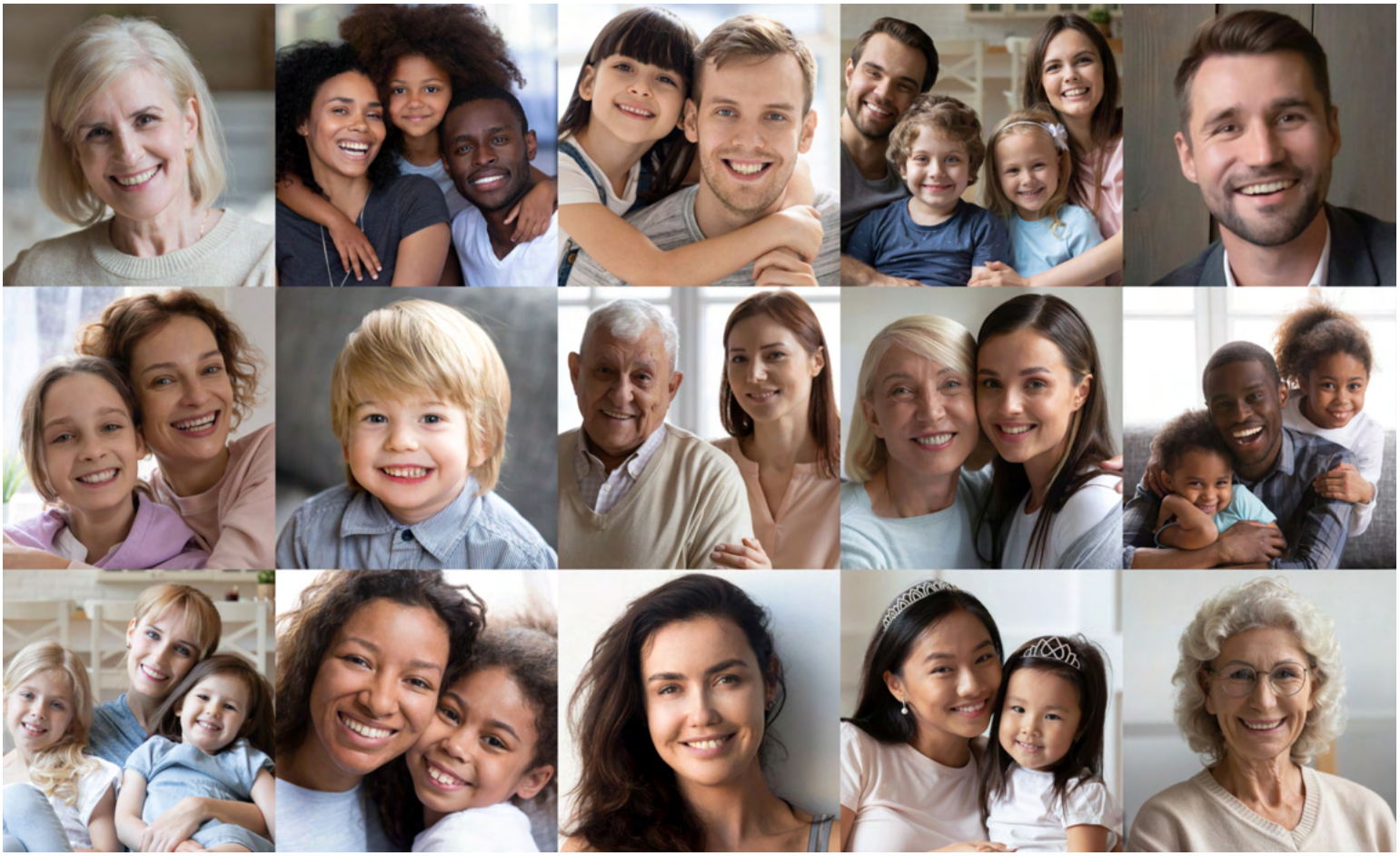
# Amazing People. Amazing Benefits. Find Your Fit.

## 2022 Benefits Guide (U.S. Employees)

For new hires, rehires, transfers and employees newly eligible for benefits



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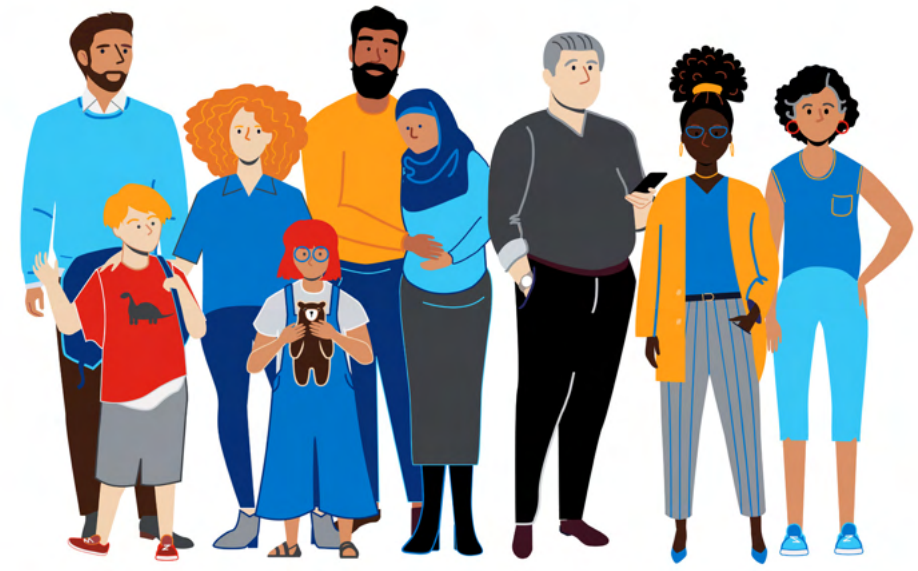

Lumen (referred to hereafter as the Company) is committed to green initiatives. You can help by saving this guide as a PDF instead of printing on paper. However, if you would like a paper copy of this guide you may print it, or alternatively, contact the Lumen Health and Life Service Center at Businessolver (referred to hereafter as the Service Center) at 833-925-0487 to request one to be mailed to you.

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# Welcome to Lumen

We are on a mission to further human progress through the technologies we deliver over the Lumen platform. Whether you're working with our customers directly or supporting them from behind the scenes, you plan an important part in our ability to make amazing things happen.

Our people help our customers do inspiring things, we're proud to offer benefits that inspire you to be your best, both at work and at home. You'll find an amazing range of options from which to choose to meet your needs and "Find Your Fit".

This Benefit Guide explains details regarding your benefit plan and coverage options, offers helpful tools and information to review and provides step-by-step instructions to follow when enrolling. Please take the time to read and learn about the benefits so that you can make informed decisions that best meet you and your dependent's needs.

We believe a high performing workforce is our competitive advantage when our employees are healthy and diligent about their healthcare. Well-being (or lack thereof) impacts business and you personally through your professional and personal life. The many programs offered through the Well Connected Wellness Program, help employees "be well", so they can bring their best selves to all areas of life.

- Visit the **U.S. Benefits** page on the Intranet for more information.
- To enroll, login to the Health and Life website at **lumen.com/healthandlife** or **lumen.com/healthbenefits**.
- Refer to the Helpful Resources section in this guide for contact information.

# Employee Classifications and Eligibility

## Employee Classifications

An “employee,” for purposes of all Company benefit programs and policies is an individual who is directly employed by Lumen and is treated and classified as a Company employee for payroll and benefit purposes.

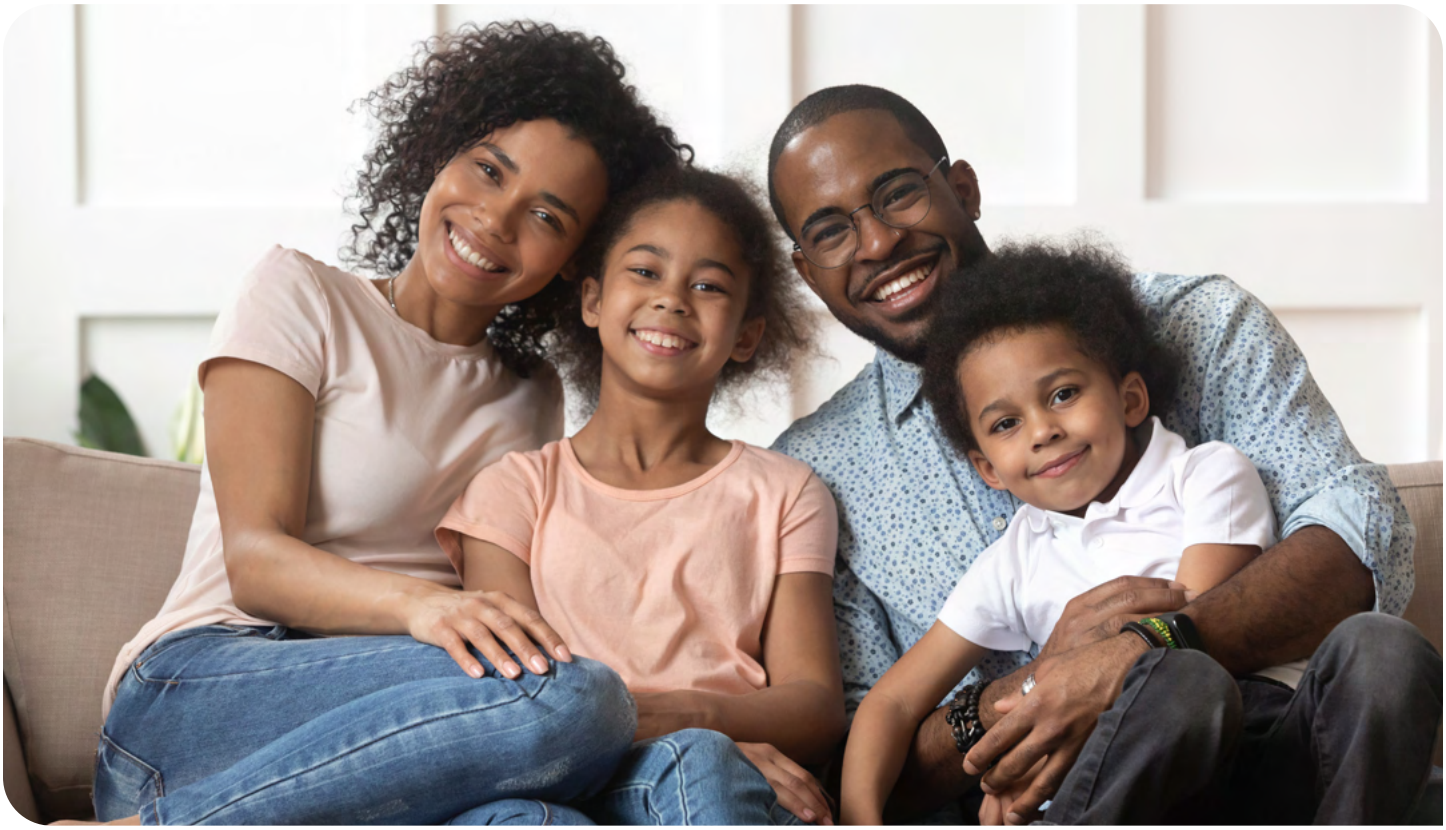
**Union Represented employees should refer to their Collective Bargaining Agreement.**

Based on workweek:

- **Full-time** - Positions which normally are scheduled to work a **minimum of 30 hours per week** can be classified as Full-time status with management and budgetary approvals. Employees in a Full-time status category are eligible for all employee benefits, subject to eligibility requirements of the particular benefit plan and satisfaction of relevant waiting periods. The Full-time or Part-time status assigned to your employment, not scheduled or actual hours worked, determines benefit eligibility.
- **Part-time** - Employees in a Part-time status category who are regularly scheduled to work **at least 20 hours per week** are eligible for the following benefits, subject to eligibility requirements of the particular benefit plan and satisfaction of relevant waiting periods: prorated holiday (4 hours), PTO (50% of eligible accrual) and leave policies (such as bereavement) (4 hours); Company-sponsored activities; and participation in the applicable 401(k) plan. The status assigned to your employment (i.e. Full-time or Part-time), not scheduled or actual hours worked, determine benefit eligibility.

Based on planned duration of position:

- **Regular** - Positions approved for an indefinite period of time are classified as regular.
- **Temporary** - Positions approved for a finite period of time to fill temporary and/or occasional needs, **generally less than six months duration** are classified as temporary. Employees in this category are eligible for Medical benefits as required by the ACA but are not eligible for any other Company benefits, PTO, or holidays. Temporary employment should not exceed six continuous months without review by Human Resources, division management and approval by the Vice President, Benefits.



## Eligibility

Please refer to the employee classifications to determine your eligibility in the benefit plan options or programs. Union Represented employees should refer to their Collective Bargaining Agreement.

| Employee Classification | Eligibility | Premiums |
|---|---|---|
| **Full-time** or **Term Full-time** employees | As a Full-time employee, you and your eligible dependent(s) may enroll in:<br>• Medical/prescription drug<br>• Dental<br>• Vision<br>• Flexible Spending Accounts (Health Care, Limited Purpose Health Care, and Dependent Day Care)<br>• Health Savings Account (HSA) when enrolled in the High Deductible Health Plan with Optional Health Savings Account (HSA)<br>• Well Connected Wellness Program (employees do not need to be enrolled in the medical/prescription drug plan to participate in the Wellness Program)<br>• Fitness Reimbursement Program<br>• Disability<br>• Life Insurance<br>• Commuter Spending Accounts (Parking and Transit)<br>• Voluntary Lifestyle Benefits (not Company-Sponsored ERISA benefits) | Premiums are determined based on how you answer questions during your enrollment. Premiums can be adjusted up or down based on:<br>• Tobacco-Free Discount<br>• Working Spouse/Domestic Partner Surcharge |
| **Part-time, Term Part-time** or **Seasonal** (Qwest Union Represented only) employees | As a Part-time, Term Part-time or Seasonal employee, you and your eligible dependent(s) may enroll in:<br>• Medical/prescription drug<br>• Flexible Spending Accounts (Health Care, Limited Purpose Health Care, and Dependent Day Care)<br>• Health Savings Account (HSA) when enrolled in the High Deductible Health Plan with Optional Health Savings Account (HSA)<br>• Well Connected Wellness Program (employees do not need to be enrolled in the medical/prescription drug plan to participate in the Wellness Program)<br>• Disability (available to Part-time Seasonal Qwest Union Represented employees if hired before Jan. 1, 2018 and to Part-time Non-Union employees). | Premiums are 150% of the Full-time rates and are determined based on how you answer the questions during your enrollment:<br>• Tobacco-Free Discount<br>• Working Spouse/Domestic Partner Surcharge |
| **Temporary Full-time, Temporary Part-time** and **Incidental** (Qwest Union Represented only) employees<br><br>**Note:**<br>> or = 20 hours but <30 hours per week | As a Temporary Full-time, Temporary Part-time or an Incidental employee, you and your eligible dependent(s) may enroll in:<br>• Medical/prescription drug<br>• Well Connected Wellness Program (employees do not need to be enrolled in the medical/prescription drug plan to participate in the Wellness Program) | • Premiums are 100% of the total cost |

## When Benefits Begin

- **Regular Full-time and Regular Part-time employees** - coverage effective date is 31 days from date of hire.
- **Temporary Full-time, Temporary Part-time and Incidental employees** - coverage effective date is 91 days from date of hire.
- **Rehired Employees** – coverage effective date is 31 days from date of rehire. If your rehire date is in the same month you terminated, your coverage effective date will be your rehire date.
- **Rehired Retirees** (eligible for retiree health and/or life benefits) - coverage effective date is the first of the month from your rehire date. If your rehire date is the first day of a month, coverage effective date is on your rehire date.

Refer to the Legal and Important Required Notices section of this guide under "**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**" for further information.

# Plan Overviews

## Summary of Benefit Options and Programs

The below information provides a brief summary of the benefit options or programs that may be available to you and/or your eligible dependents. You can find additional details including Summary Plan Descriptions (SPD) and Summary of Material Modifications (SMM) for the Benefit Option or Program on the **Intranet**.

Review **ALEX**. ALEX can help you learn about benefit options that are right for you and your eligible dependents. ALEX provides estimates and suggestions, but you make the final decision on which Plans you want to enroll in. You cannot enroll through ALEX as it is only used as a tool to assist you in making your decisions. You will need to enroll through the Health and Life website.

| Option/Program | Benefit information |
|---|---|
| **401(k)** | **Non-Union Employees**<br>**When will I be eligible to participate in the 401(k) Plan?**<br>Once Principal (our 401(k) provider) has been notified that you are a new employee or newly eligible (via weekly updates), you will receive an enrollment packet from Principal containing your 401(k) information. After reviewing this information, you may login to the Principal site and make your plan election. You will become a participant following 30 calendar days of employment. Your contributions will begin on the first full payroll following your participation date. The 401(k) Savings Plan has automatic enrollment at 3%, but you can opt out of the Plan by changing the deferral election to 0% or by electing a different percentage or deferral election within 30 days of employment.<br>**Union Represented Employees**<br>**When will I be eligible to participate in the Union 401(k) Plan?**<br>Please refer to your Collective Bargaining Agreement for details on your ability to participate in the 401(k) Savings Plan. |
| **Commuter Spending Account** | We offer a pre-tax benefit account that can be used to pay for public transit — including passes, fare cards or vouchers for the bus, train, subway, or vanpool. This account can also be used for parking expenses — including parking vouchers, direct pay parking and pre-tax cash reimbursement as part of your daily commute to and from work. You can contribute up to $280 per month on a pre-tax basis for transit and parking during the calendar year and then reimburse yourself for expenses incurred throughout that calendar year. If you leave the Company and you have already contributed to a Commuter Spending account, IRS rules state any unused funds will be forfeited.<br>**How to Enroll**<br>You may enroll in the Commuter Spending Account anytime during the year from the Health and Life website. Enrollment or changes to your Commuter Spending Account must be received by the tenth of the month prior to the month you want the change to take effect (for example, by January 10 for a February change or election). Payroll contributions will be processed the first two pay periods of each month (semi-monthly). |
| **Dental** | There are two dental plan options to choose from. However, you can elect to waive your dental coverage. Both of these options cover exams, cleanings and fillings, as well as comprehensive dental work – such as crowns and root canals for covered participants. Both of the dental plan options are offered by MetLife.<br>**Note:** If you do not enroll within the allotted time frame, you will be defaulted to waiving dental coverage. |

| Option/Program | Benefit information |
|---|---|
| **Employee Assistance Program (EAP)** | The EAP provides confidential professional counseling, education, and referral services to you and your family members for a variety of problems. EAP provides up to eight (8) Counseling Sessions per problem per year, by either Face-to-Face, Telephonically, or by Video Counseling. Personal counselors will help you decide which counseling option fits your needs. You can review articles, resources and enroll in webinars as well on the EAP website.<br><br>**Important:** This benefit is available to all employees and any members in the household even if not enrolled in any benefit plan. |
| **Flexible Spending Accounts (FSA)** | You must enroll each year to contribute to a dependent day care or health care (traditional or limited purpose) FSA. Contributions are pre-tax and are fully funded by you. FSA limits are determined by the IRS and are subject to change.<br><br>**Note:** If you enroll in the High Deductible Health Plan (HDHP) and elect an FSA, you will be enrolled in the Limited Purpose FSA whether or not you choose to enroll in a Health Savings Account (HSA).<br><br>**Dependent Day Care FSA** – You can contribute between $150-$5,000 per year. You can use this FSA for eligible out-of-pocket day care expenses for eligible dependents so you (and your spouse, if married) can work or attend school Full-time. Funding is available as contributions are deducted from your paycheck and loaded to UnitedHealthcare's system.<br><br>**Traditional Health Care FSA** – You can contribute between $150-$2,850 per year. You can use this FSA for a range of eligible out-of-pocket health care expenses not covered by medical, prescription drug, dental or vision for you and any eligible dependent, even those not covered by a Company health care plan option. The annual amount you elect to contribute is available for you to use on Jan. 1 of each year.<br><br>**Limited Purpose FSA (for those enrolled in the HDHP)** - You can contribute between $150-$2,750 per year. You can use this FSA for eligible out-of-pocket dental and vision care expenses, including deductibles, copayments and coinsurance not covered by other plans. Medical and prescription drug expenses are not eligible for reimbursement. The annual amount you elect to contribute is available for you to use on Jan. 1 of each year. |
| **Fitness Reimbursement Program** | To promote employee health and wellness, we will reimburse employees for a portion of the cost for individual fitness membership and class fees.<br><br>All Full-time employees, as well as spouses/domestic partners enrolled in a Lumen medical plan are eligible.<br><br>**Note:** The IRS considers your fitness reimbursement a taxable fringe benefit. Applicable taxes will appear under the imputed income section on your paycheck. |
| **Health Savings Account (HSA)** | HSAs are designed to help you to save for qualified medical expenses if you are enrolled in the High Deductible Health Plan (HDHP), including prescriptions and eligible dental and vision expenses. You can use your HSA money tax free for medical expenses for your dependents whether or not they are on your health insurance. An HSA allows you to set aside pre-tax money from your paycheck to pay for expenses you will have now and in the future. This account rolls over from year to year and the money in the account is 100% yours. You can open up an HSA at any time throughout the year.<br><br>Health Savings Accounts are the most tax advantaged account ever created (three tax advantages in one account). Tax deductible, tax free growth, and tax free distribution.<br><br>**Important Note:** This program is not a Company-sponsored plan or benefit. It is not a plan covered under the federal law known as "ERISA." The Company has simply chosen to allow OptumBank to make its programs available to Lumen employees, but please be advised that this is a voluntary program and only you can decide whether the benefits provided by this program are appropriate for you and your family. You are encouraged to research all suitable alternatives and consult with your personal advisors. The Company is not able to provide you with advice regarding the program. Your participation is your decision, completely voluntary and at your own expense. |

| Option/Program | Benefit information |
|---|---|
| **Health Reimbursement Account (HRA)** | **Eligibility: All who are enrolled in one of the CDHP options.**<br><br>**Overview:** If you are enrolled in either the Consumer Driven Health Plan Option 1 or Option 2, you will receive a Company funded HRA to help with your out-of-pocket portion of the deductible and out-of-pocket maximum expenses. You incur medical and prescription drug expenses and pay the full cost of them with money in your HRA first, then you pay out-of-pocket until your deductible is met.<br><br>**Note**: If you elect a CDHP and a Health Care FSA, money will be taken from your HRA first and then once exhausted, money will be taken from your FSA. You do not have the option to have your FSA pay first as the HRA is part of the medical plan. In addition, you receive the full allocation on Jan. 1st or whatever day you become eligible. |

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

- If you move from one plan to another (CDHP Option 2 to CDHP Option 1 or vice versa) any remaining funds from the prior year will be available after 90 days. The 90 days allow enough time for prior year claims to process. Once the 90 days have passed, the carryover becomes available.
  - Any CDHP HRA balance may also be rolled over if you change from a CDHP Plan benefit option to the HDHP with Optional HSA Plan benefit option. After the run-out period, any rollover balances will be deposited into a post deductible HRA account. The balance would be available once you have met your HDHP deductible. See the HDHP With HSA SPD for more information.
  - If you elect the Bind Health Plan and have a prior CDHP HRA balance, these dollars will follow you. Your prior account HRA dollars will not be available until after the run-out period (for Claims from your prior coverage to clear under the CDHP Plan benefit option HRA). This typically takes 90 days.

**Note: Under the Bind Health Plan, you will not receive a Health Care Savings Card to use.**

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|---|---|
| **Imputed Income** | Imputed Income is income that the IRS requires you to be taxed on in certain circumstances as noted below:<br><br>• **Your company-paid basic life insurance is over $50,000**. This is listed as GROUP TERM LIFE INS TXBLE under the imputed income section of the paystub located on the left-hand side.<br>• **Your company-paid Short-Term Disability enrollment election is Post-Tax.** This is listed as STD BENEFIT under the imputed income section of the paystub located on the left-hand side. **Note:** This does not mean you are on STD. It means you elected to enroll in the Post-Tax option which calculates an imputed income amount.<br>• **You are covering your Domestic Partner or your Domestic Partner's child/ren under the Medical/Prescription Drug, Dental and/or Vision plan.** This is listed as HEALTHCARE IMPUTED INCOME under the imputed income section of the paystub located on the left-hand side.* Domestic Partners (DP) are not considered spouses under the Internal Revenue Code (IRC). Unless the DP otherwise qualifies as a tax dependent under the Internal Revenue Code, he or she may not receive tax-free benefits from employer benefit plans.<br>• **You receive Wellness rewards via gift card (calculated each quarter).** This is listed as WELLNESS REWARD under the imputed income section of the paystub located on the left-hand side. **Note:** This means you elected to have your Wellness rewards in the form of a gift card instead of through your health account, if applicable.<br>• **Your company-paid Incentive Award based on a recognition** - e.g., exceeding sales goal, Milestone Anniversary such as 20, 30, 40 years of service, etc. This is listed as IMP – INCENTIVE AWARDS under the imputed income section of the paystub located on the left-hand side.<br><br>**Important Note:** Please do not contact the Payroll team with questions related to Imputed Income. All benefit related questions should go through the Service Center. |
| **Life & Accidental Death & Dismemberment (AD&D)** | The Lumen Life and AD&D Insurance Plans provide a wide range of benefits in the event of death or other covered losses.<br><br>Coverage and benefit premium deductions may increase or decrease throughout the year in certain situations (for example, if you have a change in pay or change age brackets; age brackets update every 5 years: 30, 35, 40, 45, etc.).<br><br>In some cases you may be required to provide Evidence of Insurability (EOI). |

| Option/Program | Benefit information |
|---|---|
| **Long-Term Disability** | Long-Term Disability is designed to help protect your income in the event you are unable to work due to a covered disability.<br><br>Long-Term Disability (LTD) provides partial income protection for you in the event of an extended disability after the Short-Term Disability (STD) elimination period. You are eligible to enroll in Supplemental LTD after completing one year of service, during Annual Enrollment. If you become eligible after Annual Enrollment ends, you will have the opportunity to enroll prior to the end of the plan year by calling the Service Center. |
| **Medical and Prescription Drug**<br><br>**Note:** If you are an employee eligible for benefits, a resident in Hawaii, and enroll in medical coverage, you will automatically be enrolled in Blue Cross/Blue Shield. | **Medical and Prescription Drug Overview**<br><br>Lumen offers you and your eligible dependents four medical plan options. The Bind Health Plan, High Deductible Plan (HDHP) with an optional Health Savings Account (HSA) administered by UnitedHealthcare and two Consumer Driven health plans (CDHPs) with a Company-funded Health Reimbursement Account (HRA) administered by UnitedHealthcare. |
| | **Bind Health Plan**<br><br>With the Bind Health plan, you can see treatment options and costs before getting treatment or choosing a doctor. With this information, you can make informed decisions and find savings opportunities. If you want an overview of how the Bind Health Plan works, visit **lumen.com/bind**.<br><br>**How it works:**<br><br>Your coverage starts at your first doctor's appointment or prescription fill because the Bind plan is a $0 deductible plan.<br><br>See clear, upfront prices for treatments, doctors and prescription drugs. Know before you go what your health care choices will cost.<br><br>Get the coverage you'd expect from your health insurance through the broad, UnitedHealthcare Choice Plus national provider network.<br><br>A unique feature allows you to activate coverage any time during the plan year for less common, non-emergency procedures with large price variations- like an upper GI endoscopy or cataract surgery – should those needs arise. Activate the coverage at least three business days prior to the treatment, test or procedure. |
| | **High Deductible Health Plan (HDHP) with Optional Health Savings Account (HSA)**<br><br>This plan is administered by UnitedHealthcare. You can choose your healthcare providers; however, the Plan pays a greater benefit when you use providers that are in the network.<br><br>The HDHP has the option for you to open a personal tax-advantage, HSA, to save your own money and pay for qualified medical expenses now and in the future. You can choose to establish your HSA with any financial institution; however, Lumen partners with OptumBank to allow your contributions to be set up as pre-tax through bi-weekly payroll deductions. Contribution elections do not carry over into the new year; therefore, you must elect to participate annually.<br><br>You pay the full cost of the medical expenses until your deductible is met. You can also pay for covered services with money you have set aside in your HSA.<br><br>**Note:** Temporary Full-time, Temporary Part-time and Incidental employees are not eligible to open up an HSA. |

| Option/Program | Benefit information |
|---|---|
| | **Consumer Driven Health Plans (CDHPs), Option 1 and Option 2** |
| | These plans are administered by UnitedHealthcare. You can choose your healthcare providers; however, the Plan pays a greater benefit when you use providers that are in the network. The Company provides a subsidized Health Reimbursement Account (HRA), refer to the comparison chart for HRA amounts.<br><br>The HRA, Participant Responsibility (your out-of-pocket portion of the deductible) and out-of-pocket maximum are all based on the coverage level you elect (Employee Only, Employee/Spouse/Domestic Partner, etc.), even if only one covered person uses the entire HRA benefit. You incur medical expenses and pay the full cost of the medical expenses with money in your HRA first, then you pay out-of-pocket until your deductible is met.<br><br>Prescription drug expenses for CDHP options are paid the same as any other medical expense. You will be responsible for the cost of the prescription drugs until you have met or satisfied your deductible.<br><br>To help reduce costs and make filling medications more convenient, maintenance medications for conditions, such as diabetes, cholesterol and high blood pressure, must be filled by mail order. You can fill your prescription up to two times at a retail pharmacy. After that, it will not be covered, and you will pay the full retail price. |
| **Telemedicine** | Telemedicine services take the wait out of visiting a doctor and the app makes it fast, easy and convenient. Choose doctors from one of the nation's largest Telehealth networks. You can schedule appointments and arrange for private, secure, and confidential visits. Prescriptions are issued only when clinically appropriate. No controlled substances will be prescribed, and the availability of some prescriptions may be restricted by law in some states.<br><br>**Important:** Telemedicine is not a separate plan option. You are automatically enrolled if you elect a Lumen medical plan. |
| **Prescription Drug** | There is one prescription drug plan regardless which medical plan you elect; Optum Rx. In addition, Optum Rx is our mail order vendor. If your medication requires you to go through mail order (maintenance medication taken regularly such as for high cholesterol, hypertension, etc.), you cannot opt-out of using Optum Rx.<br><br>**Important:** Prescription Drug is not a separate plan option. You are automatically enrolled if you elect a Lumen medical plan.<br><br>**Note:** If you are enrolled in the Bind Health Plan, mail order is not required. |
| **Pension (Qwest Union Represented employees)** | Your pension plan is a qualified, defined benefit plan that promises to pay you a pension benefit if you meet the plan's vesting requirements. |
| **Short-Term Disability**<br><br>**Note:** You must have one year of service to be eligible for this benefit. For specific details, refer to the STD Summary Plan Description and the collective bargaining agreement (CBA), if applicable, on the Intranet. | When you have medical circumstances that require time off work, Lumen provides Short-Term Disability benefits to continue all or a portion of pay to eligible employees when you are disabled. |
| **Survivor Benefit Plan***<br><br>*For active Full-time Non-Union employees only | The Survivor Benefit Plan will pay your eligible designee six months of your base salary in the unlikely event of your death as an active Full-time employee. |

| Option/Program | Benefit information |
|---|---|
| **Tobacco-Free Discount** | To promote a healthy work environment, Lumen provides a tobacco-free discount that supports our ongoing focus on wellness. If you and your eligible dependents enroll in a Lumen medical Plan option and are non-tobacco users OR are enrolled in a Company recognized tobacco cessation program, you will receive a discount to the cost of your medical Plan premium. A Company recognized program includes the Quit for Life program, but also a tobacco cessation program of your choice, such as one sponsored by a local hospital or by the American Lung Association.<br><br>The discount is calculated on the total cost of coverage, not the actual medical bi-weekly premium amount.<br><br>You will be required to answer the tobacco question either online or through the Service Center. Tobacco products include but are not limited to the following: chewing tobacco, cigarettes, cigars, e-cigarettes, hookahs, nicotine gels/dissolvables, pipe tobacco, tobacco snuff, vapors and any other products associated with tobacco use.<br><br>**Note:** Temporary employees are not subject to the Tobacco-Free Discount. |
| **Vision** | There is one vision plan option. However, you can elect to waive your vision coverage. The vision plan is offered by EyeMed (First American Administrators/EyeMed Vision Care, LLC.).<br><br>You can save money if you select "INSIGHT" (in-network). You can receive access to enhanced benefits and save even more if you choose to visit an in-network PLUS Provider within the INSIGHT network. Your vision care services include but are not limited to contact lenses, eye exams, glasses (frames and lenses), retinal screening and laser vision correction.<br><br>**Note:** If you do not enroll within the allotted time frame, you will be defaulted to waiving vision coverage. |
| **Voluntary Lifestyle Benefits** | Voluntary Lifestyle Benefits provides you and your family with voluntary benefits choices, in addition to your Lumen Health & Welfare Benefits options, at affordable rates. |
| **Well Connected Wellness Program** | The Well Connected program is designed to help you achieve a state of balance in your personal and professional life. It doesn't matter if you are working on your physical wellness, financial wellness, or another area, the wellness program is designed to help you live an optimal life. The Well Connected program provides access to a number of resources and activities to support your health and performance. |
| **Well Connected Rewards** | The Well Connected program is designed to help you achieve a state of balance in your personal and professional life. It doesn't matter if you are working on your physical wellness, financial wellness, or another area, the wellness program is designed to help you live an optimal life. The Well Connected program provides access to a number of resources and activities to support your health and performance.<br><br>The Well Connected program can improve your wellbeing and you can earn up to $600 each Plan year for you or $1,200 for you and your covered spouse/domestic partner enrolled in one of the Lumen medical plan options. You may select Gift Card or Health Account (Health Reimbursement Account - HRA, Health Savings Account - HSA) for your Well Connected Rewards option based on your medical election.<br><br>Selecting Gift Card will apply an imputed income calculation that will reflect on your paycheck. In addition, you must follow the Gift Card rules.<br><br>Selecting Health Accounts will not be taxable; the rewards will be added to your medical account to use for deductible and out-of-pocket expenses. If you have any unused rewards, the amount will roll over into the following Plan year as long as you remain in the same medical plan.<br><br>**Note:** If you are a Company Couple, and your spouse/domestic partner is enrolled as a dependent under your medical plan benefit option, your spouse/domestic partner will only be eligible for wellness rewards in the form of a gift card. |
| **Working Spouse/ Domestic Partner Surcharge – $100 per pay period** | You will need to answer the working spouse/domestic partner surcharge question either online or through the Service Center if you enroll your spouse/domestic partner in a medical plan option.<br><br>A $100 surcharge per pay period applies if you cover your spouse/domestic partner under our medical Plan but they are eligible for medical coverage through his/her employer and they choose to waive their employer's medical coverage. This surcharge applies unless:<br><br>• Your base pay is less than $30,000; or<br>• Your base pay is less than $100,000 and your spouse/domestic partner works for an employer that employs fewer than 50 employees. If this applies to you, you will need to contact the Service Center.<br><br>**Note:** Temporary employees are not subject to the Working Spouse/Domestic Partner Surcharge. |

# Tobacco-Free Discount and Working Spouse Domestic Partner Surcharge Questions

**Be sure to review the below information during your enrollment as it could impact the cost of your medical premiums as well as your Health Account.**

**Note:** The questions below are for informational purposes only to show how they are displayed on the Health and Life website. If you are not sure how to answer these questions, contact the Service Center for assistance. You may be eligible for a discount to your medical benefit cost based on how you answer the question on tobacco products usage. The discount is calculated on the total cost of coverage, not the actual medical bi-weekly premium amount.

## Tobacco-Free Discount

You may be eligible for a discount to your medical benefit premiums based on how you answer the following question. If you do not answer the below Tobacco-Free Discount question, you will default to "Yes" and will not be eligible for the discounted premium.

To promote a healthy work environment, Lumen provides a tobacco-free discount that supports our ongoing focus on wellness. If you and your eligible dependents enrolled in a Lumen medical Plan option are **non**-tobacco users **OR** are enrolled in a Company recognized tobacco cessation program, you will receive a discount to the cost of your medical Plan premium.

## What is a Company Recognized Program?

Quit For Life is a Wellness Coaching Program sponsored by Lumen. You can alternatively enroll in a tobacco cessation program of your choice, such as one sponsored by a local hospital, the American Lung Association or one recommended by your doctor. The Plan will accommodate the recommendations of an individual's personal doctor, if needed.

## What is a Tobacco Product?

Tobacco products include but are not limited to the following: chewing tobacco, cigarettes, cigars, e-cigarettes, hookahs, nicotine gels/dissolvables, pipe tobacco, tobacco snuff, vapors and any other products associated with tobacco.

**Please Note: The Plan is committed to helping you achieve your best health. Quit For Life is a Wellness Coaching Program available to you and covered dependents over the age of 18 at no cost. You can find more information related to this Program at lumen.com/wellconnected.**

**IMPORTANT**: If you are unsure of how to answer the question below or if you have a medical condition that does not allow you to stop using tobacco products and/or does not allow you to enroll in a tobacco cessation program, please contact the Service Center at **833-925-0487** for further assistance prior to completing your enrollment to learn about alternatives to obtain the discount. The Plan will accommodate the recommendations of an individual's personal doctor, if needed. You will be required to answer the questions below when you elect your benefits.

**Please select your response to the following below:**

**Yes** –I and/or my dependents enrolled in my medical plan smoke or use tobacco products and are not enrolled in a Company-recognized tobacco cessation program. Therefore, I am not eligible for the discount.

**No** – Neither I nor any of my dependent(s) enrolled in my medical plan smoke or use tobacco products; or those that do use tobacco products are enrolled in a Company-recognized Program, a tobacco cessation program of my choice or my doctor's recommendation. Therefore, I am eligible for the discount.

To verify your selection, please review your Benefit Summary after you complete your enrollment. Under the medical plan details on your statement, it will indicate as a line item:

a. "Your medical premium deductions reflects that you are receiving the tobacco-free discount," or
b. "Your medical premium deduction reflects that you are not receiving the tobacco-free discount."

## Working Spouse/Domestic Partner Surcharge

You may be subject to a working spouse/domestic partner per pay period surcharge based on how you answer the following question:

**Yes – All** of the following apply and therefore, I **will be** subject to the surcharge.

- I am married or in a domestic partner (DP) relationship.
- My spouse/DP is NOT employed by Lumen.
- My spouse/DP is currently employed.
- My spouse/DP is eligible to enroll in their Employer group medical plan.
- My spouse/DP has elected not to enroll in their Employer group medical plan.
- I will enroll my spouse/DP in the Lumen group medical plan.

**No** – At least **one** of the following applies and therefore, I **will not be** subject to the surcharge.

- I am not married or in a domestic partner (DP) relationship.
- My spouse/DP is employed by Lumen.
- My spouse/DP is not currently employed.
- My spouse/DP is self-employed.
- My spouse/DP is not eligible to enroll in their Employer group medical plan.
- My spouse/DP has elected to enroll in their Employer group medical plan.
- My spouse/DP is enrolled in Medicaid, Medicare or another plan that is not defined as an "Employer group medical plan."
- My spouse/DP's annual enrollment has already passed.
- My spouse/DP's employer has less than 50 employees and my Lumen base salary is less than $100k.

**Note:** You are not subject to the Working Spouse/Domestic Partner surcharge if your base pay is less than $30,000. If your base pay amount **changes** during the benefit plan year, the surcharge will be automatically reassessed and effective on the date of the change, if applicable.

**Yes** – applies ($100 per pay period surcharge)

**No** – no surcharge ($0)

To **verify** your selection, please review your Benefit Summary after you complete your enrollment.

Any questions related to benefit premiums should be directed to the Service Center. Please **DO NOT** contact the Payroll department through chat, email, HR tickets or phone as Payroll staff will be unable to assist you with benefit premium questions.

# Explore Your Options and Enroll

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

## Tips to help you enroll (based on a Full-time eligible employee)

- Enter your personal preference on how you wish to receive benefit communication on the **Health and Life website**
- Enroll by your deadline noted in the count down banner.
- Read the Tobacco-Free Discount and Working Spouse/Domestic Partner Surcharge questions.
- Enroll in a Savings or Spending Account: Health Care Flexible Spending Account (FSA), Dependent Day Care FSA and/or a Health Savings Account, if applicable.
- If you enroll in Supplemental Life Insurance that requires Evidence of Insurability/Statement of Health, be sure to submit the form directly to the carrier.
- Print your Summary of Benefits after you enroll for your records.
- Expect to receive ID cards for medical/prescription drug, dental, and or vision coverage.
- Be sure to review your paychecks to know what benefit premiums are being deducted to ensure they are as you expected and are accurate.

**Note: If you don't enroll, you will only receive the Company-paid benefit plans, if eligible, based on your status.**

- Basic Life
- Basic Accidental Death and Dismemberment (AD&D)
- Business Travel Accident (BTA)

**To access the Health and Life website, make sure you are using the latest version of one of the following supported browsers; Mecrosoft Edge, Firefox, Chrome or Safari.**

**If you are using IE11, you will need to update your "Default Browser" settings. Windows 10 users can check/update default browser settings by going to: Start menu/Settings/Apps/Default apps. To change settings, click on the browser and a list of available will pop-up for you to select.**

## Enroll

You can enroll through the following available options:

**Mobile:**

- Download the free MyChoice Mobile App for Android or iOS

Search: **MyChoice™ Mobile App**, available for free in the App Store and Google Play

**Website:**

- Health and Life website: **lumen.com/healthandlife**

**Phone:**

- **833-925-0487**

If you enroll on the the Health and Life website, you can chat with Sofia, your personal artificial intelligence benefits assistant who can answer general questions and help guide you as you enroll.

Member Advocates are available Mon-Fri, 7 a.m. to 7 p.m. (CST).

We encourage you to enroll via mobile or website but if you choose to call, you may have the option to select VirtualHold. You will not lose your place in line if you select this option. A Member Advocate will call you back, once available.

# Appendix

# Things to Know

## Dual Coverage Rule

The Health Care Plan provisions prohibit any person from being enrolled or covered in more than one Company medical/prescription drug, dental, vision, dependent supplemental life and supplemental accidental death and dismemberment (AD&D) benefit Plan option. Dual coverage is not available if your spouse/domestic partner or dependent child is an employee, whether active, inactive, or in a retired status.

## Qualified Life Events

If you experience a Qualified Life Event (QLE) such as divorce, marriage, having a baby, losing coverage from another Plan, etc., you have the opportunity to make certain changes under the Health Care Plan and Life Insurance Plan, "the Plan." In order to make changes, you must make this request within 45 days of the QLE effective date either through the Health and Life website at **lumen.com/healthandlife** or by calling the Service Center at **833-925-0487**.

## Making Changes to your Plan or Coverage Level (Tier)

If you are moving to another dependent's coverage or changing your coverage level under UnitedHealthcare, you should also contact UnitedHealthcare after you have notified the Service Center either through the website or phone, if your change in benefits requires moving deductibles, HRA funds or accumulators as this is a manual process for United Healtcare. .

## Adding Dependents

Your dependent(s) will not be eligible for coverage until you have provided documentation that confirms their eligibility under the Plan. The Service Center will send information to you with additional details on how to complete the dependent verification process.

You can upload your supporting documentation after you complete your enrollment. A few examples of documentation are birth certificate, marriage certificate, first page of your tax return, etc.

**Note:** The Company may periodically conduct audits of covered dependents to determine their continued eligibility for benefits under the Plan.

### Ending Coverage for Dependents Who No Longer Meet Eligibility Requirements

During the year, if your dependent no longer meets eligibility requirements for coverage under the Plan, you are required to notify the Service Center either by disenrolling your dependent on the Health and Life website, **lumen.com/healthandlife** or calling the Service Center within 45 days to terminate his/her coverage. For example, if you experience a divorce, you must notify the Service Center. Health Care coverage will end for the affected dependent retroactive to the end of the month in which the event occurred.

In the event of a divorce that is not reported timely, you will be responsible for any claims paid after eligibility ended. For example, if you are divorced on April 24, coverage for your ex-spouse would end on April 30. You would be required to advise the Service Center no later than 45 days from April 24.

If you receive a court order that indicates you are required to provide continued coverage for your ex-spouse, you will need to obtain coverage outside of the Company offered plans as the Company does not allow ex-spouses to be covered under the Plan.

**EXCEPTION:** Once a dependent child reaches age 26, he or she will be automatically removed from the Plan at the end of the month in which the dependent turned age 26. Your dependent will be offered continuation of coverage through COBRA; therefore, you do not need to notify the Service Center.

## When Health and Life Benefits End

Coverage ends under the Health Care Plans, including FSAs and HSA on the last day of the month of your termination date (not always your last day worked). AD&D, Business Travel Accident, Commuter, Disability, and Life insurance coverage ends on your termination date. **Note:** Reach out to the Voluntary Lifestyle Program if you are enrolled at the time of termination to discuss your available options as a former employee.

When coverage under the Health Care Plans ends, you and/or your enrolled dependent(s) are eligible to continue coverage under the federal law known as COBRA (generally limited to 18 or 36 months, depending on the reason for coverage loss). You must notify the Service Center within 60 days from loss of coverage if you wish to enroll in COBRA regardless if you are offered a subsidized COBRA rate/s or an unsubsidized rate. Refer to the COBRA Rights Notice for further information sent by the Service Center to you and/or your Spouse/Domestic Partner separately within 20 business days from your hire/rehire date.

If you and/or your eligible dependents were enrolled in basic and/or supplemental life insurance and/or accidental death and dismemberment insurance, you may be able to covert or port to an individual policy. For more information contact the applicable vendor administrators.

For more details when coverage ends, refer to the Benefits Resource Guide for Departing Lumen Employees available on the **Intranet**.

# Miscellaneous Medical Information

**Note:** Dependent children of any age are NOT covered for maternity benefits, including complications during pregnancy and at birth with the exception of specific prenatal services that are considered preventive under the Patient Protection and Affordable Care Act (PPACA). **Exception:** This benefit is allowed for covered dependents that reside in Massachusetts due to State law.

## Health Care Reform Requirements

Medical Plan benefit options under the Health Care Plan comply with the Health Care Reform benefit coverage and affordability requirements. As long as you are enrolled in a Medical Plan benefit option in 2022, your coverage will meet (or exceed) the mandated affordability and coverage requirements. Since the Company's Medical Plan benefit options meet Health Care Reform requirements, it is unlikely you will receive any kind of financial help (subsidy) from the government to pay for any coverage you may purchase from a public exchange.

## All Medical Benefit Options are Self-funded

The medical benefit options offered under the Health Care Plan are self- funded. This means the Company pays claims for benefits with its own funds as well as employees' premium deductions, rather than contracting with an insurance company that assumes the risk. Everyone plays a vital role in the financial health of the Company, and you can help reduce health care costs by living a healthy lifestyle, using preventive care benefits and taking advantage of the wellness programs provided by the Company.

## Virtual Network Plan

If you live outside the CDHP, HDHP or Bind network area and enroll in a medical plan, you will be automatically enrolled in the Virtual Network Plan. The Virtual Network is designed to help those who live in rural areas and/or areas that have no access to adequate provider networks and facilities that are contracted with Bind or UHC. For the CDHP or HDHP, you may be required to pay the provider at the time of service and then submit a medical claim to UHC for processing and reimbursement. Under this plan, you must satisfy your annual deductible first, before the Plan pays 80 percent coinsurance for most covered services. Preventive care services are covered at 100 percent with no deductible. Covered services will be subject to reasonable and customary (R&C) charges, and you are responsible for any amount over R&C.

## Certain Plan Provisions are Prorated

If you enroll in a CDHP, your HRA will be prorated based on your benefits effective date under the Plan listed in this chart.

### HRA prorated chart:

| If your benefits effective date is... | You will receive... |
|---|---|
| **January - March** | 100% of HRA allocation amount |
| **April - June** | 75% of HRA allocation amount |
| **July - September** | 50% of HRA allocation amount |
| **October - December** | 25% of HRA allocation amount |

# Medical Plan Comparison

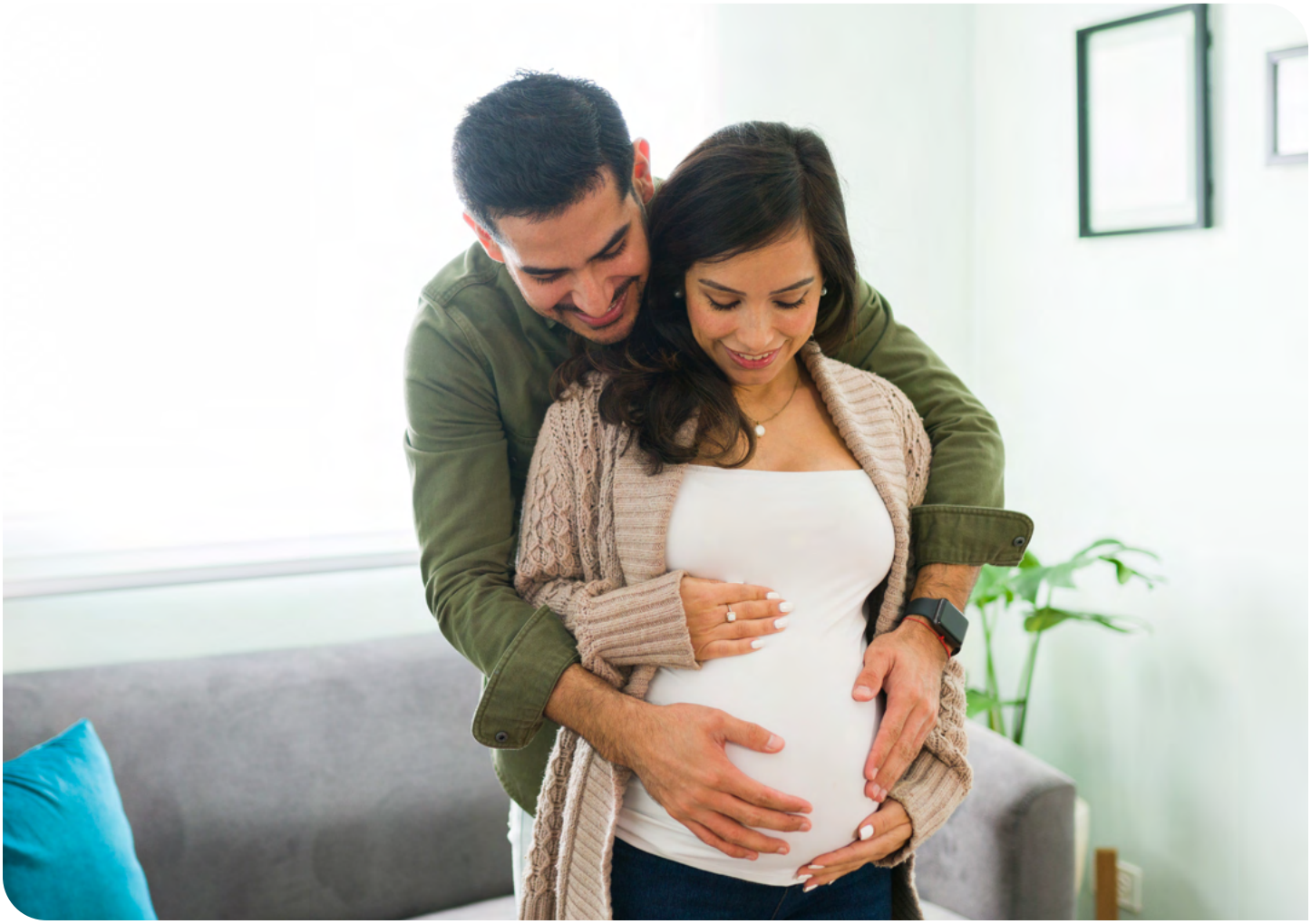
This chart is only a snapshot summary of medical benefits. For specific details on how services are covered or excluded, please contact Claims Administrator (Bind Health Plan or UnitedHealthcare) or refer to the Summary Plan Description on the **Intranet**.

| | Bind Health Plan | | UnitedHealthcare HDHP with Optional HSA | | UnitedHealthcare CDHP Option 1 | | UnitedHealthcare CDHP Option 2 | |
|---|---|---|---|---|---|---|---|---|
| **HSA/HRA Contributions** | Not Applicable - See Flexible Spending Account Options for more information | | With Employee-Funded HSA (maximum contribution):<br>• $3,650 Employee<br>• $7,300 Employee + One or more enrolled<br>**Note:** If you are 55 or older, you can contribute an extra $1,000 "catch-up" contribution. | | With Company-Funded HRA Contribution:<br>• $500 Employee<br>• $750 Employee + Spouse/ Domestic Partner (Domestic Partner)<br>• $750 Employee + Children<br>• $1,000 Family | | With Company-Funded HRA Contribution:<br>• $800 Employee<br>• $1,200 Employee + Spouse/Domestic Partner (Domestic Partner)<br>• $1,200 Employee + Children<br>• $1,600 Family | |
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **You Pay** | **Annual Deductible (The Deductibles are separate for In-Network and Out-of-Network providers and are not combined)** | | | | | | | |
| | **Employee** | | **Employee** | | **Employee** | | **Employee** | |
| | $0 | $0 | $1,500 | $3,000 | $1,500 | $3,000 | $1,500 | $3,000 |
| | | | | | **Employee + Spouse/ Domestic Partner** | | **Employee + Spouse/ Domestic Partner** | |
| | | | | | $2,250 | $4,500 | $2,250 | $4,500 |
| | **Employee + Children** | | **Family** | | **Employee + Children** | | **Employee + Children** | |
| | $0 | $0 | $3,000 | $6,000 (deductible must be satisfied before coinsurance applies; no individual limits) | $2,250 | $4,500 | $2,250 | $4,500 |
| | | | | | **Family** | | **Family** | |
| | | | | | $3,000 | $6,000 (deductible must be satisfied before coinsurance applies; no individual limits) | $3,000 | $6,000 (deductible must be satisfied before coinsurance applies; no individual limits) |
| | **Annual Out-of-Pocket Maximum (The Out-of-Pocket Maximums are separate for In-Network and Out-of-Network providers and are not combined)** | | | | | | | |
| | **Employee** | | **Employee** | | **Employee** | | **Employee** | |
| | $3,600 | $7,200 | $3,600 | $7,200 | $3,600 | $7,200 | $3,200 | $6,400 |
| | **Employee + Spouse/ Domestic Partner** | | | | **Employee + Spouse/ Domestic Partner** | | **Employee + Spouse/ Domestic Partner** | |
| | $5,400 | $10,800 | | | $5,400 | $10,800 | $4,800 | $9,600 |
| | **Employee + Children** | | | | **Employee + Children** | | **Employee + Children** | |
| | $5,400 | $10,800 | | | $5,400 | $10,800 | $4,800 | $9,600 |
| | **Family** | | **Family** | | **Family** | | **Family** | |
| | $6,850 | $14,400 (Individual out of pocket must be satisfied before eligible expenses are 100% covered) | $6,850 | $14,400 (Entire family out of pocket must be satisfied before eligible expenses are 100% covered) | $6,850 | $14,400 (Entire family out of pocket must be satisfied before eligible expenses are 100% covered) | $6,400 | $12,800 (Entire family out of pocket must be satisfied before eligible expenses are 100% covered) |

| | Bind Health Plan | | UnitedHealthcare HDHP with Optional HSA | | UnitedHealthcare CDHP Option 1 | | UnitedHealthcare CDHP Option 2 | |
|---|---|---|---|---|---|---|---|---|
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Coinsurance** | 100% covered | | 85% covered (Tier 1 Premium Provider)<br>80% covered (Network Provider) | 50% covered (you may be responsible for any amount over the eligible expense) | 85% covered (Tier 1 Premium Provider)<br>80% covered (Network Provider) | 50% covered (you may be responsible for any amount over the eligible expense) | 85% covered (Tier 1 Premium Provider)<br>80% covered (Network Provider) | 50% covered (you may be responsible for any amount over the eligible expense) |
| **Primary care visit to treat an injury or illness** | $20-$90 | $180 | 85% covered (Tier 1 Premium Provider)<br>80% covered (Network Provider) | 50% covered (you may be responsible for any amount over the eligible expense) | 85% covered (Tier 1 Premium Provider)<br>80% covered (Network Provider) | 50% covered (you may be responsible for any amount over the eligible expense) | 85% covered (Tier 1 Premium Provider)<br>80% covered (Network Provider) | 50% covered (you may be responsible for any amount over the eligible expense) |
| **Specialist Visit** | $20-$90 | $180 | 85% covered (Tier 1 Premium Provider)<br>80% covered (Network Provider) | 50% covered (you may be responsible for any amount over the eligible expense) | 85% covered (Tier 1 Premium Provider)<br>80% covered (Network Provider) | 50% covered (you may be responsible for any amount over the eligible expense) | 85% covered (Tier 1 Premium Provider)<br>80% covered (Network Provider) | 50% covered (you may be responsible for any amount over the eligible expense) |
| **Preventive Care: (No Deductible)** | | | | | | | | |
| **Preventive care/ screening/ immunization** | 100% covered | 100% covered | 100% | Not covered | 100% | Not covered | 100% | Not covered |
| **Inpatient (Facility), Office Visit, Outpatient (Facility), Prescriptions, Urgent Care** | | | | | | | | |
| **Outpatient Lab and Pathology** | $0 | $0 | 85% covered | 80% covered (after deductible is met) | 85% covered | 80% covered (after deductible is met) | 85% covered | 50% covered (you may be subject to balances over the eligible expense) |
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Outpatient Surgery** | Up to $2,500 (Coverage requiring activation available for certain procedures, up to $3,000) | Up to $4,000 | 85% covered (including freestanding facilities) | Not covered | 85% covered (including freestanding facilities) | Not covered | 85% covered (including freestanding facilities) | Not covered |

| | Bind Health Plan | | UnitedHealthcare HDHP with Optional HSA | UnitedHealthcare CDHP Option 1 | | UnitedHealthcare CDHP Option 2 | |
|---|---|---|---|---|---|---|---|
| **Emergency Room Services** | $500 | $500 | • 80% covered after deductible is met;<br>• 50% covered after deductible is met for non-emergency<br>• After 3 ER Visits per year a $300 penalty will apply unless member calls into UHC Nurse when requested (In-Network) | • 80% covered after deductible is met;<br>• 50% covered after deductible is met for non-emergency<br>• After 3 ER Visits per year a $300 penalty will apply unless member calls into UHC Nurse when requested (In-Network) | | • 80% covered after deductible is met;<br>• 50% covered after deductible is met for non-emergency<br>• After 3 ER Visits per year a $300 penalty will apply unless member calls into UHC Nurse when requested (In-Network) | |
| **Inpatient Hospital Care** | $1,400 | $2,800 | 80% covered (after deductible is met) | 80% covered (after deductible is met) | 50% covered (after deductible is met) | 80% covered (after deductible is met) | 50% covered (after deductible is met) |

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



| | Bind Health Plan | UnitedHealthcare HDHP with Optional HSA | UnitedHealthcare CDHP Option 1 | UnitedHealthcare CDHP Option 2 |
|---|---|---|---|---|
| **Prescription Drugs** | | | | |
| | **Tier 1 Drugs** | | | |
| | • $10 for a 31 day retail supply<br>• $25 for a 90 day retail/mail supply<br>• $200 (In-Network) for Specialty Retail Pharmacy<br>• Not Covered (Out-of-Network) for Specialty Pharmacy | • 85% covered after deductible is met<br>• Mandatory mail after two prescriptions for maintenance Rx<br>• Up to 30-day supply/90 day if mail order (In-Network)<br>• For certain preventive medications the deductible is waived | • 85% covered after deductible is met<br>• Mandatory mail after two prescriptions for maintenance Rx<br>• Up to 30-day supply/90 day if mail order (In-Network) | • 85% covered after deductible is met<br>• Mandatory mail after two prescriptions for maintenance Rx<br>• Up to 30-day supply/90 day if mail order (In-Network) |
| | **Tier 2 Drugs** | | | |
| | • $70 for a 31 day retail supply<br>• $175 for a 90 day retail/mail supply | • 80% covered after deductible is met<br>• Mandatory mail after two prescriptions for maintenance Rx<br>• Up to 30-day supply/90 day if mail order (In-Network<br>• For certain preventive medications the deductible is waived) | • 80% covered after deductible is met<br>• Mandatory mail after two prescriptions for maintenance Rx<br>• Up to 30-day supply/90 day if mail order (In-Network) | • 80% covered after deductible is met<br>• Mandatory mail after two prescriptions for maintenance Rx<br>• Up to 30-day supply/90 day if mail order (In-Network) |
| | **Tier 3 Drugs** | | | |
| | • $100 for a 31 day retail supply<br>• $250 for a 90 day retail/mail supply | • 70% covered after deductible is met<br>• Mandatory mail after two prescriptions for maintenance Rx<br>• Up to 30-day supply/90 day if mail order (In-Network)<br>• For certain preventive medications the deductible is waived | • 70% covered after deductible is met<br>• Mandatory mail after two prescriptions for maintenance Rx; up to 30-day supply/90 day if mail order (In-Network) | • 70% covered after deductible is met<br>• Mandatory mail after two prescriptions for maintenance Rx up to 30-day supply/90 day if mail order (In-Network) |
| | **Tier 4 Drugs** | | | |
| | • Not Applicable | • 60% covered after deductible is met;<br>• Mandatory mail after two prescriptions for maintenance Rx<br>• Up to 30-day supply/90 day if mail order (In-Network)<br>• For certain preventive medications the deductible is waived | • 60% covered after deductible is met<br>• Mandatory mail after two prescriptions for maintenance Rx<br>• Up to 30-day supply/90 day if mail order (In-Network) | • 60% covered after deductible is met<br>• Mandatory mail after two prescriptions for maintenance Rx<br>• Up to 30-day supply/90 day if mail order (In-Network) |
| | **Specialty Medications** | | | |
| | • **Tier 1**: $200<br>• **Tier 2**: $225<br>• **Tier 3:** $300<br>• Specialty medications are limited to a 31 day supply.<br><br>**Bind Health Plan:** Out-of-Network prescriptions drugs are not covered. | • **Tier 1:** 85% covered after deductible is met<br>• **Tier 2:** 80% covered after deductible is met<br>• **Tier 3:** 70% covered after deductible is met<br>• **Tier 4:** 60% covered after deductible is met<br>• Specialty medications are limited to a 31 day supply. | • **Tier 1:** 85% covered after deductible is met<br>• **Tier 2:** 80% covered after deductible is met<br>• **Tier 3:** 70 % covered after deductible is met<br>• **Tier 4**: 60% covered after deductible is met<br>• Specialty medications are limited to a 31 day supply. | • **Tier 1:** 85% covered after deductible is met<br>• **Tier 2:** 80% covered after deductible is met<br>• **Tier 3:** 70 % covered after deductible is met<br>• **Tier 4**: 60% covered after deductible is met<br>• Specialty medications are limited to a 31 day supply. |
| | | **UnitedHealthcare:** Out-of-Network prescription drugs are covered at 50% coinsurance after deductible has been met. | | |

# Dental Plan Comparison

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

This chart is only a snapshot summary of dental benefits. For specific details on how services are covered or excluded, please contact MetLife or refer to the Summary Plan Description on the **Intranet**.

| Option 1 | Option 2 (with orthodontia) |
|---|---|
| **Passive PPO In and Out-of-Network** (Your Dental PPO plan is passive, meaning that you will pay the same coinsurance levels, have the same deductible requirements and be allotted the same Annual Maximum value regardless of going In or Out-of- Network. In-Network services are subject to MetLife's negotiated Domestic Partner Plus network rates. Out-of- Network services will be subject to the reasonable and customary charges. You may have additional out of pocket costs for services received from Out-of-Network providers.) | |
| **Plan Year Benefit Maximum (per person)** | |
| $1,000 (does not include oral surgery) | $2,000 (does not include oral surgery or orthodontia) |
| **Orthodontia Lifetime Benefit Maximum** | |
| N/A | $1,500 (separate from annual individual benefit maximum) |
| **Plan Year Deductible (per person)** | |
| $25 for general care and major and restorative; no deductible for diagnostic, preventive or oral surgery | $50 for general care and major and restorative (does not include orthodontia); no deductible for diagnostic, preventive or oral surgery |
| **Lifetime Orthodontia Deductible (per person)** | |
| N/A | $50 |
| **Plan Pays (after deductible)** | **Plan Pays (after deductible)** |
| **Diagnostic and Preventive (cleanings and exams) — No deductible** | |
| 100%* up to maximum allowable amount; two visits per year | 100%* up to maximum allowable amount; two visits per year |
| **X-rays** | |
| Full mouth X-rays covered once every 60 months; bitewing X-rays covered once per year, except for dependent children under age 26. Children are eligible for bitewing X-rays twice per year. | Full mouth X-rays covered once every 60 months; bitewing X-rays covered once per year, except for dependent children under age 26. Children are eligible for bitewing X-rays twice per year. |
| **General Care (fillings, root canals and periodontics)** | |
| 50%* up to maximum allowable amount | 80%* up to maximum allowable amount |
| **Major and Restorative (crowns, dentures and bridges)** | |
| 50%* up to maximum allowable amount | 50%* up to maximum allowable amount |
| **Oral Surgery — No deductible** | |
| 80%* no limit | 80%* no limit |
| **Orthodontia (adult and children)** | |
| Not covered | 50%* up to the maximum allowable amount after the $50 lifetime orthodontia deductible, per person (separate from annual deductible) |

**Administrator:** MetLife, **Group number:** 148069, **Phone number:** **866-832-5756**

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

# Vision Overview

The vision care benefit has one option offered by EyeMed (aka EyeMed Vision Care/First American Administrators). **NOTE:** You also have the option to waive this coverage. Staying In-Network helps you save money on eye exams, contact lenses, and frames and lenses with a variety of options through INSIGHT (name of the in-network benefit) network to help save you even more. Since PLUS Providers are already in the network, the additional perks are built right into your vision benefits. No promo codes, no coupons, no paperwork but you still have the same vision benefits, plus a little more savings.

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

This chart is only a snapshot summary of the available vision benefits. For specific details on how services are covered or excluded, please refer to the Summary Plan Description (SPD) on the **Intranet**, or contact EyeMed.

**Summary of Benefits**

| Vision Care Services | In-Network Cost Using PLUS Providers | In-Network Cost | Out-of-Network Reimbursement |
|---|---|---|---|
| **Examination Services** | | | |
| Exam (with Dilation as necessary) | $0 copay | $10 copay | Up to $40 |
| Retinal Imaging | $0 copay | $0 copay | Up to $20 |
| **Contact Lens** (allowance includes materials only) | | | |
| Conventional | $0 copay; 15% off balance; over $150 allowance | $0 copay; 15% off balance; over $150 allowance | Up to $105 |
| Disposable | $0 copay; 100% of balance over $150 allowance | $0 copay; 100% of balance over $150 allowance | Up to $105 |
| Medically Necessary | $0 copay; paid-in-full | $0 copay; paid-in-full | Up to $210 |
| **Contact Lens Fit** And Two (2) Follow-Ups (in lieu of lenses) | | | |
| Fit and Follow-Up - Standard | Up to $40 | Up to $40 | Not covered |
| Fit and Follow-Up - Premium | 10% off retail price | 10% off retail price | Not covered |
| **Frame** (any available frames at Provider locations) | | | |
| Frame | $0 copay; 20% off balance over $185 allowance | $0 copay; 20% off balance over $160 allowance | Up to $112 |
| **Standard Plastic Lenses** (in lieu of contacts) | | | |
| Single Vision | $25 copay | $25 copay | Up to $30 |
| Bifocal | $25 copay | $25 copay | Up to $50 |
| Trifocal | $25 copay | $25 copay | Up to $70 |
| Lenticular | $25 copay | $25 copay | Up to $70 |
| Progressive - Standard | $25 copay | $25 copay | Up to $50 |
| Progressive - Premium Tier 1 | $110 copay | $110 copay | Up to $50 |
| Progressive - Premium Tier 2 | $120 copay | $120 copay | Up to $50 |
| Progressive - Premium Tier 3 | $135 copay | $135 copay | Up to $50 |
| Progressive - Premium Tier 4 | $200 copay | $200 copay | Up to $50 |
| **Lens Options** | | | |
| Anti Reflective Coating - Standard | $45 copay | $45 copay | Up to $5 |
| Anti Reflective Coating – Premium Tier 1 | $57 copay | $57 copay | Up to $5 |

**Summary of Benefits**

| Vision Care Services | In-Network Cost Using PLUS Providers | In-Network Cost | Out-of-Network Reimbursement |
|---|---|---|---|
| Anti Reflective Coating – Premium Tier 2 | $68 copay | $68 copay | Up to $5 |
| Anti Reflective Coating – Premium Tier 3 | $85 copay | $85 copay | Up to $5 |
| Photochromic – Non-Glass (Plastic) | $0 copay | $0 copay | Up to $5 |
| Polycarbonate – Standard | $40 copay | $40 copay | Not covered |
| Polycarbonate – Standard – under 19 years of age | $0 copay | $0 copay | Up to $5 |
| Scratch Coating – Standard Plastic | $15 copay | $15 copay | Not covered |
| Tint – Solid or Gradient | $0 copay | $0 copay | Up to $5 |
| UV Treatment | $15 copay | $15 copay | Not covered |
| All Other Lens Options | 20% off retail price | 20% off retail price | Not covered |
| **Low Vision** | | | |
| Supplemental Exam/Testing | $0 copay | $0 copay | Up to $125 allowance (no reimbursement) |
| Aids | 25% copayment up to the maximum of $1,000 | 25% copayment up to the maximum of $1,000 | 25% copayment up to the maximum of $1,000 |
| **Member Savings** (enrollees who register on EyeMed's website receive additional savings) | | | |
| Additional Pairs of Glasses, Conventional Lenses | 40% off glasses; 15% discount on lenses (once funded benefit is used) | 40% off glasses; 15% discount on lenses (once funded benefit is used) | Not covered |
| Non-Prescription Sunglasses and other items **not covered by Plan*** ***Note:** Safety Glasses and Provider's professional services or contact lenses are not eligible for coverage under the Plan | 20% off | 20% off | Not covered |
| Hearing Care from Amplifon Hearing Health Care Network (Call **877-203-0675**) | 40% off hearing exam and low price guarantee on discounted hearing aids (Up to 64% off aids). | 40% hearing exam and low price guarantee on discounted hearing aids (Up to 64% off aids). | Not covered |
| LASIK or PRK from U.S. Laser Network (Call **800-988-4221**) | 15% off retail or 5% off promotional price | 15% off retail or 5% off promotional price | Not covered |
| **Frequency** (Adults and Children) | | | |
| Exam | Once every plan year | | |
| Frame | Once every plan year | | |
| Lenses (in lieu on Contact Lenses) | Once every plan year | | |
| Contact Lenses (in lieu of Lenses) | Once every plan year | | |
| Low Vision | Once every other plan year | | |

## Definition of Contact Lens Fit

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

You are responsible to pay the Out-of-Network provider in full at the time of service and then submit an Out-of-Network claim for reimbursement. You will be reimbursed up to the amount shown within the Summary of Benefits section of this Guide. For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for conttimitations and Exclusions, refer to the Vision SPD.

**Offered by:** EyeMed, **Group number:** 1029819, **Phone number:** **855-874-4744**

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

# Flexible Spending Accounts (FSAs) and Health Savings Account (HSA)

To participate in FSAs or an HSA, you must enroll each year. Your FSA and/or HSA contribution elections will not carry over from one year to the next. HSA and FSA contributions are fully funded by you and your contributions are pre-tax, meaning, free from federal taxes.

| Traditional Health Care FSA | Limited Purpose Health Care FSA (for HDHP with Optional HSA) | Dependent Day Care FSA (for child/day care services) | Health Savings Account (HSA) (for HDHP with Optional HSA) |
|---|---|---|---|
| **How much can you contribute?** | | | |
| Between $150–$2850 per plan year<br>**Note:** FSA limits are determined by the IRS and subject to change for 2022. | Between $150–$2,850 per plan year<br>**Note:** FSA limits are determined by the IRS and subject to change for 2022. | Between $150–$5,000 per plan year<br>**Note:** The maximum for highly compensated employees is $2,000; if you are married and filing taxes separately, the maximum is $2,500. If you are determined to be a highly compensated employee, the Plan Administrator may need to adjust your contribution election, and you will be notified. | Up to $3,650 Employee-only<br>Up to $7,300 Employee + one or more enrolled<br>**Note:** If you are age 55 or older, you can contribute an extra $1,000 "catch-up" contribution per plan year. |
| **What types of expenses can you use it for?** | | | |
| A range of eligible out-of-pocket health care expenses not covered by a medical, prescription drug, dental or vision care plan can be used for any eligible dependent, even those not covered by a Company health care plan. | Only eligible out-of-pocket dental and vision care expenses, including deductibles, copayments and coinsurance not covered by other plans. Medical and prescription drug expenses are not eligible for reimbursement. Elect to enroll in a Health Savings Account (HSA) for eligible medical expense reimbursement. | Eligible out-of-pocket child care/elder care expenses for eligible dependents so you (and your Spouse, if married) can work or attend school Full-time. | Eligible medical, prescription, over-the-counter drugs, dental and vision care expenses. |
| **How does it work?** | | | |
| The plan year amount you elect to contribute is available to you on your benefit effective date.<br>**Note:** If you enroll in the HDHP with Optional HSA and elect an FSA, you will automatically be enrolled in the Limited Purpose FSA whether or not you contribute in an HSA. | | FSA money is available as contributions are deducted from your paycheck and loaded to UnitedHealthcare's system. | • You can open an HSA with Optum Bank (through payroll deductions), a bank of your choice, or an insurance Company or other IRS-approved trustee.<br>• HSA money is available as contributions are deducted from your paycheck and loaded to Optum Bank's system. Optum Bank must first approve (vet) your account before an account can be set up and contributions deposited.<br>• There are no federal taxes on contributions, interest earned or expenses paid from the HSA (except for Alabama, California and New Jersey).<br>**Note:** If you open up an HSA with Optum Bank (through payroll deductions), the minimum HSA contribution if $260 annually or $10 per pay period. |

## FSA Enrollment Rules

- **NOTE:** If an FSA deduction is missed or the full amount is not deducted, an adjustment is made in your account reflecting a balance. The balance is taken on subsequent pay periods, in addition to the regular deduction amount, until the balance is reduced to zero. If an HSA deduction is missed or the full amount is not deducted, the system will re-amortize and adjust the amount taken on subsequent pay periods. The FSA and/or HSA adjustment is made to ensure the total contribution amount you elected to contribute is met at the end of the Plan year.
- 2022 FSA funds can be used for eligible expenses incurred from your benefit effective date to March 15, 2023 (if still employed). You have until April 30, 2023, to file claims, or remaining funds are forfeited. The Internal Revenue Service (IRS) does not allow expenses incurred by Domestic Partners or their dependents to be reimbursed through an FSA unless you claim your Domestic Partner or their dependents on your income tax return.

# Life and Accident

| Automatic and Company-Paid Plan Benefits | |
|---|---|
| **Employee Basic Life Insurance** | Eligible employees have a benefit of 1x eligible pay (Base Pay + anticipated Short-Term Incentive) rounded up to the next higher $1,000 up to $2,000,000 maximum benefit.<br><br>If your Employee Basic Life Insurance is more than $50,000, the IRS requires you pay taxes on imputed income, which is the cost of Company-provided Employee Basic Life Insurance over $50,000. **To avoid paying taxes on imputed income, you have the option to choose the $50,000 in coverage.** If you are in this category, you will see $50,000 as an option when you go online to enroll, as well as your 1x Base Pay + anticipated Short-Term Incentive. You have the option to change your Basic Life Insurance coverage amount to $50,000 and, therefore, you would not be subject to imputed income.<br><br>**Note:** When you turn age 70, your Basic Life Insurance coverage will be reduced by 50%. If you enroll in the $50,000 coverage or choose to enroll in this coverage before turning age 70, there will be no reduction and you will keep the same coverage amount ($50,000). |
| **Employee Basic Accidental Death & Dismemberment Insurance (AD&D)** | Eligible employees have a benefit of 1x eligible pay (Base Pay + anticipated Short-Term Incentive) rounded up to the next higher $1,000 up to $2,000,000 maximum benefit. |
| **Business Travel Accident** | Eligible employees have a benefit of 3x eligible pay (Base Pay + anticipated Short-Term Incentive) rounded up to the next higher $1,000 up to $500,000 maximum benefit. |
| **You Pay the Cost** | |
| **Employee Supplemental Life Insurance**<br>(Statement of Health/Evidence of Insurability (EOI) may be required.) | 1x, 2x, 3x, 4x, 5x, 6x, 7x or 8x Base Pay rounded up to the next higher $1,000 up to $2,000,000 maximum benefit. |
| **Employee Supplemental Accidental Death & Dismemberment Insurance (AD&D)** | 1x, 2x, 3x, 4x, 5x, 6x, 7x or 8x eligible (Base Pay + anticipated Short-Term Incentive) rounded up to the next higher $1,000 up to $2,000,000 maximum. |
| **Spouse/Domestic Partner Supplemental Life Insurance**<br>(Statement of Health/Evidence of Insurability (EOI) may be required.) | $5,000, $10,000, $25,000, $50,000, $75,000, $100,000 or $200,000 (cannot elect more than 100% of Employee Basic Life + Employee Supplemental Life coverage). |
| **Child Supplemental Life Insurance**<br>(Can be for more than one child) | Each child: $3,000, $5,000, $10,000 or $20,000 (cannot elect more than 100% of Employee Basic Life + Employee Supplemental Life coverage). |
| **Spouse/Domestic Partner Supplemental Accidental Death & Dismemberment Insurance (AD&D)** | 50% of Employee Supplemental AD&D Coverage up to $750,000 maximum benefit. |
| **Child Supplemental Accidental Death & Dismemberment Insurance (AD&D)** | 25% of Employee Supplemental AD&D Coverage up to $100,000 maximum benefit. |

## Reminders:

- Ensure you add beneficiaries for all of your Life Insurance plan options by going to lumen.com/healthandlife or lumen.com/healthbenefits. The Service Center is the record keeper of beneficiary designations. Refer to the SPD for specific beneficiary payment rules, including how benefits are paid if no beneficiary is living on the date of your death or if you have not elected a beneficiary.
- Coverage and benefit premium deductions may increase or decrease throughout the year in certain situations (for example, if you have a change in pay or change age brackets; age brackets are every 5 years, i.e., 30, 35, 40, 45, etc.). If your benefit costs increase or decrease, you will receive a notification from the Service Center. Refer to the Life Insurance and AD&D SPD on the **Intranet**.
- If both you and your Spouse/Domestic Partner are employed by the Company, or on long-term disability, or in a parent/child relationship, you cannot be covered for Supplemental Life Insurance as an employee, long-term disability participant and a dependent on each other's benefit coverage. If both you and your Spouse/Domestic Partner are employed by the Company and one of you is not enrolled in the Employee Supplemental Life plan, you may enroll under the Dependent Spouse/Domestic Partner Supplemental Life plan of the other Spouse/Domestic Partner. You cannot be covered for both Employee Supplemental Life and Dependent Supplemental Life. Also, you cannot both purchase Child Supplemental Life and AD&D Insurance coverage for the same dependent children. You must decide which parent will cover the children.

# Voluntary Lifestyle Benefits

**Note:** You must be a Full-time or Term Full-time employee to enroll in Voluntary Lifestyle Benefits. Information on these programs can be found on the **Intranet**.

This Voluntary Lifestyle Benefits program is not a company-sponsored plan or benefit. It is not a plan covered under the federal law known as "ERISA". The Company has simply chosen to allow these vendors to make these programs available to employees. Please be advised that this is a voluntary program, and only you can decide whether the benefits provided by this program are appropriate for you and your family. You are encouraged to research all suitable alternatives and consult with your personal advisors. Employees are encouraged to review the privacy and security policies and the practices of the various vendors and make sure they are comfortable with them prior to entering into any transactions. The company is not able to provide you with advice regarding the program. Your participation is your decision, completely voluntary and at your own expense. We do not endorse and are not responsible for any of the products, services or practices promoted on the voluntary lifestyle benefit website, **lumen.com/voluntarybenefits**. Access to this website is provided at no cost to you, and the Company does not benefit from your participation. There are no commissions or incentives paid to the Company as a result of the products or services you may choose to purchase.

| **Enroll for the following Voluntary Lifestyle Benefits within 30 days from your hire, rehire, transfer date, or during the Annual Enrollment period.** | **Enroll for the following Voluntary Lifestyle Benefits at any time** |
|---|---|
| Subject to the policy terms:<br><br>**Accident Insurance**<br>Helps cover out-of-pocket costs if you are injured in a covered accident.<br><br>**Cancer Insurance**<br>Helps supplement certain traditional medical insurance, which may only cover a small portion of the non-medical expenses that can be incurred.<br><br>**Critical Illness Insurance**<br>Pays a lump-sum benefit directly to you if you are diagnosed with a covered condition.<br><br>**Hospital Indemnity Insurance**<br>Designed to help offset some of the costs associated with a hospital stay, such as copayments, deductibles or even lost income.<br><br>**Legal Services***<br>Gives you access to a network of attorneys for advice and representation on a wide range of legal matters. | **Choice Auto and Home Program****<br>Comparison shop for coverage and rates from multiple top-rated carriers.<br><br>**Employee Perks**<br>A free one-stop-shop program for exclusive discounts to many national and local merchants.<br><br>**Identity Protection Program**<br>Provides comprehensive identity, credit and privacy protection with full-service remediation.<br><br>**Pet Insurance**<br>Affordable, comprehensive medical plans for your pet that you can use with any veterinarian, anywhere.<br><br>**Purchasing Power Program**<br>Gives you the ability to purchase products such as electronics, appliances, furniture and more. Eligible after 6 months of employment.<br><br>**SmartPath Financial Coaching**<br>SmartPath Financial Coaching offers unbiased, sales-free guidance from certified coaches that are 100% focused on you. Whether it be through the budgeting app., webinars or a full library of video tutorials, articles and other helpful tools, SmartPath assists employees in making decisions about their financial journey. |

***Note:** You can only cancel participation in the Legal Plan during the Annual Enrollment period.
**The Choice Home Program may not be part of the benefit offering in Florida or Massachusetts

## To enroll:

- Visit **lumen.com/voluntarybenefits**; or
- Call 800-380-0378 Mon-Fri, 8 a.m. - 5 p.m. (CST)

# Helpful Resources

When you need more detailed information about Plan specifics, review your SPDs and SMMs located on the **Intranet**, or the Health and Life website. If you would like a paper copy of these materials, contact the Service Center. Please be advised that mailing time can take up to two weeks.

| Benefit Option | Phone | Online |
|---|---|---|
| | **Health Care** | |
| **Health and Life Service Center** | **833-925-0487**<br>Mon-Fri, 7 a.m. - 7 p.m. (CST) | **lumen.com/healthandlife**<br>Search: **MyChoice™ Mobile App**, available for free in the App Store and Google Play |
| **Health Care Advocacy Services**<br>• For issues with your Health Care claim(s) that you are unable to resolve on your own or through the Claims Administrator or your Health Care provider. | **833-925-0487**<br>**317-671-8494** (International callers)<br>Mon-Fri, 7 a.m. - 7 p.m. (CST) | N/A |
| **Medical** | **Bind:**<br>**833-576-6519**<br>Mon-Fri, 6 a.m. - 9 p.m. (CST)<br>Group Number: 78800186 | Search: **MyBind**, available for Free in the App Store and Google Play<br>**lumen.com/bind**<br>(This website provides an overview of how this plan can best work for you.) |
| | **UnitedHealthcare:**<br>**800-842-1219**<br>Group Number: 192086 | **UnitedHealthcare: myuhc.com**<br>Search: **UHC App**, available for free in the App Store and Google Play |
| | **Blue Cross/Blue Shield:**<br>Hawaii Medical Services Association (HMSA)<br>**800-776-4672** | **HMSA: hmsa.com** |
| **Flexible Spending Accounts** | **UnitedHealthcare: 877-311-7849**<br>**Group Number:** 199383 | **myuhc.com**<br>Search: **UHC App**, available for free in the App Store and Google Play |
| **Health Savings Account through Optum Bank** | **Optum Bank: 866-234-8913** | **optumbank.com**<br>Search: **Optum Bank App**, available for Free in the App Store and Google Play |
| **Maternity Support Program** | **Bind:**<br>**833-576-6519**<br>Mon-Fri, 6 a.m. - 9 p.m. (CST)<br>**UnitedHealthcare**: **800-842-1219** | **mybind.com**<br>**UnitedHealthcare: myuhc.com**<br>Search: **UHC App**, available for Free in the App Store and Google Play |
| **Maternity and Parental Coach** | **Sedgwick**<br>**844-223-7153**<br>**LumenParentalCoach@Sedgwick.com** | N/A |

| Benefit Option | Phone | Online |
|---|---|---|
| **Prescription Drug Program** | **Bind:**<br>833-576-6519<br>Mon-Fri, 6 a.m. - 9 p.m. (CST) | lumen.com/choosebind<br>**Access Code: enroll2022** |
| | **UnitedHealthcare**: 800-842-1219 | **UnitedHealthcare:** myuhc.com |
| **Telemedicine** | **Bind:**<br>**Doctor On-Demand**<br>833-576-6519<br><br>**UnitedHealthcare:**<br>• MDLive: 888-632-2738<br>• UHC Virtual Care Services | patient.doctorondemand.com<br>lumen.com/MDLive<br>Search: **MDLive**, available for free in the App Store and Google Play<br>myuhc.com/virtualvisits<br>Search: **UHC App**, available for free in the App Store and Google Play |
| **2nd.MD (Second opinions for all conditions)**<br>(An expert medical consultation service offered at no cost to you and your eligible dependents over the age of 18 who are enrolled in a Company medical plan.) | 866-842-1151 | lumen.com/2ndmd<br>Search: **2nd.MD**, available for free in the App Store and Google Play |
| **Dental Plans** | **MetLife:** 866-832-5756 | metlife.com/mybenefits |
| **Vision Care Plan** | **EyeMed:** 855-874-4744 | lumen.com/visioncare<br>Search: **EyeMed**, available for free in the App Store and Google Play |
| | **Life Insurance & Disability** | |
| **Life, Accident, & Business Travel Accident (BTA)** | **Service Center:** 833-925-0487<br>Mon-Fri, 7 a.m. - 7 p.m. (CST) | lumen.com/healthandlife |
| **Short-Term Disability** | **Sedgwick:** 844-223-7153 | lumen.com/disability |
| **Long-Term Disability** | **The Standard:** 855-290-9480 | N/A |
| | **Retirement** | |
| **401(k) Savings Plan** | **Retirement Service Center:**<br>877-379-0118 | lumen.com/401k |
| **Combined Pension Plan** | **Service Center:** 800-729-7526, Option 1, then Option 3 | lumen.com/pension |
| | **Wellness** | |
| **Employee Assistance Program** | **Optum:** 866-270-0033 | lumen.com/EAP |
| **Real Appeal** | 844-344-7325 | lumen.com/realappeal |
| **Well Connected, Rally, and Coaching Programs**<br>(Prevention and Well Being) | 877-818-5826 | lumen.com/wellconnected<br>Search: **Rally Coach™** available for Free in the App Store and Google Play |
| **Fitness Reimbursement Program** | **N/A** | Access on the Intranet |
| | **Voluntary Lifestyle Benefits** | |
| **Voluntary Lifestyle Benefits** | **Mercer:** 800-380-0378<br>Mon-Fri, 8 a.m. - 5 p.m. (CST) | lumen.com/voluntarybenefits |

## Summary of Benefits and Coverage (SBC) Availability

We offer an array of resources to help you understand and choose your benefits. SBC's notify you of an additional resource required by Health Care Reform that summarizes important information about any health coverage options in a standard format, to help you compare features across Plan options. Look for the SBC on the Health and Life website anytime.

# Claims and Appeals for Enrollment Issues

If you wish to file a claim or appeal regarding enrollment for you and/or your eligible dependents in a benefit Plan option or change in benefit Plan options, you must submit a Claim Initiation Form, which you can find on the Health and Life website in the Resource Center.

### Decisions concerning the Plan

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

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

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

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

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

If an appeal is approved on a retroactive benefit basis, you may experience retroactive premium deductions on your paychecks. Refer to the Payroll & Benefits schedule available on the **Health and Life website** and on the **Intranet**.

For example, if your appeal is approved and your medical/prescription drug coverage level changes from Employee Only to Employee + Family, you will be responsible for paying the retroactive benefit premium difference between the Employee Only and Employee + Family coverage amount. Review any and all deductions on your pay stub for accuracy.

# Legal and Important Required Notices

## U.S. Reserved Rights

*Lumen reserves the right to amend or terminate any employee policy – with respect to any or all classes of employees – without prior consultation with any employee, subject to any applicable laws and collective bargaining agreements. Lumen has the sole right and discretion to interpret and administer the terms of this Policy, including resolution of any questions regarding its scope, application or meaning. The decision of the Company shall be conclusive and binding on all persons.*

## Honesty is the Best Policy

As an employee, you are held to the Code of Conduct's standard of honesty and truthfulness. Falsifying or omitting information when enrolling for coverage under the Plan will be cause for disciplinary action, up to and including termination. If you have questions about whether your responses in the enrollment process are accurate, please call the Service Center.

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.

## Important note regarding enrollment elections

By electing to participate in the Company-sponsored Plans (including but not limited to the Lumen Health Care Plan, Lumen Bind On Demand Health Plan,

or Lumen Retiree and Inactive Health Plan, and if applicable, the Lumen Disability Plan, Lumen Business Travel Accident Insurance Plan, Lumen Life Insurance Plan and the Lumen Survivor Benefit Plan), by your submission of information, you have agreed to be bound to and by the provisions of each of the Plans and their administrative practices, including, but not limited to with respect to the recovery of over and underpayments, terms and conditions for eligibility and Benefits. You certify that the submission of information by you in this enrollment process is true and accurate to the best of your knowledge; you agree that you'll submit new information timely as changes occur.

You understand that if you are found to have falsified any document in support of a claim for eligibility or reimbursement, the Plan Administrator may, subject to and as may be permitted under the requirements of law, without anyone's consent, terminate your

and/or your dependent(s) coverage, and the Claims Administrator may refuse to honor any claim you

or your dependent(s) may have made or will make under the Plans if applicable. You understand that you are liable and bear the full financial responsibility for the misappropriation of Plan funds through the filing of false documentation under any of the Plans; You certify that you or your dependent(s) are eligible to enroll in a benefit option, including voluntary or supplemental coverages. Please refer to the applicable Plan document or SPD for details about eligibility for coverage or call the Claims Administrator - limitations may apply including, but not limited to, being actively at work in order to be eligible for coverage. You understand that it is your responsibility to confirm your eligibility to enroll in a benefit option, including voluntary or supplemental coverages; enrolling in and paying for coverage for which you are ineligible will not entitle you to Benefits; you understand that it is

your responsibility to terminate benefit coverage once you or your dependent(s) become ineligible, such as when a dependent is no longer eligible for coverage. This excludes dependents who turn age 26, as they are automatically removed from coverage.

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

## Company's Reserved Rights

This document summarizes certain provisions of the Company-sponsored Plans (including but not limited to the Lumen Health Care Plan, Lumen Bind On Demand Health Plan, or Lumen Retiree and Inactive Health Plan, and if applicable, the Lumen Disability Plan, Lumen Business Travel Accident Insurance Plan, Lumen Life Insurance Plan, and the Lumen Survivor Benefit Plan). For specific employee benefit Plan information, refer to the respective official Plan Documents, including the applicable Summary Plan Description and Summaries of Material Modifications, if any. If there is any conflict between the terms of the official Plan Documents and this document, the terms of the official Plan Documents will govern. The Plan Administrator has the authority, discretion and the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan, to supply omissions and resolve conflicts. Benefits and contribution obligations, if any, are determined by the Company in its sole discretion or by collective bargaining, if applicable.

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

## A note about privacy

Keeping your personal information secure is of primary importance. That's why we, along with the benefits administrators, have implemented various security measures and policies to help reduce the risk of unauthorized processing or disclosure of your personal information. You can also help by keeping your User ID and passwords confidential. Please keep this information safe and don't share it with anyone. Never use your Social Security number as your password. Together, we can make sure your personal information stays safe and secure. Please be advised that using an email that is not secured may increase your risk of unauthorized disclosure.

Please ensure that we have your current home address. Also, we encourage you to designate a personal email address, rather than a company email address, for receiving benefit plan communications. These communications may include personal information and, per our company policy, employees have no expectation of privacy with respect to communications to/from their company email accounts. Your updated preferences will apply to all communications from our benefit plan administrators.

## Notice of privacy practices

You can review the complete notice on the Company Intranet, or at **lumen.com/healthandlife** or **lumen.com/healthbenefits**, or call the Service Center at **833-925-0487** to request a copy.

## Coverage is not advice

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

## Right to amend and/or discontinue

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

## Wellness Program Notice

Lumen's Well Connected program is a voluntary wellness program available to all employees and eligible Spouses. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic

Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health survey through Rally, our wellness platform, that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., diabetes, heart disease, or COPD). You will also be asked to complete a biometric screening, which will include a blood test for cardiac disease or diabetes. You are not required to complete the health survey or to participate in the biometric screening or other medical examinations.

However, employees and eligible Spouses who choose to participate in the wellness program will receive an incentive in the form of gift cards or a deposit into a medical account for completing both the health survey and biometric screening. Although you are not required to complete the health survey or participate in the biometric screening, only those who do so will receive the $150 incentive.

Additional incentives of up to $450 total may be available for employees who participate in certain health-related activities such as preventive screenings, walking activities, or health coaching. **If you are unable to participate in any of the health-related activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Rally at 877-818-5826.**

The information from your health survey and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as nurse engagement or the Total Health Immersion Program. You also are encouraged to share your results or concerns with your own doctor.

## Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Lumen may use aggregate information it collects to design a program based on identified health risks in the workplace, Rally will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) a registered nurse or a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

## Women's Health and Cancer Rights Act

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

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

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

You should carefully review the provisions of the Plan, the medical benefit option in which you elect to participate, and its SPD and SMM (if any) on the **Intranet** regarding any applicable restrictions. Contact the Claims Administrator of

## Health Insurance Portability and Accountability Act (HIPAA)

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

- Termination of employer contribution toward other coverage;
- Moving out of a service area if the other plan does not offer other coverage;
- Ceasing to be a dependent, as defined in the other plan;
- Loss of coverage to a class of similarly situated individuals under the other plan (for example, when the other plan does not cover temporary/ contractors).

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

## Working After Retirement

**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.

**Note:** If you had VEBA Life Insurance, that coverage will not 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.** You will, however, 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 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 Service Center to have 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 Service Center at **833-925-0487**. If you returned to work for a supplier on assignment to the Company, the Company 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).

## If you voluntarily elect to drop coverage

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

## Continuation of coverage

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of employment. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a

maximum of 36 months of coverage. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information. Qualifying events for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment. Qualifying events for Spouses/Domestic Partners or dependent children include those events above, plus, the covered employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, death of the covered employee, and the loss of dependent status under the plan rules. If a QB chooses to continue group benefits under COBRA, they must timely enroll and make their premium payment by the due date before eligibility is sent to the Claims Administrators. Upon receipt of premium payment, the coverage will be reinstated. Thereafter, premiums are due on the first of the month. If premium payments are not received in a timely manner, federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Service Center at **833-925-0487.**

## Other coverage options

There may be other, more affordable coverage options for you and your family through the **Health Insurance Marketplace**, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period," even if the plan generally doesn't accept late enrollees. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA doesn't limit your eligibility for coverage for a tax credit through the Marketplace.

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

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or you may not be able to change to another coverage option.

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

## California Department of Managed Health Care Notification

### Grievance Process and Independent Medical Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your behavioral health care service plan, you should first telephone your plan at **800-999-9585** or 711 for TTY (at operator request say "1-800-999-9585") and use the plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance.

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

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