CenturyLink Health & Life Benefits Guide

For Represented New Hires, Rehires, Transfers and Employees Now Eligible for Benefits Who are Covered by Qwest/CWA or Qwest/IBEW Local 206 Agreements
This document summarizes certain provisions of CenturyLink’s Medical Plan, CenturyLink’s Disability Plan, and the CenturyLink Group Life Insurance Plan (collectively referred to as the “Plan”). For specific employee benefit plan information, refer to the respective official Plan Documents, including the applicable Summary Plan Description and Summaries of Material Modifications, if any. If there is any conflict between the terms of the official Plan Documents and this document, the terms of the official Plan Documents will govern.

The Plan Administrator has the authority, discretion and the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan, to supply omissions and resolve conflicts. Benefits, premiums and contribution obligations, if any, are determined by CenturyLink in its sole discretion. While the Plan has processes in place to prevent errors, if a clerical error happens (however occurring) such error does not create a right to a Benefit or level of contribution rate under the Plan.

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. CenturyLink reserves the right to amend or terminate any or all of the Plans and any or all Benefits provided and to change costs—with respect to all classes of Participants, retired or otherwise—and their beneficiaries, without prior notice to or consultation with any Participants and beneficiaries, subject to applicable law, collective bargaining and the terms of the respective official Plan documents.

Plan coverage is not healthcare advice. Please keep in mind that the sole purpose of the Plan is to provide payment for certain eligible healthcare expenses—not to guide or direct the course of treatment for any employee, retiree or eligible dependent. If your healthcare 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 healthcare provider can decide what the right healthcare 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 healthcare recommendations or advice.
Dear CenturyLink Employee:

We are pleased to offer you and your eligible dependents, a balanced, competitive program of valuable benefits that provide choices in healthcare, protection against the unexpected, as well as financial planning for your future. In addition, we offer a full range of voluntary programs and services that round out your total compensation package with the Company.

This guide highlights your CenturyLink benefits, provides easy-to-follow instructions for enrolling and gives you other helpful information. Please take some time to read and familiarize yourself with the entire program so you can make informed decisions about the benefits you elect.

Welcome to Annual Enrollment for 2012
Who’s Eligible to Participate in the Plan?

You and your dependents may be eligible for coverage under the CenturyLink Medical Plan and the CenturyLink Group Life Insurance Plan (the “Plan”). Eligibility is determined by the Plan. Refer to the applicable bargaining agreement or contract for further information related to eligibility under the Plan.

Eligible dependents generally include your:

- Spouse — person to whom you are legally married;
- Same-sex domestic partner — provided you certify (by completing a Domestic Partner Certification form) that you and your partner are: each other’s sole domestic partner and intend to remain so indefinitely; are not related by blood; are not legally married to any other person; are at least 18 years of age; and are mentally competent to consent to the domestic partnership; and are financially interdependent prior to applying for coverage and intend to reside together indefinitely;
- Disabled dependent — An unmarried child who is determined by the Health Plan (Claims Administrator) to be incapable of self-support and fully dependent on the participant for support.
- Your children, up to the end of the month in which they attain age 26. children include:
  - Your natural children
  - Your legally adopted children including children who are legally placed for adoption. In the case of a pending adoption, the effective date is the placement date in the home.
  - Stepchildren
  - Foster children
  - Children of your domestic partner (natural, legally adopted or placed for adoption or foster children).
— Children for whom you are the legal guardian, such as grandchildren, nieces or nephews

— Unmarried children who turn age 26 while covered under the Plan and continue to depend on you for support because of a physical handicap that occurred prior to the age of 26, or who are incapable of self-support due to mental disability, mental illness or developmental disability — where the condition occurred prior to the age of 26; subject to administrative approval by the Claims Administrator. Contact the CenturyLink Service Center within 45 days prior to your child’s 26th birthday for details and forms.

— Children under a Qualified Medical Child Support Order (QMCSO)—coverage will be provided to any of your dependent child(ren) if a QMCSO is issued, regardless of whether the child(ren) currently resides with you. A QMCSO may be issued by a court of law or issued by a state agency as a National Medical Support Notice (NMSN), which is treated as a QMCSO. If a QMCSO is issued, the child or children shall become an alternate recipient who is treated as covered under the Plan and subject to the limitations, restrictions, provisions and procedures, same as all other Plan participants. A dependent child covered by the Plan under a QMCSO cannot be removed from coverage unless there is written authorization of release from the issuing authority, authorized court of law or authorized state agency.

If a dependent covered under a QMCSO is removed during any Annual Enrollment period, the Plan will reinstate the dependent and you will be responsible for any applicable premiums.

If you have currently waived coverage under the Plans, and the QMCSO requires your dependent child(ren) to be covered, you will be automatically set up with default coverage (PPO Medical and Dental) based on what the QMCSO requires. You will have healthcare deductions at the employee + 1 or family coverage level.

**Note:** A new spouse or domestic partner can only be covered if you timely complete the dependent verification process. You will be required to submit an affidavit and other verification documents to enroll in coverage for your dependent.
General Information

The following Class II dependents (eligible for medical coverage under the Health Plan only) if they depend upon you for a majority of their support:

- Any of your unmarried children who do not qualify as Class I dependents
- Unmarried grandchildren
- Parents, grandparents, brothers or sisters
- Your spouse’s parents or grandparents

Additionally, to be eligible, Class II dependents must live in your home, or in a household provided by you in the vicinity of your home, for at least six months during the 12 consecutive months preceding the effective date of coverage (excluding Class II newborns if enrolled within 45 days of birth) and must continue to reside with you or in a household provided by you and receive income and other financial support at an annual rate specified by the Plan Administrator from all sources other than the participant and spouse.

Class II dependents can be covered only for medical benefits under the Health Plan, but not for any other benefits under the Health Plan, including vision and dental benefits, Healthcare Flexible Spending Account (Healthcare FSA) and Dependent Daycare FSA. You must pay for the full cost of coverage for a Class II dependent. Verify the cost of coverage before adding a Class II dependent.

Coverage Categories

You may choose among the following coverage categories for each of the healthcare benefit options (medical/prescription drug, dental and vision):

- Employee
- Employee +1
- Family
General Information

Who You Cannot Cover
The following is not an exhaustive list of several of the more common person(s) whom you cannot cover under your CenturyLink benefits program (and the list is subject to change):

- Common law spouses, unless recognized by the employee’s state of residence; documentation will be required for approval;
- Ex-spouses, regardless of Divorce Decree or Court Orders;
- Any other person who does not qualify as an eligible dependent as defined in this section of the Guide.

Adding Dependents
You and your dependents may be eligible for coverage under the CenturyLink Medical and Group Life Insurance Plans (collectively referred to as the “Plan”).

To cover a new dependent under the Plan, you must verify that he or she is eligible.
How Do I Verify My Eligible Dependent(s)?

If you add a dependent to the Plan as a new hire or following a Qualified Life Event (QLE), you are required to verify that your dependents are eligible for coverage according to the requirements stated in the Plan. This step ensures that CenturyLink spends healthcare and life insurance benefit dollars wisely and can continue to provide benefits to eligible participants and eligible dependents in the future.

**Coverage for dependents will become effective prior to completion of the verification process.** However, for each newly added dependent you would like to cover, you must provide proof of relationship, (i.e., spouse, child and stepchild) and financial interdependency (i.e., spouse/common-law spouse and domestic partner).

You must enroll your eligible dependents within 45 days following a Qualified Life Event (QLE). The effective date will be the event date and not the date you submit or notify of your request. In addition, if your coverage level changes because of a QLE, you will have a retroactive deduction on your paycheck once it is processed.

Once you enroll your newly added dependent(s), you will receive a verification kit. You will need to complete a Dependent Verification Form for each new dependent. If your completed verification documentation is not timely received by the Service Center, your dependent(s) will lose coverage retroactive to the date they were added and you will be responsible for any claims that were incurred during the ineligible period. Applicable premium adjustments will be processed after the verification process is completed. There could be a slight delay in receiving your retro credit due to payroll process.

To view the eligibility documentation required, go to the CenturyLink Health and Life Benefits website at [www.centurylinkhealthandlife.com](http://www.centurylinkhealthandlife.com). Click on the Knowledge Center tab, then on Plan Information. Scroll down to Dependent Verification Documents Required. You can also sign on through single sign on through the intranet on HRLink.

**Changing Coverage During the Year**

After you enroll as a new hire, if you have a change in your family status that allows for a change in your benefits, you have 45 days from the date of the event to make changes to your benefits.
Qualified Life Events (QLE) Include:

- Marriage;
- Divorce;
- Birth or adoption of a child;
- Loss of other coverage due to termination of your spouse’s/domestic partner’s employment;
- Significant cost curtailment or change in health coverage attributable to your spouse’s or domestic partner’s employment;
- Loss of Medicare, Medicaid or CHIP coverage;
- Entitlement to Medicare, Medicaid or CHIP coverage;
- Your dependent no longer qualifies as an eligible dependent due to exceeding the age of eligibility;
- You or your spouse/domestic partner gaining/losing eligibility for coverage;
- Death of a spouse/domestic partner or child.

If your dependents are no longer eligible for coverage, it is your responsibility to notify the Plan within 60 days of the QLE. Otherwise they will not be eligible for continuation of coverage under COBRA. Your dependents will be terminated retroactively to the termination effective date and you will be responsible for repaying claims paid for services received while they were ineligible for coverage under the Plan.

For more information on COBRA, refer to page 48.
General Information

PLEASE NOTE: In selecting your coverage and advising of your eligibility and the eligibility of your dependents, if applicable, you are held to the standard of honesty and truthfulness. Falsifying or omitting information in enrolling for coverage under the Plan will be subject 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 CenturyLink Service Center.

Choosing a Medical Plan
The CenturyLink Health and Life Benefits website, www.centurylinkhealthandlife.com, provides healthcare cost and estimating tools to help you make informed decisions about choosing and using the benefits that are best for you and your eligible dependents, if applicable.

- Estimate and compare what you might pay out-of-pocket for medical services.
- Compare the costs of deductibles, copayments, coinsurance, and other details of the benefit plan options you are eligible for.
- If you want to see if your doctor is in the benefit plan option you’re considering or looking for a new provider, you’ll find help here.
- Estimate your contribution needs for either the Healthcare or Dependent Daycare FSA with this helpful tool.

Claims and Appeals
Claims and appeals relating to enrollment in a benefit plan option or change in benefit plan options must be submitted in writing using a Claim Initiation Form, which can be requested through the CenturyLink Service Center.

In most cases, claims and appeals are reviewed within 30 days of receipt. Additional time may be requested to review appeals. If additional time is required, you will be notified. Call the CenturyLink Service Center at 1 800-729-7526 for further assistance or ask additional questions regarding the claims and appeals process.

Decisions Concerning the Plan
Claims and appeals are reviewed and decisions are made based on benefit plan provisions. The Claims Administrators, the Benefits Appeals Committee 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 interpretation of the Plan document and determination of eligibility for benefits.
Medical (Including Prescription Drug)

You may have free access to a registered nurse 24 hours a day, 7 days a week through your medical plan administrator. In non-emergency situations, call your carrier to get help identifying symptoms and choosing appropriate care.

If you use specialty drugs, you need to purchase them through a designated pharmacy or you may pay the full cost of the medications. These medications are used to treat complex, chronic and expensive conditions such as anemia, hepatitis C and more. To locate a participating specialty pharmacy, call 1 866-429-8177.

CenturyLink offers medical and prescription drug coverage that can help you stay well – through preventive care benefits, such as annual physicals – and get treatment when you’re ill or injured. You and CenturyLink share the cost of this coverage.

You may have more than one medical benefit option available to you, so review your available options online to see which medical benefit options are available and what your default coverage will be if you don’t actively enroll. It may be “no coverage” if you do not make elections. For more information, see the plan comparison charts on the CenturyLink Health and Life Benefits website at www.centurylinkhealthandlife.com or review the Summary Plan Description. See page 40 for more information on the tools available to you during enrollment. If you elect to waive medical coverage you are automatically electing to waive prescription drug coverage.

For all CenturyLink employees, the Company uses three different administrators to administer our medical plans. Regardless of where you live, UnitedHealthcare administers retail and home-delivery pharmacy services for the PPO and HDHP medical benefit options. Medical plan administrators are as follows:

<table>
<thead>
<tr>
<th>For This Option...</th>
<th>The Plan Administrator Is...</th>
<th>If You Live In...</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPO</td>
<td>Medica</td>
<td>Western Wisconsin and Minnesota</td>
</tr>
<tr>
<td>PPO</td>
<td>UnitedHealthcare</td>
<td>All Other States</td>
</tr>
<tr>
<td>HDHP</td>
<td>Medica</td>
<td>North Dakota, South Dakota, western Wisconsin and Minnesota</td>
</tr>
<tr>
<td>HDHP</td>
<td>UnitedHealthcare</td>
<td>All other states</td>
</tr>
</tbody>
</table>

Health Maintenance Organizations (HMOs) are available in some areas. See page 21 for details and review your Enrollment Worksheet for eligibility options.

This information is intended only as a highlight of the health plan benefit options. In the event of a conflict, the terms of the official Plan Documents will govern. Please note there may be other Plan benefits not shown in this overview or which may have been changed. If you have questions regarding whether other benefits and coverage may be available, please consult the Summary Plan Description and Summaries of Material Modifications (SMMs), or call the claim administrator of the benefit option directly.
Coordinating Medical Claims

The CenturyLink medical benefit plan options coordinate benefits with other group health plans (including Medicare for retirees) to cover you and your enrolled dependents. That means your CenturyLink medical coverage and other group health benefit options work together to pay covered expenses. Medical coverage, however, is non-duplicative. So, if you have coverage under more than one group health plan in addition to your CenturyLink Plan, the CenturyLink Plan, together with payments from other group health plans, will never pay more than what you would have received if your CenturyLink coverage was your only health plan. Contact your Medical Claims Administrator to ensure you have the proper information to process claims based on coordination of benefits.

If the CenturyLink Plan is primary (the first to pay), benefits will be paid as if no other group health plan exists.

If the CenturyLink Plan is secondary (the second to pay), benefits will be reduced by the benefits paid by the primary plan. Benefits from your CenturyLink Plan will be paid to the extent that, when benefits from both plans are added together, the total is not more than what the CenturyLink Plan would have paid if you had no other coverage from another group health plan.

Note: Each year, your medical benefit plan option administrator may require you to complete a Coordination of Benefits (COB) questionnaire, either online or by paper. Please be sure to fill out this form when requested to avoid any delay in your claims being paid.
Example of Coordinating Benefits

Assuming the annual deductible has been met and the CenturyLink medical plan pays 80 percent when using a network provider, here’s how benefits would be calculated if CenturyLink were coordinating benefits with another group plan. In this example, “The Plan” refers to CenturyLink.

Step 1: Calculate primary payment

Provider charge.................................$1,000
The Plan would have paid......................\times 80% 
..............................................................$800

Step 2: If other insurance paid less

The Plan would have paid.........................$800
Other insurance paid..............................$600
The Plan would pay the difference............$200

Step 2: If other insurance paid more

The Plan would have paid.........................$800
Other insurance paid..............................$900
The Plan would pay...............................$0

Step 2: If other insurance paid the same

The Plan would have paid.........................$800
Other insurance paid..............................$800
The Plan would pay...............................$0
Medical (Including Prescription Drug)

High Deductible Health Plan (HDHP)
The HDHP is a managed care plan administered by UnitedHealthcare (UHC) and Medica. Although you have the freedom to see any provider you choose, the Plan pays greater benefits when you use providers in the UHC Choice Plus and Medica Choice networks. Prescription drug coverage is administered by UnitedHealthcare. Please see the chart on page 20 for UHC and Medica contact information.

If you choose this medical benefit option, you will make lower paycheck contributions than if you choose another benefit option. However, the trade-off is that you could potentially have higher out-of-pocket costs when using services under the Plan (specifically, a higher deductible and out-of-pocket maximum).

Here’s how the HDHP works:
- When you use in-network providers, eligible preventive care services will be paid at 100 percent by the Plan. Check with UnitedHealthcare for a list of covered preventive care services.
- As you and your eligible dependents receive healthcare services, you will pay the full cost for those services out-of-pocket until you satisfy your annual deductible.
- If you satisfy the deductible, you pay a percentage of your eligible expenses and the Plan pays the rest (called coinsurance). If you use in-network pharmacies and providers, you pay 20 percent of the costs and the Plan pays the remaining 80 percent. If you use out-of-network services, the Plan pays 50 percent of eligible expenses as determined by UnitedHealthcare. You are responsible for charges in excess of eligible expenses.
- The HDHP option has an associated annual out-of-pocket maximum and, if you reach this maximum amount, the Plan pays 100 percent of additional eligible expenses for the rest of the year.

When you enroll in the HDHP, you can be reimbursed for your out-of-pocket expenses through a Health Savings Account (HSA). Since this is not a CenturyLink-sponsored benefit, you can open the HSA through many sources, including UnitedHealthcare online at www.optumhealthbank.com or a financial institution.
When you receive healthcare services, you can use your HSA to pay for out-of-pocket healthcare costs that aren’t covered by the CenturyLink Medical Plan. Withdrawals are tax-free as long as the funds are used to pay for eligible healthcare services and expenses. Review a list of eligible expenses at the IRS website (www.irs.gov) in IRS Publication 502 — “Medical and Dental Expenses.”

Money you save through the HSA can remain in the account from one year to the next. HSAs are fully portable, meaning you can keep the account even if you change medical plans, retire or leave CenturyLink.

You aren’t eligible to establish or contribute to an HSA if you enroll in the Traditional Healthcare FSA or a medical benefit option other than the HDHP (including a spouse/domestic partner’s medical plan), or if you are a dependent on another person’s tax return. You may be eligible to enroll in a Limited Healthcare FSA. Check with your tax advisor for information on HSA rules.

Preferred Provider Organization (PPO)

Depending on where you live, UnitedHealthcare, Medica and Highmark Blue Cross Blue Shield are the administrators for the PPO option. If you enroll in this medical benefit option, you may receive services from any provider. However, the Plan pays greater benefits if you receive care from an in-network provider or facility. Prescription drug coverage is administered by UnitedHealthcare.

For services such as surgery, emergency room services and others, you will need to pay the deductible before the PPO medical benefit option begins paying the costs associated with those services. If you satisfy the deductible, you pay a percentage of eligible expenses and the Plan pays the rest (called coinsurance). For other services, such as office visits, you are responsible for a copay.

If you receive covered services from a provider that is not in the network, you may pay a larger portion of the costs associated with those services. Before receiving services from an out-of-network provider, contact the claims administrator to ask for the total out-of-pocket expenses associated with that service or treatment.

Review your Enrollment Worksheet to see if you are eligible to enroll in a PPO medical benefit option.
Important Definitions

- **Copay**: A flat dollar amount you pay for certain covered medical services and prescription drugs.

- **Coinsurance**: The percentage of certain eligible expenses you pay for a covered medical service.

- **Deductible**: The annual amount you must pay towards certain eligible expenses before the Plan begins to pay for benefits.

- **Out-of-pocket maximum**: The annual cap on the amount you may be required to pay for covered medical expenses, depending upon your medical benefit option.

The term “Eligible Expenses” is defined by the Plan and explained in the Summary Plan Description. If you have a question regarding whether an expense or service is a covered eligible expense, contact the claims administrator for the benefit option you elect.

### No-Network or HDHP No-Network

If you live in an area where there isn’t a UnitedHealthcare, Highmark or Medica network of doctors, you may be eligible for the No-Network or HDHP No-Network medical benefit options. Highmark administers the No-Network benefit option in California, Idaho, Indiana, Michigan, Montana, New Jersey, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Virginia, Washington and Wyoming. UnitedHealthcare administers the No-Network benefit in all other states and the HDHP No-Network benefit in all states. UnitedHealthcare also administers the retail and home delivery pharmacy services for all the No-Network and HDHP No-Network medical benefit options.

If you elect the HDHP No-Network option, your preventive care services including well baby care, routine physical exams and preventive care lab, X-rays and other preventive tests are covered at 100 percent. For all other services, you will need to pay the deductible before the No-Network benefit option starts paying for services. You also share the cost by paying coinsurance when you receive care, up to an out-of-pocket maximum.

The benefits you receive are based on “eligible expenses” charges, as determined by the claims administrator; you are responsible for costs in excess of the eligible expenses. See the plan comparison charts or the Summary Plan Description for more information.

If the CenturyLink Health and Life Benefits website at [www.centurylinkhealthandlife.com](http://www.centurylinkhealthandlife.com) shows that the No-Network benefit options are your only medical benefit options, you may request to opt-in to the PPO or HDHP network option if you can verify that there are network providers in your area (Medica Choice Network if you live in Minnesota, North Dakota, South Dakota or western Wisconsin; UHC Choice Plus Network if you live in any other state). To request to opt-in, contact the CenturyLink Service Center at 1 800-729-7526.
This information is intended only as a highlight of the health plan benefit options. In the event of a conflict, the terms of the official Plan Documents will govern. Please note there may be other Plan benefits not shown in this overview or which may have been changed. If you have questions regarding whether other benefits and coverage may be available, please consult the Summary Plan Description and Summaries of Material Modifications (SMMs), or call the claims administrator of the benefit option directly.

**Quick Glance — UnitedHealthcare Prescription Drug - PPO**

<table>
<thead>
<tr>
<th>Retail Pharmacy (up to a 30-day supply)</th>
<th>Tier 1</th>
<th>$10 copay</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Tier 2</td>
<td>$30 copay</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>$50 copay</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mail Order (up to a 90-day supply)</th>
<th>Tier 1</th>
<th>$25 copay</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Tier 2</td>
<td>$75 copay</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>$125 copay</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty Mail Order (up to a 30-day supply)</th>
<th>Tier 1</th>
<th>$10 copay</th>
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<tbody>
<tr>
<td></td>
<td>Tier 2</td>
<td>$30 copay</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>$50 copay</td>
</tr>
</tbody>
</table>

**Pharmacy Copay Maximum – $1,800 per individual per calendar year**

| Drug Formulary | UnitedHealthcare Prescription Drug List (PDL) |

**Quick Glance — In-Network Medical Options**

<table>
<thead>
<tr>
<th></th>
<th>PPO</th>
<th>Out-of-Network</th>
<th>HDHP</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Network</td>
<td>Out-of-Network</td>
<td>Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$300/person; $600/family</td>
<td>$600/person; $1,800/family</td>
<td>$1,500/single coverage; $3,000/two or more enrolled eligible dependents</td>
<td>$3,000/single coverage; $6,000/two or more enrolled eligible dependents</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum (combined for network and out-of-network expenses)</td>
<td>$1,000/person; $3,000/family Excludes Deductible (copays do not apply to out-of-pocket maximum)</td>
<td>$3,500/person; $7,000/family Excludes Deductible (charges above allowable amount not included)</td>
<td>$3,000/single coverage; $6,000/two or more enrolled eligible dependents Includes Deductible (charges above allowable amount not included)</td>
<td>$6,000/single coverage; $12,000/two or more enrolled eligible dependents Includes Deductible (charges above allowable amount not included)</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>Come-out whole method</td>
<td>Non-duplication method</td>
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# Medical (Including Prescription Drug)

**Quick Glance — In-Network Medical Options (continued)**

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<tr>
<th></th>
<th>PPO</th>
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<th>HDHP</th>
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<tbody>
<tr>
<td></td>
<td>Network</td>
<td>Out-of-Network</td>
<td>Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>Choice of Doctor/Facility</strong></td>
<td>May use any doctor/facility; however, plan pays higher benefits with network providers, no primary care physician or referrals required</td>
<td>May use any doctor/facility; however, plan pays higher benefits with network providers, no primary care physician or referrals required</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td>$25 copay</td>
<td>60% after deductible</td>
<td>100% preventive care benefits</td>
<td>50% after deductible</td>
</tr>
<tr>
<td><strong>Plan Generally Pays</strong></td>
<td>90% after deductible and/or copay</td>
<td>60% of allowable amount after deductible</td>
<td>80% after deductible</td>
<td>50% of allowable amount after deductible</td>
</tr>
<tr>
<td><strong>You Generally Pay</strong></td>
<td>10% coinsurance after deductible and applicable copay</td>
<td>40% coinsurance after deductible and charges over allowable amount or not paid by plan</td>
<td>20% coinsurance after deductible</td>
<td>50% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Office Visit</strong></td>
<td>PCP (primary care doctor) 100% after $25 copay; Specialist 100% after $30 copay (deductible does not apply)</td>
<td>Plan pays 60% after deductible</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 50% after deductible</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 60% after deductible</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 50% after deductible</td>
</tr>
<tr>
<td><strong>Inpatient (Facility)</strong></td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 60% after deductible</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 50% after deductible</td>
</tr>
<tr>
<td><strong>Outpatient (Facility)</strong></td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 60% after deductible</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 50% after deductible</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays network level if emergency; otherwise 60% after deductible</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays network level if emergency; otherwise 50% after deductible</td>
</tr>
<tr>
<td><strong>Claims Procedure</strong></td>
<td>No claims to file</td>
<td>You may need to file claims</td>
<td>No claims to file</td>
<td>You may need to file claims</td>
</tr>
<tr>
<td><strong>Prescriptions</strong></td>
<td>See Prescription Drug Coverage section for details Administered by UnitedHealthcare</td>
<td>There is a $1,800 out-of-pocket maximum per individual per calendar year for prescriptions.</td>
<td>80% after deductible network; 50% after deductible out of network Administered by UnitedHealthcare</td>
<td>Prescriptions are paid the same as any other medical expense under the HDHP and applies toward out-of-pocket maximum.</td>
</tr>
</tbody>
</table>

**Note:** This chart is only a summary of your benefits. For specific details on how services are covered, please contact your medical plan carrier.
**Medical (Including Prescription Drug)**

---

**Quick Glance — Out-of-Network Medical Options**

<table>
<thead>
<tr>
<th></th>
<th>No-Network</th>
<th>HDHP—No-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$500/person; $1,500/family</td>
<td>$1,500/single coverage; $3,000/two or more enrolled eligible dependents</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td>$1,350/person; $1,000/family</td>
<td>$3,000/single coverage; $6,000/two or more enrolled eligible dependents</td>
</tr>
<tr>
<td>Excludes Deductible (charges above allowable amount not included)</td>
<td><strong>Annual Out-of-Pocket Maximum</strong> (Amounts over reasonable and customary) $1,800 per person per year</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>Come-out whole method</td>
<td>Non-duplication method</td>
</tr>
<tr>
<td>Choice of Doctor/Facility</td>
<td>May use any doctor/facility</td>
<td>May use any doctor/facility</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>100% preventive care benefits</td>
<td>100% preventive care benefits</td>
</tr>
<tr>
<td>Plan Generally Pays</td>
<td>80% of allowable amount after deductible</td>
<td>80% of allowable amount after deductible</td>
</tr>
<tr>
<td>You Generally Pay</td>
<td>20% coinsurance (after deductible) and charges over allowable amount or not paid by plan</td>
<td>20% coinsurance (after deductible) and charges over allowable amount or not paid by plan</td>
</tr>
<tr>
<td>Office Visit</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 80% after deductible</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Plan pays 80% after deductible</td>
<td>Plan pays 80% after deductible</td>
</tr>
<tr>
<td>Inpatient (Facility)</td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 80% after deductible</td>
</tr>
<tr>
<td>Outpatient (Facility)</td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 80% after deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 80% after deductible</td>
</tr>
<tr>
<td>Claims Procedure</td>
<td>You may need to file claims</td>
<td>You may need to file claims</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>See Prescription Drug Coverage section for details Administered by UnitedHealthcare</td>
<td>80% after deductible Administered by UnitedHealthcare</td>
</tr>
<tr>
<td></td>
<td>There is a $1,800 out-of-pocket maximum per person per calendar year for prescriptions.</td>
<td>Prescriptions are paid the same as any other medical expense under the HDHP and applies toward out-of-pocket maximum.</td>
</tr>
</tbody>
</table>

**Note:** This chart is only a summary of your benefits. For specific details on how services are covered, please contact your medical plan carrier.
This information is intended only as a highlight of the health plan benefit options. In the event of a conflict, the terms of the official Plan Documents will govern. Please note there may be other Plan benefits not shown in this overview or which may have been changed. If you have questions regarding whether other benefits and coverage may be available, please consult the Summary Plan Description and Summaries of Material Modifications (SMMs), or call the claims administrator of the benefit option directly.

### PPO and HDHP — Deductible and Out-of-Pocket Example

**Example:** John elects Single + 1 coverage and has $20,000 in eligible in-network expenses

<table>
<thead>
<tr>
<th></th>
<th>PPO Plan</th>
<th>HDHP Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network Deductible</td>
<td>$300 single</td>
<td>$1,500 single</td>
</tr>
<tr>
<td></td>
<td>$600 family (includes single + 1)</td>
<td>$3,000 family (includes single + 1)</td>
</tr>
<tr>
<td>Annual In-Network Out-of-Pocket Maximum</td>
<td>$1,000 single; excludes deductible</td>
<td>$3,000 single; includes deductible</td>
</tr>
<tr>
<td></td>
<td>$3,000 family (includes single + 1);</td>
<td>$6,000 family (includes single + 1);</td>
</tr>
<tr>
<td></td>
<td>excludes deductible</td>
<td>includes deductible</td>
</tr>
<tr>
<td>John’s Medical Claims Plan Deductible</td>
<td>$20,000 (must satisfy single deductible limit)</td>
<td>$20,000 (must satisfy family deductible)</td>
</tr>
<tr>
<td></td>
<td>$19,700 under the family deductible)</td>
<td>$17,000</td>
</tr>
<tr>
<td>Applied to Coinsurance</td>
<td>$19,700 (10% coinsurance)</td>
<td>$17,000 (20% coinsurance)</td>
</tr>
<tr>
<td>In-Network Coinsurance Level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>John’s Coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$1,970 John only pays $1,000 of coinsurance</td>
<td>$3,400 John only pays $3,000 in coinsurance</td>
</tr>
<tr>
<td></td>
<td>because the annual out-of-pocket maximum is $1,000 but does not include the deductible</td>
<td>because he meets the annual family out-of-pocket maximum of $6,000</td>
</tr>
<tr>
<td>John’s Annual Out-of-Pocket Expense</td>
<td>$300 deductible</td>
<td>$3,000 deductible</td>
</tr>
<tr>
<td>Total Out-of-Pocket Expenses</td>
<td>$1,000 coinsurance</td>
<td>$3,000 coinsurance</td>
</tr>
<tr>
<td></td>
<td>$1,300</td>
<td>$6,000</td>
</tr>
<tr>
<td></td>
<td>John has met the annual single out-of-pocket maximum limit under the family out-of-pocket maximum. John will still be responsible for office visit copayments and prescription drug copays, but the Plan will pay 100% of all his other eligible expenses for the remainder of the calendar year. John’s dependent will still need to meet his/her single deductible and out-of-pocket maximum.</td>
<td>John has met the annual family out-of-pocket maximum. The plan will pay 100% of all eligible expenses, including prescriptions, for John and his dependent for the remainder of the calendar year.</td>
</tr>
</tbody>
</table>
Prescription drug coverage provides...

- $0 copay for diabetic supplies (syringes, needles and strips) – retail and mail order
- 60,000 network pharmacies
- Smoking cessation prescription medication available if enrolled in the Quit Power smoking cessation program

Certain Medications Not Covered
(The list below is not all inclusive and is subject to change)

Some drugs and medications are not covered under the prescription drug program, such as:

- Allergy shots (which may be covered under the medical benefit plan options);
- Drugs for cosmetic purposes only;
- Drugs not approved by the Food & Drug Administration (FDA);
- Drugs with no FDA-approved indication for treatment of a particular condition;
- Experimental or investigative drugs;
- Infertility drugs (which may be covered under the medical benefit plan options);
- Over-the-counter (OTC) drugs; and
- Vitamins, minerals and food supplements (except prenatal vitamins).

Healthcare Identification Cards

If you need to obtain healthcare services prior to receiving your ID card, visit the website for the administrator of the coverage you elected or contact the CenturyLink Service Center at 1 800-729-7526. Many administrators offer members the opportunity to register and login to print temporary ID cards, view eligibility, check claims status and more. You may enroll as a member on the website once the Plan Administrator has received your eligibility and updated its system, which can take up to three weeks.
Review your Enrollment Worksheet to see if you are eligible to enroll in the No-Network and HDHP No-Network benefit options. If you participate in one of these medical benefit options, the following information applies:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Phone</th>
<th>Online</th>
</tr>
</thead>
<tbody>
<tr>
<td>HDHP Medical Plan</td>
<td>UnitedHealthcare: 1 800-782-9883 all states except Minnesota, North Dakota, South Dakota and western Wisconsin Medica: 1 800-996-2038 in Minnesota, North Dakota, South Dakota and western Wisconsin NurseLineSM available 24 hours a day, 7 days a week; 1 888-887-4112</td>
<td>UnitedHealthcare: <a href="http://www.myuhc.com">www.myuhc.com</a> Medica: <a href="http://www.mymedica.com">www.mymedica.com</a></td>
</tr>
<tr>
<td>PPO Medical Plan</td>
<td>UnitedHealthcare: 1 800-782-9883 Medica: 1 800-996-2038 NurseLine available 24 hours a day, 7 days a week: 1 888-887-4112 Highmark Blue Cross Blue Shield: 1 888-778-8334 Blues On Call: 1 888-BLUE-428 Pre-certification: 1 800-452-8507 Mental Health: 1 800-258-9808</td>
<td>UnitedHealthcare: <a href="http://www.myuhc.com">www.myuhc.com</a> Medica: <a href="http://www.mymedica.com">www.mymedica.com</a></td>
</tr>
<tr>
<td>Prescription Drug Program</td>
<td>UnitedHealthcare: 1 800-782-9883</td>
<td>UnitedHealthcare: <a href="http://www.myuhc.com">www.myuhc.com</a></td>
</tr>
</tbody>
</table>
**Health Maintenance Organizations (HMOs)**

In some areas, CenturyLink offers managed care benefit options called HMOs. If you join an HMO, you may need to designate a primary care physician who will coordinate your care (for example, refer you to network specialists). If you receive care from a provider or facility outside the HMO network (except in emergency situations), you will be responsible for the full cost of services. Your prescription drug coverage is provided by the HMO. Review your Enrollment Worksheet to see if you are eligible to participate in one of the following HMOs:

<table>
<thead>
<tr>
<th>If you live in...</th>
<th>The available HMO is...</th>
<th>The associated website/phone number is...</th>
<th>Steps to a Healthy Life tools available through the HMO include...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>HealthNet of Arizona</td>
<td><a href="http://www.healthnet.com">www.healthnet.com</a> 1 800-289-2818</td>
<td>Health Coach: 1 800-893-5597 Website includes Hospital Comparison Report, wellness information, Decision Power Healthy Discounts and more</td>
</tr>
<tr>
<td>Colorado</td>
<td>Kaiser Permanente Colorado</td>
<td><a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a> Denver/Boulder Service Area: 1 303-338-3800 Colorado Springs Service Area: 1 888-681-7878</td>
<td>Advice Line: 1 303-338-4545 or 1 800-218-1059 Your Health Record provides secure online access to medical records, lab results, medications, and the ability to schedule appointments and e-mail your doctor routine health questions. Healthy Lifestyle Program at <a href="http://www.kp.org">www.kp.org</a></td>
</tr>
<tr>
<td>Minnesota</td>
<td>HealthPartners of Minnesota</td>
<td><a href="http://www.healthpartners.com">www.healthpartners.com</a> 1 800-883-2177 or 1 952-883-5000</td>
<td>CareLine Nurse Line: 1 800-551-0859 or 1 612-339-3663 BabyLine: 1 800-845-9297 or 1 612-333-2229</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Lovelace Health Plan</td>
<td><a href="http://www.lovelacehealthplan.com">www.lovelacehealthplan.com</a> 1 505-727-LOVE (5683) or 1 800-808-7363</td>
<td>Nurse Line: 1 877-725-2552 Wellness/Disease Management Programs: 1 505-727-5344 or 1 877-480-9368</td>
</tr>
<tr>
<td>Utah</td>
<td>SelectHealth</td>
<td><a href="http://www.selecthealth.org">www.selecthealth.org</a> 1 800-538-5038</td>
<td>Member Advocate Line: 1 800-515-2220 Behavioral Health Advocates: 1 800-876-1989</td>
</tr>
</tbody>
</table>
Dental and Vision

Money Saving Tips: Dental and Vision

- Understand what’s covered under the Plan. Review the plan comparison charts by using the Compare Coverage tool on the CenturyLink Health and Life Benefits website at www.centurylinkhealthandlife.com. For more information, review the Summary Plan Description or call the claims administrator.

- Think about your anticipated dental and vision costs. Set aside money in the Healthcare FSA to pay for eligible expenses that aren’t covered under the Plan. Learn more on page 26.

- Healthy teeth and gums have a positive impact on your overall health, so take advantage of covered preventive care services associated with the Plan.

Medical, dental and vision coverage is bundled for active employees and cannot be elected separately. For example, if you elect family medical coverage you must elect family dental and vision coverage.

Dental

CenturyLink’s dental coverage is administered by MetLife.

While you may receive services from any provider, you may pay less in out-of-pocket costs if you receive care from providers in the MetLife network (the Preferred Dentist Program). If you receive services from an out-of-network provider, you may pay more out-of-pocket costs for these services, and you may need to complete and submit a claim form to have benefits paid.

Generally, preventive and diagnostic care services (such as cleaning, oral exams and X-rays) are covered by the Plan up to reasonable and customary (R&C) rates. If the costs exceed R&C rates, you will be responsible for paying the excess charges.

For services other than preventive and diagnostic care, you will need to pay an annual deductible before the Plan begins paying a benefit. For restorative care and orthodontia, review the schedule of allowances in the Summary Plan Description to determine the coverage and out-of-pocket expenses you will be responsible for paying. Call MetLife for additional details about covered services.

You will not receive an ID card from MetLife. When you have an office visit, tell the dentist that you are covered by MetLife through the CenturyLink Medical Plan.
Money Saving Tips: Dental and Vision

- Before receiving services, you may want to confirm that your provider is in the network since you pay less when using network providers. Visit the plan’s website or call the member services department for details.
- Take advantage of the annual eye examination – it can help you identify problems early.

Vision

CenturyLink’s vision coverage is administered by Vision Service Plan (VSP).

Plan participants have access to a large network of vision care providers under the Vision Service Plan (VSP) network. While you may receive services from any provider, you receive significantly greater benefits if you use providers in the VSP network. If you receive services from an out-of-network provider, you will be reimbursed for a portion of the costs, but will pay higher out-of-pocket costs.

You will not receive an ID card from VSP. When you have an office visit with an in-network provider, please let the provider know that you are covered with VSP. Providing the first name, last name and date of birth of the primary member will allow the network provider to locate your coverage in VSP’s systems. In the event they are unable to locate your coverage, providing the last four digits of the primary member’s Social Security Number may be necessary in order to verify eligibility. As long as you use an in-network provider, you will not need to file a claim form.

If you use an out-of-network provider, you will need to pay all charges when you receive services, then file a claim to be reimbursed. For more information on filing claims for out-of-network providers, contact VSP directly at the number below.

Dental and Vision Coverage

<table>
<thead>
<tr>
<th>For this plan...</th>
<th>The claims administrator is...</th>
<th>Website/phone number is...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>MetLife</td>
<td><a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a> 1 888-356-4191</td>
</tr>
<tr>
<td>Vision</td>
<td>Vision Service Plan (VSP)</td>
<td><a href="http://www.vsp.com">www.vsp.com</a> 1 800-877-7195</td>
</tr>
</tbody>
</table>

This information is intended only as a highlight of the health plan benefit options. In the event of a conflict, the terms of the official Plan Documents govern. Please note there may be other Plan benefits not shown in this overview or which may have been changed. If you have questions regarding whether other benefits and coverage may be available, please consult the Summary Plan Description and Summaries of Material Modifications (SMMs), or call the claims administrator of the benefit option directly.
Flexible Spending Accounts

You and your dependents can save money by setting aside before-tax dollars in a Flexible Spending Account (FSA). CenturyLink offers two different FSAs:

- Healthcare FSA — you can contribute from $150 to $5,000 per calendar year before-tax. You may use your Healthcare FSA for reimbursement of expenses incurred from your benefits start date to the end of the calendar year.

- Dependent Daycare FSA — you can contribute from $150 to $5,000 per year before-tax. You may use your Dependent Daycare FSA for reimbursement of expenses incurred from your benefits start date to the end of the calendar year.

Both FSAs are administered by UnitedHealthcare.

How FSAs Work

When you put money into an FSA to pay out-of-pocket eligible healthcare or dependent daycare expenses, you save money on taxes. That is because the money you use to fund an account comes out of your pay before federal income and Social Security taxes are deducted. The result? You pay less in taxes and have more take-home pay.

Eligible Dependents

The Healthcare FSA reimburses qualified expenses incurred by you and/or an eligible dependent, such as your spouse or any other person who would qualify as a dependent under federal income tax rules.

The Dependent Daycare FSA reimburses qualified daycare expenses for:

- your dependent child under age 13;
- your physically or mentally disabled spouse; or
- any other person who qualifies as your dependent for federal income tax purposes — including a handicapped child of any age or a dependent parent who is physically or mentally incapable of self-care.

Use the Dependent Daycare FSA for reimbursing expenses associated with daycare for a dependent while you (and your spouse) work.

The IRS does not recognize domestic partners and their dependent children; therefore, expenses incurred for domestic partners and their children are not eligible for reimbursement through your FSA.

For a full list of “eligible expenses” for “eligible dependents,” review the SPD or contact UHC.

Coverage of Over-the-Counter Drugs

Certain types of over-the-counter (OTC) medications are eligible for reimbursement, including antacids, allergy medicines, pain relievers and cold medicines only with a prescription. Some OTC drugs are considered “dual-purpose,” meaning that they may be used for personal/cosmetic or general health as well as a medical purpose. Dual-purpose drugs may be reimbursed with supporting documentation stating medical necessity and a doctor’s written prescription. Medications that are used for your general health, such as dietary supplements, vitamins (except prenatal), toiletries and sundry items, are not eligible for reimbursement. The Health Care Spending Card (HCSC) cannot be used to purchase over-the-counter medications that require a prescription. You will need to pay for the medication out of your pocket and submit a claim to your FSA. Your claim must include the prescription for the medication (exception for insulin and OTC supplies, such as bandages, crutches, etc.).
Flexible Spending Accounts

Planning Your Contribution Amount

Plan your contributions carefully. The amount you elect to contribute to an FSA can be used only while you are a participant and only for eligible expenses incurred from your benefits start date to the end of the calendar year. Except in limited circumstances, you will not be allowed to increase or decrease the amount you deposit during the year (see paragraph below). And, you forfeit the money in your account if it is not used to reimburse eligible expenses incurred within the dates of service mentioned above. You cannot get money back if you have not spent it on eligible expenses as established by the IRS. (Forfeited amounts will be used to pay administrative costs of the plan.)

Note: Your FSA election amount will be equally divided over the remaining pay periods in the calendar year from date of hire.

You Forfeit Unused Account Balances

You may submit a reimbursement request to UnitedHealthcare no later than March 31, 2013 for any claims incurred through the end of 2012. Claims received after March 31, 2013 that do not have a U.S. Postal Service postmark date on or before that March 31 date will not be considered for payment. Claims sent by fax must be received by UnitedHealthcare by close of business March 31, 2013.

Remember, after that period ends, any unused amounts are forfeited — so it is important to estimate your expenses carefully when determining your annual election.

Debit Card Feature

The FSAs have a convenient debit card, called a Health Care Spending Card (HCSC), that can be used for certain IRS-qualified healthcare expenses. Your HCSC will have your annual Healthcare FSA election “stored” on the card. New members will receive an HCSC after your enrollment has been processed.

When you have a qualified expense — for example, a prescription drug copay — you may pay for the expense using your HCSC. This eliminates some paper claim filings and, more importantly, saves you time and money by not requiring you to pay from your pocket and then wait for reimbursement after completing a separate claim form.
Flexible Spending Accounts

Traditional Healthcare FSA
If you enroll in a medical benefit option other than the HDHP — or if you enroll in the HDHP benefit option, but do not have a Health Savings Account (HSA) — you can set aside between $150 and $5,000 in before-tax dollars to reimburse yourself for eligible medical, dental and vision expenses that aren’t covered by CenturyLink’s benefit plans (or any other benefit plans, such as a spouse’s employer plan). Examples of eligible expenses include office visit copays, prescription drug copays, eyeglasses/contact lenses, dental expenses, and more. Note that you’ll need a prescription to be eligible for reimbursement of the cost of over-the-counter (OTC) medicines or drugs from the Healthcare FSA. Visit www.myuhc.com for details about qualified expenses.

Tips: Why participate? You can save on taxes when you set aside money in a Healthcare FSA. You need to estimate your eligible expenses carefully, since the Internal Revenue Service (IRS) requires you to forfeit any money left over in your account at the end of the calendar year.


Limited Healthcare FSA
If you enroll in the HDHP benefit option and contribute to a Health Savings Account (HSA), you cannot enroll in the Traditional Healthcare FSA. Instead, you can participate in the Limited Healthcare FSA to be reimbursed for eligible dental and vision expenses, and eligible medical expenses once you have exceeded your HDHP deductible. You can enroll in the Limited Healthcare FSA and also contribute to an HSA, but you need to be careful about which healthcare products/services are reimbursed from each account.

Money Saving Tip: Other Ways to Save on Taxes
- If you have expenses associated with taking care of children or elderly dependents while you work, you can save on taxes by participating in the Dependent Daycare FSA (see page 28 for more information).

Want to save money on your out-of-pocket healthcare expenses? The Traditional Healthcare FSA or the Limited Healthcare FSA can help. Both are administered by UnitedHealthcare.

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Obtaining Reimbursement

There are several ways to submit an eligible expense and receive reimbursement under the FSAs:

- **If you are enrolled in the CenturyLink medical/prescription, dental or vision plans, your claims will automatically be submitted to your FSA via an electronic file feed. If you don’t want your claims to automatically roll to your FSA, you can turn this feature off on UHC’s website once you are an enrolled member. Refer to [www.myUHC.com](http://www.myUHC.com).**

- Use your HCSC to pay for qualified healthcare expenses.

- **Submit a paper claim by mail or fax (address and fax number are shown on the FSA claim form). Claim forms can be found on the Legacy CenturyLink Intranet.**

You also have the option to set up direct deposit and have your FSA reimbursement deposited directly into your bank account. Direct deposit can be set up on the UnitedHealthcare website (after Jan. 1 if you are a new UHC member).
Flexible Spending Accounts

For questions about eligible healthcare and dependent daycare expenses, call the CenturyLink Service Center at 1 800-729-7526 or refer to the CenturyLink Flexible Spending Account Summary Plan Description on the Legacy CenturyLink Intranet or the CenturyLink Health and Life Benefits website at www.centurylinkhealthandlife.com. You can also refer to IRS Publication 502-Medical and Dental Expenses and IRS Publication 503-Child and Dependent Daycare Expenses found on www.irs.gov.

No Matter What, Save Your Receipts!

While many transactions can be approved without requesting receipts, some may require you to send in additional information to document the claim. If required, UnitedHealthcare will send you a substantiation request. We recommend that you retain all receipts for all debit card purchases at least until the end of the following plan year. Retaining substantiation is an IRS requirement. In addition to the HCSC, you also may choose to file a paper claim for reimbursement.

Tip: When you first become eligible, start putting your healthcare receipts in an envelope marked “2012 Healthcare Receipts.” When you need to substantiate a claim, you’ll know where to find the receipts.

Eligible Dependent Daycare Expenses

Dependent daycare expenses are eligible for reimbursement only if your dependent lives in your home and the expenses permit you (if single) or you and your spouse (if married) to work full-time or part-time or attend school full-time. Employment may consist of service either within or outside the home (including self-employment).

According to federal law, eligible dependent daycare expenses include (but are not limited to) the cost of:

- a qualified child daycare center;
- a babysitter while you are working;
- a nursery school;
- a preschool;
- a day camp;
- either in-home or adult daycare for an incapacitated spouse or dependent parent, excluding nursing home charges;
- before- or after-school care for dependents under age 13.

Important Note: If you have concerns about whether your dependent or your daycare or medical expenses are “eligible,” call UHC.
What Is Not Eligible

Expenses not eligible for reimbursement through your Dependent Daycare FSA include (but are not limited to):

- activity fees;
- child care for when you are not working (expenses not work related);
- education expenses (except where kindergarten expenses cannot be separated from the cost of daycare);
- finder and placement fees for daycare providers;
- healthcare expenses;
- insurance;
- late fees;
- meals not included in tuition;
- membership fees;
- miscellaneous supplies;
- overnight camps;
- pre-paid daycare expenses;
- registration, enrollment, application or deposit fees;
- transportation.

Note: You cannot be reimbursed for expenses for child care provided by a dependent of yours. For example, if you pay your teenage son or daughter to care for another child of yours, you cannot use the Dependent Daycare Flexible Spending Account to pay for that expense.
Flexible Spending Accounts

Quick Glance — Flexible Spending Accounts

<table>
<thead>
<tr>
<th></th>
<th>Healthcare</th>
<th>Dependent Daycare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible Expenses</td>
<td>Eligible out-of-pocket healthcare expenses that are not covered by a medical, prescription drug, dental or vision care plan, including deductibles, copayments, coinsurance and over-the-counter medications (with a prescription). For additional details about eligible and ineligible expenses, refer to the CenturyLink FSA SPD on the Legacy CenturyLink Intranet or the CenturyLink Health and Life Benefits website <a href="http://www.centurylinkhealthandlife.com">www.centurylinkhealthandlife.com</a></td>
<td>Eligible out-of-pocket daycare expenses for the care of children under age 13, an incapacitated spouse or dependent parent so you (and your spouse, if you are married) can work or attend school full-time. For additional details about eligible and ineligible expenses, refer to the CenturyLink FSA SPD on the Legacy CenturyLink Intranet or the CenturyLink Health and Life Benefits website <a href="http://www.centurylinkhealthandlife.com">www.centurylinkhealthandlife.com</a></td>
</tr>
<tr>
<td>You Can Contribute*</td>
<td>$150 to $5,000 a calendar year*</td>
<td>$150 to $5,000 a calendar year per family*</td>
</tr>
<tr>
<td>Making Mid-Year Changes</td>
<td>Limited changes allowed with qualified status change</td>
<td></td>
</tr>
<tr>
<td>Minimum Claim/Reimbursement Amount</td>
<td>$25</td>
<td></td>
</tr>
<tr>
<td>Direct Payment of Services</td>
<td>Health Care Spending Card (HSCS) from UnitedHealthcare (a convenient MasterCard debit card that has your account elections “stored” on the card so you can use it to pay qualified expenses, eliminating the need for filing some claims for reimbursement)</td>
<td></td>
</tr>
<tr>
<td>Reimbursement of Out-of-Pocket Expenses</td>
<td>Most healthcare (medical, prescription, dental and vision) claims are submitted automatically to UnitedHealthcare; however paper claim forms for Healthcare or Dependent Daycare can be mailed or faxed to the address or fax number on the form. You have until March 31, 2013 to submit FSA claims incurred between your benefits start date and December 31, 2012.</td>
<td></td>
</tr>
<tr>
<td>Administrator</td>
<td>UnitedHealthcare, Group # 743797</td>
<td></td>
</tr>
</tbody>
</table>

If you are married and file separate federal income tax returns, the maximum that you can contribute to the Dependent Daycare FSA is $2,500. **If you are considered a highly compensated employee (defined by the IRS as making more than $110,000 in 2011), the maximum you can set aside in the Dependent Daycare FSA is $2,000. This amount is subject to change as determined by the Plan Administrator.**

*Annual elections are divided over the remaining pay periods in the calendar year.*
Life Insurance and Accidental Death & Dismemberment

Tips for Choosing Life Insurance and AD&D Coverage

- Think about how much income your dependents would need if something happened to you. Do you have other life insurance coverage? Will this be enough? Supplemental coverage can help bridge the gap.

- When you enroll, update your beneficiary information for all applicable life insurance coverage (Basic Life and AD&D coverage and Supplemental Life and AD&D coverage) at the CenturyLink Health and Life Benefits website at www.centurylinkhealthandlife.com.

Questions About Life Insurance and AD&D?

Contact the CenturyLink Service Center at 1 800-729-7526.

Basic Life Insurance

If you are an active occupational employee, CenturyLink provides Basic Life and AD&D coverage of one-times your annual pay at no cost to you. This coverage provides a level of security for your dependents should you die while employed by CenturyLink.

- Basic and Supplemental Life coverage is administered by MetLife.

- Accidental Death and Dismemberment Insurance (AD&D) is administered by Zurich.

- You pay taxes on the value of Employee Life Insurance coverage over $50,000 — commonly called inputed income. This is added to your taxable pay so that your beneficiaries will not pay taxes on benefits they receive from this plan. Beneficiaries will have to pay taxes on interest that is received from the death benefit.

Supplemental Life Insurance and AD&D Coverage

For additional protection, consider purchasing Supplemental Life Insurance. When you purchase this coverage, you automatically receive an equal level of Supplemental AD&D coverage. This Supplemental Life coverage is administered by MetLife; the AD&D coverage is administered by Zurich. You can elect coverage of up to $3 million in the following increments:

- Equal to your annual pay
- Two times annual pay
- Three times annual pay
- Four times annual pay
- Five times annual pay
- Six times annual pay
- Seven times annual pay
- Eight times annual pay

1 Annual pay is defined as your base rate of pay as of Sept. 1, 2011, plus certain other payments or commissions for the period of Sept. 1, 2010 through Aug. 31, 2011.

2 All life insurance coverage is issued by MetLife, Metropolitan Life Insurance Company, 200 Park Avenue, New York, New York 10166, Contract Series: 148069-G-1. The Booklet-Certificate contains all details, including any policy exclusions, limitations and restrictions that may apply.

3 AD&D coverage is issued by Zurich American Life Insurance Company, 1400 American Lane, Schaumburg, IL 60196, Customer Service: 1 800-727-1080.
Important Note!

If a dependent covered under the Plan no longer meets the eligibility requirements for coverage, you are responsible for contacting the CenturyLink Service Center at 1 800-729-7526 to terminate his or her coverage. Benefits will not be paid for an ineligible dependent, even if premiums are paid in advance.

The amount you pay for this coverage will depend on your age and the level of coverage you select. Detailed cost information is available at the CenturyLink Benefits website at www.centurylinkhealthandlife.com.

You will need to complete an Evidence of Insurability (EOI) form to demonstrate good health if you choose coverage greater than two times annual pay during the initial enrollment period.

If you are approved, coverage will become effective the first day of the month following EOI approval. Your premiums for the cost of this additional coverage will be automatically deducted from your pay check.

Spouse/Domestic Partner Life Insurance

You also can elect coverage for your spouse or domestic partner in these amounts: $5,000, $10,000, $25,000, $50,000, $75,000 or $100,000. The amount you pay for coverage is based on your spouse/domestic partner’s age and the amount of coverage you elect.

Your spouse/domestic partner will need to complete an EOI form if you choose coverage greater than $25,000 during the initial enrollment period.

Dependent Child Life Insurance

You can elect coverage for your eligible children or your domestic partner’s children for the following amounts: $3,000, $5,000 or $10,000. No EOI is required for this coverage.

Important Note!

If a dependent covered under the Plan no longer meets the eligibility requirements for coverage, you are responsible for contacting the CenturyLink Service Center at 1 800-729-7526 to terminate his or her coverage. Benefits will not be paid for an ineligible dependent, even if premiums are paid in advance.

The amount you pay for this coverage will depend on your age and the level of coverage you select. Detailed cost information is available at the CenturyLink Benefits website at www.centurylinkhealthandlife.com.

You will need to complete an Evidence of Insurability (EOI) form to demonstrate good health if you choose coverage greater than two times annual pay during the initial enrollment period.

If you are approved, coverage will become effective the first day of the month following EOI approval. Your premiums for the cost of this additional coverage will be automatically deducted from your pay check.

Spouse/Domestic Partner Life Insurance

You also can elect coverage for your spouse or domestic partner in these amounts: $5,000, $10,000, $25,000, $50,000, $75,000 or $100,000. The amount you pay for coverage is based on your spouse/domestic partner’s age and the amount of coverage you elect.

Your spouse/domestic partner will need to complete an EOI form if you choose coverage greater than $25,000 during the initial enrollment period.

Dependent Child Life Insurance

You can elect coverage for your eligible children or your domestic partner’s children for the following amounts: $3,000, $5,000 or $10,000. No EOI is required for this coverage.
Business Travel Accident Insurance

Business Travel Accident (BTA) Insurance provides benefits for accidental loss of life or limb, or for permanent paralysis when traveling on Company business or during the relocation process. The Plan provides a benefit equal to 3x annual pay, up to $1,000,000. The Company provides this coverage at no cost to you.

Beneficiary Designation

You can name any individual(s), your estate, almost any organization or your trust as your beneficiary for Basic Life Insurance, Employee Supplemental Life Insurance, Basic AD&D Insurance, Supplemental AD&D Insurance and/or Business Travel Accident Insurance. You can designate or update your beneficiary at any time online or by calling the CenturyLink Service Center.

If you have Supplemental Life Insurance and/or Business Travel Accident Insurance, unless otherwise specified, the coverage amount is payable to the same beneficiary (or beneficiaries) as named for your Basic Life Insurance in the event of your death. Your named beneficiary will apply to both your Basic and Supplemental coverage amounts, unless otherwise specified.

Designate a Beneficiary Online


Click on Register as a New User and follow the prompts to set up your User ID and password the first time you log in.

From the home page, click on Update Your Beneficiary Information and follow the prompts to make updates as needed.

Please note: Once you enter your beneficiary designations on this site, you will receive a new beneficiary designation confirmation statement.
Designate a Beneficiary By Calling
You can also update your beneficiary information by calling the CenturyLink Service Center at **1 800-729-7526**. Follow the prompts to speak to a Representative. Representatives are available Monday through Friday from 7:30 a.m. to 5:30 p.m. Mountain time. You are the automatic beneficiary for the spouse and child life insurance plans, as well as the Supplemental AD&D Plan if you elected the Employee and Dependent coverage level.

Tips to Follow When Designating a Beneficiary
- The total percentage for all beneficiaries must be 100 percent for each primary and contingent (secondary) beneficiary and plan. **What this means** is that the allocation equals 100 percent for all of your primary beneficiaries and 100 percent for all of your contingent (secondary) beneficiaries.
- Use the correct date of birth format: mm/dd/yyyy.
- Social Security Number is required for beneficiaries. You will also need the address and phone number of any beneficiaries.
- You may name a person and/or organization (trust or charity) as a beneficiary.
- If you are electing a Trust or Estate as your beneficiary, please make sure you provide the Executor information (such as name, address, and phone number with area code) of the person who handles the Trust/Estate.
Short-Term Disability

Disability Benefits

Disability benefits paid through the CenturyLink Disability Plan will be reduced if you receive disability benefits through other sources (for example, state disability benefits or Workers’ Compensation), except for benefits provided by personally purchased disability income plans. Review the appropriate Summary Plan Description for more information. If you have questions about the CenturyLink Disability Plan, call the CenturyLink Service Center at 1 800-729-7526.

Short-term disability (STD) coverage is designed to help active eligible occupational employees replace a portion of their income should they become ill or injured. During the enrollment period, you have the opportunity to choose whether your premium is deducted on a before-tax or after-tax basis. If an election is not made, you will default to an after-tax premium deduction. CenturyLink provides an allowance equal to the premium of your STD coverage.

New Employees: When this option becomes available to you, the first day following one year of continuous service, you will have the opportunity to elect to have STD premiums paid on a before-tax option. You will not be able to change your election until the next Annual Enrollment period. CSA/CSSAs must complete two years of continuous service.

Explanation: Employees are asked to make an election to receive short-term disability benefits on a before- or after-tax basis, in the event you must be away from work and qualify for short-term disability pay. If you elect to pay taxes on the STD premium out of your wages on an after-tax basis, if you ever receive the STD benefits, you will receive the benefits and not have to pay taxes on them. If you elect to have the STD premium taken out of your wages on a before-tax basis, if you ever receive the STD benefits, you will be taxed on the value of the benefits you receive. If no election is made, the default is after-tax, which means your STD benefit, if you ever receive it, will not be taxed.

If you qualify for an STD benefit, here’s a comparison chart that shows how the benefit would be paid out based on your election.

<table>
<thead>
<tr>
<th></th>
<th>After-Tax Election</th>
<th>Before-Tax Election</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly Salary</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Estimated Weekly Taxes on STD Premium</td>
<td>$3</td>
<td>$0</td>
</tr>
<tr>
<td>STD Benefit Payment</td>
<td>$700</td>
<td>$700</td>
</tr>
<tr>
<td>Taxes on STD Payment</td>
<td>$0</td>
<td>$210</td>
</tr>
<tr>
<td>Take Home STD Benefit</td>
<td>$700</td>
<td>$490</td>
</tr>
</tbody>
</table>

Please note that this example is for tax illustrative purposes only, using the wage replacement benefit of 70 percent. Pay during STD is equal to 70 percent of base pay, and begins on the eighth consecutive day of absence.

Your STD maximum benefit period exhausts after receiving benefits for 12 months.
Long-Term Disability

Long-Term Disability Plans
After your STD benefits exhaust, you are eligible to apply for LTD benefits. Nobody expects a prolonged illness or disabling injury, but it can happen without warning.

Long-Term Disability benefits begin paying benefits after you exhaust your Short-Term Disability benefit and meet all of the LTD benefit requirements. Information on Short-Term Disability benefits and eligibility can be found in your Summary Plan Description.

How It Works
Disability coverage can provide income protection in cases of sickness or injury that prevents you from working. The Plan pays benefits based on your base pay — which is your regular wage or salary rate plus average night differentials, if applicable. It does not include overtime, bonus or commissions.

If you become “totally disabled” as defined by the Plan and are approved for benefits by the LTD Carrier, you may begin receiving Basic LTD benefits (subject to the applicable waiting period).

Benefit Amount
The LTD Plan pays a benefit which, when added to all other sources of disability income, less any offsets, will equal 60 percent of your:

- Base pay, or if applicable,
- Normal take-home pay, if you’re receiving non-taxable Workers’ Compensation payments.

In either event, your benefit will be based on your base pay in effect immediately prior to your termination from employment.

Refer to the Summary Plan Description for additional detail and definitions for base pay, normal take-home pay and payments offset by other benefits. The administrator is The Standard.
Commuter Spending Account

Commuter Spending Account

Interested in taking mass transit to work and saving some money along the way? Do you want to drive to work, but save on parking expenses? If so, enroll in the Commuter Spending Account to pay for your mass transit and parking expenses with before-tax money.

Here’s how the program works:

**Mass Transit Expenses:** Set aside up to $125 before-tax per month for mass transit purchases, including passes, fare cards or vouchers for the bus, train, subway or van pool. Make your purchases online at the Your Spending Account website. Go to the CenturyLink Health and Life Benefits website at www.centurylinkhealthandlife.com. Click on the Save on commuting expenses message in the upper right of the screen and follow the prompts. Reduce your environmental impact while saving money by participating in this important program. Follow the instructions shown to enroll.

**Parking Reimbursements:** If you drive to work, set aside up to $240 before-tax per month to be reimbursed for parking expenses including parking vouchers, direct pay parking and before-tax cash reimbursement. Simply enter your claim online, then print a copy of the claim form, sign it and fax it to Your Spending Account within 180 days of the expense date. You may also choose to have Your Spending Account pay your parking provider directly.

**Note:** Fuel does not qualify under mass transit expenses or parking reimbursements.

Consider Commuter Check Cards

While you’re enrolling in the Commuter Spending Account, you might consider ordering a Commuter Check Card to make paying for your commuter expenses even easier. There are two types of cards — one for transit and one for parking expenses. You can order one or both. The Transit Card is accepted at transit agencies, transit retail centers and vending machines for the purchase of things like transit passes, tickets, fare cards and vanpool passes. The Parking Card is accepted at any parking facility that accepts MasterCard for payment. You decide how much to load to the card each month, or you can set up a recurring amount to have it done automatically. Using the cards is fast, convenient and simple.

**Note:** Enrollment for the Commuter Spending Account is a separate election from enrollment in other benefits; you can enroll at anytime during the year. Elections or changes must be made prior to the 10th of any given month to be effective the following month. See the Saving Tip on this page for more information.

This information is intended only as a highlight of the health plan benefit options. In the event of a conflict, the terms of the official Plan Documents will govern. Please note there may be other Plan benefits not shown in this overview or which may have been changed. If you have questions regarding whether other benefits and coverage may be available, please consult the Summary Plan Description and Summaries of Material Modifications (SMMs), or call the claims administrator of the benefit option directly.
To access the Employee Assistance Program...

Call **1 800-803-3737** or log onto www.achievesolutions.net/centurylink.

Anytime, any day, professionals are there to provide help when you need it most.

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**CenturyLink Benefits Provided at No Cost to You**

**Employee Assistance Program (EAP)**

Another way to stay healthy is by limiting the stress in your life. That’s where the Employee Assistance Program can help.

The Employee Assistance Program offers you and your dependents professional and confidential counseling services at no cost to you. Get information and referrals to help you with big decisions about childcare, eldercare, education, legal services and more.

The EAP is administered by ValueOptions.

**Legal Services**

- Access to over 22,000 attorneys in the U.S. and Canada
- Free 30-minute telephonic or face-to-face consultation with a state-specific attorney per separate issue, per year
- Ability to retain the same attorney for ongoing representation at a 25 percent discounted rate
- Help with a variety of issues such as separation and divorce, living wills, criminal matters and document preparation

**Mediation Services**

- Access to over 2,000 professional mediators
- Free 30-minute telephonic or face-to-face with a qualified mediator per separate issue, per year
- Referrals for face-to-face professional mediation at 25 percent below normal fees
- Help with a variety of issues such as child custody, child support, debt division, inheritance disputes and property division

**Financial Services**

- Telephone-based financial information from credentialed financial professionals including licensed CPAs and Certified Financial Planners
- Up to 30-minutes of telephonic consultation per separate issue, per year
- Consultation on issues such as financial planning, investments, credit and collections, taxes, home buying, recovering from debt and school funding
- Referrals to debt counseling and consolidation services

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This information is intended only as a highlight of the health plan benefit options. In the event of a conflict, the terms of the official Plan Documents will govern. Please note there may be other Plan benefits not shown in this overview or which may have been changed. If you have questions regarding whether other benefits and coverage may be available, please consult the Summary Plan Description and Summaries of Material Modifications (SMMs), or call the claims administrator of the benefit option directly.
CenturyLink offers a full array of benefits, including (but not limited to):

- **CenturyLink Disability Plan**, which includes short- and long-term coverage to help maintain a level of income if you are unable to work.
- **Paid Time Off**, to help you take care of yourself and enjoy all life has to offer.
- **Scholars Choice College Savings Plan (529 Plan)** to help you save for future education expenses for yourself or your dependents.
- **Employee Discounts** that can help you save on items you use every day.
- **Adoption Assistance**, to help cover a portion of the expenses associated with adopting a child.

Other Important Benefits Available to You

**Retirement and Savings**

- **CenturyLink Savings and Investment Plan 401(k)**, which can help you build your retirement savings.

If you have your password, you can update your address by contacting the CenturyLink Service Center at 1 800-729-7526 and selecting the QSIP 401(k) option, or by going to the QSIP 401(k) website at [www.qwestbenefits.ingplans.com](http://www.qwestbenefits.ingplans.com) and selecting Personal Information. If you do not have your password, you must send your change of address in writing to the following address.

Your request must include your name, complete Social Security Number, complete old address, complete new address, signature and date.

Qwest Savings & Investment Plan
P.O. Box 57160
Jacksonville, FL 32241

**Career**

- **PATHWAYS**, which gives you access to prepaid tuition vouchers and tuition reimbursement for a variety of education and training opportunities, including undergraduate and graduate degree programs.

This information is intended only as a highlight of the health plan benefit options. In the event of a conflict, the terms of the official Plan Documents will govern. Please note there may be other Plan benefits not shown in this overview or which may have been changed. If you have questions regarding whether other benefits and coverage may be available, please consult the Summary Plan Description and Summaries of Material Modifications (SMMs), or call the claims administrator of the benefit option directly.
Use the Tools and Enroll

You have 30 days from your hire/rehire or transfer date to enroll.

Visit the CenturyLink Health and Life Benefits website at www.centurylinkhealthandlife.com to review your Enrollment Worksheet for the plans that are available to you and their associated costs, as well as plan comparison information. You may also call the CenturyLink Service Center at 1 800-729-7526 to request a paper copy of these materials.

The CenturyLink Health and Life Benefits website at www.centurylinkhealthandlife.com provides a simple, step-by-step process for enrolling in your benefits. Each step offers guidance or tools to help you make your decisions for the benefits that best meet your needs.

Step 1 – Review Your Healthcare Costs
Estimate and compare what you might pay out-of-pocket for medical services.

Step 2 – Compare Coverage
Compare the costs of deductibles, copayments, coinsurance, and other details of the plan options you are eligible for.

Step 3 – Find a Doctor
Whether you want to see if your doctor is in the plan option you’re considering or you’re looking for a new provider, you’ll find help here.

Step 4 – Consider a Spending Account
Estimate your contribution needs for either the Healthcare or Dependent Daycare FSA with this helpful tool.

Step 5 – Enroll in your Benefits
This final step will walk you through everything you need to do to enroll in your benefits.

Important Note: Be sure to click on Continue in the Complete Your Enrollment section to save your elections. Once you are finished, you should print a copy of your completed enrollment information for your records.

This information is intended only as a highlight of the health plan benefit options. In the event of a conflict, the terms of the official Plan Documents will govern. Please note there may be other Plan benefits not shown in this overview or which may have been changed. If you have questions regarding whether other benefits and coverage may be available, please consult the Summary Plan Description and Summaries of Material Modifications (SMMs), or call the claims administrator of the benefit option directly.
Enroll Now in Your Benefits

First-time user?

There are two ways to log on to the CenturyLink Health and Life Benefits website

- Use the single sign-on link on the HRLink home page in the Health and Wellness section
- Log on directly using the URL, www.centurylinkhealthandlife.com via your Internet browser

The next time you log on through the single sign-on link

- Click on the Your Benefits Resources™ link.
- Enter your Active Directory (AD) ID and Active Directory password. This is the ID and password you use to access your computer at work. If you have AD ID or password issues, please contact the CenturyLink Help Desk at 1 877-726-4357.
- You will land on the Health and Life Benefits website log on page. Click Register as a New User and follow the steps to create your Health and Life Benefits website user ID and password.
- When you are done, you will see a Log On Completed Successfully message. Click the Continue button, which will take you to your CenturyLink Health and Life Benefits Home Page where your benefits enrollment will begin.
- From the home page, you’ll see the Action Needed! announcement at the top of the page. Click on the Enroll button to begin your enrollment.
- Follow the easy step-by-step process to make your choices and enroll in your benefits. The system will prompt you to review and update (if needed) your dependent and beneficiary information as you go through the process.

Once you are finished and have saved each enrollment option change, you should print a copy of your completed enrollment information for your records. If you have a preferred e-mail address on file, you will receive an e-mail indicating you’ve saved one or more elections. The e-mail will contain a link that will allow you to access your enrollment elections.

If you don’t have an e-mail address on file, you will receive a detailed confirmation statement through the mail after the enrollment period ends.

You can also request a paper confirmation statement by calling the CenturyLink Service Center at 1 800-729-7526.

Enroll Online — Refer to your enrollment deadline on the Health and Life Benefits website, generally 30 days from your hire/rehire or transfer date.

Accessing the CenturyLink Health and Life Benefits website for the first time from the single sign-on link located on the HRLink home page of the CenturyLink intranet

- Click on the Your Benefits Resources™ link.
- Enter your Active Directory (AD) ID and Active Directory password. This is the ID and password you use to access your computer at work. If you have AD ID or password issues, please contact the CenturyLink Help Desk at 1 877-726-4357.
- You will land on the Health and Life Benefits website log on page. Click Register as a New User and follow the steps to create your Health and Life Benefits website user ID and password.
- When you are done, you will see a Log On Completed Successfully message. Click the Continue button, which will take you to your CenturyLink Health and Life Benefits Home Page where your benefits enrollment will begin.
- From the home page, you’ll see the Action Needed! announcement at the top of the page. Click on the Enroll button to begin your enrollment.
- Follow the easy step-by-step process to make your choices and enroll in your benefits. The system will prompt you to review and update (if needed) your dependent and beneficiary information as you go through the process.

Once you are finished and have saved each enrollment option change, you should print a copy of your completed enrollment information for your records. If you have a preferred e-mail address on file, you will receive an e-mail indicating you’ve saved one or more elections. The e-mail will contain a link that will allow you to access your enrollment elections.

If you don’t have an e-mail address on file, you will receive a detailed confirmation statement through the mail after the enrollment period ends.

You can also request a paper confirmation statement by calling the CenturyLink Service Center at 1 800-729-7526.
Enroll Now in Your Benefits

A Note About Privacy

The protection and security of your personal information is of primary importance to CenturyLink. That’s why we, along with the benefits administrator, 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 protecting the confidentiality of your User ID and password for accessing the CenturyLink Health and Life Benefits website. 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.

Important notes: CenturyLink Service Center Representatives are available to answer your questions. To speak with a Representative about enrolling, you must call or enroll through the website before your 31st day of employment.

Your CenturyLink Health and Life Benefits website user ID and password will only be used when you access the Health and Life Benefits website directly using the URL via your Internet browser. It does not need to match your Active Directory (AD) ID information. It is not used when you use the Single Sign-on link on the HRLink home page.

Forget your Health and Life Benefits website user ID or password?

As mentioned above, you must register as a new user the first time you access the site to set up your user ID and password. In the future, if you forget your Health and Life Benefits website user ID or password, click on the appropriate link on the log on page and follow the prompts. You will receive your log on information within 15 minutes. You can also call the CenturyLink Service Center at 1 800-729-7526 for assistance. (Note: It can take up to 10 days to receive your log on information through the mail.)

Forget your CenturyLink Active Directory (AD) user ID or password?

Contact the CenturyLink Help Desk at 1 877-726-4357.

The next time you log on through the single sign-on link

- Click on the Your Benefits Resources website.
- You will enter your ID and Active Directory password. This is the ID and password you use to access your computer at work. If you have AD ID or password issues, please contact the CenturyLink Help Desk at 1 877-726-4357.
- This time you will land on your employee Welcome Page.
Enroll Now in Your Benefits

Accessing Health and Life Benefits website for the first time using the URL via your Internet browser

- Enter www.centurylinkhealthandlife.com in your Internet browser
- You will land on the Health and Life Benefits website log on page. Click Register as a New User and follow the steps to create your user ID and password for the Health and Life Benefits website.
- Click the Continue button, which will take you to the Home Page where your benefits enrollment will begin.
- From the home page, you’ll see the Action Needed! announcement at the top of the page. Look for Make Your Annual Enrollment Choices and click Enroll.
- Follow the easy step-by-step process to make your choices and enroll in your benefits. The system will prompt you to review your dependent and beneficiary information as you go through the process.
- Once you are finished and have saved each enrollment option change, you should print a copy of your completed enrollment information for your records. If you have a preferred e-mail address on file, you will receive an e-mail indicating you’ve saved one or more elections. The e-mail will contain a link that will allow you to access your enrollment elections.

  If you don’t have an e-mail address on file, you will receive a detailed confirmation statement through the mail.

  You can also request a paper confirmation by calling the CenturyLink Service Center at 1 800-729-7526.

Important notes: CenturyLink Service Center Representatives are available to answer your questions. To speak with a Representative about enrolling, you must call or enroll through the website before your 31st day of employment.

Your Health and Life Benefits website user ID and password will only be used when you access the YBR site directly with the URL and your Internet browser. It does not need to match your AD ID information. It is not used when you use the single sign-on link on the HRLink home page.
Take Steps to a Healthy Life

CenturyLink provides resources to help active employees and their dependents use benefits wisely throughout the year. Use the resources listed below to improve your health and save money both now and in the long term. Each medical claims administrator also offers tools that can help.

<table>
<thead>
<tr>
<th>Tool</th>
<th>When to Use It</th>
<th>Where to Find It</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quit for Life® – Smoking Cessation Program</strong></td>
<td>If you use tobacco, call Quit for Life today! CenturyLink and the American Cancer Society have joined forces to help you quit for good. Through the program, you have access to free Nicotine Replacement Therapy (including patches, gum, and lozenges), and the support you need to kick the habit.</td>
<td>1 866-784-8454 (1 866-Quit.4.Life) <a href="http://www.quitnow.net">www.quitnow.net</a></td>
</tr>
<tr>
<td><strong>NurseLine</strong></td>
<td>In non-emergency situations, you may have access to a NurseLine. It’s a quick, easy way to get your questions answered by a qualified registered nurse. The NurseLine is available 24 hours a day, seven days a week and it’s free.</td>
<td>Call your medical claims administrator (see pages 20–21 for contact information)</td>
</tr>
<tr>
<td><strong>Flu Shot</strong></td>
<td>Generally in the fall, active employees have access to low-cost flu shots, courtesy of CenturyLink.</td>
<td>Various CenturyLink locations</td>
</tr>
<tr>
<td><strong>Disease Management Programs for Participants Not Eligible for Medicare</strong></td>
<td>If you have a chronic condition and you are not eligible for Medicare, CenturyLink works with our medical claims administrators to provide disease management programs that can help you manage your condition. Take advantage of this resource to learn more about your condition and the steps you can take to feel better and get healthier.</td>
<td>Call your medical plan claims administrator (see pages 20–21 for contact information)</td>
</tr>
<tr>
<td><strong>Employee Assistance Program (EAP) and Work/Life Resources</strong></td>
<td>Use this free resource when you and your dependents need confidential counseling to address issues such as relationships, drug and alcohol dependencies, financial difficulties, work/life balance, legal issues and more. The EAP is available 24 hours a day, seven days a week. When you need help with some of life’s big decisions, turn to Achieve Solutions. This free resource can save you countless hours by researching and providing referrals for: • Child care, elder care and pet care • Adoption • Legal Services • Education • Daily living • Financial Services</td>
<td><a href="http://www.achievesolutions.net/centurylink">www.achievesolutions.net/centurylink</a> 1 800-803-3737</td>
</tr>
</tbody>
</table>

**Good Health — Your Greatest Asset**

At CenturyLink, we believe there’s nothing more important than good health. Not only do you look and feel better, but staying healthy is also the best way to manage your healthcare costs. That’s why, in addition to taking advantage of the resources listed here, we encourage you to eat a healthy diet, get a little exercise every day and take control of the things you can to maintain and support this important asset. When we’re healthy, everybody wins.
This Guide presents only the highlights of certain benefits available to eligible employees of CenturyLink and its affiliated companies, and their eligible dependents. The full details and provisions are provided in the official formal plan documents and/or certificates. If there is any conflict between the terms of the Plan documents and this document, the terms of the Plan documents will govern. CenturyLink has reserved to the Plan Administrator the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan.

**Right to Amend**

Plan benefits are determined by CenturyLink in its sole discretion and CenturyLink 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 participant classes, retired, or otherwise, and their beneficiaries at any time without prior notice or consultation subject, as applicable, to collective bargaining. 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.

**Women’s Health and Cancer Rights Act of 1998**

- 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 plan benefit option in which you elect to participate, and its Summary Plan Description and Summary of Materials Modifications (if any) regarding any applicable restrictions.

**Newborns’ and Mothers’ Health Protection Act (NMHPA)**

As required by the Department of Labor, CenturyLink is providing this notice about the Newborns’ and Mothers’ Health Protection Act.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

Please contact Member Services of your medical provider for more information.
Legal and Required Notices

Health Insurance Portability and Accountability Act (HIPAA)

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

- Termination of employer contribution toward other coverage;
- Moving out of a service area if the other plan does not offer other coverage;
- Ceasing to be a dependent, as defined in the other plan;
- Loss of coverage to a class of similarly situated individuals under the other plan (e.g., when the other plan does not cover part-time employees).

If your spouse or other dependent has special enrollment rights, you may enroll and make changes to your enrollment in any health plan benefit option available to you based upon your home ZIP code and plan service areas within 45 days following the qualifying event. For example, if you have single coverage in a CenturyLink benefit option, and your spouse loses coverage under his/her employer’s plan and has special enrollment rights, both you and your spouse may enroll in any of the CenturyLink benefit options available to you, provided your dependent verifies his or her eligibility for the CenturyLink Medical Plan. Refer to page 6 for information about how to verify your dependent’s eligibility for coverage.
Continuation of Coverage

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. 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. COBRA coverage is not extended for those terminated for gross misconduct.

Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information. Qualifying events for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment.

Qualifying events for spouses or dependent children include those events above, plus, the covered employee’s becoming entitled to Medicare, divorce or legal separation of the covered employee, death of the covered employee, and the loss of dependent status under the plan rules. If a QB chooses to continue group benefits under COBRA, he or she must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, your coverage will be cancelled after a 30-day grace period.

If you have any questions about COBRA or the Plan, please contact the CenturyLink Service Center at 1 800-729-7526.
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 plan benefit option in which you elect to participate and its Summary Plan Description and Summary of Material Modifications regarding any applicable restrictions.

**Notice of Grandfathered Plan**

The benefit options available to the active Occupational employees of legacy Qwest are “grandfathered health plan options” under the Patient Protection and Affordable Care Act (PPACA). As permitted by the PPACA, “grandfathered” health plan options can preserve certain basic health coverage that was already in effect when the law was enacted. Being “grandfathered” means that the CenturyLink Medical Plan may not include certain consumer protections of the PPACA with these options that apply to other plan options, for example, the requirement for the provision of preventive health services without any cost sharing. However, “grandfathered” health plan options must comply with certain other consumer protections in the PPACA, for example, the elimination of certain lifetime limits on benefits. In addition, a “grandfathered health plan” may decide to voluntarily comply with certain provisions of the PPACA without affecting its status.

Questions regarding which protections apply and which protections do not apply to a “grandfathered” health plan benefit option and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at CenturyLink, 1801 California Street, Suite 4590, Denver CO 80202. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1 866-444-3272** or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plan options.