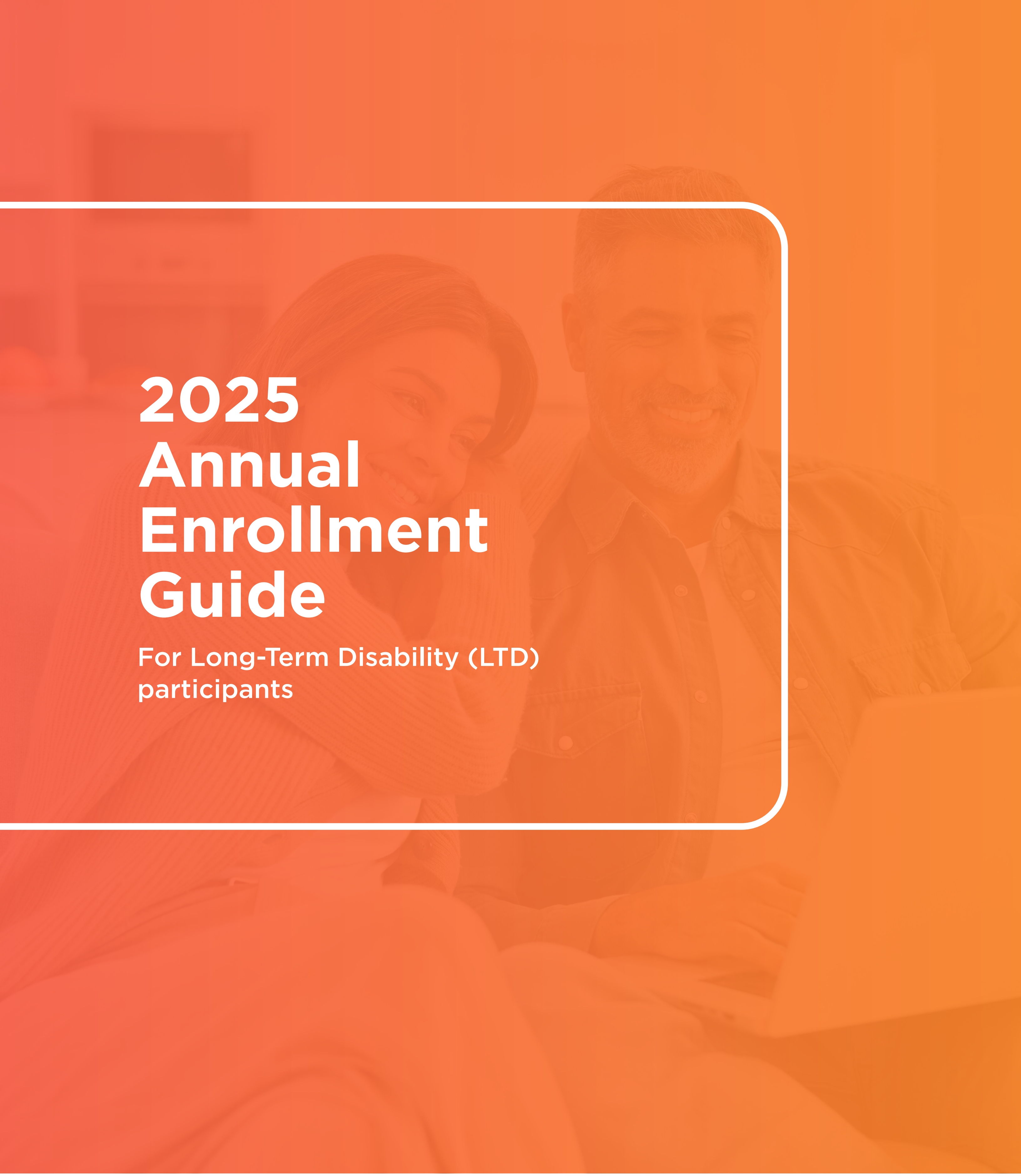


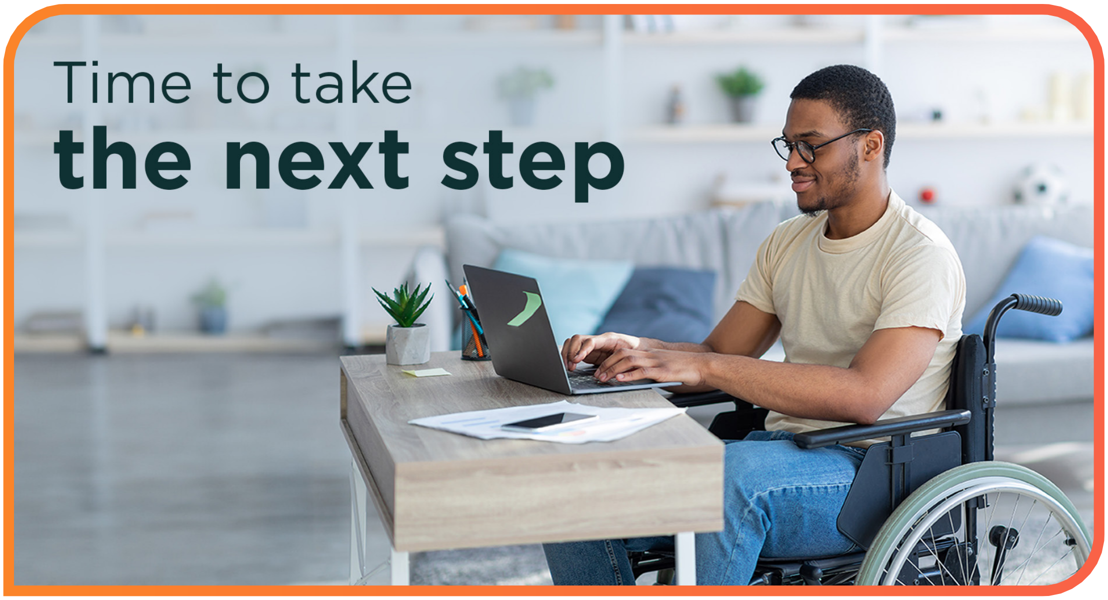
2025 Annual Enrollment Guide

For Long-Term Disability (LTD) participants

Table of Contents

Some references/provisions in this guide do not apply to all LTD participants. For more information, log in to the Health and Life website at lumen.com/healthbenefits or contact the Lumen Health and Life Service Center at 833-925-0487.

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".



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.

Dependent reverification request – take the next step and get prepared now!

Starting in 2025, dependent reverification will be required every three to five years. If you have a spouse, domestic partner or common law spouse that is enrolled in a Lumen benefit: medical, dental, vision or a life insurance plan, you can expect to receive a Dependent Reverification Notice. The first group will start to receive the request towards the end of May 2025. You don't need to contact the Service Center if you haven't received a notice by May 31, 2025 as reverification notices will process throughout the year and into future years. You will be notified when reverification is required for your dependent(s).

You will not need to provide your marriage certificate or a marriage license. You will need to provide documentation that is within six months of the notice (listed within the request). Examples of supporting documentation are: mortgage statement, residential lease statement or rental agreement, property tax statement, bank or credit card statement. You can submit two documents listing you or your dependent's name on each document (your name on one document and your dependent's name on another document) as long as the address matches on each document and it is the address that the Service Center has on file. You can black out any financial information.

Medical

Tobacco-Free Discount is changing to a Tobacco Surcharge

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.

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

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.

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	Copay range: $20 to $90*	Copay 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.
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)

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 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.

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	Prepare
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	Prepare
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	Contact the Service Center at 833-925-0487 if you or your dependent(s) become Medicare eligible.	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, Medicare becomes your primary coverage and the Company becomes secondary. Your benefits will be reduced if you do not enroll in a timely manner in Medicare Part B coverage.

Benefit details	Plan/Option information	Prepare
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	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. Take the next step and enroll in a tobacco cessation program today!
Working Spouse/Domestic Partner Surcharge	If you are subject to the Working Spouse/ Domestic surcharge, the amount will be added to your monthly medical cost and will therefore, not reflect separately on your Benefit Summary.	Answer the Working Spouse/Domestic Partner question during your enrollment.
1095-C	The IRS requires individuals to report on their healthcare coverage. Lumen is required to supply this information on a standard form. You will use this form when preparing your taxes. You will receive this form generally in Feb., if applicable.	You can choose to receive this form electronically or via mail. You can review your status on your **Account Profile** on the Health and Life website or by calling the Service Center at 833-925-0487.
Zip code updates	Review your Annual Enrollment Worksheet	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 the 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.
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:** 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.
11. Review the Life insurance plans. Make sure to review and update your beneficiary information. Complete all of the beneficiary information fields, not only those that indicate it is a required field. This will ensure that if a claim is filed, it's processed accurately and timely.
12. Review Your Elections, including plans, coverage levels and contributions/premiums in their entirety and select **Approve** to authorize your transaction.
13. Read the Confirmation pop up and select **I Agree**.

14. On the Transaction Complete page, print your Benefit Summary as this is your confirmation statement. Take note of the Confirmation Number for your records.
15. If an election has been made that requires Statement of Health/Evidence of Insurability (EOI), you will be provided information on how to complete the application immediately following your enrollment.
16. If you added new dependent(s) to coverage, you will see information regarding the dependent verification process. Read the requirements carefully. After you complete your enrollment, instructions and next steps will be provided 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.

You will receive periodic reminders during Annual Enrollment encouraging you to enroll if you have entered your email address as your preferred method to receive benefit communications. These are just friendly reminders. You do not need to contact the Service Center, unless you haven't enrolled and would like to enroll and work directly with the Service Center. They can take your elections over the phone or help guide you through the Health and Life website.

Medical Plan overviews

Surest Health PPO, Surest Select Health PPO and HDHP

You can choose the medical plan options listed, or you can suspend or waive this coverage. When you waive medical coverage, you also waive prescription drug coverage.

Note: Dependents can enroll in medical coverage if the LTD participant is enrolled in medical coverage. If the LTD participant waives medical coverage, the dependent(s) can't enroll or continue coverage. For example, if medical is elected but not dental, dependent(s) can enroll in medical only.

	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 enrolled)**	
	$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 enrolled)**	
	$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)
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**

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	Surest Health PPO		New - Surest Select Health PPO		HDHP	
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
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**

	Surest Health PPO		New - Surest Select Health PPO		HDHP	
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.	
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.	

	Surest Health PPO	New - Surest Select Health PPO	HDHP
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).

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 LTD 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 benefit maximum, deductibles, and orthodontia coverage. Both of the dental plan options are administered by MetLife.

This chart is only a snapshot summary of dental benefits.

Note: Dependent(s) can enroll in dental coverage if the LTD participant is enrolled. If the LTD participant waives dental coverage, the dependent(s) can't enroll. For example, if you elect dental but waive medical and vision, dependent(s) can enroll in dental only.

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.

Note: Dependent(s) can enroll in vision coverage if the LTD participant is enrolled. If the LTD participant waives vision coverage, the dependent(s) can't enroll. For example, if you elect vision but waive medical and dental, dependent(s) can enroll in vision only.

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

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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
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
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.

Life Insurance

The Life Insurance plans are Term Life Insurance coverages which pays the claim when you pass away. The claim is paid to your beneficiary or beneficiaries on file at the Service Center. The Service Center is the recordkeeper for all beneficiary information.

A beneficiary can instead receive a one-time, lump sum check if required by state law, regulation, or at the beneficiary's request. However, the TCA is the automatic default. **Important:** Your beneficiaries likely won't have to pay income tax on the payment(s) they receive. The Service Center and MetLife are not financial advisors and decisions on the tax rules should be discussed between you, your beneficiaries and your financial or tax advisors.

If your spouse or child(ren) pass away and you elected to enroll in the Spouse/DP Supplemental Life and/or Child(ren) Supplemental Life prior to your Short-Term Disability date, you are automatically the beneficiary to the Spouse/DP Supplemental Life and Child(ren) Supplemental Life plans.

Automatic and Company-paid Plan benefits	
Individual (LTD Participant) Basic Life Insurance	Eligible participants 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 of 1x Eligible pay. If your Basic Life coverage amount is more than $50,000, the IRS requires you pay taxes on imputed income. **To avoid paying taxes on imputed income, you have the option to choose Individual Basic Life - $50k.** If you are eligible, you will see two options: Basic Life - $50k and Basic Life - 1x Eligible pay. If you change to Basic Life - $50k you would not be subject to imputed income. **Important:** If you elect Basic Life - $50k and at a later date (including a future Annual Enrollment) you decide you want to go back to the Basic Life - 1x Eligible pay, you will be required to complete a Supplemental Enrollment form and the Claims Administrator will determine if you are approved.
You Pay the Cost	
You are eligible for the below coverage **only** if you were enrolled prior to your Short-Term Disability (STD) date. You cannot elect to increase any life insurance coverage amount while you are an LTD participant. You can only keep the current coverage amount (provided payments are paid timely), or waive the supplemental life plan(s). **Note:** If you are adding a new dependent, they are not eligible to enroll in any supplemental life plan.	
Individual LTD Supplemental Life Insurance	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.
Spouse/Domestic Partner Supplemental Life Insurance	$5,000, $10,000, $25,000, $50,000, $75,000, $100,000 or $200,000 (cannot elect more than 100% of Individual Basic Life + Individual Supplemental Life coverage).
Child Supplemental Life Insurance (Can be for more than one child)	Each child: $3,000, $5,000, $10,000 or $20,000 (cannot elect more than 100% of Individual Basic Life + Individual Supplemental Life coverage). **Note:** The elected amount will be for each child you enrolled and there will be one premium regardless of the number of children enrolled.

Note: For LTD participants, Individual Supplemental Life Insurance, Spouse/Domestic Partner Supplemental Life Insurance, and Child Supplemental Life Insurance is available for up to 36 months from your STD start date, provided all premiums are paid timely.

For more information about continuing your life insurance coverage either with a Waiver of Premium (WOP) claim or paying for coverage, please refer to the Life Insurance Summary Plan Description available on the Health and Life website or by requesting a copy through the Service Center.

Take the next step to review services **MetLife Advantages** provides at no cost to you when you are enrolled in a Basic Life (regardless if enrolled in the Basic Life - 1x Eligible pay or the Basic Life - $50k).

Grief Counseling: provides you, your dependent(s) and your beneficiary or beneficiaries up to five (5) private counseling sessions with a licensed grief counselor to help cope with a loss or major event. For more information, contact LifeWorks US, Inc. at 888-319-7819.

Funeral Assistance Services are provided through LifeWorks US, Inc. For more information, contact 888-319-7819.

If you are enrolled in a Supplemental Life plan, the plan(s) offers additional services through **MetLife Advantages**. These are:

- **Will Preparation:** offers you and your spouse/DP face-to-face meetings or phone calls with a MetLife Legal Plans attorney to prepare or update a will, living will or power of attorney. Contact MetLife Legal Plans, Inc. at 800-821-6400.
- **Probate Services:** provides you and your beneficiary or beneficiaries of your estate with face-to-face meetings or phone consultations with a participating MetLIfe Legal Plans attorney to help settle your or your spouse/DP's estate. Contact MetLife Legal Plans, Inc. at 800-821-6400.

Reminders:

Please confirm that you have current and up-to-date beneficiaries for all of your Life plans (both company-paid and individual-paid) by going to lumen.com/healthbenefits.

- Select the **Change My Benefits** tile from the home page. Click on **Basic Info**, **Change of Beneficiary**
- Today's date will appear, select **Continue**
- Select **Start Change**
- Sofia will appear, select **Start Enrollment**
- If you have dependents, they will appear first which may differ from your Beneficiaries, select **Looks Good**, if you don't have dependents, select **No** and **Next**
- View your current beneficiary information, select **Edit** by each name
- To add a new beneficiary scroll to the bottom, select **Add New Beneficiary** (enter the information in all fields)

Note: Enter the information not only in the required fields but all fields to ensure a claim is processed accurately and timely. Claims may be delayed or not paid if there is incomplete beneficiary information on file. The Service Center is the record keeper of beneficiary information. Refer to the Life and AD&D Insurance Plan Summary Plan Description (SPD) in the **Reference Center** on the Health and Life website to find out what happens when no beneficiary information is on file or the information is incomplete or outdated.

Important Plan rules

- If both you and your Spouse/DP are employed by the Company, or on Long-Term Disability, or in a parent/child relationship and are employed by the Company, you cannot be covered on each other's benefits. If both you and your Spouse/DP are employed by the Company and one of you is not enrolled in the Employee Supplemental Life plan, you may enroll under the Spouse/DP Supplemental Life plan. You cannot be covered under Employee Supplemental Life and Spouse/DP Supplemental Life. Also, you cannot both enroll in the Child(ren) Supplemental Life and AD&D

coverage for the same dependent children. You must decide which parent will cover the child/ren.

- Coverage amount and benefit premium deductions may increase or decrease throughout the Plan year in certain situations (for example, if you have a change in pay or change age brackets; age brackets are every five years, i.e., 30, 35, 40, 45, etc.). If your benefit premiums increase or decrease, you will receive an email notification sent to your personal email address on file from the Service Center indicating an updated Benefit Summary is available on the Health and Life website. You can view and print your updated.

Notifications of a death: All notifications of someone passing (whether it is the participant or a dependent) should be provided to WTW, the Pension Administrator who will then notify all Lumen Claims and Plan Administrators to process the notification. Please do not reach out to each Service Center. They will not be able to process until they receive notification from WTW. WTW is available Mon-Fri, 8 a.m. to 7 p.m. (CST) at 888-324-0689.

WTW will need first and last name, SSN, date of birth, date of passing, mailing address, phone number with area code as well as if the deceased is an employee, the following: Legacy Company (CenturyTel, Embarq, Qwest, etc.) and status (active employee, on a leave, LTD, etc.). Information will also be requested of the caller such as first and last name, phone number with area code and the relationship to the deceased. Please do not delay calling if you don't have all the information requested but the more information you have, the better for all the administrators to process accurately and timely.

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.

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 and to help you compare features across Plan options. SBC's are available in the Reference Center on the Health and Life website.

Administrator/Plan/Program	Website/Group number	Phone number
To Report a passing of the LTD participant or a dependent, please contact the Pension Administrator, WTW who will notify all Lumen Claims and Plans Administrators.	N/A	888-324-0689 Mon-Fri, 8 a.m. - 7 p.m. (CST)
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.	N/A	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 including prescription drug through OptumRx	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)

Administrator/Plan/Program	Website/Group number	Phone number
Virtual Care Surest Health PPO and Surest Select Health PPO	lumen.com/joinsurest **Search:** Surest App, available for free in the App Store and Google Play	800 531-6329 Mon-Fri, 6 a.m. – 9 p.m. (CST)
HDHP	myuhc.com **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)
MDLIVE is available for all plans	lumen.com/mdlive	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)
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)
Disability and Life Insurance		
Long-Term Disability – MetLife	metlife.com/mybenefits	833-622-0135 Mon-Fri, 8 a.m. - 11 p.m. (CST)
Life Insurance	lumen.com/healthbenefits **Search:** MyChoice™ Mobile App, available for free in the App Store and Google Play **Policy Numbers:** Basic Life and Supplemental AD&D - 148069	833-925-0487 317-671-8494 (International callers) Mon-Fri, 7 a.m. - 7 p.m. (CST) If you have questions about an open or closed claim, please contact Metropolitan Life Insurance Company directly at 800-638-6420, Mon-Fri, 7 a.m. - 4 p.m. (CST)

Administrator/Plan/Program	Website/Group number	Phone number
MetLife Legal Plan, Inc.	Will Preparation and Probate Services when enrolled in a Supplemental Life plan	800-821-6400 Mon-Fri, 7 a.m. - 7 p.m. (CST)
LifeWorks US, Inc.	Grief Counseling and Funeral Assistance Services when enrolled in a Basic Life and Basic AD&D plan	888-319-7819 Available 24 hours a day/7 days a week

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)

Claims and appeals for enrollment issues

If you wish to file a claim or appeal regarding eligibility or enrollment for you and/or your eligible dependent(s) in a benefit Plan option or change in benefit Plan options, you must submit a Claim Initiation Form, which you can find on the Health and Life website in the **Reference 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 and your dependent(s) eligibility, if applicable, you are held to the standard of honesty and truthfulness. Falsifying or omitting information in enrolling for coverage under the Plan will subject you to disciplinary action, up to and including termination. If you have questions about whether your responses 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 applicable 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 to ask additional questions regarding the claims and appeals process after reviewing the SPDs.

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

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

This document summarizes certain provisions of the Disability Plan, the Life Insurance Plan and the Individual and Inactive Health Plan (collectively referred to as the "Plan"). For specific employee benefit plan information, refer to the respective official Plan documents, and 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.

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. QLE for spouses/domestic partners or dependent children include those events above, plus, the covered Individual's becoming entitled to Medicare, divorce of the covered Individual, death of the covered Individual, 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. Then, 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 (The local DNIS for international callers is 317-671- 8494).

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(s) will not be eligible for continuation of health care coverage under the federal law known as COBRA. Eligibility for COBRA continuation coverage occurs only in cases of QLEs. For more information on what is a QLE, refer to the General Information Summary Plan Description (SPD) available in the Reference Center on the Health and Life website.

Important note regarding enrollment elections

By electing to participate in the 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 including voluntary or supplemental coverages. 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; 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 (SPD) and Summaries of Material Modifications (SMMs), if any. If there is any conflict between the terms of the Plan documents and this correspondence, the terms of the Plan documents will govern.

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 and print the complete notice at lumen.com/healthbenefits. You may obtain a paper copy upon request by calling the Service Center at 833-925-0487 (The local DNIS for international callers is 317-671-8494).

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.