of committing a crime
- contraceptive devices
- services for which you have no legal obligation to pay, including those which would normally be provided without charge in the absence of this Plan
- charges in excess of those considered Reasonable and Customary by UnitedHealthcare
- charges connected with any dental care or treatment except those specifically provided for under the terms of this Plan
- charges for personal services such as radio and TV rental, guest meals, and barber services
- charges for eyeglasses or hearing aids and examinations or prescriptions for them except the initial pair of eyeglasses or hearing aid required because of injury or surgery which occurs while covered under the Plan
- care in a nursing home, convalescent home, home for the aged, custodial care or rest cures
- cosmetic surgery or treatment unless required because of injury or disease, or to correct a birth defect
- thermography (except as provided under Chiropractic services)
- services of providers other than those defined under this Plan
- amounts paid by Medicare or other non-Lumen plans

Claiming Benefits (Company Plan)

All the Benefits provided by the Company Medical Plan can be claimed using the claim form for Lumen Retiree and Inactive Medical Plans. You can obtain a claim form by calling UnitedHealthcare Customer Service at 800-842-1219, or log onto myuhc.com.

Follow the instructions for completing the form and send it along with all itemized bills to the address shown on the claim form to UnitedHealthcare, P.O. Box 30555, Salt Lake City, UT 84130. Medicare-eligible individuals should also send the Explanation of Medicare Benefits (EOMB Form).

Claims should be as complete as possible and must show:

- participant's full name and Social Security number
- full name and Social Security number of patient
- date of service and where provided
- diagnosis
- type of service
- amount charged
- registration or license number of registered nurse or licensed practical nurse (if applicable)

In addition, bills for prescription drugs should show the prescription number, the purchase date, and the name of the prescribing Physician. Any pharmacy ledgers submitted for consideration must be signed by the pharmacist. Bills for nursing care should be accompanied by a note from the attending Physician stating that nursing care is required.

In most cases you will be able to submit your claims immediately after the services are rendered, and it is recommended that claims be submitted to the Claims Administrator within 90 days. Claims which are not submitted within 15 months from the date the services were rendered will not be accepted for payment. Prescription drug claims can be submitted when they are incurred, and not just at the end of the calendar year.

If you have questions about a claim, you should contact UnitedHealthcare Customer Service at the address or phone number shown on the claim form, or 800-842-1219.

Note: On limited occasions, you may believe you have a claim relating to the Plan that cannot be handled by UnitedHealthcare. In such cases, you should submit your claim in writing to the Plan Administrator. You will be contacted about your concern, and if appropriate, your claim will be considered by the Plan Administrator under the same type of process as described under "Benefit Claims and Appeals Procedures" below.

Benefit Claims and Appeal Procedures

Network Benefits

In general, if you receive Covered Health Services from a Network provider, the Claims Administrator will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Coinsurance, please contact the provider or call the Claims Administrator at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Out-of-Network Benefits

If you receive a bill for Covered Health Services from a Out-of-Network provider, you (or the provider if they prefer) must send the bill to the Claims Administrator for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to the Claims Administrator at the address on the back of your ID card. The Claims Administrator's address is also shown in the Claims Administrator and Contact Information section.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- you are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Plan should have paid for it; or
- you pay Coinsurance and you believe that the amount of the Coinsurance was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

How to File Your Claim

You can obtain a claim form by visiting myuhc.com or calling the toll-free number on your ID card or contacting Lumen Health and Life Service Center for Health and Welfare Benefits. If you do not have a claim form, simply attach a brief letter of explanation to the bill and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Retiree;
- the number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:
- the Current Procedural Terminology (CPT) codes;
- a description of, and the charge for, each service;
- the date the Sickness or Injury began; and
- a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the othercarrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with the Claims Administrator at the address on your ID card. When filing a claim for outpatient Prescription Drug Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

After the Claims Administrator has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the Out-of-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

The Claims Administrator will pay Benefits to you unless:

- the provider notifies the Claims Administrator that you have provided signed authorization to assign Benefits directly to that provider; or
- you make a written request for the Out-of-Network provider to be paid directly at the time you submit your claim.

The Claims Administrator will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider has assigned Benefits to that third party.

Health Statements

Each month in which the Claims Administrator processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at myuhc.com. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that the Claims Administrator send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at myuhc.com. See the Glossary section for the definition of Explanation of Benefits.

Important - Timely Filing of Out-of-Network Claims

All claim forms for Out-of-Network services must be submitted within 12 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. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call the Claims Administrator at the number on your ID card before requesting a formal appeal. If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

When appealing a denied claim, please be aware that there are Service Claim appeals processed by the Claims Administrator as well as Eligibility/Participation appeals processed by the Plan Administrator. Both types of appeal have two levels of appeal processing each with their own requirements as described below.

How to Appeal a Denied Service Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your Level 1 appeal in writing within 180 days of receiving the claim denial which is also called an “adverse benefit determination”. You do not need to submit Urgent Care appeals in writing. Your appeal of a denied claim should include:

- the patient’s name and ID number as shown on the ID card;
- the provider’s name;
- the date of medical service;
- the reason you disagree with the denial; and any documentation or other written information to support your request

Note: If you are appealing an excluded drug, submit a letter to UHC from your doctor stating the medical condition that requires the non-covered drug and the length of projected use. The appeal will be reviewed and, if approved, you will be able to purchase your prescription at your local network pharmacy or by mail order by paying the applicable Coinsurance amount. If it is denied, you may appeal as explained below.

The applicable Coinsurance amount. If it is denied, you may appeal as explained below. You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare Self-Insured - Appeals
Box 30432
Salt Lake City, Utah 84131-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call the Claims Administrator at the toll-free number on your ID card to request an appeal. The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Review of an Appeal

The Claims Administrator will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if the Claims Administrator upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

There are offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Claims Administrator within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, you may request to examine documents relevant to your claim and/or appeals and submit opinions and comments. The Claims Administrator will review all claims in accordance with the rules established by the U.S. Department of Labor.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by the Claims Administrator, or if the Claims Administrator fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of the Claims Administrator's determination.

You may request an external review of an adverse benefit determination if the denial is based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. **Please Note this Deadline:** A request must be made within (4) four months after the date you received the Claims Administrator's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). The Claims Administrator has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by the Claims Administrator of the request;
- a referral of the request by the Claims Administrator to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, the Claims Administrator will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the preliminary review, the Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Claims Administrator will assign an IRO to conduct such review.

The Claims Administrator will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

The Claims Administrator will provide to the assigned IRO the documents and information considered in making the Claims Administrator's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by the Claims Administrator; and

- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and the Claims Administrator will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Claims Administrator. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and the Claims Administrator, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing the Claims Administrator determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances, you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, the Claims Administrator will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the review, the Claims Administrator will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Claims Administrator will assign an IRO in the same manner the Claims Administrator utilizes to assign standard external reviews to IROs. The Claims Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Claims Administrator. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to the Claims Administrator.

You may contact the Claims Administrator at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- **Urgent Care request for Benefits -** a request for Benefits provided in connection with Urgent Care services, as defined in the Glossary section;
- **Pre-Service request for Benefits -** a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- **Post-Service -** a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and the Claims Administrator are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	24 hours
You must then provide completed request for Benefits to the Claims Administrator within:	48 hours after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	72 hours
If the Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	5 days
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	15 days
You must then provide completed request for Benefits information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial request for Benefits is complete, within:	15 days
• after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination

Pre-Service Request for Benefits Type of Request for Benefits or Appeal	Timing
The Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within	15 days after receiving the second level appeal

Post-Service Request for Benefits Type of Request for Benefits or Appeal	Timing
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial claim is complete, within:	30 days
• after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination (file first level appeal) no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre- service timeframes, whichever applies.

Eligibility/Participation Claim

After you receive an initial denial of a submitted claim, there are two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Claims Administrator within 180 days from the receipt of the first level appeal determination. The below chart outlines both the timeline for filing an appeal by you and for receiving responses from the Claims Administrator.

Eligibility/Participation Claims Type of Claim or Appeal	Timing
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The Claims Administrator must notify you of the benefit determination:	
• if the initial claim is complete, within:	30 days
• after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination (file first level appeal) no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	180 days after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision for eligibility/participation claim within:	60 days after receiving the second level appeal (up to an additional 30 days may be required if necessary)

Time Deadline to File a Benefit Claim and the Time Deadline to File a Benefit-Related Lawsuit

The Health Plan provides that no person has the right to file a civil action, proceeding or lawsuit against the Health Plan or any person acting with respect to the Health Plan, including, but not limited to, the Company, any Participating Company, the Committee or any other fiduciary, or any third party service provider unless it is filed within the timing explained as follows below:

Initial Claim: The time frame for filing an initial claim for a premium Payroll Adjustment is the earlier of:

1. Within 180 days of an adverse decision by the Plan Administrator, or
2. The earlier of:
   - Within 180 days of the effective date of an election that is later claimed to be erroneous, or
   - 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. Appeals from a claim denial must also be timely filed as described in the Summary Plan Description.

Legal Action Deadline: After you have exhausted or completed the claims and appeals procedures as explained above, you may pursue any other legal remedy, such as bringing a lawsuit or civil action in court provided, that you file a civil action, proceeding or lawsuit against the Plan or the Plan Administrator or the Claims Administration no later than the last day of the twelfth month following the later of (1) the deadline for filing an appeal under the Plan or (2) the date on which an adverse benefit determination on appeal was issued to you with respect to your Plan benefit claim.

This means that you cannot bring any legal action against the Plan, the Employee Benefits Committee or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action, you must do so no later than the last day of the 12th month from the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan, or the Claims Administrator.

The Required Forum for Legal Disputes

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

False or Fraudulent Claims

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

When You are Eligible for Medicare

Medicare Eligibility

You and your Dependents each become eligible for all parts of Medicare when each participant reaches age 65, or before reaching age 65 if disabled and 24 months of disability payments have been received from Social Security. Medicare is also available at any age if the individual has chronic kidney disease and requires dialysis or a kidney transplant.

For all Lumen medical plan benefit options: In order to have the maximum coverage, you must enroll in Medicare Part A and B upon becoming eligible and you must maintain coverage under both Parts A and B at all times.

Medicare Part D. As long as the Health Plan has creditable prescription drug coverage, you do not need to take Medicare Part D when you are enrolled under the Company Medical or the UHC Medicare Advantage medical benefit options. You will be notified annually of the plans creditable coverage status.

Medicare Status and the UHC Medicare Advantage Benefit Option: You or your eligible Dependent(s) must be Medicare eligible and enrolled in both Medicare Part A and B in order to elect this benefit option. See **"Additional Enrollment Information"** and the **"Termination of Medical Coverage"** sections for more information on enrolling and disenrolling from the Medicare Advantage benefit option.

Medicare Status and the Health Reimbursement Account (HRA) Benefit Option: You and your eligible Dependent(s) must be Medicare eligible and should be enrolled in both Medicare Part A and B if you elect this option. Since this option has no medical or prescription drug coverage, you must have your Medicare Parts A and B in order to enroll in an individual Medicare type policy to obtain your own medical and prescription drug benefits outside of the Company. Once you obtain your individual policy and depending on what type of individual Medicare policy you purchase, a Medicare Part D policy may also be needed for prescription drug coverage. As a reminder, Medicare enrollment dates for individual Medicare plans may vary from the Company Annual Enrollment dates and are governed by Medicare.

Medicare Part B Reimbursement

The government charges monthly premiums for Medicare Part B. Upon request and proof to the Company of your Medicare Part B coverage, the Company will reimburse Retirees and their eligible Class I Dependents for their Medicare Part B premiums paid to the Federal government as described below. **Note:** The Company will not reimburse for any late enrollment Medicare Part B penalties.

Medicare Part B reimbursement occurs once the Lumen Health and Life Service Center receives a copy of the Medicare card which includes Part B, confirming your enrollment in the required Medicare coverage. Reimbursement will begin effective the first of the following month after receipt. Retroactive reimbursements will not be made.

Note: If Medicare requires you to pay a higher Medicare Part B premium due to high- income eligibility, you must notify the Lumen Health and Life Service Center regarding your reimbursement amount. Again, proof (the Social Security Administration letter) must be received before the higher amount will be paid to you.

You Are Not Eligible for Medicare Part B Reimbursement, if:

- You are a LTD Recipient who is not eligible for retiree health care
- You are a Surviving Spouse of a Primary Participant who was eligible for Medicare Part B reimbursement
- You are a Surviving Spouse

Medicare Part B Reimbursement Overpayments: If you receive an overpayment of Medicare Part B premium payments regardless of the source of the error, the Plan will seek reimbursement of that overpayment. Refer to "Refund of Overpayments" in the "General Information" section later in this SPD for more information on how overpayments are recovered. For this reason, it is very important to confirm that you are receiving the correct Medicare Part B Reimbursement. For questions call the Lumen Health and Life Service Center at 866-935-5011 or 800-729-7526.

Chronic Kidney Disease

If you or any of your eligible Dependents become eligible for Medicare due solely to chronic kidney disease requiring dialysis or a kidney transplant, Plan coverage will continue as the primary coverage during the first 30 months. During this 30-month period, claims for Covered Expenses should be filed with UnitedHealthcare first - then filed with Medicare. After the 30-month period, claims should be filed with Medicare first. Your claims should also be filed with Medicare first during any period of time that you or any of your eligible Dependents are eligible for Medicare by reason of both chronic kidney disease and either another disability or becoming age 65. Upon proof to the Lumen Health and Life Service Center, the Company will reimburse eligible Plan participants their premiums paid to the government for Medicare Part B coverage, if it is for them or a Class I Dependent as described above.

Coordination of Benefits

Coordination of Benefits (Company Plan) and other Plans

The Plan contains a Coordination of Benefits (COB) provision for the Company Medical Plan. Under this provision, if you or any of your Dependents are covered under more than one group medical or prepayment plan, employer-sponsored plan, or are entitled to medical Benefits from any other source (excluding Medicare or your own individual insurance policy), you can receive up to 100% of covered medical expenses from all plans combined - but not more than that. This prevents anyone from collecting more than actual expenses; but at the same time, it generally provides full reimbursement for the allowable benefit of the Covered Expenses.

Under the COB provision, the Claims Administrator determines which plan has primary responsibility and which plan has secondary responsibility. The primary plan always pays first. Briefly, COB works like this:

1. The Benefits of a Plan which does not have a provision for Coordination of Benefits will be primary.
2. The Benefits of a Plan which covers the claimant directly, rather than as a Dependent, will be primary.
3. The Benefits of a Plan which covers the claimant as a dependent child shall be determined as follows:
   - If a Dependent child is covered under both parents' plans, the parent whose birthday falls earlier in the calendar year pays first. If both parents have the same birthday, the Plan which covered one parent longer pays first. The Plan which covered the other parent for a shorter time pays second.

- When the parents are separated or divorced, neither the birthday rule nor the gender rule apply. If there is a court decree that establishes financial responsibility for the health care expenses with respect to the child(ren), the Benefits are determined in agreement with the court decree. Otherwise, if the parent with custody has not remarried, the Plan of the parent with custody is primary, and the Plan of the non-custodial parent is secondary. If the parent with custody has remarried, the Plan of the parent with custody is primary, the step-parent's Plan is secondary, and the Plan of the parent without custody pays third.

4. If the rules in 1, 2 and 3 immediately above do not establish an order of benefit determination, the Benefits of a Plan which has covered the claimant for the longer period of time shall be primary, with the following exception; the Benefits of a Plan covering the person as a laid-off or retired Employee, or a Dependent of such person, shall be determined after the Benefits of any other Plan covering the person as an Employee (or a Dependent of an Employee).

Benefit claims should always be filed first with the primary plan. After the primary plan has paid its portion of the bill, a copy of the original bill and the "explanation of benefits" from the primary plan carrier must be sent to UnitedHealthcare in order to receive consideration for secondary Benefits.

Coordination With Other Benefit Plan Options

Coordination of Benefits, if any, may be different for the other benefit plan options. Check with that plan directly for more information on how COB works.

Coordination with Medicare (Parts A & B) and Benefit Plan Options

Company Medical Plan benefit option. As an eligible Retiree, your Plan coverage may continue. If you or any of your eligible Dependents or Sponsored Children becomes eligible for Medicare during this time - unless eligibility is due solely to chronic kidney disease - claims should be submitted to Medicare before being submitted under the Plan. Therefore, you are required to obtain Medicare Parts A and B upon Medicare eligibility and maintain them at all times.

Under the Company Medical Plan, Medicare Benefits are calculated according to the carve-out method and coordinated with Medicare. The Plan is not a Medicare Supplement plan (sometimes called "gap" plans) and does not automatically pay the balance due after Medicare has made payment. To determine the amount payable after Medicare's payment, Benefits that would be available in the absence of Medicare are calculated first. These Benefits are then reduced by any Benefits that would be payable from Medicare, whether or not you actually apply for benefits from Medicare. Your combined amount due from Medicare and the Plan will never exceed the amount available under theCompany Medical Plan alone.

Example: If the Covered Benefit is payable at 80% and Medicare would have paid 80%; then the Company Plan pays $0. If Medicare would have paid 60% for this benefit, then the Company Plan pays 20% to equal the 80% benefit covered by the Plan. It does not pay 100% of your cost.

Remember, it's important to sign up for Medicare when first eligible and maintain them at all times to assure the highest level of coverage and to avoid a gap in coverage.

UHC Group Medicare Advantage benefit option. If you are enrolled under the UHC Group Medicare Advantage benefit option, your Medicare coordination of benefits are managed for you by UHC according to those plan provisions. Therefore, you are required to maintain your Medicare Parts A and B at all times. You typically only have to pay your copay at the time of service, if any, applicable to the benefit coverage. You do not have to worry about what portion Medicare covers.

Health Reimbursement Account benefit option. If you are enrolled in the HRA benefit option, it will depend on which type of individual policy you purchase as to how Medicare coordination is applied. However, these Medicare type policies require that you maintain your Medicare Part A and B. Contact your specific carrier for more information.

Note: Regardless of which medical benefit option you elect, upon request and with proof of Medicare Part B coverage, the Company will reimburse Retirees and their eligible Class I Dependents for their Medicare Part B premiums paid to the government when enrolled in the Plan as described above under "Medicare Part B Reimbursement."

Coordination with Medicare and Pharmacy Benefits

Company Medical Plan benefit option. Unless otherwise notified by the Company, the Company Medical Plan's coverage of prescription drugs is creditable; therefore, you are not required to also enroll in a separate Medicare Part D plan. (Note: Pharmacy and prescription Benefits for participants who enroll in both a Medicare Part D prescription plan and who enroll in both the Company Medical Plan benefit option under the Health Plan shall have those Benefits coordinated and prescription drug claims would be filed with Medicare first, as it would become Primary, before the Company Plan.) Unless the Plan is primary, prescription Benefits under the Plan will be reduced by the amount payable by Medicare Part D for the same Covered Expenses (whether the amount payable by Medicare is actually made). This prescription Benefit coordination applies only to Medicare Part D coverage and not to prescription Benefits under private plans. To the extent your pharmacy and prescription expenses are not paid by your Medicare Part D plan, claims can be filed with the Plan.

UHC Group Medicare Advantage benefit option. If you are enrolled in the Group Medicare Advantage benefit option, prescription drug coverage is provided under that benefit option and you should not need to purchase additional Medicare Part D coverage. Medicare benefits are managed for you by the UHC Medicare Advantage plan according to the plan provisions for coverage. Contact the UHC Medicare Advantage plan at the number on the back of your ID card for creditable coverage and Medicare Part D coordination information.

Health Reimbursement Account benefit option. If you are enrolled in the HRA, it will depend on which type of individual polic(ies) you purchase/enroll in as to whether or not you need separate or additional Medicare Part D coverage. Contact your specific carrier (or broker) for more information.

Note: Regardless of which Lumen benefit option you select, coordination with Medicare will be applied according to the specific benefit provisions of that option.

Credit for Savings (Company Plan)

When the Company Plan does not have to pay full Benefits due to Coordination of Benefits, the savings will automatically be credited to you to pay for unpaid allowable expenses of the same type in the same calendar year. For example, if the Plan saves $100 on your medical expenses due to Coordination of Benefits, you will be credited with that $100 to use toward a medical Deductible or your portion of a medical coinsurance payment. These "saving credits" are forfeited at the end of each year. Therefore, you must meet your Deductible each year before the credits can start accumulating. Contact UHC directly for more information.

Right of Full Restitution (Subrogation) and Reimbursement

The Health Plan does not provide Benefits for any accident, Injury or Sickness for which you or your eligible Dependents have, or may have, any claim for damages or entitlement to recover from another party or parties arising from the acts or omissions of such third party (for example, an auto accident). This includes, but is not limited to, any claim for damages or entitlement to recover from your or another party's:

- Underinsured and uninsured motorist coverage
- No fault and medical payments coverage
- Other medical coverage
- Worker's compensation
- Short term and long-term disability coverage
- Personal injury coverage
- Homeowner's coverage
- Other insurance coverage available

No-fault insurance benefits and auto medical payments coverage should always be selected as the primary coverage if given a choice when purchasing automobile insurance coverage as the Benefits available under this Plan are secondary to automobile no-fault and medical payments coverage.

In the event that another party fails or refuses to make prompt payment for the medical expenses incurred by you or your eligible Dependents when expenses arise from an accident, Injury or Sickness, subject to the terms of the Plan, the Plan may conditionally advance the payment of the Benefits. If the Plan advances payment of Benefits, the terms of this entire subrogation and reimbursement provision shall apply, and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the Covered Individual identifies the medical benefits the Plan advanced. The Plan's right of full reimbursement shall not be reduced or limited in any way by the Covered Individual's actual or alleged comparative fault or contributory negligence in causing the injury(ies) or accident for which the Plan advanced medical benefits.

Benefits Conditional Upon Cooperation

By participating in the Plan, you and your eligible Dependents acknowledge and agree to the terms of the Plan's equitable or other rights to full restitution, reimbursement or any other available remedy. You will take no action to prejudice the Plan's rights to restitution, reimbursement or any other available remedy. You and your eligible Dependents agree that you are required to cooperate in providing and obtaining all applicable documents requested by the Plan Administrator or the Company, including the signing of any documents or agreements necessary for the Plan to obtain full restitution, reimbursement or any other available remedy.

Other Party Liability

If you or your Eligible Dependent is injured or becomes ill due to the act or omission of another person (an "other party"), the Plan Administrator shall, with respect to Services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution, reimbursement, subrogation or any other available remedy to recover the amounts the Plan Administrator paid for Services provided to you or your Eligible Dependent from any recovery

(defined below) obtained by or on behalf of you or your Eligible Dependent, from or on behalf of the third party responsible for the injury or illness or from your coverage, including but not limited to uninsured/underinsured motorist coverage, other medical coverage, no-fault coverage, workers' compensation, STD and LTD coverage, personal injury coverage, homeowner's coverage and any other insurance coverage available.

The Plan Administrator's right to restitution, reimbursement or any other available remedy, is against any recovery you or your Eligible Dependent receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage or other coverages listed above, related to the illness or injury (the "Recovery"), without regard to whether the you or your Eligible Dependent has been "made whole" by the Recovery and without reduction for any attorney fees and costs paid or owed by or on your behalf by you or your Eligible Dependent. You and your eligible Dependents are responsible for all expenses incurred to obtain payment from any other parties, including attorneys' fees and costs or other lien holders, which amounts will not reduce the amount due to the Plan as restitution, reimbursement or any other available remedy.

You or your Eligible Dependent is required to:

1. Notify the Plan Administrator in writing of any actual or potential claim or legal action which such you or your Eligible Dependent expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,
2. Agree to fully cooperate with the Plan Administrator to execute any forms or documents needed to enable the Plan Administrator to enforce its right to restitution, reimbursement or other available remedies; and,
3. Agree to assign to the Plan the right to subrogate and recover Benefits directly from any third party or other insurer. A Plan representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Plan's equitable (or other) right to obtain full restitution, reimbursement or any other available remedy.
4. Agree, to reimburse the Plan Administrator for Benefits paid by the Plan Administrator from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage or other coverage; and,
5. Provide the Plan Administrator with a lien in the amount of Benefits actually paid. The lien may be filed with the third party, the third party's agent or attorney, or the court; and,
6. Notify HMS Claims Recovery Solutions at 1 888-556-3373 or at resources.hms.com/tpl-questionnaire.com, or fax at 1 402-384-5190 as soon as possible, that the Plan may have a right to obtain restitution, reimbursement or any other available remedy of any and all Benefits paid by the Plan. This also means that if you or your Eligible Dependent goes to the Hospital because of an accident, Sickness or Injury that is the result of the actions of another party, you must inform the hospital staff that the Sickness or Injuries are the result of the actions of another for which that other person may be liable. Generally, the hospital staff notes this information on the report that is submitted to the Plan's Claims Administrator. You will later be contacted by the Plan or its recovery vendor and you must provide the information requested. If you retain legal counsel, your counsel must also contact the Plan or its recovery vendor; and,
7. Inform the Plan t in advance of any settlement proposals advanced or agreed to by another party or another insurer; and
8. Provide the Plan Administrator all information requested by the recovery vendor and the Plan Administrator regarding an action against another party, including an insurance carrier; this includes responding to letters from the Plan and its recovery vendor on a timely basis; and
9. Not settle, without the prior written consent of the Plan Administrator, or its designee, any claim that you or your eligible Dependents may have against another party, including an insurance carrier; and
10. Take all other action as may be necessary to protect the interests of the Plan.

In the event you or your eligible Dependents do not comply with the requirements of this section, the Plan may deny Benefits to you or your eligible Dependents or take such other action as the Plan Administrator deems appropriate.

Note: The Plan (Health, Life, Disability, BTA/ADD) is subject to ERISA. Certain plans - specifically, the Health Plan and Disability Plan - are self-funded, and for those plans you and your Eligible Dependent are also required to do the following:

1. Ensure that any Recovery is kept separate from and not comingled with any other funds or you or your Eligible Dependent's general assets (for example, your household checking account) and agree to hold and retain that the portion of any Recovery required to fully satisfy the lien or other right of Recovery of the Plan in trust for the sole benefit of the Plan until such time it is conveyed to the Plan Administrator; and
2. Direct any legal counsel retained by you or your Eligible Dependent or any other person acting on behalf of you or your Eligible Dependent to hold 100% of the Plan's payment of benefits or the full extent of any payment from any one or combination of any of the sources listed above in trust and without dissipation except for reimbursement to the Plan or its assignee and to comply with and facilitate the reimbursement to the Plan of the monies owed it.

What Happens to Settlements, Refunds, Rebates, Reversions to the Plan

For purposes of this Plan, any and all reversions, settlements, rebates, dividends, refunds or similar amounts or forms of distribution, of any type whatsoever, paid, provided or in any way attributable to the maintenance of a benefit program under this Plan, including but not limited to any outstanding benefit payments or reimbursements that revert to the Company after remaining uncashed or unclaimed for a period of 12 months, shall be the sole property of the Company, and no portion of these amounts shall constitute "assets" of the Plan, unless and to the extent otherwise required by applicable law.

See **"Refund of Benefit Overpayments"** in the **"General Information"** section near the end of this SPD for more information regarding the Plan's rights of recovery.

Termination of Medical Coverage

There are several situations that will cause the medical care coverage for you or your covered Dependents to end. However, your Dependents may be eligible to continue coverage, at a cost. For more information, see the "Continuation of Medical Coverage" section below.

Note: The information for termination of and continuation of Medical coverage is different than the information for DENTAL coverage. Please see these same sections in your "Retiree Health Care Dental Plan SPD" for details.

Medical coverage will end as described below:

Death of Retiree ("primary participant"). All coverage ends for the Surviving Spouse, other Class I Dependents, Class II Dependents, and Sponsored Children on the last day of the month in which the primary participant dies. However, if continued coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") is elected, medical coverage will continue with the level of Company subsidy (if any) previously in effect through the last day of the sixth full calendar month following the date of the primary participant's death for the Surviving Spouse, other Class I Dependents, Class II Dependents and Sponsored Children previously covered the day before the QLE, under the Lumen Retiree and Inactive Health Plan. See all Surviving Spouse information under the **"Continuation of Medical Coverage (Under COBRA)"** section later in this SPD.

Termination from the UHC Medicare Advantage benefit option. For the death of a retiree, termination from this benefit option is treated as it is under the Company Medical Plan with 6 months of subsidized coverage as described above, and

the same COBRA rules will apply. See all Surviving Spouse information under the **"Continuation of Medical Coverage (Under COBRA)"** section later in this SPD.

Special Termination Rules for exiting a Medicare Advantage benefit option. If you do not elect to continue this benefit option at Annual Enrollment, during the year or through COBRA (upon a QLE), you must take additional steps before Medicare will release you from this benefit plan option. In order for you to voluntarily terminate or cancel your enrollment from the Medicare Advantage benefit option—you must complete the Medicare disenrollment process. We cannot simply move you from one benefit option to another once you have enrolled in the Medicare Advantage benefit option. Contact the Lumen Health and Life Service Center and request/complete the disenrollment form. Medicare will not release you from this enrollment without the form or another type of formal request in writing when you are initiating cancellation of this plan. All terminations/cancellations will be effective the first of the following month after the form is received by the Lumen Health and Life Service Center. Medicare does not allow any retroactive termination effective dates and may not allow a re-enrollment until the next Annual Enrollment period.

Note: The Plan may terminate you from these benefit options for certain other reasons such as failure to pay, moving out of the service area or the discontinuance of the group UHC Medicare Advantage benefit option without the disenrollment form.

Contact the Lumen Health and Life Service Center for more details. Also, see the **"Additional Enrollment Information"** section later in this SPD.

Termination from the Health Reimbursement Account benefit option. You may change your election from this HRA benefit option each year at Annual Enrollment or during the year if you have an eligible Qualifying Life Event. The enrollment (and disenrollment processes) with an individual Medicare policy is directly between you and the carrier. You must follow Medicare rules and your selected carrier's rules and provisions related to all aspects of participation in that policy.

Nonpayment of contributions or cancellation. Coverage for all participants whose coverage requires a premium contribution (e.g., Class II, Sponsored Children or Surviving Spouse premiums) ends on the last day of the month during which you stop paying the required premium contribution for you or your covered Dependents or when you request cancellation of premium contributions. If you are enrolled in the Medicare Advantage benefit option or individual Medicare plans, you must also complete any required disenrollment information.

If your coverage is terminated due to non-payment, you will not be allowed to add coverage until the next Annual Enrollment, with coverage effective January 1st of the following plan year. You will be informed of your right to appeal that determination. If you experience a QLE, you may be allowed to add coverage due to that QLE (loss of other coverage, marriage, etc.) in accordance with Plan rules. Your requested change in coverage must be consistent with the QLE you experienced. You must notify the Lumen Health and Life Service Center within 45 days of the QLE in order to change your coverage. For surviving dependents, non- payment or waiver of coverage will discontinue participation in the benefit options at any time in the future.

Note: In the event your coverage is terminated due to non-payment or insufficient payment, and you have sent in a payment which is received by our Claims Administrator but not on a timely basis, that payment may be cashed due to the delay in updating records internally; however, you will receive a refund of such payment and your coverage will not be reinstated, except as determined upon appeal. Additionally, if you receive a notice that your coverage has been terminated due to non-payment or insufficient payment, it is suggested that you call the Lumen Health and Life Service Center for more information. Checks that are returned or EFTs that are refused are not re-deposited. Payment is to be timely received by the Claims Administrator or coverage will be terminated.

Class I Dependents: Coverage for these Dependents also ends:

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

Class II Dependents and Sponsored Children: Coverage for these Dependents also ends:

- On the last day of the month in which the person ceases to qualify as a Class II Dependent or Sponsored Child. Class II and Sponsored Dependent children may elect coverage under COBRA independently of the Surviving Spouse and/or Class I Dependents.

Loss of long-term disability recipient status. Coverage for you and your covered Dependents ends on the last day of the month in which you die or when your long-term disability status ends. If you are also receiving a the provisions of COBRA. If you are not receiving a service or disability pension at the time of your death, continuation coverage under COBRA for your Dependents is not available.

Continuation of Medical Coverage (Under COBRA)

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

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

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

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

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

- the death of your Spouse;
- divorce from your Spouse;
- your Spouse becoming entitled to Medicare; or
- the commencement of certain bankruptcy proceedings involving the Company.

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

- the death of the Retiree;
- parents' divorce;
- you cease to be a "Dependent child" under the terms of the Plan. (Example: child reaching his/her age limitation, or any other change in status which affects eligibility for coverage).

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

The covered Retiree, Spouse, or Dependent Child has the responsibility to directly inform the Lumen Health and Life Service Center of a divorce or a child losing Dependent status under the Plan, both of which are "Qualifying Events." Notice to the Lumen Health and Life Service Center must be made within 60 days after the later of the date of the Qualifying Event, or the date your Qualified Beneficiaries would lose coverage due to a Qualifying Event. If notice is not received within 60 days, rights to continue coverage will terminate.

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

If your Qualified Beneficiaries elect continuation coverage, the Company is required to give them coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or retirees or family members. Under the law, the Qualified Beneficiary(ies) losing coverage have 60 days from either the date of loss of coverage or from the date of the notice, whichever is later, to elect continuation coverage. They then have 45 days from the date of the initial election to make their first premium payment and any other premium payments that are due during those first 45 days. Subsequent premiums must be paid in full within 31 days of each premium due date. Please Note: Some states offer financial aid to help certain individuals pay for COBRA coverage. Contact your appropriate state agency regarding availability and eligibility requirements.

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

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

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

Your Qualified Beneficiaries will not have to show that they are insurable to choose continuation coverage. However, under the COBRA law, they will have to pay the group rate premium for their continuation coverage plus an administration fee, if applicable. The law also requires that, at the end of the 36-month continuation coverage period, they must be allowed to enroll in an individual conversion Medical Plan 2 if one is available under the terms of the Plan. If an individual conversion Medical Plan is available and they wish to enroll, they must follow the instructions in the "Coverage Conversion" section of this Summary Plan Description.

Domestic Partner Continuation Coverage

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

- the death of the Retiree; or
- termination of the Domestic Partner relationship between the Eligible Retiree and Domestic Partner.

The covered Retiree or Domestic Partner has the responsibility to notify the Company Health and Life Service Center of a termination of relationship between a Retiree and a Domestic Partner. Coverage will end at the end of the month in which the Continuation Event occurs. Notice to the Lumen Health and Life Service Center must be made within 60 days after the later of the date of the Continuation Event or the date you would have lost coverage. If notice is not received or postmarked within 60 days, rights to continue coverage will terminate. Participants should call the Lumen Health and Life Service Center at 866-935-5011 or 800-729-7526, Option 2, and then option 1 and speak with a Customer Care Representative.

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

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

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

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

- The Company no longer provides group health coverage for any of its employees or Retirees;
- The premium for continuation coverage is not paid in a timely manner;

- They first become, after the date of the election, covered under another group health plan which does not contain a preexisting condition, exclusion or limitation that would apply to them; or
- They first become, after the date of election, entitled to Medicare.

Continuation Beneficiaries will not have to show that they are insurable to choose continuation coverage. They will have to pay the group rate premium for their continuation coverage plus any administration fee. At the end of the 36-month continuation coverage period, they will be allowed to enroll in an individual conversion medical plan, if available. To enroll, the Continuation Beneficiary should follow the directions under the Coverage Conversion section.

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

Surviving Spouse Medical Continuation Coverage

Upon the death of a Retiree, the Company will subsidize the COBRA medical coverage (if elected) for Surviving Spouses, certain Dependents (COBRA like coverage for Domestic Partners) for up to six months (see "Death of Retiree" in the **"Termination of Medical Coverage"** section). The subsidized coverage will be equal to the Company's normal contribution toward the Company-sponsored Retiree Health Care Medical Plan. Applicable contributions/premiums will not be subsidized (e.g., Class II Dependent and/or Sponsored Child premiums). At the end of the six-month period, a Surviving Spouse may continue COBRA medical coverage for an additional 30 months by paying the applicable rate.

At the expiration of 36 months of medical coverage under COBRA, the Surviving Spouse will be given the opportunity to elect medical coverage as an individual and for any eligible Dependents who were covered under the Plan at the time of death (this includes Class I Dependents in utero at the time of death). Referred to as "Surviving Spouse benefits," this coverage is available under the Retiree and Inactive Health Plan, at the applicable group rate.

This Surviving Spouse coverage will not end until the death of the Spouse as long as applicable enrollment and premiums are made timely. For other Dependents covered at the time of death (i.e., Class I Dependents, Class II Dependents, Sponsored Children), whom may have elected 36 months under COBRA, the coverage will end with the expiration of their COBRA Benefits.

Note: If the Surviving Spouse is enrolled in the HRA benefit option at the time of the Retiree's death, the existing HRA allocation will continue for 6 months (as subsidized COBRA) and access to the HRA balance at the time of death is permitted during those 6 months or until the end of the year, whichever comes first. If COBRA is continued beyond the 6 months, then HRA funding allocations will continue, but the initial balance is forfeited at the end of the year the death occurs. Contact the Lumen Health and Life Service Center for more information about your options and how these benefits are applied.

Spouses of LTD Participants. Extended Spouse coverage does not apply to Spouses of former employees who die while receiving LTD benefits, unless such former Employees are also retired on a service or disability pension.

COBRA Coverage Cost

The cost of COBRA coverage for your Qualified Beneficiaries will be the applicable group rate plus a 2% administration fee (except as described under "Surviving Spouse Medical Continuation" above). COBRA premiums may be waived or subsidized (e.g., coverage will continue at Company expense, except for applicable contributions such as Class II Dependent premium contributions) for a temporary time for surviving Dependents in the event of your death. See Surviving Spouse Medical Continuation Coverage above.

Coverage Conversion (Not Available For Dental Coverage)

You may be entitled to convert your Company Medical Plan benefit option medical coverage to a nongroup plan (before or after electing COBRA coverage). Your Class I Dependents, Class II Dependents, and Sponsored Children are also entitled to conversion. No physical exam is required. Contact the Claims Administrator for conversion information. Some plans may not offer conversion for Medicare-eligible participants. Dental care cannot be converted. Also, you cannot convert your medical coverage if it was terminated for failure to pay a COBRA premium.

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

Extension of Benefits (Company Plan)

When Plan coverage terminates, no further Benefits will be paid by the Plan unless the individual is then receiving care in the Hospital. If so, "Hospital Care Benefits" only will continue to be paid during the continued confinement for up to one year following the year in which termination of coverage otherwise occurs.

Additional Enrollment Information

Health Enrollment Level

Choosing Your Coverage Level. You have the following coverage levels to choose from when deciding who

needs medical coverage (if you are Medicare eligible or non- Medicare eligible):

- No Coverage
- Single (Retiree or Surviving Spouse only)
- Single + Spouse or Domestic Partner
- Single + Children
- Family

Note: Each individual covered as either a Class II Dependent or Sponsored Child is only eligible for the Company guaranteed benefit option. You must also be enrolled in this option to cover these specific Dependents. They will be enrolled under their own individual coverage (Single coverage) and their coverage is not included when determining your coverage level or cost.

Changing Your Enrollment Elections

Once every year you will have an opportunity to elect from the benefit options that are offered in that year and move from one to the other during Annual Enrollment. Under certain circumstances, you may be able to change plans during the year as noted below.

If you and your Dependent(s) are all Medicare eligible—you must enroll in the same benefit plan option. For example:

- You must both elect the Company Medical Plan benefit option, the UHC Medicare Advantage PPO Plan or the HRA benefit option. You cannot be in different benefit options when you are both Medicare eligible.

If you or a Dependent is not Medicare eligible yet, then you can make separate elections for Medicare and non-Medicare family members—until you are both Medicare eligible. For example:

- The non-Medicare person may remain in the Company Medical Plan benefit option (or No Coverage), while the Medicare eligible participant may elect to either stay in the Company Medical Plan or the UHC Medicare Advantage PPO Plan Plan or the HRA benefit option.
- Then, when the non-Medicare eligible person becomes Medicare eligible during the plan year--they must also enroll in the same Medicare benefit option that the first Medicare eligible participant has already elected for that year. For example: If the Medicare eligible person enrolled in the UHC Medicare Advantage PPO Plan and the non-Medicare eligible person was in the Company Medical Plan benefit option—the non-Medicare person will have a QLE and will need to move to the UHC Medicare Advantage PPO Plan at that time. Note: Enrollment paperwork must be completed PRIOR to the month in which the newly Medicare eligible person becomes Medicare eligible so that the effective date can be the first of the month upon becoming Medicare eligible.
  Note: If for some reason, the newly Medicare eligible person cannot enroll (or is not approved) in the Medicare Advantage PPO Plan at this time, then both participants would have to move back to the Company Medical benefit plan option-- or the newly Medicare person (if the Dependent) can be dropped from coverage allowing the Retiree to remain in the UHC Medicare Advantage PPO Plan. At the next Annual Enrollment period, both the Retiree and the Dependent will be able to elect the same benefit option for the new Plan year, according to Plan provisions.

Default Status

If you do not make elections within the specified timeframe, you will be assigned default coverage as described below.

Annual Enrollment/During the Year

If you are currently enrolled and you do not submit new coverage elections during Annual Enrollment, you will default to the same health care options you currently have (if available). This includes completing the enrollment process if you elect the UHC Group Medicare Advantage PPO Plan or are not approved by UHC for this benefit option. Similar default processes apply during the year.

Medicare Eligibility During the Plan Year

When you or a Dependent become Medicare eligible during the year, under this QLE and you will be able to elect to participate in one of the Medicare eligible benefit options (UHC Group Medicare Advantage PPO Plan or the HRA) if you choose. Or, you may also remain in the Company Medical Plan benefit option (which would be your default if you do nothing at the time you become Medicare eligible). However, Medicare Parts A and B are also required to be enrolled as Medicare eligible in the Company plan benefit option.

UHC Group Medicare Advantage PPO Plan. Upon becoming Medicare eligible, it is assumed that you have your Medicare Part A and B as required for this option. If you want to enroll in the Medicare Advantage PPO Plan but do not enroll timely, or are not approved, you will default to the same health care option you had while awaiting approval. In addition, since all Medicare eligible family participants must be enrolled in the same plan, if one family member is not able to enroll in the UHC Group Medicare Advantage PPO Plan, both participants to change benefit options or require the Dependent to be dropped from coverage.

For example:

- If one participant is Medicare eligible and elects to remain in the Company Medical Plan option and then another family member becomes Medicare eligible; they must both remain in the Company Medical Plan for the remainder of that year.

–OR–

- If one participant is Medicare eligible and elects to enroll in the UHC Group Medicare Advantage PPO Plan and then another family member becomes Medicare eligible; they must both enroll in the UHC Group Medicare Advantage PPO Plan. If the second participant is not approved, then both participants must default to the Company Medical Plan benefit option for the remainder of the year, in order for both participants to have coverage. Alternatively, if it is the Dependent who cannot qualify for the UHC Group Medicare Advantage PPO Plan, then the Dependent may be dropped from all coverage to allow the Retiree to remain in the UHC Group Medicare Advantage PPO Plan.

HRA benefit option. Upon becoming Medicare eligible during the year, if you elect the HRA benefit plan option, it is assumed that you have your Medicare Part A and B as required for the individual Medicare policies. Because this is an action you must complete on your own, we also assume that you have enrolled timely in coverage outside of the Company and the HRA account is automatically set up for you at the time you elect this benefit plan option. Therefore, there is no default for this option. You are simply removed from all company medical coverages, except for the HRA account, which can only be used to reimburse you for outside medical Medicare premiums. See the "Enrolling in Medicare policies" in the III. HIGHLIGHTS OF PLAN BENEFIT OPTIONS section above.

Non-Medicare family members may remain in the Company Medical Plan benefit option while the Medicare eligible family members may elect to move to another Medicare benefit option.

Waived Coverage. You may waive your right to coverage under the Health Care Plan. This allows you to enroll under the health plan of a Spouse or Domestic Partner who also covered under any of Lumen Health Care Plan benefit options, Tri-care or any non-Lumen Medicare or other health care plan. **Note:** You may choose to resume coverage upon notification to the Service Center of a QLE or at the next Annual Enrollment. Surviving Spouses, however, cannot participate in future coverage if they drop coverage at any time.

When Health Coverage Begins

The following indicates when coverage is effective for Retirees and Dependents in specific circumstances:

Retirees:

- If you make changes during Annual Enrollment, your new coverage will begin on the first day of the new calendar year. (However, if enrolling in the UHC Medicare Advantage PPO Plan, enrollment and approval by UHC must occur prior to the month coverage is to be effective.)
- Coverage changes due to Qualified Life Events are generally effective the first day of the calendar month following the Company's receipt of the election. The exceptions are changes due to birth or adoption, divorce, or other loss of eligibility under the Plan (refer to section below).

QMCSO

If you are a Retiree who wishes to provide coverage for your biological Children who (1) do not reside with you for more than half of the year (other than a full-time student) and (2) for whom you do not provide a majority of the Child's support, you must obtain a court order known as a "Qualified Medical Child Support Order" or QMCSO in order for the Child(ren) to be eligible for coverage under the Health Plan. See the **"Legal Notices"** section for more information.

Dependents:

- **New Class I Dependent.** Coverage elections are retroactive to the date the Dependent is acquired for birth or adoption. All other changes (marriage, loss of other coverage, etc.) will become effective on the first day of the month following notification to the Lumen Health and Life Service Center, provided the Dependent is enrolled within 45 days. If not enrolled within this 45-day period, the Dependent cannot be added until the next Annual Enrollment Period or next applicable Qualified Life Event.

For common-law marriages, (if you reside in a state that recognizes common-law marriages) coverage is effective the first day of the month following receipt of an approved notarized affidavit of marriage, provided notification was given within 45 days of the date the affidavit was notarized.

- **Domestic Partner and Children of a Domestic Partner.** Coverage is effective the first day of the month following receipt and approval of an affidavit of domestic partnership and proof of ownership. For Children of a Domestic Partner, coverage begins the first of the month following receipt and approval of an affidavit of domestic partnership and the applicable dependent verification documents if enrollment is submitted together with the domestic partnership affidavit. Otherwise, coverage begins on the date a Child of a Domestic Partner is acquired (birth or adoption) provided the child is enrolled within 45 days. If not enrolled within this 45-day period, the child cannot be added until the next Annual Enrollment Period or next applicable Qualified Life Event. Children of a Domestic Partner are eligible for Health Plan coverage as long as the Domestic Partner is covered and the Child(ren) must qualify as the Domestic Partner's Dependent(s) for federal tax purposes.

Qualified Life Events — Changing Your Health Care Coverage

Generally, your benefit option choices under the Health Plan (medical and dental) will remain in effect for the full calendar year.

However, you can also make changes to your benefit plan options during the year. Such changes for you or your Dependents will generally be effective the first day of the calendar month following your notification to the Lumen Health and Life Service Center.

Qualified Life Event Reminder:

If you experience a Qualified Life Event such as marriage, death, divorce, adoption or birth, or losing other coverage, you must contact the Lumen Health and Life Service Center at lumen.com/healthbenefits or 866-935-5011 or 800-729-7526 within 45 days of the event in order to change your coverage elections. If you miss the 45-day window, you will not be able to make changes until the next Annual Enrollment. Remember, you must add your newborn or adopted Child to your coverage, even if you already have family coverage, within 45 days of birth or adoption to cover your Child under the Plan.

Mid-Year Ability to Drop/Change Coverage Level

Qwest Pre-91 Retirees can change Health Plan benefit coverage levels with an associated QLE as described above at any time during the year. Benefit options can only be changed during the year due to you or your Dependent's Medicare eligible status.

Qualified Life Events

The following changes in your family situation are Qualified Life Events and may provide an opportunity for you to modify your benefit choices. All of the following should be reported to the Lumen Health and Life Service Center:

- Birth, adoption, or death of a Class I Dependent (deaths are also reported to the Lumen Health and Life Service Center by selecting the option "To Report a Death")
- Your marriage or divorce
- Start or end of your Spouse/Domestic Partner's employment impacting previous coverage or need
- Significant changes in the health care coverage provided by your Spouse/Domestic Partner's employer

The Plan Administrator also has the discretion to recognize other changes allowed by the Internal Revenue Service (IRS). The Company may require documentation of a Qualified Life Event prior to processing a change in coverage election.

Report Change of Status Due to Qualified Life Event: Gain in Eligibility

To qualify for a change in your benefit option choices, you must contact the Lumen Health and Life Service Center within 45 days of the Qualified Life Event change. Changes to your coverage (including obtaining Legal Guardianship) are effective on the first day of the month following the date of your notification to the Lumen Health and Life Service Center, except for newborns or newly adopted children. Changes for newborns and newly adopted children are retroactive to the birth date or date of adoption. Changes to coverage due to a Qualified Life Event received more than 45 days after the Qualified Life Event will not be accepted and your coverage will remain the same.

Report Change of Status Due to Qualifying Life Event: Loss in Eligibility Changes in your coverage elections due to a loss of your Dependents' eligibility, reported timely within 45 days of the Loss will be effective as of the first day of the month following the event effective date. However, please note:

- Coverage will be dropped retroactively for an ineligible Dependent if you contact the Lumen Health and Life Service Center after 45 days of the Qualified Life Event. You will be responsible for any retroactive repayment of claims incurred and paid by the carrier after your Dependent loses eligibility
- COBRA: If you fail to notify the Lumen Health and Life Service Center within 60 days of the change, the Dependent losing eligibility and coverage will not be eligible to continue coverage through COBRA. You will be responsible for any retroactive repayment of claims incurred and paid by the carrier after your Dependent loses eligibility
- You must report the death of any covered participant as soon as possible

Consistency Rule. Any change in your decision for coverage due to a Qualified Life Event must be consistent with the Qualified Life Event. For example, if you have a divorce you may only drop your former Spouse; with respect to coverage for your Children in this situation, you may add your Children if you did not previously cover them under the Plan provided that you provide over half of their support and they reside with you, or you have a QMCSO to add them.

Depending on the reason for your change of status, you can make the following coverage changes (for a summary list of changes allowed due to various life events, you may also access the Lumen Health and Life Service Center Web site at lumen.com/healthbenefits

- **Health Plan Benefit Option.** Qwest Pre-91 Retirees are allowed to change to a different medical benefit option at each Annual Enrollment period, or only if a QLE due to a change in Medicare eligibility status of the Retiree or a Dependent.

Health Plan—HIPAA Special Enrollment Provisions

Loss of Other Coverage. You may enroll yourself and any of your eligible Dependents in the medical and dental if you:

- Previously declined coverage under this Health Plan for yourself and your Dependents because either you or your Dependents had coverage under another group health plan or other health insurance; and
- You stated the reason for declining Health Plan coverage at the time coverage was declined was because you were covered by the other health plan; and
- Your other health coverage ceases because you have exhausted a COBRA continuation period, because you stopped being eligible under the other coverage or because an employer stopped making contributions to the other coverage.

You may not enroll under special enrollment if you lost the other coverage because you failed to pay the contribution or if you lost the other coverage for cause (for example, you misrepresented something on the application form). You may not enroll your Dependent unless you already are enrolled or are enrolling yourself along with your Dependent.

The effective date for special enrollment coverage is the first day of the first month following notification to the Lumen Health and Life Service Center. However, you must enroll and authorize any payroll deduction within 45 days of the loss of other coverage and you must provide any certification or documentation regarding the other coverage reasonably requested by the Plan Administrator.

Adding a New Dependent. If you are covered under the Retiree and Inactive Health Plan, or if you are eligible to be covered but have previously waived coverage for any reason, and if you are adding a new Dependent through marriage, birth, adoption, or placement for adoption, then you may enroll in the Health Plan:

- Yourself
- Your Spouse or Domestic Partner
- Your Dependent Children, whether or not they are recently added

You may not enroll your Dependent unless you already are enrolled or are enrolling yourself along with your Dependent. The effective date for coverage when you add a new Child is the date of birth, adoption, or placement for adoption. The effective date for coverage when you add a Dependent through marriage is the first day of the first month after notification of your marriage.

Dependent Special Enrollment. Your Spouse, who is not enrolled, may enroll for coverage in the event of a birth or adoption of a Dependent provided your Spouse is an eligible Dependent and the enrollment occurs within 45 days of such birth or adoption. Coverage for your Spouse will be retroactive to the date of the birth or adoption provided you have made the required contributions, if any, to the Plan.

Change in Home Address. Simply moving or changing residence is not considered a Qualified Life Event. However, if you move outside the service area for your medical benefit option, you will have the ability to choose another applicable medical benefit option. You must notify the Lumen Health and Life Service Center as follows:

Log on to lumen.com/healthbenefits and follow these steps:

1. From the home page, go to Your Profile and click on the Personal Information
2. On the Personal Information page, under Mailing Addresses, click on Change next to Permanent Address.
3. You will then be routed to a page that will allow you to update your permanent address.

OR

Dial 866-935-5011 or 800-729-7526 and press option 2 and then option 1 for the Medical, Dental and Life benefits. (Note: you may also press the option for pension information to update your address with them as well.)

Note: Although all health care benefit options are national plans, there could be some zip codes that are not eligible for the UHC Medicare Advantage benefit option. Check with your individual Medicare policies for rules on address changes.

Additional Special Enrollment Rights

Under additional Special Enrollment rules, you are allowed to enroll yourself and eligible Dependents in the Health Plan upon the loss of other coverage, referred to as "the other plan," to include the following:

- Termination of employer contributions towards other coverage
- Moving out of carrier's service area if the other plan does not offer other coverage
- Ceasing to be a "Dependent", as defined in the other plan
- Loss of coverage to a class of similarly situated individuals under the other plan (e.g., when the other plan does not cover part-time employees)

If your Spouse or other Dependent has special enrollment rights, you may enroll and make changes to your enrollment in any health plan benefit option available to you based upon your home ZIP code and plan service area within 45 days following the qualifying event. For example, you have single coverage in a Company benefit option, and your Spouse loses coverage under his/her employer's plan and has special enrollment rights, both you and your Spouse are allowed to enroll in the Company benefit options available to you provided your Dependent provides proof of eligibility for the Company Plan.

Children's Health Insurance Program Reauthorization Act (CHPRA)

The Children's Health Insurance Program Reauthorization Act of 2009, extends and expands the state Children's Health Insurance Program (CHIP). Among other things, the law allows states to subsidize premiums for employer provided group health coverage for eligible children and families. It also provides additional special enrollment rights, under the Retiree and Inactive Health Plan. The Plan is amended to permit participants and dependents who are eligible for but who have not previously enrolled in coverage, to "special enroll" in the Plan 2 in two additional circumstances:

1. The participant's or dependent's Medicaid or CHIP health coverage is terminated due to loss of his or her eligibility, and the employee requests coverage under the Plan within 60 days after the termination of this Medicaid or CHIP coverage, or
2. the participant or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and the participant requests coverage under the Plan within 60 days after he or she is determined to be eligible for the Medicaid or CHIP subsidy.

To find out more about special enrollment rights under the Plan, call the Lumen Health and Life Service Center at 866-935-5011 or 800-729-7526.

See the **"Legal Notices"** section regarding the HIPAA Notice and other enrollment rights.

Plan Administrator

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

Lumen Employees' Benefit Committee
214 E 24th St
Vancouver, WA 98663

Discretionary Authority. The Plan Administrator has the right and discretion to determine all matters of fact or interpretation relative to the administration of the Plan - including questions of eligibility, interpretation of Plan provisions and all other matters.

The decisions of the Plan Administrator, and any other person or group to whom such discretion is delegated, shall be conclusive and binding on all persons.

Claims Administration

Claims under the Plan are processed and paid by:

UnitedHealthcare Insurance Company
P.O. Box 30555
Salt Lake City, UT 84131

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

Whenever you have a question or concern regarding your Benefits or a claim, please call the Claims Administrator for the benefit option using the telephone number for Customer Service listed on your ID card.

The Claims Administrators shall not be deemed or construed as an "employer" for any purpose with respect to the administration or provision of Benefits under the Plan. The Claims Administrators shall not be responsible for fulfilling any duties or obligations of an "employer" with respect to the Plan.

Plan Funding and Payment of Benefits

This Plan is self-insured by the Company. UnitedHealthcare provides claims processing services for the Company and administers the payment of Benefits. All Plan Benefits are paid through the claims processing system established with the Claims Administrator. Except for contributions you may make toward your Plan coverage as described in the earlier section on "Cost," the Company pays for your Plan Benefits from its general assets. However, the Company may choose to fund a portion of your health care coverage from one or more trusts established by the Plan sponsor or its affiliates. These trust funds would then be available for payment of your Plan Benefits in lieu of payment directly from the

Company's general funds. The Company's contributions, if any, to the trust funds may be in the form of the Company's common stock, in accordance with the requirements of ERISA. If the Plan is terminated, any Plan assets will be applied to the payment of Benefits, insurance premiums, or administrative expenses incurred in the provision of Benefits, and in no event will trust assets be returned to the Company.

The UnitedHealthcare Medicare Advantage PPO Plan is fully insured. The Health Reimbursement Account is subsidized by Company general assets and are subject to "caps" established for a Plan Year by the Company. Both of these Plans are subject to change and are not guaranteed offerings in future years.

Plan Records

The Plan and all of its records are kept on a calendar-year basis beginning January 1 and ending December 31 of each year.

Plan Sponsor, Employer Identification Number of Plan Sponsor and Plan Number

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

Plan Sponsor	Employer Identification Number of Plan Sponsor (assigned by the IRS)	Plan Identification Number (assigned by the Company)
Lumen, Inc. 100 CenturyLink Dr. Monroe, LA 71203-2041	72-0651161	511

The Plan Sponsor is Lumen, Inc. The Plan Sponsor provides certain administrative services in connection with the Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of Benefits and subrogation or recovery; care coordination; and complaint resolution assistance. These external administrators are referred to as the Claims Administrators. The Lumen Employee Benefits Committee is the Plan Administrator and a named fiduciary for the Plan. The Lumen Employee Benefits Committee has also designated the Claims Administrator of each plan benefit option under the Plan as the claim fiduciary and delegated to each the authority and discretion to administer the Plan benefit option.

Plan Continuance

Information regarding Benefit commitments by the Company to Pre-91 Retiree Plan participants.

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

Pre-'91 Retirees:

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

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

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

Any medical and/or dental coverage that meets the minimum commitments described above may only be changed by the Company in a manner that keeps your Plan 2 in compliance with those commitments. An example of a permissible change would be the selection of a new Claims Administrator (as has occurred in the past). No change may be made if the Plan Administrator (acting in the best interest of the Pre-'91 Retirees as a whole) determines that the change violates any of the commitments described earlier in this section. These commitments are binding on Lumen, Inc., the sponsor of the Plan, and cannot be revoked. In all events, however, The Company has the obligation to conform its Plans to the requirements of applicable laws. Please note however, that as a standalone retiree health care plan, the Plan is exempt from the requirements of the Patient Protection and Affordable Care Act ("PPACA"). While the Company has decided to voluntarily comply with certain provisions of PPACA, this voluntary compliance is separate from and not a part of the health care coverage commitment to Qwest Pre-1991 Retirees. This voluntary compliance with certain provisions of PPACA also does not waive the Plan's exempt status. The Company may choose in its sole discretion to no longer apply these provisions at any time.

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

Plan Documents

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

Invalid Provisions

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

Participating Companies

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

Participating Providers and Employers

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

Legal Service

Process in legal actions with respect to the provisions of the Plan should be directed to the Plan Administrator or on the Plan Sponsor's agent for service of legal process:

Agent for Service of Legal Process:

Lumen Technologies, Inc.
Associate General Counsel/ERISA
931 N. 14th Street
Denver, CO 80202

Plan Type

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

Your Rights as a Plan Participant

As a Participant in the Retiree and Inactive Health Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits.

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of

the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of the Summary Annual Report.

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor or you may file suit in a federal court.

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

Assistance with Your Questions

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

A Word About Your Privacy

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

General Information

Miscellaneous Information

Our Relationship with Providers

The relationships between us and Network Providers and the Claims Administrator are:

- Solely contractual relationships between independent contractors
- Not that of agents or Employees

Furthermore, the Claims Administrator shall not be deemed or construed as an employer or Plan Administrator for any purpose with respect to the administration or provision of Benefits under the Plan.

The relationship between us and you are that of employer and Employee, Dependent or other classification as defined in the Plan.

Your Relationship With Providers

The relationship between you and any Provider is that of patient and Provider.

- You are responsible for choosing your own Provider.
- You must decide if any Provider treating you is right for you. This includes Network Providers you choose and Providers to whom you have been referred.
- You must decide with your Provider what care you should receive.
- Your Provider is solely responsible for the quality of services provided to you.

Records And Information

At times, the Plan or the Claims Administrator may need information from you. You agree to furnish the Plan and/or the Claims Administrator with all information and proofs that are reasonably required regarding any matters pertaining to the Plan. If you do not provide this information when requested, it may delay or result in the denial of your claim.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you, to furnish the Plan or the Claims Administrator with all information or copies of records relating to the services provided to you. The Plan or the Claims Administrator has the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the enrollment form.

The Plan agrees that such information and records will be considered confidential. We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required by law or regulation.

For complete listings of your medical records or billing statements, we recommend that you contact your Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms. If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records. In some cases, we and the Claims Administrator will designate other persons or entities to request records or information from or related to you and will release those records as necessary. Our designees have the same rights to this information as we have.

During and after the term of the Plan, we and our related entities may use and transfer the information gathered under the Plan, including claim information for research, database creation, and other analytic purposes.

Interpretation of Plan

The Plan Administrator and the Claims Administrator have sole and exclusive discretion in:

- Interpreting Benefits under the Plan
- Interpreting the other terms, conditions, limitations, and exclusions set out in the Plan, including this SPD
- Determining the eligibility, rights, and status of all persons under the Plan
- Making factual determinations, finding and determining all facts related to the Plan and its Benefits
- Having the power to decide all disputes and questions arising under the Plan

The Plan Administrator and the Claims Administrator may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Claims Administrator may, in its sole discretion, offer Benefits for services that would not otherwise be covered health services. The fact that the Claims Administrator does so in any particular case shall not in any way be deemed to require them to do so in other similar cases.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. Clerical errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by the Plan or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan Documents.

Administrative Services

The Plan Administrator or its delegate(s) may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing and utilization management services. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Examination of Covered Persons

In the event of a question or dispute regarding Benefits, the Plan may require that a Network Physician of the Plan's choice examine you at our expense.

Conformity with Statutes

Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered), is hereby amended to conform to the minimum requirements of such statutes and regulations. As a self-funded plan, the Plan generally is not subject to State laws and regulations including, but not limited to, State law benefit mandates. However, for those benefit options that are insured, the Benefits are subject to State laws and regulations including, but not limited to, State law benefit mandates.

Incentives to You

At various times the Claims Administrator may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not you choose to participate is yours alone, but you should discuss participating in such programs with your Provider. These incentives are not plan Benefits and do not alter or affect your Benefits. Contact the Claims Administrator if you have any questions.

Other Incentives

Rebates may be payable by pharmaceutical and other companies with respect to certain prescriptions and supplies covered by the Plan. These rebates, if any, are retained by the Plan 2 in general assets to defray the cost of the Plan.

Refund of Benefit Overpayments

If the Plan pays Benefits for expenses incurred by a Covered Person, that Covered Person, or any other person or organization that was paid, must refund the overpayment if either of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person
- All or some of the payment we made exceeded the cost of Benefits under the Plan (including Medicare Part B premiums)

The refund equals the amount the Plan paid in excess of the amount the Plan should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future Benefits.

Additionally, if the Covered Person was determined not to be eligible for any Benefits under the Plan, that individual must refund the amount of the excess Benefit payment.

Time Limitation on Civil Actions

You cannot bring any legal proceeding or action against the Plan, the Plan Administrator or the Company unless you first complete all the steps in the claims and appeal process described in this SPD.

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

Legal Notices

Notice of HIPAA Rights

To request a HIPAA certificate for you or any of your eligible Dependents who were enrolled under your health coverage contact the Lumen Health and Life Service Center at 833-925-0487 or 317-671-8494 (International callers) or 800-729-7526.

HIPAA Guaranteed-Issue Requirements

HIPAA requires that all health insurance carriers that offer coverage in the individual market accept any eligible individuals who apply for coverage without imposing a pre- existing condition exclusion. However, you may lose this right to avoid having pre- existing condition exclusion apply to you if you have more than a 63-day gap in health coverage. To take advantage of this HIPAA right, you must elect COBRA and maintain it (by timely paying the premium) for the duration of your maximum COBRA coverage period, and then apply for coverage with an individual insurance carrier before you have a 63-day lapse in coverage. Since we do not sponsor this other health coverage, you should contact that insurer directly, your independent insurance specialist or the State insurance commissioner for more information.

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. Please review it carefully.

Privacy Officer Designation/Contact Information. Linda Gardner is the designated Chief Privacy Officer (“Privacy Officer”). The Privacy Officer has designated the HIPAA Compliance Committee or its designee to answer any questions regarding this Notice or the subject addressed in it.

Please forward inquiries to the:

HIPAA Compliance Committee
Lumen, Inc.

600 New Century Parkway, Floor 01 New Century, KS 66031

-or-

E-Mail: askHIPPA@centurylink.com

-or-

Call the the Company Integrity Line at 800-333-8938, Select Option 1 (Personal Health Information or HIPAA issues)

General Information About This Notice. This Notice relates to the use and disclosure of your medical information by the Plan maintained by Lumen, Inc.

The term "Plan" as used in this Notice means only the portions of this plan that provide group health benefits (for example, medical, dental, vision, employee assistance and medical expense reimbursement).

The Plan continues its commitment to maintaining the confidentiality of your medical information for the purpose of your Plan coverage. This Notice describes the Plan's legal duties and privacy practices with respect to that information. This Notice also describes your rights and the Plan's obligations regarding the use and disclosure of your medical information. Your personal doctor or health care provider may have different policies or notices regarding the doctor's or health care provider's use and disclosure of your health information created in the doctor's or health care provider's office or clinic.

This Notice applies to:

- The portions of the Plan listed above that provide group health benefits;
- Any employee or other individuals acting on behalf of the Plan; and
- Third parties performing services for the Plan.

The Plan is required by law to:

- Follow the terms of the Notice that are currently in effect;
- Provide you with specific information about your rights with respect to your medical information;
- Maintain the privacy of your medical information;
- Give you this Notice of the Plan's legal duties and privacy practices with respect to medical information about you
- Notify you if there is a breach of your unsecured PHI.

Plan Use And Disclosure of Your Medical Information. The Plan is required by law to maintain the privacy of your PHI. PHI is any information that identifies you, such as your name or address, paired with medical information such as:

- your past, present or future physical or mental health or condition; or
- the provision of health care to you; or
- the past, present or future payment for the provision of health care.

The Plan may use your PHI in certain ways that are described below in more detail. If PHI is intended to be used or disclosed by the Plan for underwriting purposes, be advised that the Plan will not use or disclose an individual's genetic information for such purposes.

Use or Disclosure for Treatment. The Plan may use and disclose your PHI to others to facilitate your medical treatment, which includes the provision, coordination, or management of your health care and can include consultation between one or more of your providers. For example, the Plan may disclose information regarding your prior prescriptions to a pharmacist to determine if a pending prescription will conflict with a prior prescription. For these purposes, the Plan may disclose information to business associates of the Plan.

Use or Disclosure for Payment. The Plan may use and disclose your PHI to others, such as a Business Associate, so that the Plan can facilitate proper payment for treatment and services provided to you. This includes, but is not limited to, making coverage determinations, claims management, subrogation and recovery, reviews for medical necessity and appropriateness of care, utilization and notification reviews. For example, the Plan may use your PHI to determine your benefit eligibility or coverage level, to pay a health care provider for your medical treatment or to reimburse you for your direct payment to a health care provider. The Plan may tell a health care provider, or Business Associate whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Use or Disclosure for Health Care Operations. The Plan may use and disclose your PHI to the extent necessary to administer and maintain the Plan. For example, the Plan may use your PHI in the process of negotiating contracts with third party carriers, such as HMOs and provider networks, for legal services, for internal audits (including fraud and abuse compliance programs), business planning, or for cost management purposes. For these purposes, the Plan may disclose your PHI to business associates of the Plan.

Disclosure to Lumen. With respect to your Plan coverage, the Plan may use and disclose your PHI to The Company as permitted or required by the Plan documents or as required by law. Certain employees of The Companywho perform administrative functions for the Plan may use and disclose your PHI for Plan administration purposes. Any PHI disclosure to The Company by the Plan for other than plan administration purposes will require your written authorization. At no time will PHI be disclosed to The Company for employment-related actions or decisions, except for drug and alcohol test results under certain circumstances.

Disclosures to Family, Close Friends or Designated Individual. Under certain circumstances, and as permitted by law, the Plan may release to a family member, other relative, or someone who is involved in your health care or payment for your care, PHI that is directly relevant to their involvement. Upon your death, the Plan may disclose such PHI to a family member, other relative or other person involved in your care or payment for health care prior to your death, unless doing so is inconsistent with your known, expressed preference.

Special Situations. The following are examples of when the Plan may disclose your PHI without your written authorization (this list is not exhaustive and there may be other situations when it would be necessary to disclose PHI that are not addressed here):

Required by law. The Plan may disclose medical information about you when required to do so by federal, state, or local law. For example, we may disclose medical information when required by a court order in litigation, such as a malpractice action.

Public Health Risks. The Plan may use or disclose your PHI for public health reasons. These reasons may include the following:

- Prevention or control of disease, injury or disability;
- To report child abuse or neglect;

- To report reactions to medications or problems with products;
- To notify individuals of recalls of medications or products they may be using; and
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence. As permitted or required by law, the Plan may disclose your PHI to an appropriate government authority if the Plan reasonably believes you are the victim of abuse, neglect or domestic violence. If the conduct does not involve a child, the Plan will make this disclosure only if the victim agrees or when required or authorized by law.

To Avert a Serious Threat to Health or Safety. The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your PHI in a proceeding regarding the licensure of a physician. The Plan may also release medical information about you to authorized government officials for purposes of public health or safety.

Health Oversight Activities. As authorized by law, the Plan may disclose your PHI to health oversight agencies. Such disclosure will occur during audits, investigations, inspections, licensure, and other government monitoring and activities related to health care provision or public benefits or services.

Law Enforcement, Judicial Proceedings, Lawsuits, and Disputes. The Plan may disclose your PHI in response to a court or administrative tribunal order, subpoena, warrant, summons or other lawful process, provided that the Plan discloses only the PHI expressly authorized by such legal process.

If you are involved in a lawsuit or a dispute, the Plan may disclose your PHI when responding to a subpoena, discovery request or other lawful process where there is no court order or administrative tribunal order. Under these circumstances, the Plan will require satisfactory assurance from the party seeking your PHI that such party has made reasonable effort either to ensure that you have been given notice of the request or to secure a qualified protective order.

National Security and Intelligence Activities. The Plan may release medical information about you to authorized federal officials for intelligence, counterintelligence and any other national security activities authorized by law.

Military and Veterans. If you are or were a member of the armed forces, the Plan may release your PHI as required by military command authorities. The Plan may also release PHI about foreign military personnel to the appropriate authority.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement officer, the Plan may disclose your PHI to the institution or officer. This may happen, for instance, if the institution needs to provide you with health care, to protect your health or safety or the health and safety of others or to protect the safety and security of the correctional institution.

Organ, Eye and Tissue Donation. The Plan may release your PHI to an organization that handles organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation. This may happen, for instance, if you are an organ donor or are seeking an organ transplant.

Coroners, Medical Examiners and Funeral Directors. Upon your death, the Plan may release your PHI to a coroner or medical examiner for purposes of identifying you or to determine a cause of death, and to funeral directors as necessary to carry out their duties.

Workers' Compensation and Disability Plan. The Plan may release your PHI to comply with Workers' Compensation or similar programs, such as the Disability Plan.

Your Written Authorization. Generally, the Plan must have your written authorization to use or disclose your PHI in circumstances not covered by this Notice or the laws that apply to the Plan. For example the following require your valid authorization prior to the use or disclosure of your PHI:

- **Psychotherapy notes.** The Plan must have your written authorization for many uses or disclosure of any psychotherapy notes.
- **Marketing.** We are required to advise that the Plan must have your written authorization for any use or disclosure of PHI for marketing; however, the Plan does not use PHI for marketing.
- **Sale of Protected Health Information.** We are required to advise that the Plan must have your written authorization for any disclosure for the sale of your PHI; however, the Plan does not sell PHI.

If you provide the Plan with authorization to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization. However, you must understand that the Plan is unable to take back any disclosures already made based on your prior authorization.

Your Rights. You have the following rights regarding your PHI maintained by the Plan:

Right to Request a Restriction. You have the right to request a restriction or limitation on the Plan use or disclosure of your PHI for treatment, payment, or health care operations purposes. You also have the right to request a limit on the type of PHI the Plan discloses about you to someone who is involved in your care or the payment of your care. For example, you may ask the Plan not to disclose your PHI to a certain family member or you may ask the Plan to limit your PHI provided to a large case manager who is assigned to you. In most cases, the Plan is not required to agree to your request. If the Plan does agree, the Plan will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions on the use and disclosure of your PHI, you must complete and submit a written request to the HIPAA Compliance Committee or its designee (e.g. a claims administrator such as UnitedHealthcare). Your written request must specify the following:

- The information you want to limit;
- Whether you want the Plan to limit the use, disclosure, or both; and
- To whom you want the restrictions to apply.

Right to Receive Confidential Communications. You have the right to request that the Plan communicate with you about your PHI in a certain manner or at a certain location. For example, you may request that the Plan contact you only at work and not at home, or the Plan send written correspondence to a post office box.

To request a specific manner to receive confidential communications, you must complete and submit a written request to HIPAA Compliance Committee or its designee (e.g. a claims administrator such as UnitedHealthcare). The Plan will accommodate all reasonable requests if you clearly state that you are requesting the confidential communication because you feel that disclosure could endanger you. Your request must specify how or where you wish to be contacted.

Right to Inspect and Copy Documents Containing PHI. In most cases, you have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. "Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care

provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the Designated Record Set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30- day extension is automatically allowed if the Plan is unable to comply with the 30 day deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your Designated Record Set. Requests for access to PHI should be made in writing to the HIPAA Compliance Committee or its designee (e.g. a claims administrator such as UnitedHealthcare). A reasonable, cost-based fee may be charted.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial and a description of how you may complain to the HIPAA Compliance Committee or the Secretary of the U.S. Department of Health and Human Services.

Right to Amend your PHI. You have the right to request the Plan to amend your PHI or a record about you in a Designated Record Set for as long as the PHI is maintained in the Designated Record Set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is automatically allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a Designated Record Set should be made to the HIPAA Compliance Committee or its designee (e.g. a claims administrator such as UnitedHealthcare). You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set and provide the reasons in support of an amendment to your PHI.

Right to Receive an Accounting of Disclosures of Your PHI. You have the right to request a list of the disclosures of your PHI the Plan has made about you, subject to certain exceptions. For example, the accounting need not include PHI disclosures made:

- To carry out treatment, payment or health care operations; or
- To individuals about their own PHI; or
- Based on your own authorization; or
- Due to emergency; or
- Disclosures incident to other permissible or required disclosures.

In order to receive an accounting of disclosures, you must submit a written request to the HIPAA Compliance Committee. Your request must include the following:

- The time period for the accounting, which may not be longer than 6 years and may not include dates prior to April 14, 2003; and
- The form (i.e., electronic, paper, etc.) in which you would like the accounting

Your first request within a 12-month period will be free. The Plan may charge you a reasonable, cost-based fee for providing you any additional accounting. The Plan will notify you of the costs involved, and you may choose to withdraw or modify your request before you incur any costs.

If the accounting cannot be provided within 60 days, a single 30 day extension is automatically allowed if the Plan is unable to comply with the deadline.

Right to Receive a Paper Copy of This Notice. You have the right to receive a paper copy of this Notice, even if you previously agreed to receive this Notice electronically.

In order to receive a paper copy, you must submit a written request to the HIPAA Compliance Committee. You also may obtain a copy of this Notice under HRLink>Benefits>Important Benefits and Documents.

Personal Representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action on your behalf. Proof of such authority may take one of the following forms:

- The power of attorney for health care purposes notarized by a Notary Public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. The Plan also retains discretion to deny access to a parent to PHI of a minor child where permitted by law.

Filing a Complaint Against the Plan. If you believe your rights have been violated, you may file a written complaint with the Plan. The written complaint should contain a brief description of how you believe your rights have been violated. You should attach any documents or evidence that supports your belief, along with the Plan Notice of Privacy Practices provided to you, or the date of such Notice. The Plan takes complaints very seriously. You will not be retaliated against for filing such a complaint. Please call the Company Integrity Line at 800-333-8938 and select Option 1 (Personal Health Information or HIPPA issues) for additional information.

Please send all written complaints to:

HIPAA Compliance Committee
Lumen Technologies, Inc.
931 14th Street, 9th Floor, Denver, 80202

-or-

E-mail: askHIPPA@centurylink.com

You may also file complaints with the United States Department of Health and Human Services, which may be contacted at the following address:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building Washington, D.C. 20201

800-368-1019

The Plan will not retaliate against you for filing a complaint.

Additional Information About This Notice.

Changes to This Notice. The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

This notice has been in effect and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, or if the Plan needs to amend this Notice due to changes in its operation, then this notice will be amended and an updated Notice will be made available to you. Any revised version of this Notice will be distributed and made available on the Lumen Health and Life Benefits website within 60 days of the effective date of any material change to the Plan or other privacy practices stated in this Notice.

No Guarantee of Employment. Nothing contained in this Notice shall be construed as a contract of employment between The Company and any employee, nor as a right of any employee to be continued in the employment of The Company or as a limitation of the right of The Company to discharge any of its employees, with or without cause.

No Change to Plan. Except for the privacy rights described in this Notice, nothing contained in this Notice shall be construed to change any rights or obligations you may have under the Plan. You should refer to the Plan documents, including your summary plan description and summaries of material modifications, for complete information regarding any rights or obligations you may have under the Plan.

Notice of Creditable Coverage (NOCC)

This is an Important Notice from The Company About The Company Health Care Plans' Prescription Drug Coverage and Medicare Prescription Drug Coverage.

This Notice is mailed to you each year. Please watch for it in your mail typically the month of October.

Read this notice carefully—it explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you should enroll.

This Notice also advises of the determination each year as to whether or not the prescription drug coverage is considered to have Creditable Coverage, meaning you can enroll in the Company Plan and not pay a higher premium (a penalty) for Medicare prescription drug coverage if you later decide to join a Medicare drug plan.

However, Qwest Pre-1991 Retiree who decides to enroll in the Medicare Advantage Plan, Waive with HRA Plan or the No Coverage option, you will not continue to be eligible to receive Retiree and Inactive Health Plan prescription drug or medical coverage. You will receive your prescription drug or medical coverage under the alternative option you elect.

Again, refer to the annual mailing of the NOCC for more details.

Qualified Medical Child Support Orders (QMCSO)

The Health Plan complies with all Qualified Medical Child Support Orders ("QMCSO"). A QMCSO is a court order, under State family or child support laws mandates that one parent is obligated to provide coverage under an employer's group medical plan to a minor child at the parent's expense. This allows your minor child to be enrolled in a group health plan

anytime throughout the year. The child remains enrolled in the plan until a new court order removes the QMCSO or the child becomes ineligible for coverage under the plan's terms (for example, the child reaches age 26 or the parent is no longer eligible). Typically, a custodial parent will obtain a QMSCO or NMSN as part of a child support arrangement.

- If you have a QMCSO, you must send a copy of it to the Service Center.
- If you have currently waived coverage under the Plans, and the QMCSO requires your dependent children to be covered, you will be automatically set up with default coverage (the "Retiree Health Care Commitment" or, "Guaranteed Coverage" Medical and Dental Plan) depending on the court order.

You may still need to establish that you are the child's parent if the QMCSO does not establish your relationship to the child. Stepchildren are not covered by a QMCSO. This means that if you are a Retiree and your spouse is required by court order to provide health coverage for his or her children, who are your stepchildren, that court order is not a QMCSO on you, and the Plan is not subject to it. You may validate stepchildren by providing the documents required as outlined above.

If you have questions regarding a QMCSO, where to send your QMCSO or whether you have one on file, contact the Lumen Health and Life Service Center at 866-935-5011 or 800-729-7526.

Circumstances that May Affect Your Plan Benefits

Under certain circumstances all or a portion of your Benefits under the Plan may be denied, reduced, suspended, terminated, or otherwise affected. Many of these circumstances have been addressed elsewhere in this SPD. Such circumstances, in general, include but are not limited to:

- You are no longer in an eligible class of participants or your Dependents are no longer eligible Dependents
- The Plan is amended or terminated, subject to the terms of the written agreement specific to Qwest Pre-'91 Retirees
- You attain the maximum benefit or limit available under the Plan, such as may apply to certain Health Plan benefit options
- The expense incurred was not Medically Necessary, was Investigational or Experimental, was specifically excluded, or exceeded the Reasonable and Customary charge
- There is duplicate health care coverage, or you become eligible for Medicare (Part A, Part B or both), and Plan Benefits are coordinated with the Benefits provided under another group health or dental plan or Medicare
- You misrepresent or falsify any information required under the Plan; you will not be permitted to benefit under the Plan from your own misrepresentation
- You have been overpaid a benefit and the Plan seeks restitution
- If you or your Dependents receive benefits from the Plan for injuries caused by a third party, the Plan has the right to obtain restitution, or to obtain recovery by other equitable means, including the repayment of the benefits paid under the Plan from any part of payments received from your insurance carrier or from or by any other party, including an insurance carrier
- Your coverage under the Plan is terminated for one of a variety of reasons, for example, failure to timely pay a COBRA premium
- You become reemployed, directly or indirectly, by Lumen or any Lumen Company, or one of its suppliers or contractors
- You delay bringing a claim for a benefit beyond the time periods permitted by the Plan, which such delay would impact your ability to bring an action or civil suit. Refer to the heading in this SPD entitled "Time Limitation on Civil Actions" in the "General Information" section.

Falsification or Misrepresentation

Coverage for you or your Dependent(s) will be terminated if you or your Dependent(s) falsify or intentionally omit medical history on the application for coverage, submit fraudulent, 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 your or your Dependent's coverage. You and your Dependent(s) will not be permitted to benefit under the Plan from your own misrepresentation. If a person 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, 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. You are also advised that suspected incidents of this nature are turned over to Corporate Security to investigate and to address the possible consequences of such actions. You may be periodically asked to submit proof of eligibility to verify claims. All participants are required to cooperate with requests to validate eligibility.

Women's Health and Cancer Rights Act of 1998

This notice is being provided to you in accordance with the requirements of the Federal law entitled the Women's Health and Cancer Rights Act of 1998 (the "Act").

The Retiree and Inactive Health 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 the following Benefits:

- reconstruction of the breast on which the mastectomy has been performed
- surgery and reconstruction of the other breast to produce symmetrical appearance
- prosthesis and treatment of physical complications associated with all 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 Health Plan, this coverage is subject to the Health Plan's Annual Deductible, required Coinsurance payments, benefit maximums and Copay provisions that may apply under benefit options of the Health Plan. You should carefully review the provisions of the Health Plan, the health plan benefit option in which you elect to participate and its SPD regarding any applicable restrictions.

If you have any questions regarding this coverage, please contact your health care Claims Administrator by calling the number listed on your ID card.

Statement of Rights Under the Newborns' and Mothers Health Protection Act (NMHPA)

Under federal law, the Health Plan generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Health Plan may pay for a shorter stay if the attending Provider (the Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn child earlier than the 48 or 96 hours described above.

Also, under federal law, the Health Plan may not set the level of Benefits or Out-of- Pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Health Plan may not, under federal law, require that a Physician, or other Provider, obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). If you participate in the UHC Medicare Advantage PPO Plan, you should refer to UHC to find out if there are additional rules or Benefits available pursuant to State law. Refer to the contact information on the back of your ID card.

Predecessor Health Care Plans

Qwest Retiree Health Care Medical Plan 1 Predecessor Plans:

- **USWC Central (Mountain Bell) Medical Expense Plan** for occupational and management Employees who retired prior to January 1, 1991;
- **USWC Eastern (Northwestern Bell) Medical Expense Plan I** for occupational Employees who retired prior to January 1, 1987, and management Employees who retired prior to January 1, 1986;
- **USWC Western (Pacific Northwest Bell)** occupational and management Employees who retired prior to April 1, 1986 and did not elect the "Health Care Plan";
- **U S WEST Direct Medical Expense Plan** for occupational Employees who retired prior to January 1, 1991, and management Employees who retired prior to January 1, 1986;
- **U S WEST Enterprises Medical Expense Plan** for occupational Employees who retired prior to January 1, 1991.

Qwest Retiree Health Care Medical Plan 2 Predecessor Plans:

- **U S WEST Business Resources, Inc.** Medical Expense Plan for CWA occupational Employees who retired after January 1, 1986;
- **U S WEST Corporate Communications, Inc.** Medical Expense Plan for CWA occupational Employees who retired prior to January 1, 1991;
- **USWC Eastern (Northwestern Bell) Medical Expense Plan II** for occupational Employees who retired after December 31, 1986;
- **U S WEST non-regulated companies' Choice Plus Plan** for management and non-bargained Employees who retired after January 1, 1986;
- **U S WEST non-regulated companies' Choice Plus Plan** for IBEW non- management Employees who retired after January 1, 1987.

Qwest Retiree Health Care Medical Plan 3 Predecessor Plan:

- **The Pacific Northwest Bell Telephone Company Health Care Plan.**

Qwest Retiree Health Care Medical Plan 4 Predecessor Plan:

- **The Northwestern Bell Telephone Company Health Incentive Plan (HIP).**

Note: See your dental benefit option SPD for information about dental Benefits.