2025 Annual Enrollment Guide

For COBRA participants

LUMEN®

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Lumen will be referred to hereafter as "the Company". The Lumen Health and Life Service Center will be referred to hereafter as "the Service Center".

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Welcome to Annual Enrollment

It's a perfect **time to take the next step** to advance your understanding of Lumen's benefits. We encourage you to explore the plans and programs available by connecting to detailed resources on the Health and Life website at lumen.com/healthbenefits and to thoroughly review this guide.

If you don't make changes by Nov. 20, you will be automatically enrolled in the plans and coverage levels displayed on your Pre Annual Enrollment Notice sent to you based on your Contact Preference (email or mail) and is also in your **Personal Documents** located on the home page on the Health and Life website. Save a copy of your Pre Annual Enrollment Notice as you will not receive a 2025 Benefits Summary.

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What's new for 2025

The information listed below is a "Summary of Material Modifications" (this "SMM") for purposes of the Employee Retirement Income Security Act of 1974 ("ERISA"). This SMM notifies you of certain changes to the Company-sponsored plans that are subject to ERISA (collectively, the "Plan") and only summarizes certain Plan provisions. For more Plan details, refer to your Summary Plan Descriptions ("SPDs") as well as the Legal and Important Required Notices section in this guide.

Please keep this SMM with your SPDs for future reference. Note that if there is a conflict between the terms of the Plan documents and this SMM, the terms of the Plan documents will control. The Plan Administrator has the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan and the Company reserves the right to amend and/or terminate any benefits or plans.

Please read this section in its entirety to learn what's new for 2025, as there may be changes that impact you.

Premiums

COBRA coverage is limited to medical, dental and/or vision coverage, as applicable. Refer to your Pre Annual Enrollment Notice for more information. Eligibility files sent to Claims Administrators, such as MetLife, Surest and UnitedHealthcare, are transmitted on a weekly schedule. Consequently, there may be a delay before the Claims Administrator's system reflects a COBRA paid through date, depending on the timing of the payment.

With costs continuing to increase across the country, premiums for most plans will also increase for 2025. Lumen continues to look for ways to control healthcare cost increases while still offering plans and programs that offer value and provide the best health outcomes.

Note: Account Statements are not mailed from the Service Center. If you selected to receive communication by email, you will receive an email notification when your statement is available.

Medical

Tobacco-Free Discount is changing to a Tobacco Surcharge

If you are eligible for COBRA medical subsidy, the Tobacco Surcharge applies to you if you are a tobacco user and are not enrolled in a Company-recognized tobacco cessation program.

Lumen is changing the way participants are charged for medical coverage when you or a covered dependent use tobacco products. There will be an $80 tobacco surcharge applied which will be added to your medical premium. If you are currently receiving the tobacco-free discount, you will automatically default to no tobacco surcharge. Similarly, if you are not currently receiving the discount, you will automatically default to the surcharge. Be sure to answer the Tobacco Surcharge question during Annual Enrollment.

If you and your dependent(s) are enrolled in a Lumen medical plan and use tobacco products and are not enrolled in a *Company-recognized tobacco cessation program, an $80 surcharge will be added to your medical premium. However, if you and your dependents are enrolled in a Company-recognized tobacco cessation program, the $80 surcharge will not apply.

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 other products associated with tobacco.

*Pelago is now offering a company-recognized tobacco cessation program in addition to Quit for Life.

The Consumer Driven Health Plan (CDHP) and the Doctors Plan, administered by UnitedHealthcare (UHC), will no longer be offered.

CDHP participants will be enrolled in the **new Surest Select Health PPO**, **Doctors Plan** participants will be enrolled in the **Surest Health PPO** if no action is taken during Annual Enrollment.

Similarities between Surest Health Plans

- You can easily search for the coverage you need, knowing your cost upfront before you access care
- No deductible, no coinsurance, no balance billing, you pay copays which can vary
- You will need to provide your provider and pharmacy a copy of your new Surest Health ID card
- Because Surest Health uses the same UHC provider network, you don't need to change providers as long as your provider remains in the UHC network
- Your prescriptions remain with OptumRx

Note: The new Surest Select Health PPO premiums are the same as the 2024 CDHP premiums for non-tobacco users or those who enroll in a Company-recognized tobacco cessation program.

If you are enrolled in the CDHP or Doctors Plan, the following changes will occur based on the plan you will be automatically enrolled in if you take no action, or the plan you select.

Plan/Program	Surest Health PPO	New - Surest Select Health PPO	HDHP
Health Reimbursement Account (HRA)	Spendown HRA*	Spendown HRA*	Post Deductible HRA**
Prescriptions (OptumRx)	Home delivery **is** available; however, **not** required	Home delivery **is** required after two fills at a retail pharmacy for maintenance prescriptions	Home delivery **is** required after two fills at a retail pharmacy for maintenance prescriptions

***Spenddown HRA for Surest Health Plans**

If you elect one of the Surest Health Plans and have a remaining balance in your 2024 CDHP HRA, these dollars will follow you. Your prior HRA dollars will become available on Feb. 1 after a run-out period (for claims from your prior coverage to clear.

The Spenddown HRA funds will be used to reimburse medical and prescription drug expenses. Claims will automatically roll over to your Spenddown HRA.

If you received eligible health care services during the run-out period, you could use the money once available to pay yourself back by manually submitting a claim. If you have any questions, please contact UnitedHealthcare.

****Post Deductible HRA**

If you elect the HDHP with Optional HSA and have a remaining balance in your 2024 CDHP HRA, these funds will follow you. Your prior HRA funding will become available after a 90 day run-out period.

The Post Deductible HRA funds can be used to reimburse medical and prescription drug expenses after your annual in-network deductible has been satisfied. You will be required to manually submit the **Request for Reimbursement** form available on the UHC website.

Note: Don't forget to register for a Surest Health Plan and/or a UnitedHealthcare High Deductible Health Plan (HDHP) webinar to learn more about these plans. Details and registration information can be found on the Annual Enrollment page on the Health and Life website.

If you would like to change to a different available plan, you can make the change during Annual Enrollment, refer to your available options on the Health and Life website.

Summary of updates (in addition to the below chart, review the Medical Plan overviews section in this guide for more information)

Plan name	Maintained in 2025: Surest Health PPO (same plan offered in 2024)	New in 2025: Surest Select Health PPO	Maintained in 2025: HDHP
Medical	**(If enrolled in the Doctors Plan in 2024, you default to this plan for 2025)**	**(If enrolled in the CDHP in 2024, you default to this plan for 2025)**	
Deductible (individual)	$0	$0	$1,650
Coinsurance (individual paid)	0%	0%	20%
Out-Of-Pocket Maximum (individual)	$3,600	$3,200	$3,600
Office visit – PCP	Copy range: $20 to $90*	Copy range: $10 to $65*	20% coinsurance after deductible has been satisfied.
Office visit – Specialist			20% coinsurance after deductible has been satisfied.
Complex Imaging (MRI, CT Scan, etc.)	$250 to $775 copay*	$75 to $550 copay*	20% coinsurance after deductible has been satisfied.
Emergency Room	$500 copay	$375 copay	20% coinsurance after deductible has been satisfied.
Urgent Care	$65 copay	$35 copay	20% coinsurance after deductible has been satisfied.
Procedures (Ambulatory Surgical Center, in-patient hospital and out-patient hospital)	$50 to $3,000 copay*	$15 to $2,500 copay*	20% coinsurance after deductible has been satisfied.
Maternity	$500 to $2,000 copay* Bundled copay, see the Plan Overview section for more information.	$400 to $1,600 copay* Bundled copay, see the Plan Overview section for more information.	20% coinsurance after deductible has been satisfied.

Plan name	Maintained in 2025: Surest Health PPO (same plan offered in 2024)	New in 2025: Surest Select Health PPO	Maintained in 2025: HDHP
	(If enrolled in the Doctors Plan in 2024, you default to this plan for 2025)	**(If enrolled in the CDHP in 2024, you default to this plan for 2025)**	
Prescription Drug			
Retail			
Rx - Tier 1	$10 copay	$10 copay	15% coinsurance after deductible has been satisfied. ($10 minimum)
Rx - Tier 2	$45 copay	$45 copay	20% coinsurance after deductible has been satisfied. ($45 minimum)
Rx - Tier 3	$150 copay	$150 copay	30% coinsurance after deductible has been satisfied. ($150 minimum)
Rx – Tier 4	$300 copay	$300 copay	40% coinsurance after deductible has been satisfied. ($300 minimum)
Home Delivery	Home delivery available, but not required.	Home delivery required after two fills at a retail pharmacy for maintenance medications.	Home delivery required after two fills at a retail pharmacy for maintenance medications.
Rx - Tier 1	$25 copay	$25 copay	15% coinsurance after deductible has been satisfied. ($25 minimum)
Rx - Tier 2	$112.50 copay	$112.50 copay	20% coinsurance after deductible has been satisfied. ($112.50 minimum)
Rx - Tier 3	$375 copay	$375 copay	30% coinsurance after deductible has been satisfied. ($375 minimum)
Rx - Tier 4	$750 copay	$750 copay	40% coinsurance after deductible has been satisfied. ($750 minimum)
Specialty Drugs			
Rx - Tier 1	$200 copay	$200 copay	15% coinsurance after deductible has been satisfied. ($200 minimum)
Rx - Tier 2	$225 copay	$225 copay	20% coinsurance after deductible has been satisfied. ($225 minimum)
Rx - Tier 3	$300 copay	$300 copay	30% coinsurance after deductible has been satisfied. ($300 minimum)
Rx – Tier 4	$400 copay	$400 copay	40% coinsurance after deductible has been satisfied. ($400 minimum)

*Actual copay will fall within this range, depending on the individual provider and location of service.

The updates below apply to: Surest Health PPO, the new Surest Select Health PPO and the HDHP Plans unless otherwise noted.

Chiropractor and Acupuncture – Visit limits that are medically necessary will increase from a maximum of 20 to 40 for the Plan year.

Prescription Drug (OptumRx)

When you select a Lumen medical plan, you will automatically receive prescription drug benefits through OptumRx. OptumRx is our Claims Administrator for Prescription Drug coverage regardless of which medical plan you elect. You can't opt-out of OptumRx.

Home Delivery Program – If you enroll in the new Surest Select Health PPO Plan or the HDHP with Optional HSA, you are required to participate in this program for maintenance medications after two fills at a retail pharmacy.

Price Edge Pharmacy Program – This program provides a discount price solution and helps you save on generic drugs and specific brand drugs covered or not covered by your medical plan. It can even help you save money on select over-the-counter (OTC) medications when you have a prescription. You will need to provide the pharmacy your ID card and, if available, the additional discount will automatically be applied to your medication. **Note:** Medications not covered by your medical plan, including OTC products, won't count towards your plan's out-of-pocket maximum or deductible.

Sempre Health Program – This program provides savings to you by offering discounts on specific medications when you refill on a timely basis. Anyone taking one of the medications included in the program will receive an invite through the mail. This invite will provide you with the necessary information to sign up for a discount on your medication via text, by calling, or by going on-line. In doing so you will receive discounts when refilling the medication consistently.

HDHP deductibles will increase

Plan	Coverage level	2025 deductible	2024 deductible
HDHP	Individual	**$1,650**	$1,600
HDHP	Family (Individual + One or more dependent(s) enrolled)	**$3,300**	$3,200

Specialty Programs

Calm – try it out. You and your family members in the household (even if not enrolled in a Lumen medical plan) have access to this program as part of your Employee Assistance Program (EAP) through Optum Emotional Wellbeing Solutions. Calm is the number one rated app for sleep, meditation and relaxation. Whether you have 60 seconds or 60 minutes, Calm can help you build a habit of mindfulness. Immerse yourself in Calm's soothing music and sounds made for sleep, meditation, focus and relaxation. Mental Health is Health, made for all Levels.

Calm Health – has even more to offer. Calm Health is a new app that provides content from Calm and has new features including evidence based mental health programs and screenings, self-guided learning modules and tools focused on anxiety and depression.

Genetic Risk Program – This genetic screening program is available to identify three inherited conditions, where early detection can be an important step in the treatment process, according to the Centers for Disease Control (CDC). It tests for: hereditary breast and ovarian cancer (increases the risk of breast, ovarian and other cancers), Lynch syndrome (increases the risk of colon, endometrial and other cancers), and Familial Hypercholesterolemia (impacts unhealthy cholesterol levels and may increase the risk of heart disease).

You and your eligible dependents ages 18+ in the household enrolled in a Lumen medical plan will have access to myGeneticScreen at no added cost. Your privacy is maintained—neither Lumen or the medical plan you are enrolled in will receive your screening results.

This program is delivered by LetsGetChecked and includes access to genetic counselors before and after testing to explain the test and results. Learn more about myGeneticScreen test, inherited risk and more at myGeneticScreen Knowledge Hub.

Pelago – expanded support is available. You and your eligible dependent(s) ages 15 or older and who are enrolled in a Lumen medical plan will have access to this program. Pelago is a Wellness Coaching Program that supports reaching health goals by cutting back, quitting, or managing any tobacco, alcohol, cannabis, opioid or tobacco use. Some of the key features are:

- Virtual one-on-one support from a licensed care team (health coaches, counselors, and physicians)
- 24/7 online access with appointments available within 24 hours
- A personalized care plan with life-changing outcomes
- On-demand resources and goal tracking in the digital app

You can learn more and get started in the program at lumen.com/pelago or by calling 877-349-7755.

RethinkCare expansion – You and your family members in the household have access to this program. The RethinkCare Parental Success program gives you and your family members in the household 24/7 access to e-learning tools and resources to help you understand, teach and better communicate with your child(ren), including those with developmental and learning challenges. This program will be expanded to include RethinkCare's Professional Resilience solution that provides adult neurodiversity support in the workplace through tools, resources, and consultations to help you navigate daily work activities and relationships more effectively.

Virta (Prediabetes, Diabetes, Weight Management) – New for those enrolled in the HDHP with Optional HSA and have a qualifying condition*. You will have access to a guided nutrition program that can help you lose weight, lower blood sugar, and reduce unwanted medications. Results have demonstrated improved overall health, including sustainable weight loss, healthier blood sugar, and increased energy. Many have also reversed their diagnosis of prediabetes, type 2 diabetes.

* Virta's nutrition therapy care plans may be suitable for ages 18-79, with metabolic health conditions including prediabetes, type 2 diabetes, and/or a body mass index (BMI) of 25 or greater. There are some medical conditions that would exclude patients from the Virta program. Contact UnitedHealthcare or Surest for more information.

Reminders

Benefit details	Plan/Option information	Next steps
Dependent eligibility	Your dependent(s) will not be eligible for coverage until you have accurately and timely provided supporting documentation that confirms their eligibility under the Plan or Program. If your documentation is not received and/or not approved, your dependent(s) will not be enrolled.	You can upload your supporting documentation to the Health and Life website immediately after you complete your enrollment. We highly encourage you to use the upload functionality. However, you can also choose to email, fax or mail. Keep in mind, uploading allows for a faster decision and processing timeframe to add your dependent(s) to coverage. During Annual Enrollment, you will be given 15 calendar days from the date you add your new dependent(s) on the Health and Life website. You may be sent a reminder to your personal email address on file indicating the Service Center has not yet received your documentation. You will be given an additional 15 calendar days as a grace period. If you have not provided supporting documentation that meets the eligibility requirements after the grace period date, your dependent(s) will not be covered for 2025 Lumen Health and Life benefits. **Important:** You may be asked to provide more than one supporting document to validate relationship status such as when adding a spouse/domestic partner or common-law spouse. If you only provide one supporting document but two are required, your dependent will not be enrolled.

Benefit details	Plan/Option information	Next steps
Direct bill payment	How to make payments.	Monthly Account Statements are not mailed. If you owe a premium for any of your benefits, you are encouraged to set up automatic payments (autopay) for your direct bill account (e.g., for dental coverage). If you choose to set up autopay, you must pay any outstanding balance in full, if applicable, before the autopay will begin. **Note:** If you choose to make one-time payments, each month you will incur a $2.00 service fee for each payment. This is not the same as autopay. Lumen can't waive the service fee. Follow the below steps to set up autopay on the Health and Life website or you can call the Service Center at 833-925-0487 and an advocate can walk you through the set up process: • Log in to lumen.com/healthbenefits. On the lower right side of the home page, you will see Payment Due which provides details about your monthly premium. • Scroll down until you see Make a Payment and View Account. Select **Make a Payment**. • A pop-up window will appear. • Enter Account Type, Routing Number and Account Number. • Confirm the billing and email address. • Select **Yes** to set this account up as your primary payment method. • Select **Yes** to set up auto pay. Funds are automatically deducted on the fifth of each month. • Next, click **Pay**. • This will return you to the Billing Information page where you can view your account summary, payment history and account premium information. You can instead mail-in a payment to: Businesssolver PO Box 850512 Minneapolis, MN 55485-0512 **Note:** You must include your account number and Lumen on the Memo line of the check. **Important:** Please take into consideration the USPS delivery time to ensure your payment is received within the due date.
Medicare eligible due to disability	It is **your responsibility** to notify the Service Center if you or your dependent(s) become Medicare eligible due to a disability. If you don't notify the Service Center, Medicare may assess penalties, or you or your dependent(s) may experience a gap in coverage	If you have questions regarding Medicare, you can visit medicare.gov or contact Medicare at 800-medicare. If you or your dependent(s) become eligible for Medicare, while on COBRA, you will no longer be eligible for COBRA medical coverage.

Benefit details	Plan/Option information	Next steps
Prescription drugs	The Prescription Drug List (PDL) is updated periodically throughout the year.	You can use the pricing tool on the following websites based on the medical plan you are enrolling in for 2025: • HDHP - myuhc.com • Surest Health PPO and Surest Select Health PPO - lumen.com/joinsurest
Tobacco Surcharge (The Tobacco Surcharge applies if you are enrolled and eligible for subsidized medical coverage)	If you and your eligible dependent(s), if applicable, enroll in a Lumen medical plan and are non-tobacco users or are enrolled in a Company-recognized tobacco cessation program, you are not subject to the tobacco surcharge. If you and your eligible dependent(s), if applicable, enroll in a Lumen medical plan and are tobacco users (just one individual that uses would mean you are tobacco users) and are not enrolled in a Company-recognized tobacco cessation program, you are subject to the $80 tobacco surcharge, which will be added to your medical premium. The Benefit Summary on the Health and Life website will display the medical cost and tobacco surcharge separately. **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 other products associated with tobacco.	Answer the Tobacco Surcharge questions during your enrollment. **What is a Company-recognized Tobacco Cessation Program?** Quit For Life is a Wellness Coaching Program available to you and your covered dependent(s) over the age of 18 at no cost. Pelago is a Wellness Coaching Program available to your and your covered dependent(s) ages 15 or older at no cost. You can find more information related to the Program at lumen.com/pelago or by calling 877-349-7755. 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 recommendation of an individual's personal doctor, if needed. Take the next step and enroll in a tobacco cessation program today!
Working Spouse/Domestic Partner Surcharge (The Working Spouse/ Domestic Partner Surcharge applies if you are enrolled and eligible for subsidized medical coverage)	If you are subject to the Working Spouse/ Domestic surcharge, $100 will be added to your monthly medical cost.	Answer the Working Spouse/Domestic Partner question during your enrollment.
Zip code updates	Review your Pre Annual Enrollment Notice	Medical provider networks are determined by ZIP code area, and those ZIP codes are reviewed each Annual Enrollment as providers go in-and out-of-network. Be sure to review the medical plans available to you on the Health and Life website or on your Pre Annual Enrollment Notice as options may change (based on your mailing address on file).

Enroll

When can I enroll?

Annual Enrollment is from Nov. 6 through Nov. 20. If you enroll online, enrollment ends at 11:59 p.m. (CST). If you enroll through member services, enrollment ends at 7 p.m. (CST).

Need help?

Consider using **Sofia**, your personal benefits assistant available online through the Mobile App and on the Health and Life website when you enroll. She can assist you during the enrollment process, answer commonly asked questions and direct you to documents or if she is unable to answer your question(s), transfer you to a "live" advocate where you and the advocate can use the chat feature when asking and answering questions.

Take to next steps to enroll - as easy as A, B, C

A - Mobile device enrollment - (easily accessible)

1. Download the free MyChoice Mobile App for iOS or Android from the App Store or Google Play. What comes next? You can download the Mobile App prior to Annual Enrollment. We encourage it!
2. Enter or set up a username and password (you can register using your Health and Life website Username and Password) and open the MyChoice Mobile App. Take the next steps! You can register prior to Annual Enrollment and get ready in advance.
3. Select **Enroll in Coverage** at the top of the screen to begin your enrollment. You can also select **Benefits** to review your **Benefit Summary** or select **Accounts** to go to MyChoice Accounts (MCA), if eligible for a Retiree Medicare option.

B - Health and Life website - (quick and simple)

1. Navigate to the Health and Life website and log in. If you have not accessed the Health and Life website, continue to step 2. If you have, go to step 4.
2. Review the **Getting Started Details** to agree to the electronic disclosure agreement and select **Continue**.
3. Enter your **Contact Preference** on how you wish to receive benefit communications. Make sure to enter your personal email address by selecting **Electronic Mail** and select the radio button indicating **Primary**. Click **Continue**.
4. Select **Start Here** at the top of the screen to begin your 2025 Annual Enrollment elections.
5. Read the opening message and select **Start Enrollment**.
6. Read information introducing Sofia, your personal benefits assistant. Select Start **Enrollment**.
7. Review your personal information and update an alternate address, if applicable, click **Next**.
8. Confirm all applicable dependents are on file. Add any new dependents. Review dependent demographic information.
9. You have two options when enrolling. Option 1 will provide step-by-step instructions. If you select this option, continue to step 11. Option 2 will allow you to keep the same plans/programs. This option will take you to the Benefit Summary page for your review. If you select this option, continue to step 13.
10. Elect all healthcare (medical, dental, vision) plans. **Note:** You can select to compare multiple plans for 2025 and view how they compare to your current election.

    Note: If you enroll a spouse/domestic partner in medical coverage, you may be subject to a working spouse/domestic partner surcharge. You may be also subject to the medical tobacco surcharge based on how you answer the surcharge question. **(If you are eligible for COBRA subsidy, this applies during the subsidy period)**
11. Review Your Elections, including plans, coverage levels and contributions/pricing in their entirety and select **Approve** to authorize your transaction.
12. Read the Confirmation pop up and select **I Agree**.

13. On the Transaction Complete page, print your Benefit Summary as this is your Confirmation Statement. Take note of the Confirmation Number for your records.
14. If you added new dependent(s) to coverage, you will see information regarding the requirements for dependent verification. Read the requirements carefully. After you complete your enrollment, you can go back to the homepage to review the next steps to validate your dependent(s). This is time sensitive.

Note: If you are unable to enroll on the Health and Life website, be sure to review/update the above information with the Service Center advocate.

C - Member services

- 833-925-0487; we suggest you call in the mornings, Tues-Fri, 8 a.m. - 7 p.m. (CST).

Note: Virtual Hold may be an option if you call during peak hours. You will not lose your place in line if you select this option. An advocate will call you back; however, it may not occur until the next business day.

Important: There is usually longer than normal wait time on the first and last day of Annual Enrollment. Please plan accordingly if you wish to speak to an advocate.

Medical Plan overviews

Surest Health PPO, Surest Select Health PPO and HDHP

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

	Surest Health PPO		New - Surest Select Health PPO		HDHP	
You Pay	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
	Annual Deductible (The Deductibles are separate for In-Network and Out-of-Network providers and are not combined)					
	Individual		**Individual**		**Individual**	
	$0	$0	$0	$0	$1,650	$3,300
	Individual + Child/ren		**Family**		**Family (Individual + one or more dependents)**	
	$0	$0	$0	$0	$3,300	$6,600 (deductible must be satisfied before coinsurance applies; no individual limits)
	Annual Out-of-Pocket Maximum					
	The In-Network copays apply towards the In-Network and Out-of-Network Out-of-Pocket Maximum.				The In-Network and Out-of-Network Out-of-Pocket Maximums are separate and are not combined.	
	Individual		**Individual**		**Individual**	
	$3,600	$7,200	$3,200	$6,400	$3,600	$7,200
	Individual + Spouse/Domestic Partner		**Individual + Spouse/Domestic Partner**			
	$5,400	$10,800	$4,800	$9,600		
	Individual + Child/ren		**Individual + Child/ren**			
	$5,400	$10,800	$4,800	$9,600		
	Family		**Family**		**Family (Individual + one or more dependents)**	
	$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)	$6,850	$14,400 (Entire family out of pocket must be satisfied before eligible expenses are 100% covered)

	Surest Health PPO		New - Surest Select Health PPO		HDHP	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Coinsurance	100% covered		100% covered		• 85% covered (Tier 1 Premium Provider) • 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	$10 - $65	$180	• 85% covered (Tier 1 Premium Provider) • 80% covered (Network Provider)	50% covered (you may be responsible for any amount over the eligible expense)
Specialist Visit	$20 - $90	$180	$10 - $65	$180	• 85% covered (Tier 1 Premium Provider) • 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% covered	100% covered	100% covered	Not covered
Inpatient (Facility), Office Visit, Outpatient (Facility), Prescriptions, Urgent Care						
Outpatient Lab and Pathology	$0	$0	$0	$0	85% covered	50% covered (you may be subject to balances over the eligible expense)
Outpatient Surgery	$150 - $3,000	$2,500 - $7,200	$75 - $2,500	$1,500 - $5,400	• 85% covered (when performed at an Ambulatory Surgery Center) • 80% covered (if performed as outpatient in a hospital)	Not covered

	Surest Health PPO		New - Surest Select Health PPO		HDHP	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Emergency Room Services	$500	$500	$375	$375	80% covered after deductible is met	
Inpatient Hospital Care	• Up to $3,000 • $1,400 for Inpatient Emergency Admit	• Up to $7,200 • $2,800 for Inpatient Emergency Admit	• Up to $2,500 • $1,400 for Inpatient Emergency Admit	• Up to $5,400 • $2,600 for Inpatient Emergency Admit	80% covered after deductible is met	50% covered after deductible is met
Prescription Drugs	**Tier 1 Drugs**					
	• $10 for up to a 30 day retail supply • $25 for up to a 90 day retail/home delivery supply • $200 (In-Network) for Specialty Retail Pharmacy • Specialty medications are limited to a 30 day supply **Note:** Home delivery available, but not required.		• $10 for up to a 30 day retail supply • $25 for up to a 90 day supply for home delivery • $200 (In-Network) for Specialty Retail Pharmacy • Specialty medications are limited to a 30 day supply **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions.		• 85% covered; minimum copay of $10 for retail, $25 for home delivery, $200 for Specialty; after deductible is met. • Up to 31-day supply/90 day for home delivery (In-Network). • For certain preventive medications the deductible is waived. • Specialty medications are limited to a 30 day supply. **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions.	
Prescription Drugs	**Tier 2 Drugs**					
	• $45 for up to a 30 day retail supply • $112.50 for up to a 90 day retail/ home delivery delivery supply • $225 (In-Network) for Specialty Retail Pharmacy • Specialty medications are limited to a 30 day supply **Note:** Home delivery available, but not required.		• $45 for up to a 30 day retail supply • $112.50 for up to a 90 day supply for home delivery • $225 (In-Network) for Specialty Retail Pharmacy • Specialty medications are limited to a 30 day supply **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions.		• 80% covered; minimum copay of $45 for retail, $112.50 for home delivery, $225 for Specialty; after deductible is met. • Up to 31-day supply/90 day for home delivery (In-Network). • For certain preventive medications the deductible is waived. • Specialty medications are limited to a 31 day supply. **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions.	

	Surest Health PPO	New - Surest Select Health PPO	HDHP
Prescription Drugs	**Tier 3 Drugs**		
	• $150 for up to a 30 day retail supply • $375 for up to a 90 day retail/home delivery supply • $300 (In-Network) for Specialty Retail Pharmacy • Specialty medications are limited to a 30 day supply **Note:** Home delivery available, but not required.	• $150 for up to a 30 day retail supply • $375 for up to a 90 day supply for home delivery • $300 (In-Network) for Specialty Retail Pharmacy • Specialty medications are limited to a 30 day supply **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions.	• 70% covered; minimum copay of $150 for retail, $375 for home delivery, $300 for Specialty; after deductible is met. • Up to 31-day supply/90 day for home delivery (In-Network). • For certain preventive medications the deductible is waived. • Specialty medications are limited to a 31 day supply. **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions.
Prescription Drugs	**Tier 4 Drugs**		
	• $300 for up to a 30 day retail supply • $750 for up to a 90 day retail/home delivery supply • $400 (In-Network) for Specialty Retail Pharmacy • Specialty medications are limited to a 30 day supply **Note:** Home delivery available, but not required.	• $300 for up to a 30 day retail supply • $750 for up to a 90 day supply for home delivery • $400 (In-Network) for Specialty Retail Pharmacy • Specialty medications are limited to a 30 day supply **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions.	• 60% covered; minimum copay of $300 for retail, $750 for home delivery, $400 for Specialty; after deductible is met. • Up to 31-day supply retail and Specialty/90 day for home delivery (In-Network). • For certain preventive medications the deductible is waived. • Specialty medications are limited to a 31 day supply. **Note:** Home delivery required after two refills at a retail pharmacy for maintenance prescriptions.
	Tier 1, 2, 3 and 4 - Certain life saving/emergency medications on the Vital Medication list are covered at no cost to you.		
	Specialty Medications		
	No Out-of-Network coverage for Specialty Medications.		

Surest Health PPO and the new Surest Select Health PPO - You can review treatment options and costs before receiving treatment or choosing a provider. Here's how it works:

- Coverage starts at your first visit or prescription fill because this is a $0 deductible plan.
- Clear, upfront prices for treatments and doctors. Know before you go what your healthcare choices will cost.
- Get the coverage you would expect from the UHC Choice Plus National Provider Network.
- **Shop by quality -** Copays are lower for providers and locations evaluated as high-quality, based on quality, efficiency, and overall effectiveness of care.

Refer to the below examples to see how one of the Surest plans can work for you.

Find doctors, treatments, or procedures in the Surest App, or on the website. Download the Surest App, available for free in the App Store and Google Play. To check on costs or see if your provider is in-network or to review additional information, visit lumen.com/joinsurest.

The information below assumes In Network (UHC Choice Plus) charges.

Surest plans offer 'copay ranges' for many services. To get started from your Surest App, use the Search bar, type in your condition, or symptoms like "my head hurts". Results will show care options and you can select a doctor or location to see the copay. You can also search by provider name. You also have the option to turn on filters like specialty, gender, and distance. By evaluating providers, locations, and costs in advance, you can make more informed decisions for you and your eligible dependent(s).

Childbirth	Surest Health PPO	New - Surest Select Health PPO
Copay – labor and delivery	As low as $500	As low as $400
Copays include: hospital charges, OB, anesthesiologist, epidural, emergency C-section, baby's stay (if discharged with mother)		

Emergency Room	Surest Health PPO	New - Surest Select Health PPO
Copay (copay is waived if admitted)	$500	$375
Copays include: hospital/facility charges, attending physician, radiologist, X-rays, splint		

Knee Arthroscopy	Surest Health PPO	New - Surest Select Health PPO
Copay range	$1250 - $2600	$700 - $1950
Copays include: facility charges, attending physician, radiologist, x-rays		

Pink Eye	Surest Health PPO	New - Surest Select Health PPO
Primary (PCP) or urgent care virtual visit	$0	$0
Office visit (and/or virtual visit)	$20 - $90	$10 - $65
Office visit copays include: blood work, x-rays and standard labs		

The $20 copay for the Pink Eye example in the range above represents what you would pay if you chose the highest quality provider or facility. Conversely, the $90 copay in the range represents a lower quality provider or facility.

HDHP - If you enroll in this plan, you can choose your UnitedHealthcare healthcare providers; however, the Plan pays a greater benefit when you use providers that are in the network.

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 an HSA, if applicable. Lumen doesn't offer an HSA to COBRA participants. If you are Medicare eligible, you should review the "Medicare and You" handbook at medicare.gov.

Dental Plan overviews

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, and your share of the cost of coverage. Both 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 Dental Summary Plan Description (SPD) on lumen.com/healthbenefits.

Dental Option 1	Dental 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 Benefit Maximum value regardless of going In or Out-of-Network. In-Network services are subject to MetLife's negotiated Plus network rates. Out-of-Network services will be subject to the reasonable and customary charges. You may have additional out of pocket costs for services received from Out-of-Network providers.)	
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)
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 who are eligible for bitewing X-rays twice per year.	Full mouth X-rays covered once every 60 months; bitewing X-rays covered once per year, except for dependent children under age 26 who are eligible for bitewing X-rays twice per year.
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)

*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 Plan 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 the Insight (name of the in-network benefit) network to help save you even more. Since PLUS Providers are already through the Insight 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 regardless if enrolled or not yet. You may also call EyeMed at 855-874-4744. EyeMed's retail stores include but not limited to: LensCrafters, Target Optical and most Pearle Vision locations. EyeMed offers In-Network online options at: ContactsDirect.com, Glasses.com, lenscrafters.com, ray-ban.com and targetoptical.com. You must not only enroll but also register on EyeMed's site to become eligible for additional and special offers as an "EyeMed member."

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

Vision Care Services	In-Network Cost Using PLUS Providers. PLUS Providers are distinguished on EyeMed's website when looking for a provider in a specified area.	In-Network Cost	Out-of-Network Reimbursement
Examination Services			
Exam (with Dilation as necessary)	$0 copay	$10 copay	Up to $40
Retinal Imaging	$0 copay	$0 copay	Up to $20
Low Vision Supplemental Exam/Testing	$0 copay	$0 copay	Up to $125
Low Vision Aids	25% copay up to a maximum of $1,000	25% copay up to a maximum of $1,000	25% copay up to a maximum of $1,000
Contact Lens (allowance includes materials only)			
Conventional	$0 copay; 15% off balance; over $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 - Premium	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

Vision Care Services	In-Network Cost Using PLUS Providers. PLUS Providers are distinguished on EyeMed's website when looking for a provider in a specified area.	In-Network Cost	Out-of-Network Reimbursement
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
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

Vision Care Services	In-Network Cost Using PLUS Providers. PLUS Providers are distinguished on EyeMed's website when looking for a provider in a specified area.	In-Network Cost	Out-of-Network Reimbursement
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 at thousands of convenient locations nationwide.)	40% off hearing exam and low price guarantee on discounted hearing aids (Up to 64% off aids at thousands of convenient locations nationwide.)	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

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

Offered by: EyeMed **Group number:** 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.

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 contact lenses for both eyes. The benefit does not cover Safety eyewear, solutions, cleaning products or frame cases. For other Limitations and Exclusions, refer to the Vision SPD.

Who do I contact? - Helpful resources

When you need more detailed information about Plan specifics, review your SPDs and SMMs located in the Reference Center located on the top right-hand side of the home page on the Health and Life website. If you would like a paper copy of these materials, contact the Service Center. Please be advised that mail time is based on the USPS schedule. Lumen and the Service Center is unable to overnight forms, documents, letters, etc.

Administrator/Plan/Program	Website/Group number	Phone number
Lumen Health and Life Service Center	lumen.com/healthbenefits Download the free MyChoice Mobile App for Android or iOS **Search:** MyChoice™ Mobile App, available for free in the App Store and Google Play	833-925-0487 317-671-8494 (International callers) Mon-Fri, 7 a.m. - 7 p.m. (CST)
Health Care Advocacy Services For issues with your Health Care claims that you are unable to resolve with the Claims Administrator or your Health Care provider.		833-925-0487 317-671-8494 (International callers) Mon-Fri, 7 a.m. - 7 p.m. (CST) **Note:** Request to speak to the Advocacy Services team, you will be asked a few questions before being transferred. You will need to contact the Service Center in order to reach Advocacy Services.
Medical and Prescription Drug		
HDHP	UnitedHealthcare: myuhc.com Group Number: 192086 **Search:** UHC App, available for free in the App Store and Google Play	800-842-1219 Mon-Fri, 8 a.m. - 10 p.m. (CST)
Surest Health PPO and Surest Select Health PPO including prescription drug through OptumRx	If you want more information, visit lumen.com/joinsurest **Search:** Surest App, available for free in the App Store and Google Play Group Number: 78800186	800-531-6329 Mon-Fri, 6 a.m. - 9 p.m. (CST)
Virtual Care Surest Health PPO and Surest Select Health PPO HDHP MDLIVE is available for all plans	lumen.com/joinsurest **Search:** Surest App, available for free in the App Store and Google Play myuhc.com **Search:** UHC App, available for free in the App Store and Google Play lumen.com/mdlive	800 531-6329 Mon-Fri, 6 a.m. – 9 p.m. (CST) 800-842-1219 Mon-Fri, 8 a.m. - 10 p.m. (CST) 888-632-2738
2nd.MD Access to 2nd.MD services free for eligible participants and dependent(s) enrolled in a Lumen medical plan.	lumen.com/2ndmd **Search:** 2nd.MD, available for free in the App Store	866-842-1151 Mon-Fri, 7 a.m. – 7 p.m. (CST)

Administrator/Plan/Program	Website/Group number	Phone number
Maternity Support Program	lumen.com/joinsurest **Search:** Surest App, available for free in the App Store and Google Play myuhc.com **Search:** UHC App, available for free in the App Store and Google Play	800 531-6329 Mon-Fri, 6 a.m. - 9 p.m (CST) 800-842-1219 Mon-Fri, 8 a.m. - 10 p.m. (CST)
Dental		
Dental (Option 1 and Option 2)	metlife.com/mybenefits **Search:** Metlife App, available for free in the App Store and Google Play Group Number: 148069	866-832-5756 Mon-Fri, 6 a.m. - 10 p.m. (CST)
Vision		
Vision	lumen.com/eyemed **Search:** EyeMed App, available for free in the App Store and Google Play Group Number: 1029819	855-874-4744 Mon-Fri, 8 a.m. - 11 p.m. (CST)

Change of Address Update

Follow the steps below to update your address and/or phone number.

Administrator	Website/Email	Mail/Fax/Phone number
Health and Life Benefits	lumen.com/healthbenefits • Click your name in the top right-hand corner and select **Profile** from the drop-down menu • Select **Your Information** under Profile • Update your address • **Save**	833-925-0487 317-671-8494 (International callers) Mon-Fri, 7 a.m. - 7 p.m. (CST)

Summary of benefits and coverage availability

We offer an array of resources to help you understand and choose your medical benefits options. This section notifies you of an additional resource required by Health Care Reform — a Summary of Benefits and Coverage Availability (SBC) — that summarizes important information about any medical coverage options in a standard format, to help you compare features across Plan options. SBC's are available in the Reference Center on the Health and Life website throughout the year.

Legal and important required notices

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 password confidential for accessing the Health and Life website. Please keep this information safe and don't share it with anyone. Never use your Social Security number as your password. Together, we can make sure your personal information stays safe and secure. We encourage you add your personal email address as your contact preference information on the Health and Life Website. Please be advised that using an email that is not secured may increase your risk of unauthorized disclosure. For assistance on how to add a personal email address, contact the Service Center.

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.

Company's reserved rights

The Company reserves the right to amend or terminate any of the Benefits provided in the Plan. For more information, review the Lumen Health Care Plan General Information Summary Plan Description on the Health and Life website at lumen.com/healthbenefits in the Reference Center located on the top right hand side of the home page.

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.

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 life events (QLEs) due to employment termination or reduction of hours of employment. Certain QLEs, or a second QLE 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 Qualified Beneficiaries (QBs) will receive COBRA enrollment information. QLEs for employees include voluntary/involuntary termination of employment, and the reduction in the

number of hours of employment. QLEs for Spouses/Domestic Partners or dependent children include those events above, plus, the covered employee's becoming entitled to Medicare, divorce 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. Eligibility files are sent weekly 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.

Coverage is not advice

Health Plan coverage is not health care advice. Please keep in mind that the sole purpose of the Plan is to provide payment for certain eligible health care expenses – not to guide or direct the course of treatment for any participant, 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.

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 2025, 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.

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; and
- 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 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 life event. For example, if you have Individual 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 certain benefit options available to you, provided you verify your Spouse's/Domestic Partner's eligibility for the Plan.

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 healthcare 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 Information Summary Plan Description.

Important note regarding your Annual Enrollment elections

By electing to participate in the Plans, 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 claims 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, plan or program. Please refer to the applicable Plan document or SPD in the Reference Center on the home page of the Health and Life website for details about eligibility for coverage or call the Claims Administrator - limitations may apply including, but not limited to, being actively at work (and if returning, working at least one full work day) in order to be eligible for coverage. You understand that it is your responsibility to confirm your eligibility to enroll in a benefit option, plan or program 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, for example, due to death or a divorce. This excludes dependents who turn age 26, as they are automatically removed from coverage. **Note:** In the case of a divorce, even if your court order indicates you must continue providing healthcare and/or life benefits for your ex-spouse, the Plan doesn't allow ex-spouse's coverage. You will need to remove your ex-spouse from all Lumen benefits.

For specific benefit plan information, including terms and conditions for eligibility, limitations and benefits refer to the respective Plan documents, including the applicable Summary Plan 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.

Notice of Privacy Practices

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

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 impossible to switch to another coverage option.

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

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 your 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 never 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.

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.

Women's Health and Cancer Rights Act

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

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

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

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