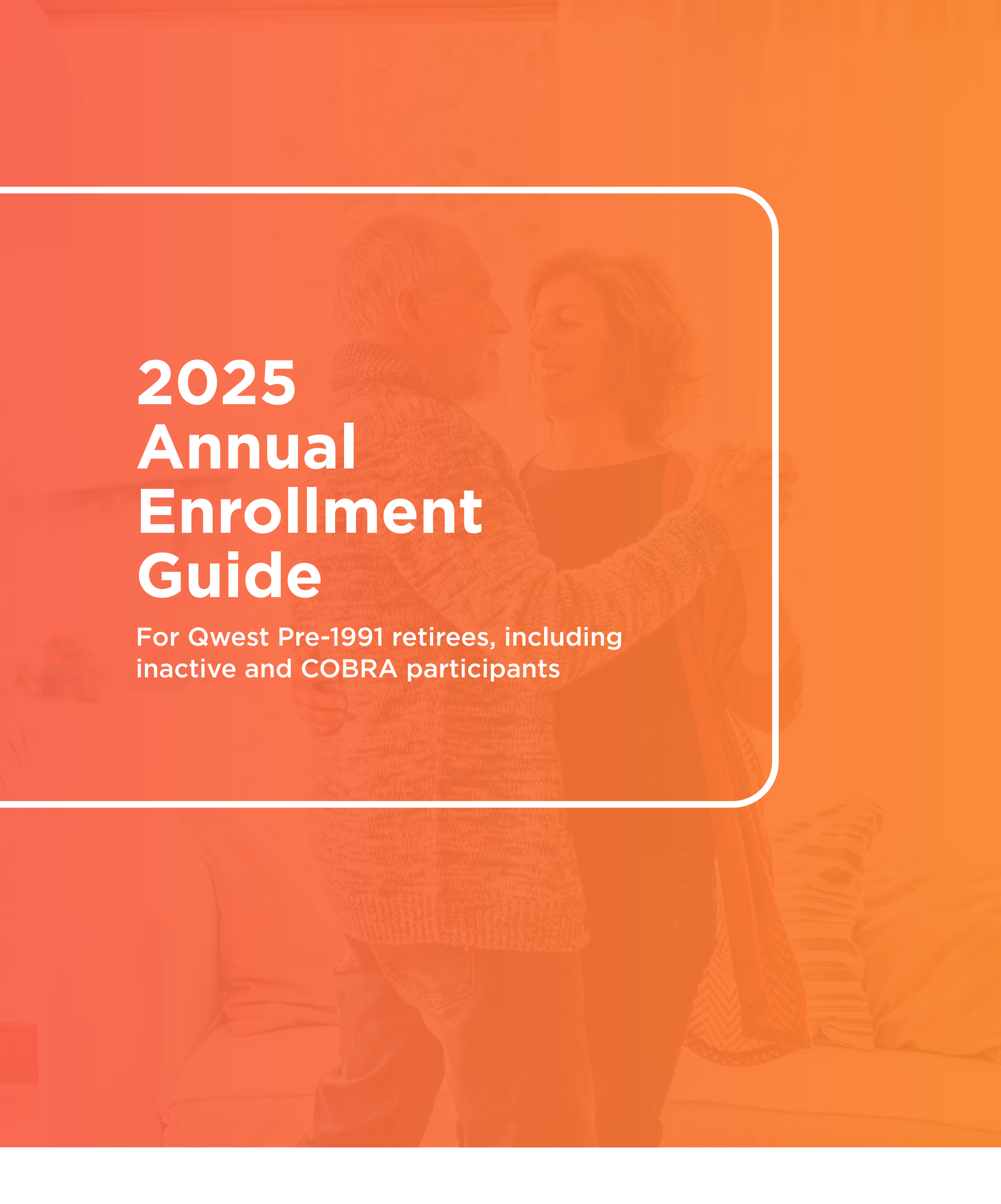

2025 Annual Enrollment Guide

For Qwest Pre-1991 retirees, including inactive and COBRA participants

LUMEN®

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Some references and benefit options in this guide apply only to Pre-1991 retirees. For more information, refer to your Pre Annual Enrollment Notice for available plans and options, the Health and Life website at lumen.com/healthbenefits or contact the Lumen Health and Life Service Center. The Lumen Health and Life Service Center will be referred to hereafter as "the Service Center".

Lumen will be referred to hereafter as "Company".

Welcome to Annual Enrollment

It's the perfect **time to take the next step** and use this opportunity to add, change or update your Lumen benefits. We encourage you to review this guide in its entirety as even if you don't want to make changes.

Go to the Health and Life website at lumen.com/healthbenefits to learn about your 2025 benefits. On the home page, you'll find helpful information in the **Reference Center** located next to your name in the top right-hand corner.

This guide pertains to **both** non-Medicare and Medicare eligible participants. If you make changes during Annual Enrollment, your changes will begin on the first day of the new Plan year. **Note:** If you are a retiree and elect to suspend or waive coverage, your dependent(s) will automatically be placed into the same suspend or waive coverage. In order for dependent(s) to have coverage, the retiree needs to be enrolled even if you are in a split-family (example: one of you is Medicare eligible and the other one is not Medicare eligible).

If enrolling in the UnitedHealthcare (UHC) Group Medicare Advantage PPO Plan, enrollment must be approved by Medicare prior to the effective date. For example, if approved by UHC in Dec., coverage under the UHC Group Medicare Advantage PPO Plan would become effective Jan 1. Please have your Medicare information available (coverage start dates for Medicare Part A and Medicare Part B as well as Medicare number) as you will be required to provide this at the beginning of your enrollment.

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.

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.

COBRA participants

As a COBRA participant, coverage is limited to medical and/or, dental coverage, as applicable. COBRA rates have changed. Not all provisions of this guide apply to COBRA participants, please refer to your Pre Annual Enrollment Notice for more information. Eligibility files sent to Claims Administrators such as UnitedHealthcare and MetLife, 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.

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 medical or dental 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 don’t receive a notice by May 31, 2025. 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.

Note: The Dependent Reverification process excludes survivors, company couples as well as parent/child relationships who are employed, on leave or retired from a subsidiary of Lumen. If you are a company couple or in a parent/child relationship and the Service Center is not aware, please contact them prior to Annual Enrollment so that they can provide you correct plan information for Annual Enrollment.

Reminders

Adding dependents during enrollment

To cover newly eligible dependents during Annual Enrollment, **action is required**.

1. Add your newly eligible dependents on the Health and Life website, or by contacting the Service Center.
2. Coverage for your dependents will become effective Jan. 1, 2025, provided supporting documentation to verify eligibility for your dependent is received timely and approved. You can upload your supporting documentation after you complete your enrollment. You can also elect to fax or mail the supporting documentation, but uploading will expedite the process.

Mail: Lumen (Businessolver.com, Inc.)
PO BOX 850552
Minneapolis, MN 55485-0552

Email: dv@businessolver.com **Note:** the email contains two of the letter “s”.

Fax: 515-273-1545

Dual coverage

If you are a Company Couple or have a children who are eligible for their own benefits because they are/were employed by the Company or a subsidiary of the Company, and the Service Center is not aware of this, please contact them at 833-925-0487 so that your record can be updated.

Add your email on the Health and Life website

Lumen is committed to green initiatives. Going green doesn’t just benefit the planet – it also helps all of us save money, time and resources. You can help with this initiative by electing to receive benefit communications through email rather than a paper copy through the U.S. Postal Service.

Update/confirm your email address

- Log in to lumen.com/healthbenefits
- Click on the **Profile** icon in the center of the home page, or, you can click your name in the top right-hand corner and select Profile from the drop-down menu
- Select **Edit** next to Contact Preferences under the Personal Preferences section
- Choose the **Electronic Mail** radio button
- Add your **Personal Email Address**
- Select the **Primary** radio button
- Save

Note: You can add your cell phone number and select the Accept SMS Terms and Conditons radio button to opt into receiving certain benefit communication via text messaging (data rates may apply).

The email will come from **DoNotReply@benefits.lumen.com**, make sure it doesn’t go to your spam or you may miss out on important benefit communications.

Form 1095-C

Form 1095-C verifies your health insurance coverage for tax purposes. If you and/or your dependent(s) were eligible for or enrolled in a non-Medicare medical option in 2024, you will receive a Form 1095-C based on your communication preference on the Health and Life website.

Life Insurance beneficiaries

Please review and confirm you have up to date beneficiary information on file for any Life Insurance Plans. The Service Center is the recordkeeper of beneficiary designations.

If you do not have a beneficiary on file or your beneficiary information is incomplete, MetLife will process payment to the following survivor(s) as follows: 1) To your Spouse/Domestic Partner; or 2) If no Spouse/Domestic Partner, to your child(ren) in equal percentages; or 3) If there is no Spouse/Domestic Partner, child(ren), to your parents in equal percentages; or 4) If there is no Spouse/Domestic Partner, child(ren), parents, to your brothers and sisters in equal percentages.

To add, review or update your beneficiary information, follow the steps below:

- 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 and 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.

Important: You can also elect to add or name contingent beneficiaries, payable when the primary beneficiaries are no longer living.

If you are unable to go online, you may contact the Service Center to review and make any applicable beneficiary information updates.

Please have the following information available for your beneficiary or beneficiaries: first and last name, mailing address, and phone number with area code. When a claim is filed, if the beneficiary's date of birth (DOB) and social security number (SSN) are listed within your beneficiary information, the claim tends to take less time to process. Please consider adding DOB and SSN to each beneficiary.

Medicare-eligible and/or non-Medicare-eligible

If you and your dependent(s) are Medicare eligible, you must enroll in the same medical plan option. If you were enrolled in the UnitedHealthcare Group Medicare Advantage PPO in 2024 and you are not changing, you will not be required to re-enroll. Therefore, no action is required and your Pre Annual Enrollment Notice will serve as your 2025 confirmation of benefits.

If you are enrolling in an individual policy not offered by the company and therefore are electing the Lumen Medicare Retiree LQ Pre91-ERO92 HRA, you must complete that carrier's enrollment form and follow their process as well as enroll in the Lumen Retiree HRA plan.

If you or one or more of your dependent(s) are not Medicare eligible and the other participant is Medicare eligible (split family), you can make separate elections. The non-Medicare participant may remain in the Company plan option or Suspended/Waived Coverage (No Coverage) option, while the Medicare eligible participant may select from one of the three Medical plan options available.

Note: If the non-Medicare eligible participant becomes Medicare eligible during the Plan year, that participant must enroll (and complete forms, if applicable) in the same benefit plan option in which the Medicare-eligible participant is already enrolled.

Other coverage options

There may be other, more affordable coverage options for you and your dependent(s) 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 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 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.

Premium payments

Account Statements will only be available on the Health and Life website. If you pay for any portion of your coverage, (e.g., Retiree Supplemental Life Insurance), you can set up your contact preference to receive a monthly email notification indicating your invoice is available to be viewed online. Refer to page 5 for instructions to add or update your contact preference. **Note:** if you are enrolled in a plan that has a benefit premium cost, it is essential to pay all premiums by the due date to maintain continuous coverage. Failure to do so will result in the cancellation of coverage for all plans with a premium benefit cost.

How do I make a payment?

Log in to the Health and Life website at lumen.com/healthbenefits. You can submit a one-time payment or set up automatic monthly payments. Click your name in the top right-hand corner from the home page and choose **View Current Account Balance** to see your current amount due or set up an online payment.

Note: If you choose to make one-time payments, you will incur a $2.00 service fee for each payment. This is not the same as autopay. We are not able to refund you for this fee.

Make your payment payable to: Businessolver, Inc. and mail to:

Businessolver, Inc.
ATTN: Direct Bill Administration
P.O. Box 850512
Minneapolis, MN 55485-0512

Important: You must include your account number and the name Lumen on the check's memo line.

Where can I find my account number?

If you have a prior monthly statement from the Service Center, the account number is located on the top of page 1 with your Account Summary detail, as well as on the detachable coupon.

You can locate a prior statement by logging in to your account at lumen.com/healthbenefits. Click your name in the top right-hand corner from the home page and choose **View Current Account Balance**. Scroll down to Payment Reminders and click on the blue link for a prior payment reminder.

If you have additional questions or need help locating your account number, call the Service Center at 833-925-0487 Mon-Fri, 7 a.m. to 7 p.m. (CST) for assistance.

Qualified Life Event (QLE)

If you experience a QLE such as marriage, death, divorce, adoption or birth, or losing other coverage, you can go to the Health and Life website at lumen.com/healthbenefits or contact the Service Center at 833-925-0487 within 45 days of the event in order to change your coverage elections. If you are adding a dependent, be sure to gather your dependent(s) Social Security numbers and birthdates before you start the enrollment process. You will be required to go through the Dependent Verification process if you add a new dependent.

Note: If you make changes during Annual Enrollment and have a subsequent change to your coverage before the end of December 2024, because of a QLE (for example, you add a new spouse to your coverage), your 2024 changes/ enrollment will not automatically be applied to 2025. As a result, you will need to update **BOTH** your 2024 and 2025 coverage by contacting the Service Center.

Retiree news, don't miss out

Stay up-to-date, visit lumenbenefits.com to get the latest retiree news. These articles are designed to share information about benefits, the Company and other topics.

Voluntary Lifestyle Benefits

Make sure to review the Voluntary Lifestyle Benefit programs availabe to you on the Voluntary Lifestyle Benefits page at lumen.com/healthbenefits.

Disaster Insurance - Protect your home and finances from a natural disaster. Eligibility is based on zip code and state and may change from time to time.

Employee Perks/Discounts – Provides you with access to hundreds of exclusive deals from brand-name retailers and local merchants.

Identity and Fraud Protection – Protects you and your family from fraud.

Legal Services – Legal experts on your side, whenever you need them.

What happens to your benefits if you return to work directly for the Company as an active employee or work for a supplier on assignment to the Company after you retire or leave employment?

If you are eligible for retiree health care or life insurance from the Company, refer to the applicable section below to see how your retiree benefits may be impacted.

If you are rehired at Lumen in a status that is eligible for active employee benefits, you will be offered the same benefits as other similarly situated employees based on your employee classification. If you have retiree supplemental life insurance coverage, you will be eligible to elect active supplemental life insurance coverage. If there is a loss of supplemental life coverage between what you previously had prior to your rehire date and the amount as an active employee, you may convert the difference with Metropolitan Life Insurance Company. If you continued supplemental life coverage through Metropolitan Life Insurance Company, you will be required to surrender this policy when you return to retiree status in order to resume your retiree supplemental life coverage, if applicable.

If you return to work for a supplier on assignment to the Company, you are not eligible to continue your Company retiree health care benefits. This means that while you are working for the supplier, your retiree health care benefits will be suspended. However, you will be offered the opportunity to continue your retiree medical and/or dental options under COBRA. Your retiree basic and/or retiree supplemental life coverage, if applicable, will continue under the terms of the Life Insurance Plan (the Plan). In addition, please be advised that as a worker for a supplier or Company contractor, you are not eligible for active employee health care benefits. Retiree health care benefits are reinstated once your work with the supplier/contractor for the company has ended. You will need to call the Service Center to have your benefits reinstated.

Once your employment or assignment ends, you may resume your retiree health care, basic and supplemental life insurance coverage, if applicable, in accordance with the terms of the Plan by calling the Service Center at 833-925-0487 (The local DNIS for international callers is 317-671-8494). If you returned to work for a supplier on assignment, the Company will validate that your assignment has ended before you will be allowed to resume your retiree health care coverage. **Note:** If you are Medicare eligible and have enrolled in an individual Medicare policy, you may need to complete a disenrollment process to be released by that carrier from the individual plan (which can take up to 60 days).

Enroll

If you don't want to make any changes, **no action** is required. When enrolling on the Health and Life website, the coverage level for Retiree will be shown as "Individual". For example, Retiree coverage will be shown as Individual coverage, Retiree + Spouse/Domestic Partner will be shown as Individual + Spouse/Domestic Partner, etc.

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 over the phone, enrollment ends at 7 p.m. (CST).

How to enroll:

Mobile device enrollment - (easily accessible)

1. Download the free MyChoice Mobile App for iOS or Android from the App Store or Google Play.
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.
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 My Choice Accounts (MCA).

Health and Life website - (quick and simple)

Note: You will be required to enter information regarding your Race and Ethnic Identification. You can indicate you do not wish to share this information during your enrollment by checking the box, **I choose not to answer** for both questions. This will not impact your benefit eligibility.

1. Navigate to lumen.com/healthbenefits and log in. If you have not accessed the Health and Life website, continue to step 2. If you have, go to step 5.
2. Create your account following the steps to input your information, create your username and password and security questions. Once registered, log in to your account.
3. Review the **Getting Started Details** to agree to the electronic disclosure agreement and select **Continue**.
4. 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**.
5. Select **Start Here** at the top of the screen to begin your 2025 Annual Enrollment elections.
6. Read the opening message and select **Start Enrollment**.
7. Review your personal information and update an alternate address, if applicable, click **Next**.
8. Confirm Medicare Eligibility for you and/or any dependent(s).
9. Review dependents on file and confirm demographic details are accurate, click **Looks Good.**
10. Review Medicare information, if applicable, for start coverage dates and your Medicare number. Answer Race and Ethnicity questions.
11. You have two options when enrolling. Option 1 will provide step-by-step instructions. If you select this option, continue to step 12. Option 2 will allow you to view the same benefits. This option will take you to the Benefit Summary page for your review. If you select this option, continue to step 14.
12. Elect all health care (medical, dental) plans.
13. Review Life Insurance plans and review/update beneficiary information ensuring you have added not only the required fields but all the fields to make certain a claim is accurately and timely processed.
14. Review your elections, including plans, coverage levels and pricing in their entirety on the **Benefit Summary** page and select **Approve** to authorize your transaction.

15. Read the Confirmation pop up and select **I Agree**.
16. If you added a new dependent, you will see information regarding the dependent verification process. Read through the requirements carefully. This is time sensitive.
17. On the Transaction Complete page, click **Benefit Summary PDF** to upload to your computer or print your Benefit Summary. Take note of the Confirmation Number for your records and keep the Benefit Summary as your confirmation statement as you will not be sent another statement.

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.

Also, consider using **Sofia**, your personal benefits assistant available on the Health and Life website when you log in.

More to know about Medicare

If you and/or your dependent(s) are eligible for Medicare, please review the following information carefully.

Medicare Part A – Hospital Insurance

- This covers in-patient care in a hospital, skilled nursing facility care, nursing home care (inpatient care in a skilled nursing facility that's not custodial or long-term care), certain home health services and hospice care.
- Generally, it is available at no cost to eligible participants and is paid for by a portion of Social Security taxes. You are automatically enrolled when you and or your dependent(s) turn age 65.

Medicare Part B – Medical Insurance

Part B covers two types of services: Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice. Part B also covers preventive services to prevent illness or detect it at an early stage when treatment is most likely to work best.

Part B covers:

- Clinical research, ambulance services, durable medical equipment, Mental health (inpatient, outpatient, and partial hospitalization) and limited outpatient prescription drugs.

Note: There is a cost for Medicare Part B since the health plan requires coordination with Medicare Part B. If you don't enroll in Medicare Part B, your benefits, if any, will be reduced, and you will be responsible for paying your health care expenses.

A delay in enrollment in Medicare Part B could also result in ongoing penalties for the cost of Medicare Part B.

Medicare Part D – Prescription Drug Coverage

This covers the cost of certain prescription drugs. Details are available in the Notice of Creditable Coverage that is mailed each fall. You can refer to the Medical and Prescription Drug overview in this guide for more information.

Important note:

- If you enroll in the Guaranteed Coverage Plan or UnitedHealthcare Group Medicare Advantage PPO Plan, you do not need to enroll in a separate Medicare Part D plan because prescription drug coverage is included in those benefit options, as defined by the Plan.
- If you elect the Lumen Retiree HRA Plan option, you may need to enroll in a Medicare Part D plan, depending on which type of individual medical policy you elect on your own.

For more information about Medicare benefits, review the Medicare & You handbook at medicare.gov or call 800-MEDICARE (800-633-4227) and ask to have a copy mailed to you.

Medical overview for Medicare eligible participants

Enrollment in Medicare Parts A and B are required. If you and your dependent(s) are Medicare eligible, you must enroll in the same benefit plan option.

The Medical Plan (shown as the Retiree Medical Plan 1, 2, 3 or 4 on the Health and Life website).

- The Medical Plan pays a substantial share of the costs of the hospital, surgical and medical care you and your dependent(s) receive each year.

Health Reimbursement Account (HRA) plan option combined Individual Medicare Policy - shown as the Lumen Medicare LQ Pre-91 - ERO'92 HRA

- If you elect to participate in this Plan option, you are waiving coverage under the Guaranteed Coverage Commitment Plan as well as the UHC Medicare Advantage PPO benefit option.
- The HRA provides you with Company-funded dollars to help you purchase an individual Medicare policy.
- The HRA is funded annually by the Company, on Jan. 1 of each year in the amount of $3,800. Unused dollars are forfeited at the end of each year.
- The HRA is a Plan option under the Company group retiree plan. You must purchase an individual Medicare and/or prescription drug policy directly from the insurance carrier(s) of your choice, pay the insurance premium directly to them, and then receive reimbursement for the premium from your HRA. For additional information, review the Navigation Guide located in the **Reference Center** in the HRA folder.
- In order for your individual Medicare medical policy to be effective Jan. 1, you must enroll with Medicare during their Open Enrollment window, between Oct. 15 and Dec. 7. For assistance, you can call Via Benefits at 888-825-4252. Please do not contact the Service Center to enroll in an individual Medicare policy as they will be unable to assist you. Starting Nov. 6, you will need to contact the Service Center letting them know you want to enroll in the Lumen Retiree HRA Plan option.
- If you are already enrolled in this option, you can submit 2025 recurring claims for reimbursement starting in Dec. If you submit prior to this date, the claim will be automatically denied and will not be reprocessed.
- Expenses or services incurred in 2025 must be submitted to the Service Center by March 31, 2026. Claims must be postmarked, uploaded or faxed by 11:59 p.m. (CST). Claims received after this date and time will be denied. Make sure to keep a copy of your submission if faxing or mailing via a fax transaction receipt or through the USPS.

Note: If you and your Medicare eligible dependent(s) select the Lumen Medicare LQ Pre-91 - ERO'92 HRA plan option and you later want to change options or return to the coverage you had under the Medical Plan (Guaranteed Coverage Plan), you will be required to wait until the next Annual Enrollment period due to Centers for Medicare or Medicaid Services (CMS) rules.

UnitedHealthcare Group Medicare Advantage Preferred Provider Option (MA PPO) - shown as the UnitedHealthcare Group Medicare Advantage PPO on the Health and Life website

- You can see any provider (in or out-of-network) that participates in Medicare and accepts the plan, at the same cost.
- 100% coverage for preventive services.
- Care and disease management programs (e.g., diabetes, heart failure, and more).
- UHC House Calls are designed to complement your doctor's care. A licensed and knowledgeable health care practitioner will review your health history and current medications, perform a health screening, identify risks and provide health education in the comfort of your home.
- **Personal Emergency Response System (PERS) –** PERS is a wearable monitoring device at no cost to you that provides access to emergency assistance to give your family peace of mind, should you experience a fall.
- **Telephonic Support** (Previously referred to as NurseLine) **–** Registered nurses answer your call 24 hours a day, seven days a week.
- **Renew Active –** Free gym memberships, brain games, cooking classes, etc.
- **Healthy at Home –** Meals, transportation and in-home personal care at no charge for up to 30 days following an inpatient facility visit.

To enroll in this plan, you will need you or your dependent's Medicare information. This can be found on your red, white, and blue Medicare ID card. Contact UnitedHealthcare for additional information regarding these benefits, services, and offerings at 877-886-7313. You must call the Service Center to enroll in this plan.

Note: If you and your dependent(s) are enrolling in this plan and one or both applications are denied by Medicare, you will both return to the coverage you had under the Company Medical Plan, the Medical Plan (Guaranteed Coverage Plan).

Medical Plan overviews

For the UnitedHealthcare Group Medicare Advantage PPO and the Guaranteed Coverage Plans, Retiree Medical Plans 1-4

Note: Non-Medicare-eligible retirees and non-Medicare eligible dependents can only enroll in the applicable Guaranteed Coverage Plan Option Retiree Medical Plans 1-4. *The UnitedHealthcare Group Medicare Advantage PPO is available to Medicare eligible participants only.

Note: Dependent(s) can enroll in healthcare coverage if the retiree is enrolled. If the retiree suspends or waives healthcare coverage, the dependent(s) cannot enroll. For example, if retiree elects medical but suspends dental, dependent(s) can enroll in medical only.

<table>
<tr><th></th><th>UnitedHealthcare Group Medicare Advantage PPO*</th><th colspan="3">Guaranteed Coverage Plan Options</th></tr>
<tr><th></th><th>Your in- and out-of-network costs</th><th>Retiree Medical Plans 1 & 2</th><th>Retiree Medical Plan 3</th><th>Retiree Medical Plan 4</th></tr>
<tr><td>Annual Out-of-Pocket Maximum (Medical Only)</td><td>$150</td><td>$1,000</td><td>$1,000</td><td>$250</td></tr>
<tr><td>Deductible</td><td>$0</td><td>1% of Pension ($150 max)</td><td>1% of Pension ($150 max)</td><td>$100</td></tr>
<tr><td>Coordination of Benefits with Medicare</td><td>UnitedHealthcare (UHC) handles on your behalf</td><td>Claims must be submitted to Medicare Part A or B first, then to UHC for coordination with Plan 1 & Plan 2</td><td>Claims must be submitted to Medicare Part A or B first, then to UHC for coordination with Plan 3</td><td>Claims must be submitted to Medicare Part A or B first, then to UHC for coordination with Plan 4</td></tr>
<tr><th colspan="5">Medical Benefits</th></tr>
<tr><td>Primary Care Physician Office Visit</td><td>$0</td><td>20% after deductible</td><td>20% after deductible</td><td rowspan="6">10% after deductible</td></tr>
<tr><td>Specialist Physician</td><td>$10</td><td>20% after deductible</td><td>20% after deductible</td></tr>
<tr><td>Preventive services</td><td>$0</td><td>Not covered</td><td>20% after deductible</td></tr>
<tr><td>Emergency</td><td>$50</td><td>$0</td><td>$25</td></tr>
<tr><td>Hospital Copay Per Admit</td><td>$0</td><td>$0</td><td>$0</td></tr>
<tr><td>Outpatient services</td><td>$0</td><td>$0</td><td>$0</td></tr>
<tr><th colspan="5">Additional benefits and programs not covered by Medicare</th></tr>
<tr><td>Hearing aids</td><td>$500 allowance (every 3 years, In-Network Providers only)</td><td>Not covered</td><td colspan="2">Not covered (exception if resulting from an accidental injury or surgery)</td></tr>
<tr><td>Telephonic Support</td><td>Speak with a registered nurse (RN) 24 hours a day, seven days a week</td><td>Not available</td><td>Not available</td><td>Not available</td></tr>
<tr><td>Vision Services: Eye exam</td><td>$0</td><td>Not covered</td><td>Not covered</td><td>Not covered</td></tr>
</table>

<table>
<tr><th></th><th>UnitedHealthcare Group Medicare Advantage PPO*</th><th colspan="3">Guaranteed Coverage Plan Options</th></tr>
<tr><th></th><th>Your in- and out-of-network costs</th><th>Retiree Medical Plans 1 & 2</th><th>Retiree Medical Plan 3</th><th>Retiree Medical Plan 4</th></tr>
<tr><td colspan="5">Additional benefits and programs not covered by Medicare</td></tr>
<tr><td>Routine eyeglass or contact lenses Allowance (every 12 months)</td><td>$130 for eyeglasses OR $175 for Contact Lenses</td><td>Not covered</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td>Fitness Program</td><td>Stay active with a basic membership at a participating location at no cost to you</td><td>Not covered</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td colspan="5">Prescription drug benefits retail (30-day supply)</td></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$4 copay</td><td colspan="2" rowspan="5">20% after deductible
Prescription must be submitted to the medical plan for reimbursement</td><td rowspan="5">Covered under the Medical Plan:
• Brand name: 90% of eligible expenses after satisfying deductible.
• Generic: 100% of eligible expenses after satisfying deductible.</td></tr>
<tr><td>Tier 2 (Preferred Brand and non-Preferred Generic)</td><td>$15 copay</td></tr>
<tr><td>Tier 3 (non-Preferred Brand)</td><td>$40 copay</td></tr>
<tr><td>Tier 4 (Specialty)</td><td>$40 copay</td></tr>
<tr><td>Coverage Gap</td><td>Full coverage</td></tr>
<tr><td colspan="5">Prescription drug benefits retail (90-day supply)</td></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td><td rowspan="5">$3 copay</td><td rowspan="5">$0 copay</td><td rowspan="5">$2 copay</td></tr>
<tr><td>Tier 2 (Preferred Brand and non-Preferred Generic)</td><td>$0 copay</td></tr>
<tr><td>Tier 3 (non-Preferred Brand)</td><td>$0 copay</td></tr>
<tr><td>Tier 4 (Specialty)</td><td>$0 copay</td></tr>
<tr><td>Coverage Gap</td><td>$0 copay</td></tr>
</table>

Reminder: Prior to becoming Medicare eligible, you must timely enroll in Medicare Part B. Contact your local Centers for Medicare and Medicaid Services (CMS) office for more information or go online to medicare.gov.

If you are enrolled in one of the Guaranteed Coverage Plans, (Plans 1-4, as applicable), Medicare becomes your primary coverage and the Guaranteed Coverage Plan becomes secondary. Your benefits will be reduced if you do not enroll timely in Medicare Part B coverage.

Dental Plan overview

The dental option you are enrolled in is indicated on your Pre **Annual Enrollment Notice**.

Note: Dependent(s) can enroll in dental coverage if the retiree is enrolled. If the retiree suspends or waives dental coverage, the dependent(s) cannot enroll. For example, if retiree elects dental but suspends medical, dependent(s) can enroll in dental only.

It pays to use network dentists

You may receive services from any provider under your Plan benefit option, but your out-of-pocket costs may be less if you receive care from MetLife network providers (in the Preferred Dentist Program).

If you receive services from a an out-of-network provider, your out-of-pocket costs may be more and you may need to complete and submit claim forms for reimbursement.

Here's a brief look at how the Dental Plan option pays benefits

Preventive and Diagnostic Care Services (cleanings, oral exams, x-rays)

The Plan pays 100% up to reasonable and customary (R&C) rates, but no more than what the dentist charges. If costs exceed R&C rates, you will be responsible for paying the excess charges.

All other Services

You pay according to a schedule of allowances. Review the schedule of allowances in the applicable Summary Plan Description (SPD) available on the Health and Life website or by requesting a copy from the Service Center to determine the out-of-pocket expenses you must pay.

To make updates, you will need to log in to the Health and Life website or contact the Service Center. If you are already enrolled and would like to continue your coverage into the new year, no action is required to continue the dental plan option.

For questions or benefit information, visit the MetLife website at metlife.com/mybenefits or call 866-832-5756. Call MetLife for details about covered services.

Life Insurance

The Life Insurance plans are Term Life Insurance coverage which pays the claim when you pass away.

The claim is paid to your designated beneficiary or beneficiaries on file at the Service Center.

To help take the pressure off of having beneficiaries make immediate financial decisions after your loss, MetLife will set up a Total Control Account (TCA), a flexible settlement option that allows beneficiaries full access to the life insurance proceeds to use now or in the future. TCA provides competitive interest rates.

A beneficiary can instead receive a one-time, lump sum check if required by state law, regulation, or at the beneficiary's request. **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 should always be discussed between you, your beneficiaries and your financial or tax advisors.

Retiree Basic Life Insurance (Company-paid)

For eligible retirees, the Company provides Retiree Basic Life Insurance coverage that pays a $10,000 benefit to your designated beneficiary(ies) when you pass away.

Retiree Supplemental Life Insurance (Retiree-paid)

For eligible retirees, the Company offers Retiree Supplemental Life Insurance calculated off of your base pay and the multiplier you were enrolled in (e.g., 1x, 2x, 3x), at the time you transitioned from active employee to retiree status. The Life coverage amount pays this benefit to your designated beneficiary or beneficiaries when you pass away.

How to cancel Retiree Supplemental Life Insurance

You may cancel the Retiree Supplemental Life Insurance at any time by going to the Health and Life website at lumen.com/healthbenefits or contacting the Service Center at 833-925-0487. The cancellation will be effective the first of the month following your request. You may not re-enroll, decrease or increase coverage after retirement.

Coverage ends on the last day of the month in which you turn age 65. You may convert your Retiree Supplemental Life coverage once you turn age 65, according to the laws of the state of Washington where the policy is issued. Conversion is not automatic, and you must apply for converted life insurance coverage through MetLife. You can reach MetLife at 877-275-6387 to request a conversion application if you experience a qualified loss in coverage. MetLife must receive your completed application and premium for conversion within 31 days from the date your retiree supplemental life insurance coverage terminates. Applications received by MetLife after the 31-day period will be denied.

Review and/or update your beneficiaries for your Life Insurance Plan(s) by going to lumen.com/healthbenefits or calling the Service Center at 833-925-0487. Refer to the Reminder section in this guide for more information.

Note: To report a death, contact WTW at 888-324-0689. It is very important to contact them as soon as possible as this can impact benefits under the Retiree and Inactive Health Plan, the Life Insurance Plan and/or the Combined Pension Plan. The Service Center can't process the death until WTW is notified.

Paying for your coverage

We make it easy to pay for your Retiree Supplemental Life Insurance

Premiums are due on the first day of each month for the prior month's benefit coverage. Account Statements are not mailed. Refer to the Reminders section of this guide under Direct Bill for more information. You can contact the Service Center for payment options such as:

- Check or money order, or
- Direct debit (automatic monthly withdrawal from your checking or savings account).

Note: Your premiums may change based on canceling coverage, reaching age 65 or passing away.

Important: If you currently have deductions taken from your pension check, that will not change and deductions will continue.

Additional services provided by MetLife

Will Preparation and Probate Services are provided at no additional cost to retirees who are enrolled in the Lumen Retiree Supplemental Life Insurance Plan through MetLife. Please call MetLife Legal Plans, Inc. at 800-821-6400.

Grief Counseling and Funeral Assistance Services, which are provided through LifeWorks US Inc. for you, your dependents and your beneficiaries at no extra cost. You do not need to be enrolled in the Lumen Retiree Supplemental Life Insurance Plan to receive the services. If you are interested in learning more about this service, please call 888-319-7819.

Be sure to make timely payments

If your premium payments are not received by the Service Center in a timely manner, your payment may still be processed after the due date. In this case, a refund will be processed for the untimely payment after 21 business days and your coverage will not be reinstated. You have the right to appeal and can contact the Service Center if you wish to discuss the appeals process. **Note:** Checks that are returned or direct debit requests that are refused due to insufficient funds are not re-deposited.

Regardless of how you pay your premiums, be sure that your full amount is received by the Service Center by the last day of the month for the prior month's coverage. If not, your coverage will be terminated retroactively to the last day of the prior month for which full payment was received.

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** on the Health and Life website lumen.com/healthbenefits. If you would like a paper copy of these materials, contact the Service Center at 833-925-0487. Please be advised that mailing time is based on the USPS schedule. Lumen and the Service Center are unable to overnight forms, documents, letters, etc. **Note:** You may not receive these documents prior to the Annual Enrollment deadline.

Administrator/Plan/Program	Website/Group Number	Phone Number
To report a death, contact the Pension Administrator, WTW, who will notify all Lumen Claims and Plan Administrators.	N/A	888-324-0689 Mon-Fri, 8 a.m. - 7 p.m. (CST)
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 on your own through the Claims Administrator or your Health Care provider.	lumen.com/healthbenefits	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		
The Medical Plan (Guaranteed Coverage Plan Options)/ Prescription Drug Plans	UnitedHealthcare: myuhc.com **Search:** UHC App, available for free in the App Store and Google Play	UnitedHealthcare: 800-842-1219 Do not enroll through this number. Enrollment is completed through the Service Center.
Group Medicare Advantage Preferred Provider Option (PPO) Plan	UnitedHealthcare: retiree.myuhc.com **Search:** UHC App, available for free in the App Store and Google Play	UnitedHealthcare: 800-842-1219 Do not enroll through this number. Enrollment is completed through the Service Center.
Health Reimbursement Account (HRA)	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 (Local DNIS for international callers) Mon-Fri, 7 a.m. – 7 p.m. (CST)
Dental		
Dental	metlife.com/mybenefits **Search:** Metlife, available for free in the App Store and Google Play	866-832-5756 Mon-Fri, 6 a.m. - 10 p.m. (CST)

Administrator/Plan/Program	Website/Group Number	Phone Number
	Life Insurance	
Life Insurance Plans	**Metropolitan Life Insurance Company** metlife.com/mybenefits	800-638-6420 Mon-Fri, 7 a.m. - 4 p.m. (CST)
LifeWorks US, Inc. Grief Counseling and Funeral Assistance Services		888-319-7819 Available 24 hours a day/7 days a week
MetLife Legal Plans, Inc. Will Preparation and Probate Services Available if enrolled in the Retiree Supplemental Life Insurance Plan		800-821-6400 Mon-Fri, 7 a.m. - 7 p.m. (CST)
	Voluntary Lifestyle Benefits	
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 (Local DNIS for international callers) Mon-Fri, 7 a.m. – 7 p.m. (CST)

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

Change of Address Updates

Administrator	Website/Email	Mail/Fax/Phone Number
Lumen Health and Life Service Center	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)
Lumen Pension Service Center	lumen.pension.ehr.com	**Mail to:** Lumen Pension Service Center DEPT: LUM P.O. Box 981909 El Paso, TX 79998 **Fax:** 844-286-1282 **Note:** Your written request must include your full name, last four digits of your Social Security number, complete old and new address, signature and date. If your pension is being paid by **Athene**, call 877-813-4240 to update your address. If your pension is being paid by **Brightspeed**, call 844-516-7870 to update your address.

Income Related Monthly Adjustment Amount reimbursement and/or Medicare Part B reimbursement notification

The Social Security Administration (SSA) makes initial determinations whether the income-related monthly adjustment amount (IRMAA) applies to Medicare beneficiaries with Part B, or Medicare prescription drug coverage (or both if enrolled in both at the time a determination is made) using IRS data.

IRMAA reimbursement (if enrolled in the Medicare Advantage PPO Plan):

The IRMAA is an amount you are required to pay in addition to your monthly premium if your modified adjusted gross income on your IRS tax return from two years ago is above a certain limit.

If you are a new Participant to the Medicare Advantage PPO Plan and are subject to IRMAA and are requesting reimbursement, refer to the Request for Reimbursement below for further information. You will not be eligible to receive reimbursement from the Company until you notify and provide the Service Center with a copy of the notification letter from the Social Security Administration.

If you are enrolled in the UHC Medicare Advantage PPO Plan and your IRMAA premium has changed, you will need to provide a copy of the notification letter from the Social Security Administration which lists the premium amount in order to receive the accurate reimbursement for the IRMAA premium in 2025.

Medicare Part B reimbursement:

The Centers for Medicare & Medicaid Services (CMS) requires high-income Medicare-eligible individuals who are enrolled in the Part B program to pay a monthly Part B premium that is higher than the 2025 standard Medicare premium. The premium for high-income individuals, as defined by CMS, will vary depending upon your modified adjusted gross income and income tax filing status. The income amounts will be indexed annually by CMS for inflation.

If you are receiving the standard Medicare Part B reimbursement, your monthly reimbursement will automatically update to the standard 2025 Medicare Part B premium, as determined by Medicare. If your Medicare Part B is different than the standard amount, you will need to provide a copy of the notification letter from the Social Security Administration which lists the adjusted Medicare Part B premium amount in order to receive the accurate reimbursement for your 2025 Medicare Part B reimbursement. You will not be eligible to receive reimbursement from the Company for the updated premium amount until you notify and provide the Service Center with a copy of the notification letter from the Social Security Administration.

The Social Security Administration will directly notify each high-income beneficiary regarding his/her obligation to pay a higher Medicare Part B premium. If you are one of these affected individuals, it will be your responsibility to notify the Service Center each Plan year, refer to the below for further information.

Request for reimbursement:

Mail or fax a copy of your Social Security Administration notification letter, which includes the updated 2025 Medicare Part B and/or IRMAA premium amount/s to:

Lumen Health and Life Service Center
P.O. Box 850552
Minneapolis, MN 55485-0552
Fax: 515-273-1545

If the notification letter is postmarked or faxed on or before March 31, 2025, your reimbursement amount will be effective retroactive to Jan. 1, 2025.

If the notification letter is postmarked or fax is sent after March 31, 2025, your reimbursement amount will be prospective only, meaning it would be effective the first of the month following receipt of the letter and retroactive reimbursement will not be approved.

Questions: Contact the Service Center at 833-925-0487, Mon-Fri, 7 a.m. to 7 p.m., (CST).

Legal and important required notices

A note about privacy

Keeping your personal information secure is of primary importance to the Company. 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 confidential your User ID and password 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 to add your personal email address as your contact preference on the Health and Life website at lumen.com/healthbenefits. Please be advised that using an email that is not secured may increase your risk of unauthorized disclosure.

Company's reserved rights

This document summarizes certain provisions of the Disability Plan, the Life Insurance Plan and the Retiree 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 events such as marriage, divorce, etc. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Qualifying events for spouses/domestic partners or dependent children include those events above, plus, the covered retiree becoming entitled to Medicare, divorce of the covered retiree, death of the covered retiree, 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. 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 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 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 Employee Only coverage in a benefit option and your Spouse/Domestic Partner loses coverage under his/her employer's plan and has special enrollment rights, both you and your Spouse/Domestic Partner may enroll in any of the benefit options available to you, provided you verify your Spouse's/Domestic Partner's eligibility for the Plan.

If you voluntarily elect to drop coverage

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

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 claim you or your dependent(s) may have made or will make under the Plans if applicable. You understand that you are liable and bear the full financial responsibility for the misappropriation of Plan funds through the filing of false documentation under any of the Plans; You certify that you or your dependent(s) are eligible to enroll in a benefit option, plan or program including voluntary or supplemental coverages. Please refer to the applicable Plan document or SPD on 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 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.

For specific employee benefit plan information, including terms and conditions for eligibility, limitations and benefits refer to the respective Plan documents, including the applicable SPD and SMM, 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 “Exempt” Retiree Medical Plan status

The Retiree and Inactive Health Plan, and all of its benefit options meet the requirements of a stand-alone exempt retiree medical benefit plan under Section 732 of ERISA and, therefore, is not required to comply with benefit mandates of the Patient Protection and Affordable Care Act (PPACA). However, the Company has decided to voluntarily apply certain provisions of the PPACA to these benefit options. This voluntary application of certain PPACA provisions is separate from and not part of the health care commitment to the Qwest Pre-1991 and Qwest ERO ’92 Retiree populations. This means that for all retirees, this voluntary compliance with PPACA may be changed or ended at any time and does not waive the Plan’s status as “exempt” from PPACA. If you choose to participate in the Medicare Advantage PPO or the Lumen Retiree HRA, the policy you elect is an individual policy.

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.

Premium Assistance under Medicaid and the Children’s Health Insurance Program (CHIP)

Note: This is an updated notice.

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 877-KIDS-NOW or insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at askebsa.dol.gov or call 866-444-EBSA(3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

Alabama – Medicaid
Website: myalhipp.com
Phone: 855-692-5447

Alaska – Medicaid
The AK Health Insurance Premium Payment Program
Website: myakhipp.com
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

Arizona - AHCCCS-KidsCare
Website: azahcccs.gov/Members/GetCovered/Categories/KidsCare.html
Phone: 800-654-8713

Arkansas – Medicaid
Website: myarhipp.com
Phone: 855-MyARHIPP (855-692-7447)

California - Medi-Cal
Website: dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal_EHB_Benefits.aspx
Phone: 800-541-5555

Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado
Website: healthfirstcolorado.com
Health First Colorado Member Contact Center: 800-221-3943/State Relay 711
CHP+: colorado.gov/pacific/hcpf/child-health-planplus
CHP+ Customer Service: 800-359-1991/State Relay 711

Connecticut - HUSKY Program
Website: portal.ct.gov/HUSKY
Phone: 855-626-6632

Delaware - Delaware Healthy Children Program
Website: dhss.delaware.gov/dss/dhcp.html
Phone: 800-372-2022

Florida – Medicaid
Website: myflfamilies.com
Phone: 877-357-3268

Georgia – Medicaid
Website: medicaid.georgia.gov/programs/all-medicaid-members
Click on Health Insurance Premium Payment (HIPP)
Phone: 678-564-1162, Press 1

Hawaii - Med Quest
Website: medquest.hawaii.gov
Phone: 855-643-1643

Idaho - Idaho CHIP
Website: healthandwelfare.idaho.gov/servicesprograms/medicaid-health/childrens-healthinsurance-program-chip
Phone: 800-926-2588

Illinois - Illinois All Kids
Website: www2.illinois.gov/hfs/MedicalPrograms/AllKids/Pages/about.aspx
Phone: 866-255-5437

Indiana – Medicaid
Healthy Indiana Plan for Low-Income Adults 19-64
Website: in.gov/fssa/hip
Phone: 877-438-4479
All other Medicaid
Website: indianamedicaid.com
Phone: 800-403-0864

Iowa – Medicaid
Website: dhs.iowa.gov/hawki
Phone: 800-257-8563

Kansas – Medicaid
Website: kancare.ks.gov/consumers/apply-for-kancare
Phone: 800-792-4884

Kentucky – Medicaid
Website: kynect.ky.gov
Phone: 800-635-2570

Louisiana – Medicaid
Website: dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 888-342-6207

Maine – Medicaid
Website: maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 800-442-6003
TTY: Maine relay 711

Maryland - Maryland Children's Health Program (MCHIP)
Website: health.maryland.gov/mmcp/chp/pages/home.aspx
Phone: 855-642-8572

Massachussetts – Medicaid and MassHealth
Website: mass.gov/orgs/masshealth
Phone: 800-862-4840

Michigan - Michigan MIChild
Website: michigan.gov/mdhhs/0,5885,7-339-71547_2943_4845_4931---,00.html
Phone: 888-988-6300

Minnesota – Medicaid
Website: mn.gov/dhs
Phone: 800-657-3739

Mississippi - Mississippi Children's Health Insurance Program (CHIP)
Website: medicaid.ms.gov
Phone: 800-421-2408

Missouri – Medicaid
Website: dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

Montana – Medicaid
Website: dphhs.mt.gov/montanahealthcareprograms/HIPP
Phone: 800-694-3084

Nebraka – Medicaid
Website: ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

Nevada – Medicaid
Website: dhcfp.nv.gov
Phone: 800-992-0900

New Hampshire – Medicaid
Website: dhhs.nh.gov/programs-services/medicaid
Phone: 603-271-5218
Toll-free number for HIPP: 800-852-3345 ext. 5218

New Jersey – Medicaid and CHIP
Medicaid Website: state.nj.us/humanservices/dmahs/clients/medicaid/
CHIP Website: njfamilycare.org
Medicaid Phone: 609-631-2392
CHIP Phone: 800-701-0710

New Mexico – Medicaid
Website: insurekidsnow.gov/coverage/nm/index.html
Phone: 877-543-7669

New York - Medicaid
Website: health.ny.gov/health_care/medicaid/
Phone: 800-541-2831

North Carolina – Medicaid
Website: dma.ncdhhs.gov
Phone: 919-855-4100

North Dakota – Medicaid
Website: hhs.nd.gov/healthcare/medicaid
Phone: 844-854-4825

Ohio Medicaid - Healthy Start
Website: benefits.gov/benefit/1610
Phone: 800-324-8680

Oklahoma – Medicaid and CHIP
Website: insureoklahoma.org
Phone: 888-365-3742

Oregon – Medicaid
Website: oregon.gov/oha/hsd/medicaid-policy/pages/state-plans.aspx
Phone: 800-699-9075

Pennsylvania – Medicaid
Website: dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx
Phone: 800-692-7462

Rhode Island – Medicaid
Website: eohhs.ri.gov
Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)

South Carolina – Medicaid
Website: scdhhs.gov
Phone: 605-773-4678

South Dakota – Medicaid
Website: dss.sd.gov
Phone: 888-828-0059

Tennessee TennCare – CoverKids
Website: tn.gov/coverkids.html
Phone: 855-259-0701

Texas – Medicaid
Website: hhs.texas.gov/services/health/medicaid-chip
Phone: 800-440-0493

Utah – Medicaid and CHIP
Medicaid Website: medicaid.utah.gov
CHIP Website: health.utah.gov/chip
Phone: 877-543-7669

Vermont – Medicaid
Website: greenmountaincare.org
Phone: 800-250-8427

Virginia – Medicaid and CHIP
Website: coverva.org
Medicaid Phone: 800-432-5924
CHIP Phone: 855-242-8282

Washington – Medicaid
Website: hca.wa.gov
Phone: 800-562-3022 ext. 15473

Washington D,C. - DC Medicaid - Healthy Families
Website: dhcf.dc.gov/service/dc-healthy-families
Phone: 202-442-5988

West Virginia – Medicaid
Website: mywvhipp.com
Phone: 855-MyWVHIPP (699-8447)

Wisconsin – Medicaid and CHIP
Website: dhs.wisconsin.gov
Phone: 800-362-3002

Wyoming – Medicaid
Website: health.wyo.gov/healthcarefin/medicaid/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565

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 and with respect to the Health Plan, the written agreement specific to Pre-1991 Retirees. 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) on the Health and Life website regarding any applicable restrictions. Contact the Claims Administrator of your medical benefit option for more information.