CenturyLink Health Care Plan

Vision Plan Option

(Administered by VSP)

SUMMARY PLAN DESCRIPTION

For

Active CenturyLink Bargaining Employees

(Occupational - for Legacy Qwest Only)

CenturyLink, Inc.

Effective January 1, 2017

CenturyLink
Vision Benefits

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INTRODUCTION

CenturyLink, Inc. (hereinafter "CenturyLink" or "Company") is pleased to provide you with this Summary Plan Description ("SPD"). This SPD presents an overview of the Benefits available under the Vision Plan benefit option of the **CenturyLink Health Care Plan (the "Plan").**

This SPD must be read in conjunction with the *General Information SPD* which explains many details of your coverage and provides a listing of the other benefit options under the Plan.

The effective date of this updated SPD is January 1, 2017. If you are a Covered Person in the Vision Plan benefit option of the Plan on or after January 1, 2017, this SPD supersedes and replaces, in its entirety, any other SPD describing Vision plan Benefits that you currently may possess. In the event of any discrepancy between this SPD and the official *Plan Document*, the *Plan Document* shall govern.

This SPD, together with other plan documents (such as the Summary of Material Modifications (SMMs), the *General Information SPD* and materials you receive at Annual Enrollment) (hereafter "Plan documents") briefly describe your Benefits as well as rights and responsibilities, under the CenturyLink Health Care Plan (the "Plan"). These documents make up your official Summary Plan Description for the Vision Plan benefit option(s) as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Vision Plan benefit option under the Plan is self-funded; however, certain other benefit plan options under the Plan may be insured.

This SPD is for active CenturyLink Legacy Qwest Bargaining (Occupational) Employees. *All other CenturyLink Employees should refer to their own applicable CenturyLink Health Care Plan SPDs, with distinct terms and conditions.*

Company's Reserved Rights

CenturyLink reserves the right to amend or terminate any of the Benefits provided in the Plan – with respect to all classes of Covered Person, retired or otherwise – without prior notice to or consultation with any Covered Person, subject to applicable laws and if applicable, the collective bargaining agreement.

The Plan Administrator, the CenturyLink Employee Benefits Committee, and its delegates(s), has the right and discretion to determine all matters of fact or interpretation relative to the administration of this Vision Plan benefit option—including questions of eligibility, interpretations of the Plan provisions and any other matter. The decisions of the Plan Administrator and any other person or group to whom such discretion has been delegated, including the Claims Administrator, shall be conclusive and binding on all persons. More information about the Plan Administrator and the Claims Administrator can be found in the General Information SPD.

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

Service Center to correct the error or omission.

How to Use This Document

The SPD is designed to provide you with a general description, in non-technical language of the Benefits currently provided under the Vision Plan benefit option without describing all of the details set forth in the *Plan Document*. The SPD is not the *Plan Document*. Other important details can be found in the *Plan Document* and the *General Information* SPD. The legal rights and obligations of any person having any interest in the Plan are determined solely by the provisions of the Plan. If any terms of the *Plan Document* are in conflict with the contents of the SPD, the *Plan Document* will always govern.

Capitalized terms are defined throughout this SPD and in the *General Information SPD*. All uses of "we," "us," and "our" in this document, are references to the Claims Administrator or CenturyLink. References to "you" and "your" are references to people who are Covered Persons as the term is defined in the *General Information SPD*.

You are encouraged to keep all of the SPDs and any attachments (summary of material modifications ("SMMs"), amendments, and addendums) for future reference.

Please note that your health care Provider does not have a copy of the SPD, and is not responsible for knowing or communicating your Benefits.

See the *General Information SPD* for more information as noted in the *General Plan Information* section and throughout this SPD.

Health Plan Coverage Is Not Health Care Advice

Please keep in mind that the sole purpose of the Plan is to provide for the payment of certain health care expenses and not to guide or direct the course of treatment of any Employee, Retiree, or eligible Dependent. Just because your health care Provider recommends a course of treatment does not mean it is payable under the Plan. A determination by the Claims Administrator or the Plan Administrator that a particular course of treatment is not eligible for payment or is not covered under the Plan does not mean that the recommended course of treatments, services or procedures should not be provided to the individual or that they should not be provided in the setting or facility proposed. ***Only you and your health care Provider can decide what is the right health care decision for you****. Decisions by the Claims Administrator or the Plan Administrator are solely decisions with respect to Plan coverage and do not constitute health care recommendations or advice.*

GENERAL PLAN INFORMATION

The Vision Plan benefit option is just one Benefit option offered under the Plan. Refer to the *General Information SPD* for important and general Plan information including, but not limited to, the following sections:

- Eligibility
- When Coverage Begins
- When Coverage Ends
- How to Appeal a Claim
- Circumstances that May Affect Your Plan Benefits
- The Plan's Right to Restitution
- Coordination of Benefits
- Plan Information (e.g. Plan Sponsor and EIN, administration, contact information, Plan Number, etc.)
- Your ERISA Rights
- Notice of HIPAA Rights
- Your Rights to COBRA and Continuation Coverage
- General Administrative Provisions
- Required Notice and Disclosure
- Glossary of Defined Terms

Consequences of Falsification or Misrepresentation
You will be given prior written notice that coverage for you or your Dependent(s) will be terminated if you or your Dependent(s) are determined to falsify or intentionally omit information, submit fraudulent, altered, or duplicate billings for personal gain, allow another party not eligible for coverage to be covered under the Plan or obtain Plan Benefits, or allow improper use of your or your Dependent's coverage. You and your Dependent(s) will not be permitted to benefit under the Plan from your own misrepresentation. If a person is found to have falsified any document in support of a claim for Benefits or coverage under the Plan, the Plan Administrator may without anyone's consent terminate rescission coverage, possibly retroactively, if permitted by law (called "rescission"), depending on the circumstances, and may seek reimbursement for Benefits that should not have been paid out. Additionally, the Claims Administrator may refuse to honor any claim under the Plan. You are also advised that by participating in the Plan you agree that suspected incidents of this nature may be turned over to Plan Administrator and/or Corporate Security to investigate and to address the possible consequences of such actions under the Plan. All Covered Persons are periodically asked to submit proof of eligibility to verify claims. **Note**: All Participants by their participation in the Plan authorize validation investigations of their eligibility for Benefits and are required to cooperate with requests to validate eligibility by the Plan and its delegates.

For other loss of coverage events, refer to the *General Information SPD* as applicable.

You Must Follow Plan Procedures
Please keep in mind that it is very important for you to follow the Plan's procedures, as summarized in this SPD, in order to obtain Plan Benefits and to help keep your personal

health information private and protected. For example, contacting someone at the Company other than the Claims Administrator or Plan Administrator (or their duly authorized delegates) in order to try to get a Benefit claim issue resolved is not following the Plan's procedures. If you do **not** follow the Plan's procedures for claiming a Benefit or resolving an issue involving Plan Benefits, there is no guarantee that the Plan Benefits for which you may be eligible will be paid to you on a timely basis, or paid at all, and there can be no guarantee that your personal health information will remain private and protected.

Plan Number

The Plan Number for the CenturyLink Health Care Plan is 512.

CLAIMS ADMINISTRATORS AND CONTACT INFORMATION

Vision Service Plan

Vision care claims (800) 877-7195
P.O. Box 385018
Birmingham, AL 35238-5018

Website Address: www.vsp.com TDD (800) 428-4833

CenturyLink

CenturyLink Service Center for Health and Welfare Benefits
P.O. Box 1407 (800) 729-7526
Lincolnshire, IL 60069

Website Address: www.centurylinkhealthandlife.com

VISION PLAN BENEFIT FEATURES

Procedures for Using the Vision Plan Benefits
If you choose to receive plan benefits from a member doctor, contact VSP or a VSP member doctor. A list of names, addresses and phone numbers of member doctors in your geographic location can be obtained from VSP at (800) 877-7195, for TDD (800) 428-4833 or visit the website at www.vsp.com.

VSP will provide benefit authorization directly to the VSP member doctor. If you contact the VSP member doctor directly, you must identify yourself as a VSP member so the doctor knows to obtain benefit authorization from VSP.

When such benefit authorization is provided by VSP and services are performed prior to the expiration of the benefit authorization, this will constitute a claim against the Plan in spite of your termination of coverage or the termination of the Plan. Should you receive services from a member doctor without such benefit authorization or obtain services from a provider who is not a member doctor, you are responsible for payment in full to the provider.

You pay only the copayment to a VSP member doctor for services covered by the Plan. VSP will pay the member doctor directly according to their agreement with the doctor.

When you use a non-member doctor, called an “Open Access Provider”, you should pay the doctor his/her full fee. You will be reimbursed by VSP in accordance with the Open Access provider reimbursement schedule listed under Open Access Provider benefits. Refer to the *Benefits Summary Chart* in this SPD.

In emergency conditions, when immediate vision care is necessary, you can obtain covered services by contacting a VSP member doctor or an Open Access Provider. Emergency vision care is subject to the same benefit frequencies, plan allowances, copayments and exclusions.

In the event of termination of a member doctor’s membership with VSP, VSP will remain liable to the member doctor for services rendered to you at the time of termination and permit the member doctor to continue to provide with plan benefits until the services are completed or until VSP makes reasonable and appropriate arrangements for the provision of such services by another authorized doctor.

Benefit Authorization Process
VSP authorizes plan benefits in accordance with the latest eligibility information furnished to VSP by CenturyLink. When you request services under the Plan, your prior utilization of plan benefits will be reviewed by VSP to determine if you are eligible for new services based upon the Plan’s level of coverage.

HOW TO FILE A BENEFIT CLAIM

This section provides you with information about how and when to file a claim.

If You Receive Covered Health Services from a VSP Member Doctor
When you obtain services from a VSP member doctor, the VSP member doctor will file the claim on your behalf. You are responsible for paying the co-payments to the VSP member doctor at the time you receive care.

If You Receive Covered Vision Services from an Open Access Provider
Typically, when you obtain services from an Open Access Provider, you are responsible for requesting payment from Vision Service Plan, the Claims Administrator. You must file the claim in a format that contains all of the information required as described below. Reimbursement will be paid directly to you.

1) Your name and address
2) If the claim is for your Dependent, you must provide their name, date of birth and their relationship to you.
3) Your social security number
4) Name of your employer
5) An itemized bill from your provider that includes the following:
   - Patient Diagnosis
   - Date(s) of service
   - Procedure Code(s) and description of service(s) rendered
   - Provider of service name and address

You must submit a request for payment of benefits no later than 24 months after the date of service. However, you should pay the full bill and send your itemized statement of charges along with a claim form to:

Vision Service Plan
P.O. Box 385018
Birmingham, AL 35238-5018

Claim forms can be obtained by calling VSP Customer Service at 1-800-877-7195 or visiting the VSP website at www.vsp.com .

Note: Some Open Access providers have the ability to check eligibility and benefits and handle claims and can file your claim for you and VSP will reimburse the provider the benefit allowance directly. If the Open Access provider does not have the ability to file a claim for you, you will need to submit the claim for reimbursement as described above.

Payment of Vision Plan Benefits
Vision Service Plan will make a benefit determination as set forth below. Benefits will be paid to the VSP member doctor. Benefits will be paid to you when using an Open Access Provider, except as noted above.

Note: If you are enrolled in the Health Care Flexible Spending Account, you may be able to pay your portion of the Vision expense with your Health Care Spending Card and avoid the need to file for a claim reimbursement. See the *Flexible Spending Account(s) SPD* for more information.

Benefit Determinations--Post-Service Claims
Post-service claims are those claims that are filed for payment of benefits after care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim.

The Claims Administrator will notify you within this 30-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for the denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures. ***See elsewhere in this summary for more information on appeal procedures.***

Explanation of Benefits. Well Vision Savings statements are available on vsp.com for In-Network claims that have been processed. Simply register on vsp.com to gain access to these statements. For out-of-network claims an explanation of payment will be provided on the reimbursement check stub for your reference. You can always contact VSP Customer Care at 1-800-877-7195 for assistance or additional information or to request to receive a paper copy of your statements in the mail.

COVERED VISION PLAN BENEFITS

This section is a summary of expenses covered by the CenturyLink Vision Plan Option.

VSP Provider Benefits
If you use the services of a VSP member doctor, the Vision Plan Option will pay covered vision care services as follows:

Eye Exam
One eye examination each calendar year, paid in full after your $20 co-payment. This includes a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities. This does **not** include exams needed to evaluate medical symptoms (i.e. eye pain) or contact lens fitting and evaluation.

Glasses
Certain lenses and frames are paid in full after your $40 co-payment*, as follows:

Lenses are available each calendar year. The VSP member doctor will order the proper lenses if needed. The doctor also verifies the accuracy of the finished lenses.

Full coverage is available for polycarbonate lenses for children.

There will also be an extra charge if you select special lenses, including but not limited to tinted lenses, contact lenses (except as noted), oversize lenses, progressive multi focal lenses, certain tints and coating for lenses.

A frame is available once every two consecutive calendar years. If you select a frame that costs more than the amount allowed by the plan, there will be an additional charge. You will receive a $130 allowance ($70 at Costco) towards any frame of your choice plus 20% off any amount over the allowance.

* The $40 material copayment is charged only once when lenses and frames are purchased at the same visit.

Contact Lenses
Benefits for contact lenses are available in lieu of (instead of) glasses. The Vision Plan benefit option pays 100% for routine eye exam after $20 copayment plus up to $125 for contact lens exam (fitting and evaluation) and contacts. A 15% discount will be applied to the contact lens fitting and evaluation before the $125 allowance is applied.

Medically necessary contact lenses are covered in full when a VSP member doctor secures proper approval. Medically necessary contact lenses may be prescribed by a VSP doctor for certain conditions. A VSP doctor will determine eligibility for these types of lenses at the time of service.

Laser Vision Correction Discounts
Laser vision correction discounts are available for people who are nearsighted, farsighted or have a stigmatism, and who wear glasses or contacts. By using participating VSP doctors, you receive on average a 15% discount off laser surgery or an additional 5% off the center's promotional price.

To Request Benefits
Once you have made an appointment with a member doctor, the doctor will verify benefit coverage on your behalf prior to rendering service. If you need to locate a member doctor in your area or wish to verify your level of coverage prior to your appointment, call VSP at (800) 877-7195 or visit the web site at www.vsp.com .

Open Access Provider Benefits
If you use the services of an optician, ophthalmologist or optometrist who is not a VSP member doctor, you will be required to pay the full fee to your provider. The plan will repay you according to the reimbursement schedule shown below. There is no assurance that the schedule will be sufficient to pay for the examination or the glasses.

Some Open Access providers have the ability to check eligibility and benefits and handle claims and can file your claim for you and VSP will reimburse the provider the benefit allowance directly. If the Open Access provider does not have the ability to file a claim for you, you will need to submit the claim and reimbursement will be paid directly to you as described in the section on *How to File a Benefit Claim*.

Availability of services under the reimbursement schedule is subject to the same exclusions and limitations as those described for member doctor services.

Open Access Provider Schedule of Benefits
If you obtain services from an Open Access provider, VSP will reimburse you the following:

Professional Fees
Eye examination, up to $45 after $20 copayment

Materials
Single vision lenses, up to $45 after $40 copayment
Bifocal lenses, up to $65 after $40 copayment
Trifocal lenses, up to $85 after $40 copayment
Lenticular lenses, up to $125 after $40 copayment
Frame, up to $47 after $40 copayment

Contact Lenses
Elective Contact lens exam (fitting and evaluation) and contacts, up to $105
Medically Necessary, up to $210

Low Vision
$1,000 maximum benefit every two years (includes one supplemental exam/evaluation and the remaining allowance is for materials). If low vision supplemental testing is approved, it will be covered in full by VSP every two years. If low vision aids are approved, VSP will pay 75% of the approved amount up to a maximum of $1,000 (less any amount paid for supplemental testing) per covered individual every two years. The patient is responsible for the remaining 25% of the approved amount plus any amount over the maximum.

Benefit Summary Chart

	VSP Doctor	Open Access Provider
Eye Exams (once every plan year)	Plan pays 100% after $20 copayment	VSP reimburses you (after $20 copayment) up to a maximum of $45
Lenses: Single Vision Lined Bifocals Lined Trifocals Lenticular (One every plan year)	Pays 100% after $40 copayment[1] (Includes polycarbonate lenses for child(ren) under 26)	VSP reimburses you (after $40 copayment) up to: $45 $65 $85 $125 (Does not include polycarbonate lenses for child(ren)
Lens Options	Member pricing on any non-covered lens options (i.e. progressive lenses, high index lenses, etc.)	No discounts available
Frames (one pair every other plan year)	Plan pays 100% of VSP allowable amount of $130 ($70 at Costco) after $40 copayment,[1] you will receive a 20% discount on the charges over the VSP allowable amount.	VSP reimburses you (after $40 copayment) up to a maximum of $47
Contacts (contact lenses may be chosen once every plan year instead of eyeglass frames and lenses)	Plan pays 100% of routine eye exam plus up to $125 for contact lens exam (fitting and evaluation) and contacts; a 15% discount will be applied to the contact lens fitting and adjust before the $125 allowance is applied.	VSP reimburses you up to $105 for contact lens exam (fitting and evaluation) and contacts.
Laser Eye Surgery[2]	Discounted rates available. The VSP doctor will coordinate referrals for qualified candidates to participating VSP Laser Surgery Centers. The maximum you will pay is: PRK: Up to $1,500 per eye Lasik: Up to $1,800 per eye Custom Lasik: Up to $2,300 per eye (using wavefront technology only—other technologies not covered under Custom Lasik)	No discounts available

1 The $40 material copayment is charged only once when lenses and frames are purchased in the same visit.

2 Your pre- and post-operative services and laser correction are provided at a discounted rate at participating laser centers. While discounts will vary by location, the average is 15 percent off of the laser center's Usual and Customary price. Additionally, if the laser center is offering a temporary price reduction, you may receive an additional discount. Please consult your VSP doctor for further details.

EXCLUSIONS: VISION BENEFITS/SERVICES NOT COVERED

The Vision Plan benefit option does not pay benefits for the services listed below. The list of services below, however, is not meant to be an exhaustive list of the services not covered and it is subject to change from time to time and over time. It is your responsibility to confirm whether a vision service or product is covered under the Vision Plan benefit option by calling VSP Customer Service before services are received.

- Orthoptics or vision training and any associated supplemental testing.
- Non-prescription lenses.
- Two pairs of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this plan which are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eye. These services, if medically necessary, may be covered by the medical plans.
- Warranties, insurance and similar programs.
- Non-prescription sunglasses.
- Expenses in excess of eligible expenses.
- Services or supplies that are not covered vision services under the plan.
- Charges for any claim received by the Claims Administrator more than 24 months from the date of service.
- Any treatment, service or supply that would have been covered had the individual obtained coverage required by law, i.e., coverage required under state workers' compensation or motor vehicle insurance laws. An individual who has not complied with such legal requirements will not be eligible for any benefits for that illness, injury or condition, including any re-injury, aggravation, etc.
- Any treatment, service, or supply provided to a member for whom the member would not be held financially responsible in the absence of coverage.
- Any treatment, service or supply that was received as a result of the following:

  (a) Violent conflicts. This includes participation in an insurrection, war (whether or not declared), military service, any civil disturbance, riot, piracy, highjack, or any and all acts incident to such events. "Participation" does not include being at the scene of such an event in the performance of your duties for the Company.

  (b) Law violations. This means attempting to violate or violating criminal or motor vehicle laws, except where the violation was unwitting, unpremeditated, and

without actual (as opposed to implied) criminal intent.

- Any treatment, service or supply that is received as a result of an accident, illness or injury arising out of or related to employment or self-employment for wage or profit.

- Any treatment, service or supply which was or would have been covered had the individual obtained coverage by or through any government, including, to the extent permitted under present or future federal law, Medicare, or which was or would have been covered had the individual obtained coverage or taken advantage of any program offered by any government agency, i.e., Veterans Administration.

- Examination or treatment ordered by a court or in connection with legal proceedings unless such examination or treatment otherwise qualify as covered services.

- Charges for broken, canceled, or postponed appointments, or for the completion of claim forms or related documents required by the Plan for claims administration purposes or other Company-sponsored programs.

- Interest, finance charges, local or state sales taxes.

CLAIMS AND APPEALS PROCEDURES

Questions and Appeals – What to Do First

The Plan Administrator believes that most claim issues, such as a denied claim, can be addressed informally if promptly and objectively raised with the appropriate Claims Administrator, and that the best time to solve a problem or answer a question is when it first arises, not days, weeks or months later. In no event should it be more than a year after you have been notified and are aware of the issue.

Participants who have had a claim denied, have questions or complaints, etc., may informally contact the Claims Administrator before requesting a formal appeal. If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in the *How to File a Benefit Claim* section, you may appeal it without first informally contacting the Claims Administrator.

How to Appeal a Denied Service Claim

If a claim for Benefits is denied in part or in whole, you may call the Claims Administrator at 1 800-877-7195 or VSP.com before requesting a formal appeal. If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

When appealing a denied claim, please be aware that there are Service Claim appeals processed by the Claims Administrator as well as Eligibility/Participation appeals processed by the Plan Administrator. Both types of appeal have two levels of appeal processing each with their own requirements as described below.

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your Level 1 appeal in writing within 180 days of receiving the claim denial which is also called an “adverse benefit determination”. **Vision claims are typically post-service claims.** You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and SSN
- the provider's name;
- the date of vision service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. Most of these are typically medical related claims. **Vision services are typically only post-service claims.** If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Review of an Appeal
The Claims Administrator will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if the Claims Administrator upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal
Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Claims Administrator within 60 days from receipt of the first level appeal determination.
Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. the Claims Administrator will review all claims in accordance with the rules established by the U.S. Department of Labor.

Federal External Review Program
If, after exhausting your internal appeals, you are not satisfied with the determination made by the Claims Administrator, or if the Claims Administrator fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of the Claims Administrator's determination.

You may request an external review of an adverse benefit determination if the denial is based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the VSP toll-free number or by sending a written request to the address set out in

the determination letter. **Please Note this Deadline**: A request must be made within four (4) months after the date you received the Claims Administrator's decision.

An external review request should include all of the following:
- a specific request for an external review;
- the Covered Person's name, address, and SSN;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). The Claims Administrator has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:
- a preliminary review by the Claims Administrator of the request;
- a referral of the request by the Claims Administrator to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, the Claims Administrator will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the preliminary review, the Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Claims Administrator will assign an IRO to conduct such review. The Claims Administrator will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

The Claims Administrator will provide to the assigned IRO the documents and information considered in making the Claims Administrator's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by the Claims Administrator; and

- all other information or evidence that you or your Provider submitted. If there is any information or evidence you or your Provider wish to submit that was not previously provided, you may include this information with your external review request and the Claims Administrator will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Claims Administrator. The IRO will provide written notice of its determination (the “Final External Review Decision”) within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and the Claims Administrator, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing the Claims Administrator determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.
You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or

- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, the Claims Administrator will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the review, the Claims Administrator will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Claims Administrator will assign an IRO in the

same manner the Claims Administrator utilizes to assign standard external reviews to IROs. The Claims Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by the Claims Administrator. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to the Claims Administrator. You may contact the Claims Administrator at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined by the medical benefit option;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and the Claims Administrator are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	**24 hours**
You must then provide completed request for Benefits to the Claims Administrator within:	**48 hours** after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	**72 hours**
If the Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
	determination
The Claims Administrator must notify you of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call the Claims Administrator as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, the Claims Administrator must notify you within:	**5 days**
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	**15 days**
You must then provide completed request for Benefits information to the Claims Administrator within:	**45 days**
The Claims Administrator must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	**15 days**
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse benefit determination (file a first level appeal) no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	**30 days**
You must then provide completed claim information to the Claims Administrator within:	**45 days**
The Claims Administrator must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

How to Appeal a Denied Eligibility/Participation Claim
After you receive an initial denial of a submitted claim, there are **two** levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Claims Administrator within 180 days from the receipt of the first level appeal determination. The below chart outlines both the timeline for filing an appeal by you and for receiving responses from the Claims Administrator.

Eligibility/Participation Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator must notify you within:	**30 days**
You must then provide completed claim information to the Claims Administrator within:	**45 days**
The Claims Administrator must notify you of the benefit determination:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than (First Level appeal):	**180 days** after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**180 days** after receiving the first level appeal decision
The Claim Administrator must notify you of the second level appeal decision for eligibility/participation claim within:	**60 days** after receiving the second level appeal (up to an additional 30 days may be required if necessary)

Time Deadline to File a Claim and the Time Deadline to File a Benefit-Related Lawsuit. The Health Plan provides that no person has the right to file a civil action, proceeding or lawsuit against the Health Plan or any person acting with respect to the Health Plan, including, but not limited to, the Company, any Participating Company, the Committee or any other fiduciary, or any third party service provider unless it is filed within the timing explained as follows below:

Initial Claim: The time frame for filing an initial claim for a premium Payroll Adjustment is the earlier of:

(1) Within 180 days of an adverse decision by the Plan Administrator, or
(2) The earlier of:
    a. Within 180 days of the effective date of an election that is later claimed to be erroneous, or
    b. By the last day of the Plan Year of when the election error is claimed to have occurred. If the initial claim is not filed by this deadline, it shall be deemed untimely and denied on that basis. Appeals from a claim denial must also be timely filed as described in the Summary Plan Description.

Legal Action Deadline: After you have exhausted or completed the claims and appeals procedures as explained above, you may pursue any other legal remedy, such as bringing a lawsuit or civil action in court provided, that you file a civil action, proceeding or lawsuit against the Plan or the Plan Administrator or the Claims Administration no later than the last day of the twelfth month following the later of (1) the deadline for filing an appeal under the Plan or (2) the date on which an adverse benefit determination on appeal was issued to you with respect to your Plan benefit claim.

This means that you cannot bring any legal action against the Plan, the Employee Benefits Committee or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action, you must do so no later than the last day of the 12th month from the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan or the Claims Administrator.

SUBROGATION AND REIMBURSEMENT

The Plan has the right to subrogation and reimbursement. ***See the General Information SPD for more details regarding the Plan's right of recovery or Subrogation.***

GENERAL ADMINISTRATIVE PROVISIONS

This section summarizes the legal information about the Plan. For more information, refer to the *General Information* SPD.

Plan Document

This Benefits Summary presents an overview of your Benefits. In the event of any discrepancy between this summary and the official *Plan Document*, the *Plan Document* shall govern.

Records and Information and Your Obligation to Furnish Information

At times, the Plan or the Claims Administrator may need information from you. You agree to furnish the Plan and/or the Claims Administrator with all information and proofs that are reasonably required regarding any matters pertaining to the Plan, including eligibility and Benefits. If you do not provide this information when requested, it may delay or result in the denial of your claim.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you, to furnish the Plan or the Claims Administrator with all information or copies of records relating to the services provided to you. The Plan or the Claims Administrator has the right to request this information at any reasonable time as well as other information concerning your eligibility and Benefits. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed an enrollment form, if applicable.

The Plan agrees that such information and records will be considered confidential. We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required by law or regulation.

For complete listings of your medical records or billing statements, we recommend that you contact your Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we and the Claims Administrator will designate other persons or entities to request records or information from or related to you, and will release those records as necessary. Our designees have the same rights to this information as we have. During and after the term of the Plan, we and our related entities may use and transfer the information gathered under the Plan, including claim information for research, database creation, and other analytic purposes.

Interpretation of Plan

The Plan Administrator, and to the extent it has delegated to the Claims Administrator, have sole and exclusive authority and discretion in:

- Interpreting Benefits under the Plan

- Interpreting the other terms, conditions, limitations, and exclusions set out in the Plan, including this SPD
- Determining the eligibility, rights, and status of all persons under the Plan
- Making factual determinations, finding and determining all facts related to the Plan and its Benefits
- Having the power to decide all disputes and questions arising under the Plan

The Plan Administrator and to the extent it has delegated to the Claims Administrator may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Plan Administrator, or its authorized delegate, may, in its sole discretion, offer Benefits for services that would not otherwise be Covered Health Services. The fact that the Plan Administrator does so in any particular case shall not in any way be deemed to require them to do so in other similar cases.

Right to Amend and Right to Adopt Rules of Administration
The Plan Administrator, the CenturyLink Employee Benefits Committee, may adopt, at any time, rules and procedures that it determines to be necessary or desirable with respect to the operation of the Plans. The Company, in its separate and distinct role as the Plan Sponsor has the right, within its sole discretion and authority, at any time to amend, modify, or eliminate any benefit or provision of the Plan or to not amend the Plan at all, to change contribution levels and/or to terminate the Plan, subject to all applicable laws. The Company has delegated this discretion and authority to amend, modify or terminate the Plan to the CenturyLink Plan Design Committee.

Circumstances that May Affect Your Benefit
There are limitations that may apply to your Benefit under the Vision Plan benefit option. Some of these are listed in this SPD, but there may be other circumstances that are listed in the *General Information SPD* and you are encouraged to review that document to fully understand your benefit coverage.

Clerical Error
If a clerical error or other mistake occurs, however occurring, that error does not create a right to Benefits. Clerical errors include, but are not limited to, providing misinformation on eligibility or benefit coverages or entitlements or relating to information transmittal and/or communications, perfunctory or ministerial in nature, involving claims processing, and recordkeeping. Although every effort is and will be made to administer the Plan in a fully accurate manner, any inadvertent error, misstatement or omission will be disregarded and the actual Plan provisions will be controlling. A clerical error will not void coverage to which a Participant is entitled under the terms of the Plan, nor will it continue coverage that should have ended under the terms of the Plan. When an error is found, it will be corrected or adjusted appropriately as soon as practicable. Interest shall not be payable with respect to a Benefit corrected or adjusted. It is your responsibility to confirm the accuracy of statements made by the Plan or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan Documents.

Administrative Services
The Plan may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing and utilization management services. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Workers' Compensation Not Affected
Benefits provided under the Health Plan do not substitute for and do not affect any requirements for coverage by Worker's Compensation insurance.

Conformity with Statutes
Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered), is hereby amended to conform to the minimum requirements of such statutes and regulations. As a self-funded plan, the Plan generally is not subject to State laws and regulations including, but not limited to, State law benefit mandates. This benefit option is an "excepted benefit" not subject to the mandated requirements of the Affordable Care Act.

Refund of Benefit Overpayment
If the Plan pays Benefits for expenses incurred by a Covered Person, that Covered Person, or any other person or organization that was paid, must refund the overpayment if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person
- All or some of the payment we made exceeded the cost of Benefits under the Plan
- All or some of the payment was made in error.

The refund equals the amount the Plan paid in excess of the amount the Plan should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future Benefits including adding the amount of the overpayment to your W-2 income.

Additionally, if the Covered Person was determined not to be eligible for the Benefits under the Plan, that individual must refund the amount of the excess Benefit payment and the Plan may undertake collection actions, subject to the requirements of applicable law.