

CenturyLink Health Care Plan

General Information

SUMMARY PLAN DESCRIPTION

for

Active Qwest Represented Employees

CenturyLink, Inc.
Effective January 1, 2019

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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 general plan provisions and the rights and responsibilities of you and the Company under the Plan. Detailed descriptions of the benefit options available under the Plan can be found in each of their own specific benefit option SPDs.

The effective date of this updated *General Information SPD* is January 1, 2019. If you are a Covered Person under the Plan on or after January 1, 2019, this *General Information SPD* supersedes and replaces, in its entirety, any other *General Information SPD* describing its provisions that you currently may possess. Specific details are contained in the official Plan documents (or Policies for fully-insured benefits) and/or Trust agreements which legally govern the operation of the Plans. In the event of any discrepancy between this SPD and the official Plan Document or Policy, the Plan Document and Policy, if applicable, shall govern.

This SPD, together with other plan documents (such as the Summary of Material Modifications (SMMs), the plans and benefit options’ SPDs (hereafter “plan’s summary”), and materials you receive at Annual Enrollment) briefly describe your Benefits as well as rights and responsibilities, under the CenturyLink Health Care Plan (the “Health Plan”), the CenturyLink Disability Plan (“Disability Plan”), the CenturyLink Life Insurance Plan (“Life Plan”), and the CenturyLink Business Travel Accident Plan (“BTA Plan”). These documents make up the official Summary Plan Description for Employees as required by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). Where it is appropriate, the Health Plan, the Disability Plan, the Life Plan and the BTA Plan are referred to collectively as the “Plan”. For the most part, the Plan is self-funded; however, the Life Plan (including AD&D benefits), the BTA Plan, and certain of the long-term disability benefits are insured.

Note: This SPD is for all active CenturyLink Legacy Qwest Bargaining (Represented) Employees. All other CenturyLink Employees should refer to their own applicable CenturyLink plan SPD’s. Eligible retirees are covered by the CenturyLink Retiree and Inactive Health Care plan which has its own SPD’s, with distinct terms and conditions.

The Patient Protection and Affordable Care Act Known as the “Affordable Care Act”
The Affordable Care Act (“ACA”) requires most people to have health care coverage that qualifies as “minimum essential coverage”. The Health Plan provides minimum essential coverage. In addition, The ACA establishes a minimum value standard of benefits to a health plan. The minimum value standard is 60% (actuarial value). The coverage under the Health Plan meets the ACA minimum value standard for the benefits it provides.

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 delegate(s), have the right and discretion to determine all matters of fact or interpretation relative to the administration of the Plan — 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 this SPD.

The Plan is maintained with respect to the Company's Represented Employees pursuant to collective bargaining agreements. A copy of the current collective bargaining agreement is available from the Human Resources Labor Relations Department or by contacting your union directly.

The Required Forum for Legal Disputes. After the claims and appeals procedures are exhausted as explained above, and a final decision has been made by the Plan Administrator, if an Eligible Employee wishes to pursue other legal proceedings, the action must be brought in the United States District Court in Denver, Colorado.

How to Use this Document

This SPD is provided to explain how the Plan works. It describes your Benefits and rights as well as your obligations under the Plan. It is important for you to understand that because this SPD is only a **summary**, it cannot cover all of the details of the Plan or how the rules will apply to every person in every situation. All of the specific rules governing the Plan are contained in the Plan Document and applicable insurance Policies. You and your beneficiaries may examine the Plan Document and other documents relating to the Plan during regular business hours or by appointment at a mutually convenient time in the office of the Plan Administrator. You may also request to receive copies of the Plan documents and insurance policies by making a request to the Plan Administrator in writing. There is a per page charge for the copying expense. For additional information, refer to the *Your ERISA Rights* section.

Capitalized terms are defined in the *Glossary of Defined Terms* section and throughout this SPD or in the specific benefit option 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 *Glossary of Defined Terms*. Note: Some terms may be specific to each benefit option—see the applicable benefit option SPD for additional definitions and clarification.

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

What is an SPD?

This SPD is designed to provide you with a summary and general description, in non-technical language, of the medical/prescription drug, dental, vision, employee assistance benefits, health care and dependent day care flexible spending accounts, all covered under the Health Plan, the life benefits (including AD&D) under the Life Plan, business travel accident benefits under the BTA Plan (collectively called the “Life Plans”) and disability benefits under the Disability Plan without describing all the details set forth in all the Plan Documents. Other important details can be found in the specific SPD and benefit summaries for each plan and benefit option and the respective Plan Documents, or Policies. This SPD is not the Plan Document. The legal rights and obligations of any person having any interest in the Plan are determined solely by the provisions of the Plan Documents and Policies, if applicable. If any of the terms of the Plan Documents are in conflict with the contents of the SPD, the Plan Documents and Policies, if applicable, will always govern. The Plan Documents, Policies and this SPD supersede any and all prior documents you may have been provided regarding your benefits under the Plan.

Health Care Plan Determinations Are Not Health Care Advice

Please keep in mind that the sole purpose of the Health 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 Health 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 Health 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 Health Plan coverage and do not constitute health care recommendations or advice.***

You May Not Assign Your Health Care Benefits to Your Provider or any Third Party

Participants and Eligible Dependents may not voluntarily or involuntarily assign to a physician, hospital, pharmacy or other health care provider or any third party (your “Providers”) any right you have (or may have) to:

- (1) receive any benefit under this Health Plan,
- (2) receive any reimbursement for amounts paid for services rendered by Providers, or
- (3) request any payment for services rendered by Providers.

The Health Plan prohibits Participants and Eligible Dependents from voluntarily or involuntarily assigning to Providers any right you have (or may have) to submit a claim for benefits to the Health Plan, or to file a lawsuit against the Health Plan, the Company, the Plan Administrator, the Claims Administrator, the appeals administrator or any other Plan fiduciary, administrator, or sponsor with respect to Health Plan benefits or any rights relating to or arising from participation in the Health Plan. If Participants and Eligible Dependents attempt to assign any rights in violation of the Health Plan terms, such

attempt will be not be effective. It will be void or otherwise treated as invalid and unenforceable.

This Health Plan provision will not interfere with the Health Plan's right to make direct payments to a Provider. However, any direct payment to a Provider is provided as a courtesy to the Provider and does not effectuate an assignment of Participants' and Eligible Dependents' rights to the Provider or waive the Health Plan's rights to enforce the Health Plan's anti-assignment terms. Any such direct payment to a Provider shall be treated as though paid directly to Participants and Eligible Dependents and shall satisfy the Health Plan's obligations under the Health Plan.

Similarly, you may not assign your Disability benefits to your provider or any Third Party.

Plan Numbers

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

The Plan Number for the Life Plans (Life, AD&D, BTA) and the Disability Plan is 513.

ADMINISTRATORS CONTACT LIST

Throughout the document you will find statements that encourage you to contact the Plan Administrator, the Claims Administrator or another designated entity, for further information. Whenever you have a question or concern regarding your Benefits or a claim, please call the Claims Administrator using the telephone number for Customer Service listed on your ID card (medical benefits only) or from the *Contact Information Chart* below.

The following Chart lists the Customer Service telephone numbers for the different Plan options:

| Claims Administrator or Insurer | Telephone/Web |
|---|--|
| CenturyLink Disability Services Risk Management UNI-CALL (Worker's Compensation) | 800-729-7526, option 1, then option 4 866-UNI-CALL |
| COBRA Administration (provided by the CenturyLink Service Center) | 800-729-7526 www.centurylinkhealthandlife.com |

| Claims Administrator or Insurer | Telephone/Web |
|--|--|
| Employee Assistance Program Beacon Health Options | 800-803-3737 www.centurylink.com/EAP |
| MDLIVE | 888-632-2738 www.centurylink.com/MDLIVE |
| MetLife Dental | 888-356-4191 www.metlife.com/mybenefits |
| UnitedHealthcare Flexible Spending Accounts (FSAs) | 800-311-7849 www.myuhc.com |
| UnitedHealthcare CDHP & HDHP – all states PPO – in all states other than those listed under Highmark below | UnitedHealthcare: 800-842-1219 www.myuhc.com TDD Dial 711 for Telecommunications Relay Services |
| Highmark PPO in the following states: CA, ID, IN, MI, MT, NJ, NC, ND, OH, OR, PA, SC, SD, TN, VA, WA, & WY | 888-778-8334 www.highmarkbcbs.com |
| UnitedHealthcare Pharmacy Management (OptumRX) | 800-842-1219 TDD Dial 711 for Telecommunications Relay Services www.myuhc.com |
| Vision Services Plan (VSP) | 800-877-7195 www.vsp.com |

Participating Providers and Employers

Participants and beneficiaries under the medical plans may obtain Participating Provider Lists, where applicable, upon request to the Claims Administrator(s) and Insurer(s) listed above or upon written request to the Plan Administrator.

Participants and beneficiaries may obtain, upon written request to the Plan Administrator, information as to whether a particular subsidiary or affiliate of the Company is a participating employer in the Plan.

A Word About Your Privacy and the Health Plan

The Health Plan will use protected health information (“PHI”) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Specifically, the Health Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. Please see the *Notice of Privacy* section for more information.

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.

Questions?

If you are a Primary Participant or an eligible Dependent of a Primary Participant who has questions or needs information about your Plan benefits, you first should call the appropriate Plan telephone number on your ID Card (medical/prescription drug benefits only) during regular business hours. Alternatively, and for information regarding other Plan benefits, you can call the telephone numbers listed on the Contact Information Chart above. However, if the Claims Administrator is unable to answer your questions or provide you with the information you seek; contact the CenturyLink Service Center at **800-729-7526 and press the applicable options.**

ELIGIBILITY

You are eligible for Benefit coverage as described in the summary below:

- A regular term full-time employee is eligible for Health Care, Well Connected, Life, Disability (LTD & STD), AD&D, and BTA Insurance coverage on the 31st day of employment. Short-term disability (STD) and Basic Long-Term Disability (LTD) is subject to a one year (366th day) waiting period. You will automatically be enrolled in STD and Basic LTD after you have completed one year of service. You are eligible to enroll in Supplemental LTD the first Annual Enrollment following 365 days of continuous employment. Refer to their bargaining agreement for specific STD and LTD provisions.

- A seasonal part-time, regular part-time, regular term part-time, and incidental employee is eligible for medical, dental, and vision and the Well Connected programs only and on the 31st day of employment.

You are not eligible for health care benefits described in this summary if you are:

- An individual who is not classified by the Company as an “employee” on our payroll system, or
- An individual who is carried on the payroll of another company including but not limited to, a temporary employment service, or whom the Company has classified and/or treated as a vendor, consultant or independent contractor.

Dependent Coverage

In recognition of the wide variety of possible family arrangements, the Company has classified Dependents into a number of categories to determine coverage under the Health Plan (except for the Dependent Day Care Flexible Spending Account), and the Life Plan as noted below.

As an Employee, as defined above in this section of the SPD, you are considered to be the Primary Participant in the Benefits under the Health Plan (except for the Dependent Day Care FSA) and the Life Plan if you are eligible. Your Dependents under the Health Plan (except for the Dependent Day Care FSA), and Life Plan include:

- Legal Spouse- person to whom you are legally married.
- Common-law Spouse-- provided your relationship began in a state that recognizes such arrangements and you complete a Company-approved affidavit showing that your Spouse meets state requirements for recognition.
- Domestic Partner-- a same-sex or opposite-sex Domestic Partner is an adult (at least 18 years of age) who lives with the participant in the context of a long-term, committed relationship. Your Domestic Partner can be covered under the Plan provided you certify (by completing a Domestic Partner Affidavit/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 and have resided together continuously for at least 12 months prior to applying for coverage and intend to continue to reside together indefinitely (this does not apply to the State of Washington or except as permitted by the plan administrator on an exception basis as required by applicable law.)

Note: A new Spouse or Domestic Partner can only be covered if you complete, in a timely manner, the Dependent Verification Process. You will be required to submit an affidavit and other verification documents to validate your relationship status with your dependents. If you fail to complete and submit the necessary documentation, your dependent(s) will be removed retroactively to the effective date and you will be responsible for reimbursement of claims paid under the Plan.

- Child-- The following qualify under the Health and Life Plan's definition of Child. *All Children are covered up to the end of the month in which they attain age 26:*
 - Your biological 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
 - Any child in the process of being adopted by you (if you are responsible for the medical expenses), regardless of residence
 - Your Step-Children
 - Your Foster Children
 - Your Domestic Partner's Children (biological, legally adopted or placed for adoption or foster children)

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|--|
| Note: You are not required to cover your Domestic Partner in order to cover your Domestic Partner's Children |
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- Other minors if either you or your Spouse/Domestic Partner is the court appointed legal guardian or permanent legal custody by a court of law, such as grandchildren, nieces or nephews. For this purpose, the term "court-appointed legal guardian" means that there must be a court order specifically granting you "legal guardianship" of the Dependent(s). These terms do not include a court order that simply grants other status such as legal custody, temporary guardianship, foster placement or ward of the state. You must present the CenturyLink Service Center with a copy of the original court order establishing your status as court-appointed legal guardian
- Your Dependent Children for whom a Qualified Medical Child Support Order (QMCSO) is issued, regardless of whether the Child(ren) currently reside with you. A QMCSO may be issues by a court of law or 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 procedure, same as all other Plan participants. **Note:** Step-Children and Foster Children are not eligible under a QMCSO. See the *When Health Care Coverage Ends* section for removing a Dependent who is covered under a QMCSO.

- **Unmarried Disabled Children** - Children of any age, who have never been married, qualify if they were disabled and covered as a Child *prior* to attaining the limiting age (26) and are determined by the Claims Administrator to be indefinitely incapable of self-support and fully dependent upon you for support. **Note:** Once a disabled Child is removed from coverage after attaining the limiting age the Child will not be eligible for coverage under the Plan—reinstatement is **not** permitted

If your Child is totally disabled and is older than the age 26 limit when you first become eligible for CenturyLink’s medical coverage, then you must enroll the Child for medical coverage when you are first eligible to enroll. If approved, your Child’s medical coverage will start on the date your coverage was first effective. You must complete the application and submit it to the health insurance carrier **within 45 days** of becoming eligible for Benefits. If your Child is under the normal age 26 limit when you first become eligible for medical coverage, then you must enroll the Child for coverage before the disabled Child reaches the normal age 26 limit.

If your Child becomes totally disabled after you first become eligible for CenturyLink’s medical coverage, then you must enroll the Child for CenturyLink’s medical coverage before the normal age 26 limit. If you drop the disabled child’s CenturyLink medical coverage after the normal age 26 limit, then you may not later reenroll the disabled Child for coverage.

- **Child of a Domestic Partner** - Child of a Domestic Partner includes your Domestic Partner’s own biological children and legally adopted Children (including those who are in the legal process of adoption if the Domestic Partner has responsibility for medical expenses) regardless of residence. Such term also includes Children who reside a majority of the Calendar Year in the primary participant’s household and for whom the Domestic Partner is legally declared guardian. This does not include wards of the state, granting of custody, or foster Children

No Dual Coverage. No person may be covered both as an Employee and Dependent, and no person may be covered as a Dependent of more than one Employee. Only one of two named Employees may cover his or her common eligible Dependents at any one time. See below for more details.

Dual Coverage by Plan Participants

CenturyLink benefit plan provisions prohibit any individual from being enrolled in dual coverage in the Company’s medical, dental, vision, dependent Supplemental Life and Supplemental AD&D benefit plan options. These provisions mean that:

- CenturyLink Employees cannot elect coverage for themselves while being enrolled as a qualified Dependent under another CenturyLink Employee’s coverage; and
- Two CenturyLink Employees cannot enroll the same qualified Dependent in coverage separately.
- If you elect coverage during Annual Enrollment and are also covered under the same Plan(s) as a Dependent on another Employee’s/Retiree’s coverage, your

coverage will be corrected once the enrollment period ends. You will remain in coverage under your own record but will be removed as a Dependent from the other Employee's/Retiree's coverage.

NOTE: If you are an active CenturyLink Employee enrolled as a Dependent through a Legacy Qwest pre-1991 Retiree, and you also enroll in active Employee coverage, you will remain covered as a Dependent under the Retiree's coverage.

Dual Coverage Option for Child Supplemental Life Insurance

Dual coverage is not allowed. Co-employed Spouses/Domestic Partners who wish to have Supplemental Life coverage for their Children must select which Employee will hold the coverage for each Child.

DEPENDENT VERIFICATION

To assure compliance with Plan terms, the Company may periodically conduct audits of covered Dependents to determine their continued eligibility for Benefits under the Plan. Employees will be required to timely provide supporting documentation to verify the eligibility and relationship (for Spouse, Child and Stepchild, etc.) and financial interdependency (for Spouse/common-law Spouse and Domestic Partner) of their Dependents covered under the Plan. This documentation may include, but is not limited to, birth and marriage certificates, tax returns, court orders and/or proof of residence. To view the eligibility documentation required, log on to the CenturyLink Health and Life website at www.centurylink.com/healthandlife (if actively employed) or www.centurylinkhealthandlife.com. Click on the *Health and Insurance* tab. Then Click on *Plan Information* under *Coverage Details*. Scroll down to the ***Dependent Verification Documents Required***. You can also sign on through single sign on through the intranet on InsideLink.

Coverage for Dependents will become effective prior to completion of the verification process. Any individuals who are determined to be ineligible, or for whom proof of coverage is not received timely, will be removed from coverage retroactively to the date they were added, and you will be responsible for any health care claims that were incurred during the ineligible period. Premium adjustments, if applicable, will be processed as soon as administratively possible. The full amount of the retroactive pre-tax benefit premium contribution will be processed as current plus one retroactive deduction until the retroactive amount is reduced to zero.

See the *When Health and Life Coverage Begins* and *When Health Plan Coverage Ends* sections for adding and dropping Dependents. Also refer to *Changing Your Health Care Coverage—Qualified Life Events*' section for additional information.

RETIREE HEALTH CARE AND LIFE INSURANCE

For more details consult the *CenturyLink Retiree and Inactive Health Plan SPD*. Once you are **retired and Medicare eligible**, group medical Benefits are no longer available. See the *Medicare and Benefit Coverage* section for more details.

Re-Hired Retirees

If you return to work directly for the Company as an active employee, and you are eligible for retiree health care or life insurance from the Company, refer to the applicable section below to see how your retiree benefits may be impacted. Your retiree health care benefits may also be suspended/ impacted if you work indirectly for the Company on an assignment or project through a Company supplier or vendor. Please read below.

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

If you return to work for a supplier on assignment to the Company, you are not eligible to continue to your retiree health benefits as they must be suspended for the duration of your assignment with the supplier and you are not eligible for active benefits under the Company Plans; however, you will be offered the opportunity to continue your retiree medical and/or dental coverage under COBRA. Your retiree basic and supplemental life coverage, if applicable, will continue under the terms of the CenturyLink Life Insurance Plan (“the Life Plan”).

Once your employment or assignment ends, you may resume your retiree health care, basic and supplemental life insurance coverage, if applicable, in accordance with the terms of the Plan by calling the CenturyLink Service Center at 800-729-7526. If you returned to work for a supplier on assignment to the Company, CenturyLink will validate that your assignment has ended before you will be allowed to resume your retiree health care coverage.

Note: If you are Medicare eligible and have enrolled in an individual Medicare policy, you may need to complete a disenrollment process to be released by that carrier from the individual plan (which can take up to 60 days).

Impact On Retiree Healthcare For Transfers Between Represented and Management

The following rules will be applied solely for purposes of determining eligibility for retiree health and life coverage under the Plans.

Management to Represented Transfers:

Any Employee who:

1. was a Management Employee and transfers to or is rehired into an Represented position, and
2. retires on or after January 1, 2004

Must be employed as an Represented Employee for at least 36 consecutive months immediately prior to retiring and must satisfy all other eligibility requirements of the Plans in order to be considered eligible for coverage under the Plans as an Represented retiree. In order to be eligible for retiree health and life Benefits, Represented Employees must meet the Modified Rule of 75.

Otherwise, such Employee shall remain a Management Employee for purposes of retiree coverage under the Plans, provided that he/she satisfies all other eligibility requirements.

Please note that this rule applies solely for determining eligibility for retiree health and life coverage. For more information on retiree health coverage, consult the SPD for the CenturyLink Retiree and Inactive Health Plan.

Represented to Management Transfers:

Any Employee who:

1. was hired as an Represented Employee and transfers or is rehired into a Management position, and
2. retires on or after January 1, 2004

Must be employed as a Management Employee for at least 36 consecutive months immediately prior to retiring and must satisfy all other eligibility requirements of the Plans in order to be considered as eligible for coverage under the Plans as a Management Retiree.

Otherwise, such Employee shall remain an Represented Employee for purposes of retiree coverage under the Plans, provided that he/she satisfies all other eligibility requirements.

Please note that this rule applies solely for determining eligibility for retiree health and life coverage. For more information on retiree health coverage, consult the SPD for the CenturyLink Retiree and Inactive Health Plan.

MEDICARE AND BENEFIT COVERAGE

Medicare Eligibility

If you are an active Employee **and** you are eligible for Medicare, you will automatically be enrolled in Medicare Part A by the Social Security Administration and the Health Plan will continue to be the primary payer. You do not need to obtain Medicare Part B while you are still covered as an active Employee while actively working.

Note: You also do not need to enroll in a Medicare Part D prescription drug benefit as long as the medical benefit options available under the Health Plan provide you with “creditable coverage.” You are advised to read and review the notice that is sent annually to participants to ensure that the Health Plan continues to provide “creditable coverage.”

However, should you **retire**, you will need to notify Medicare of your change in work status immediately so that you may timely enroll in Medicare Part B by the end of the month in which you are retiring without a penalty.

Note: It is best to start the process for obtaining your Medicare Part B approximately 90 days prior to your retirement if you are going to be Medicare eligible at the time of your retirement, or soon after. Medicare will become the primary payer the first of the month after you retire if you are Medicare eligible at the time you retire, and you will no longer be covered under the group medical/prescription drug plan benefit options.

Ending Active Employment:

What Happens to Your Medical, Prescription Drug, Dental and Vision Coverage after you separate from the Company?

Your current medical, prescription drug, dental and vision coverage will continue through the last day of the month in which you separate from the company.

COBRA - Your Next Steps

You may be eligible for up to 18 months of continuation coverage under COBRA. If you wish to enroll, you must timely complete the steps outlined in your COBRA packet. You can enroll online at www.CenturyLinkhealthandlife.com or by calling the CenturyLink Service Center for Health and Welfare Benefits at 800-729-7526 (Option 2, Option 1).

NOTE: If you elect COBRA coverage, your premium costs will be outlined in the COBRA packet you receive from the CenturyLink Service Center.

Medicare Part-B Enrollment

You should start the process for obtaining your Medicare Part B approximately 30-60 days prior to your separation from the company. Medicare enrollment is generally not retroactive.

You will need to complete the Application for Enrollment in Medicare Part B (CMS-40B) and return it to your local Social Security Office. You will also need to submit the Request for Employment Information Form (CMS-L564) to your local Social Security Office. The CenturyLink Service Center will automatically complete this form and send it to your address on file upon your separation from the Company.

A delay in enrollment in Medicare Part B could result in ongoing penalties for the cost of Medicare Part B. Lack of enrollment also may delay your enrollment in a Medicare policy (subject to underwriting) and result in premium penalties for late enrollment.

When You Need Medicare Part B as a Retiree

The Medicare-eligible person will no longer be eligible for coverage under the Company group medical/prescription drug plans effective the first of the month after your separation date., The Medicare-eligible person must enroll in an individual Medicare policy (such as a Medicare Advantage or Medicare Supplement and Medicare Prescription Drug plan) prior to the month of your separation. Medicare guidelines generally prohibit Medicare enrollments from being retroactive, so the enrollment application must be completed prior to the effective date of coverage.

(Note: These late Medicare penalties are added for your lifetime, not just a one-time charge.)

The cost of the Medicare Part B premium is typically paid for from your Social Security check, if applicable, and is in addition to any *individual* Medicare policy premium you select. If you are not yet receiving your Social Security payments, you will need to arrange for another type of payment directly with Medicare for your Medicare Part B coverage.

If you are retiring, see the *CenturyLink Retiree and Inactive General Information SPD or Departing Guide on MyHR* for more information.

Let Via Benefits Help You Enroll

To help you with the Medicare enrollment process, CenturyLink has contracted with the service provider, Via Benefits. You may contact **Via Benefits** at **888-825-4252** for assistance.

Representatives can help you select a policy that best meets your needs. Although you do not have to use them to enroll, there are added benefits, such as possible automatic reimbursement of certain health care premiums. They can discuss your policy options, costs, prescription drug needs, etc., to help you make the best selection.

Declare your dependents. You must declare all dependents you wish to be covered at the time of retirement or even if you wish to add them in the future. If you do not, you will not be able to enroll your existing dependents in the future.

NOTE: You are not eligible to add "new" dependents after your initial retirement elections (i.e., if you get married 10 months after your retirement, you will not be able to add your "new" spouse).

Medicare-Eligible after retirement:

If you and/or your dependents turn age 65 or become Medicare-eligible after your retirement, you will follow the same instructions and rules as those who are Medicare-eligible at retirement, described earlier in this section.

You should receive information from the CenturyLink Service Center for Health and Welfare Benefits and Via Benefits approximately 90 – 120 days in advance of your 65th birthday. If this event occurs shortly after retirement, you should initiate the call to Via Benefits as soon as possible.

ALL HEALTH PLAN BENEFIT OPTIONS allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator network and who is available to accept you or your family members.

HEALTH PLAN ENROLLMENT

Choosing Your Coverage Level

Active Employees: If you are an Eligible Employee, you have the following coverage categories to choose from when enrolling in medical, dental and vision coverage under the Health Plan :

- Employee only
- Employee and Spouse/Domestic Partner
- Employee and Child(ren)
- Employee and Family (consisting of a Spouse/Domestic Partner and one or more dependent Children)
- Waive (no coverage)

You may elect to waive medical/prescription drug coverage under the CenturyLink Health Care Plan. If you waive medical/prescription drug coverage and you are a regular full-time employee, you may be eligible for an annual Waive Medical Rebate credit of \$750 paid evenly on a per pay period basis. The rebate is considered taxable earnings. You will not be eligible for the rebate if you are:

- (1) Covered under another CenturyLink employee's or retiree's medical record as a covered dependent; or
- (2) Out on Military Leave (without pay) or another form of leave (without pay).

You can change your coverage level during the year, subject to the limits on when coverage begins (see the *Qualified Life Events* section for more information).

Newly Eligible Employees. You will receive an email with details on how to enroll in benefits. ***If you don't receive an email prior to your Benefits effective date, contact the CenturyLink Service Center.***

If you do not make elections within the specified timeframe for New Hire Enrollment, Qualifying Life Events (QLEs) or Annual Enrollment or Retirement, you will be assigned default coverage as listed below. You will not be able to change the default coverage until the next Annual Enrollment Period, or your next applicable Qualified Life Event.

More information on changes allowed during the year is provided in the *Changing Your Health Care Coverage* section. Additional information on which of your Dependents qualify for coverage is provided in the *Dependent Coverage* section.

Default Status Rules

New Hire/Newly Eligible

- If you are newly eligible to participate in the Plan, you are an active Eligible Employee and if you fail to enroll in coverage elections in a timely manner, your coverage will default to **no coverage** for medical, dental and vision coverage. You will be eligible to receive the medical waive rebate in the event you are defaulted to no coverage. (**Note:** Regular part-time, Regular Term part-time, Seasonal, and Incidental employees are not eligible for the medical waive rebate). Your Well-connected rewards will default to gift cards
- In addition, you will also default to **no coverage** for your employee supplemental life and AD&D, Health Savings Account (HSA) spouse/domestic partner supplemental life and AD&D, child supplemental life and AD&D and the Health Care and Dependent Day Care FSAs.

Qualifying Life Events (QLEs)

- Within 45 days of the QLE, log on to the Health and Life website and select the QLE event and update. If you do not take action within 45 days of the qualifying event, for example getting married, you will not be able to update your coverage until the following annual enrollment period.

Annual Enrollment

- If you are currently enrolled and you do not submit new coverage elections during Annual Enrollment, you will retain the same health care option **coverage and**

level, you currently have (if available). Any premium costs may vary from year to year or between benefit options. In addition, you will **not** be enrolled for Health Care or Dependent Day Care Flexible Spending Accounts (FSAs) or a Health Savings Account (HSA through a payroll deduction), as these elections **must** be made on an annual basis.

Retirement

- See the CenturyLink Retiree *General SPD* for more details.

Enrollment Limitations. See the *Eligibility and Dual Coverage* section earlier in this *SPD*.

Management to Represented Transfer

- If you are transferring from a Management to Represented position and you fail to submit coverage elections by your enrollment deadline and you were enrolled in coverage you will receive the following default elections:
 1. **Medical.** Default to equivalent benefit option (Premium CDHP to CDHP, Standard CDHP to CDHP, Savings HDHP to HDHP).
 2. **Dental.** No change
 3. **Vision.** No change
 4. **FSA.** The annual election you chose as an Management Employee for your Health Care and Dependent Care FSA will carry over for the remainder of the Calendar Year.
 5. **Life Insurance.** You will receive the same or most similar benefit options you elected as a Management Employee for Basic Life, Basic AD&D, BTA, Supplemental Life, Supplemental AD&D, Spouse and Child Life insurance and AD&D.
 6. **Short-Term Disability.** No change
 7. **Basic LTD.** Coverage continues.
 8. **Supplemental LTD.** No Coverage.

Represented to Management Transfer

- If you are transferring from an Represented to Management position and you fail to submit coverage elections by your enrollment deadline and you were enrolled in coverage you will receive the following default elections:
 9. **Medical.** Default to equivalent benefit option (PPO to Standard CDHP, CDHP to Standard CDHP, HDHP to Savings HDHP).
 10. **Dental.** No change
 11. **Vision.** No change

12. **FSA.** The annual election you chose as an Represented Employee for your Health Care and Dependent Care FSA will carry over for the remainder of the Calendar Year.
13. **Life Insurance.** You will receive the same or most similar benefit options you elected as an Represented Employee for Basic Life, Basic AD&D, BTA, Supplemental Life, Supplemental AD&D, Spouse and Child Life insurance and AD&D.
14. **Short-Term Disability.** After-tax STD option.
15. **Basic LTD.** Coverage continues.
16. **Supplemental LTD. No Coverage.**

Retirement

- See the CenturyLink Retiree General SPD for more details.

Enrollment Limitations

As a Primary Participant covered under the Health Plan, you cannot also be covered under any other health plan of any CenturyLink company as a Dependent.

Dependents under the Health Plan can be covered under only one primary participant (only one of two married employees may cover his or her common eligible Dependents at any one time). In addition, no individual may be covered as a Dependent under this Plan if he or she is covered under any other health plan of a CenturyLink company—unless one retiree is covered under the Legacy Qwest Pre-1991/ERO 92 Retiree Company Guaranteed Health Care plan options.

PLAN COST

Health Plan

Your contribution level for the health care coverage (medical, dental and vision) available to you and your eligible Dependents is based on 3 things: your status on the payroll system/EWW hours, your salary/eligible pay and your coverage elections.

Benefits under the Plan are paid from the general assets of the Plan Sponsor. Any required Employee contributions are used to partially reimburse the Plan Sponsor for Benefits under the Plan.

Life and AD&D Plans

All life and AD&D insurance Benefits are insured through Life and AD&D insurance carriers purchased with premiums paid from Company general assets for Basic Life and AD&D and from premiums paid by you for Employee and Dependent Supplemental Life and Voluntary AD&D.

Business Travel Accident Plan

BTA Benefits are insured through an insurance carrier purchased by the Company from general assets.

Disability Plan

Contributions shall be paid by the Company and the Employees in such proportions as determined by the Company on a periodic basis, subject to provisions in any applicable collective bargaining agreement.

Note: Regular part-time, seasonal part-time, regular term part-time and incidental employees are not eligible for Life, AD&D, BTA, or Disability benefits.

Method of Calculating the Level or Amount of Contributions

The Plan Sponsor may require participant contributions towards the cost of providing coverage under the Plans. A schedule of such required contributions will be available to participants during Annual enrollment each year. The Company reserves the right to change the contribution amounts at any time subject to applicable collective bargaining agreements.

Tax Status of Health Care Contributions

If you are an active Employee receiving a regular salary, your contribution will be deemed to be a salary reduction election (pre-tax), and any such contributions will be deducted from your pay **before** taxes, as long as your pay is sufficient.

Tax Implications of Enrolling Your Domestic Partner under the Health Plan

Any premiums required for a Domestic Partner or Child(ren) of a Domestic Partner are paid on a **before-tax** basis and you are required to pay imputed income on the value of the Company premium paid for your Domestic Partner or Child(ren) of your Domestic Partner. If you wish to enroll your Domestic Partner there are federal and possibly state tax implications. The federal Internal Revenue Code considers the fair market value of this health care coverage to be imputed income to you, which means you will be taxed according to state and federal laws. The Company will report the annual amount of this imputed income on your W-2 Form at the end of each year. Before enrolling your Domestic Partner, you should talk with your tax advisor about the tax implications for you.

Your Health Plan Contribution Level

The Company may provide you with some amount of subsidy towards your health care (medical, dental and vision) coverage premiums. However, you also pay a portion of the cost for these benefits. (**Note:** Regular part-time, seasonal part-time, regular term part-time, and incidental employees with EWW of 20 hours or less do not receive a company subsidy towards their health care coverage).

All health care benefit plan options require participant contributions. The information you receive during Annual Enrollment will include any premium contribution requirements in that will apply to the next Plan year, if you enroll.

Medical contribution requirements vary for different salary tiers (which derive from an Employee's base salary) as follows:

- Less than \$30,000

- \$30,000 but less than \$50,000
- \$50,000 but less than \$70,000
- \$70,000 but less than \$100,000

Equivalent Work Week (EWW)

Once EWW is calculated, the only time EWW changes within the year is when your classification changes (i.e., part-time to full-time, full-time to part-time, full-time to incidental, etc.). The annual EWW calculation period is performed prior to October 1st each year and looks back at the previous 26 bi-weekly pay periods. The EWW calculation is effective January 1st of the next calendar/Plan year.

Payment of Contributions

If you are an active Eligible Employee, you are responsible for paying your portion of the premium each pay period that you are receiving covered Benefits. If you work or receive pay even one day within a pay period, you will have the full/total premium amount deducted from your paycheck.

If at any time you experience a payroll adjustment for health and/or welfare benefits coverage, the payroll adjustment will process in accordance with the payroll schedule or as soon as administratively possible. You will be responsible for any premium deductions retroactive to the event date. Any retroactive balance will process based on the current premium deduction plus one retroactive premium deduction until the retroactive balance has been satisfied (reduced to \$0.00).

If at any time you are eligible for a credit of a health care premium adjustment, the credit will process as a lump sum payment for the retroactive premium credit in accordance with the next payroll schedule or as soon as administratively possible.

Funding

Except for contributions you make toward your Plan coverage as described in the *Your Contribution Level* section, the Company pays for your Benefits from its general assets. However, the Company may choose to fund a portion of your health care coverage by making contributions to one or more trusts established by CenturyLink or its affiliates. If it so decides, these trust funds would then be available for payment of your Benefits in lieu of payment directly from the Company's general funds.

The Company's contributions to the trust funds, if any, may be in the form of the Company's common stock and up to 50% of the Plan's assets may be invested in Company common stock. If the Plan is terminated, any Plan assets will be applied to the payment of Benefits, insurance premiums, or administrative expenses incurred in the provision of Benefits. In no event will trust assets be returned to the Company.

CenturyLink has contracted with several administrators to process claims under various programs included in this Plan. None of these contracted administrators are responsible for contributing toward payment of your Plan coverage.

See *Plan Cost* section above for other Plan information.

HEALTH PLAN COVERAGE

*Your medical, dental, vision, Health Care FSAs (Traditional or Limited) and Dependent Day Care FSA benefit options are consolidated into a single Plan—the Health Plan—to provide you with coverage to meet your needs. In addition, there are other provisions that apply to your elections that you should be aware of. These are described in the next section, *Additional Medical Plan Provisions*. (**Note:** Each benefit option, including the FSAs, has its own specific Summary Plan Description.)*

Medical Benefit Options

Enrollment for health care Benefits will typically take place annually in the Fall. Refer to the below medical benefit options offered within the Plan:

- High Deductible Health Plan (HDHP) with an employee funded HSA
- Consumer-Driven Health Plan (CDHP) with an employee funded HRA
- Preferred Provider Organization (PPO)
- Waive Coverage (no coverage) *

**If you elect to waive medical coverage, you are also automatically electing to waive prescription drug coverage. Prescription drug coverage is bundled with the medical Plan in which you may enroll. See the *Additional Medical Plan Provisions*' section regarding the "medical waive rebate credit" (applicable to Regular Full-Time and Regular Term Full-Time employees only).*

Refer to the specific benefit plan option's SPD for more information about the benefits, provisions and details, defined terms, etc.).

Other Health Care Plan Benefit Options

Regardless of which medical plan benefit option you are enrolled in, the Health Plan also provides you with access to:

- Employee Assistance Program (EAP)
- Well Connected Program/Incentives
- Prescription Drugs
- Dental (Regular Full-Time and Regular Term Full-Time employee only)

- Vision (Regular Full-Time and Regular Term Full-Time employee only)
- Health Care FSAs and Dependent Day Care FSA options (Regular Full-Time and Regular Term Full-Time only)

Your Dependents are also eligible, according to the provisions summarized in the *Dependent Coverage* section. To participate in the Plan, you must submit your coverage elections in accordance with Company directions. If you fail to properly submit your coverage elections in a timely manner, the Company will assign you to a predetermined default status (see *Default Status* section).

Claims Administrators

References to your Claims Administrator will apply to your specific health plan benefit options, such as those listed below. See the full list of Claims Administrators in the *Contact Information Chart* above and in the *Plan Information* section below.

CDHP/HDHP

- UnitedHealthcare (UHC) is the Claims Administrator for the CDHP and HDHP Medical and behavioral benefit options in all states.

PPO

- Highmark is the Claims Administrator for the PPO 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 is the Claims Administrator for the PPO in states not listed above
- OptumRX is the retail pharmacy and home delivery pharmacy for all UHC and Highmark benefit options.
- **Optum** administers the Well-Connected Program/Incentives
- MetLife (Metropolitan Life Insurance Company) administers the dental program
- VSP administers the vision program
- UnitedHealthcare administers the Health Care and Dependent Day Care FSA's
- Beacon Health Options administers the Employee Assistance Plan (EAP)

ADDITIONAL MEDICAL PLAN PROVISIONS

Medical Waive Rebate Credit

(Regular Full-time and Regular Term Full-time employees only)

If you elect to waive medical coverage (including prescription drug coverage) under the CenturyLink Health Care Plan you may be eligible to receive an annual Medical Waive Rebate Credit of \$750 paid evenly on a per pay period basis. Credits will be prorated based on the effective date of the credit. To waive coverage and receive the credit, you must make an affirmative election to waive medical/prescription drug coverage during the election period (typically Annual Enrollment or with a QLE). The rebate is considered taxable earnings.

Note: You are not eligible for the rebate if you are covered under another CenturyLink Employee or Retiree's medical record as a covered Dependent or if you are out on Military Leave or another form of leave (without pay).

Opting out of the rebate credit. In certain cases, in order to be eligible for dependent medical coverage in another employer's plan, Employees would not be able to receive credit for waiving coverage under the CenturyLink Health Care Plan. Therefore, there is a QLE that allows you to opt out. To request this "Waive Opt-Out Option" call the CenturyLink Service Center **within 45 days** of learning that the other employer's plan will not allow you to receive the credit.

Working Spouse/Domestic Partner Surcharge

If your Spouse/Domestic partner has access to a group health plan through his/her employer and waives his/her own coverage and you elect to cover him/her on your CenturyLink medical Plan, a Working Spouse/Domestic Partner Surcharge of \$50 per pay period is added to your medical premium when all of the following apply:

- You are married or in a Domestic Partner relationship; and
- Your Spouse/Domestic Partner is currently employed; and
- Your Spouse/Domestic Partner is not employed by CenturyLink; and
- Your Spouse/Domestic Partner is eligible for coverage under his/her employer's group medical plan (Note: Medicare is not considered a "Group Medical Plan."); and
- You enroll your Spouse/Domestic Partner in the CenturyLink group medical/prescription drug benefit option.

If you answer "Yes" to all of the statements above, the surcharge applies to you and you must select "Yes" in response to the Working Spouse/Domestic Partner question when you enroll on the CenturyLink Health and Life Benefits website at **www.centurylinkhealthandlife.com** or when you speak to a representative at the CenturyLink Service Center.

Two exceptions where the working spouse surcharge will NOT apply:

- Your annual base salary is less than \$30,000, or

- Your annual base salary is less than \$100,000 AND your Spouse/Domestic Partner works for an employer with less than 50 employees

If you answer “No” to at least one of the statements above, the surcharge doesn’t apply to you and you will select “No” in response to the Working Spouse/Domestic Partner Surcharge question when you enroll on the CenturyLink Health and Life Benefits website or when you speak to a representative at the CenturyLink Service Center.

You have a Continuing Obligation to Update the Plan If Your Spouse or Domestic Partner Later Becomes Eligible for Coverage: If you selected the “No” response to the Working Spouse/Domestic Partner Surcharge question because your Spouse’s annual enrollment has passed or your Spouse or Domestic Partner does not work, it is **your responsibility** to notify the CenturyLink Service Center when your Spouse or Domestic Partner becomes eligible and elects to waive his or her employer’s group medical plan.

If the enrollment period has passed for a Spouse/Domestic Partner who could have enrolled in his or her employer’s medical plan and did not, and if his or her employer does not recognize your benefits Annual Enrollment period as a qualifying event for your Spouse/Domestic Partner to enroll, you may elect to cover your Spouse/Domestic Partner for a period of time under the CenturyLink Health Care Plan without paying the Working Spouse/Domestic Partner Surcharge.

The surcharge will be suspended but only until your Spouse/Domestic Partner has the opportunity to enroll for coverage with his or her employer.

Important Note: Once your Spouse/Domestic Partner has the opportunity to sign up for his or her employer’s coverage, it is **your responsibility** to notify the CenturyLink Service Center **within 45 days** of your Spouse’s/Domestic Partner’s enrollment period, to either:

- Remove your Spouse/Domestic Partner from coverage under the CenturyLink Health Care Plan; or
- Keep your Spouse/Domestic Partner covered under the CenturyLink Health Care Plan and begin paying the Working Spouse/Domestic Partner Surcharge because your Spouse/Domestic Partner chose to waive his/her employer’s group medical plan.

Note: The Working Spouse/Domestic Partner Surcharge does not apply to FSA, dental or vision coverage.

Tobacco-Free Discount

(Excludes Employees who work 20 hours a week or less)

The Company offers a 7.5 percent tobacco-free discount off the cost of medical premium contributions if all those enrolled are either non-tobacco users or are enrolled in a Company recognized tobacco cessation program. Tobacco products include but are not limited to the following: cigarettes, pipe tobacco, cigars, chewing tobacco, tobacco snuff, hookahs, e-cigarettes, nicotine gels/dissolvable, vapors and any other products associated with tobacco.

You will be asked to provide information on whether or not anyone enrolled in a medical/prescription drug benefit option under the Plan is a smoker or tobacco user and if all smokers/tobacco users are enrolled in a Company-recognized tobacco cessation program at the time you complete your enrollment. The tobacco-free discount is only available if you and your dependent(s) covered under your medical/prescription drug benefit option are tobacco-free or enrolled in a tobacco cessation program.

Company-recognized tobacco cessation programs vary based upon available resources in your area. You can find information about available tobacco cessation programs on the **InsideLink/Well Connected** page of the intranet or in the medical plan benefit option SPDs.

If you or your dependents become tobacco free or enroll in a Company-recognized tobacco cessation program at any time during the year, you can log back onto the CenturyLink Health and Life website or contact the CenturyLink Service Center at 800-729-7526 to update your tobacco use election.

LIFE COVERAGE

CenturyLink offers a full line of life and accident coverage for both you and your eligible dependents. The plans are as follows:

- Employee Basic Life Insurance
- Employee Basic Accidental Death & Dismemberment (AD&D) Insurance
- Business Travel Accident
- Employee Supplemental Life Insurance
- Employee Supplemental Accidental Death & Dismemberment (AD&D) Insurance
- Spouse/Domestic Partner Supplemental Life Insurance
- Child Supplemental Life Insurance
- Spouse/Domestic Partner Supplemental Accidental Death and Dismemberment (AD&D) Insurance
- Child Supplemental Accidental Death and Dismemberment (AD&D) Insurance

MetLife is the insurance carrier for Life Insurance. Zurich is the carrier for AD&D and Chubb is the carrier for BTA insurance. Please refer to the Life Insurance SPD for more details.

WHEN HEALTH AND LIFE COVERAGE BEGINS

- Coverage is effective 31 days from the date of hire (or rehire). **Note:** Not all employee groups are eligible for all benefits. See the *Eligibility* section earlier in this SPD for more information.
- If you make changes during Annual Enrollment, your new coverage will begin on the first day of the new Calendar Year
- Coverage changes due to Qualified Life Events are generally effective on the date of the event *if the election is made **within 45 days** of the event.* (refer to the *Qualified Life Events* section later in this SPD for examples of Qualified Life Events)

To cover a newly eligible Dependent under the Plan, you must verify that he or she is eligible under the Plan provisions by providing supporting documentation. For each newly added Dependent, you must provide proof of relationship, (e.g., Spouse, Child and Stepchild, etc) and financial interdependency (e.g., Spouse, Common-Law Spouse and Domestic Partner).

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 newly added Dependent. If your completed verification documentation is not received in a timely manner by the CenturyLink Service Center, your Dependent(s) will be removed from coverage retroactive to the date they were added, and you will be responsible for any claims that were incurred during the period in which your newly added Dependent(s) were not verified. Applicable benefit premium adjustments will be processed after the verification process is completed. There could be a slight delay in receiving a retro credit, if applicable, due to the payroll schedule and processing.

To view the eligibility documentation required, log on to the CenturyLink Health and Life website at www.centurylink.com/healthandlife (if actively employed) or www.centurylinkhealthandlife.com. Click on the *Health and Insurance* tab. Then Click on *Plan Information* under *Coverage Details*. Scroll down to the ***Dependent Verification Documents Required***.

You can also access through the Health and Life Benefits Website on HRLink.

QMCSO

Coverage will be provided to an Employee's biological Child(ren) when a Qualified Medical Child Support Order (QMCSO) has been 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.

The following indicates when coverage is effective for Employees and Dependents in specific circumstances:

Employees

- Employee back from approved leave of absence (no Company-paid coverage). Generally, health care coverage is effective the first day of the month following the return from leave. Special rules may apply to Employees returning from a military leave of absence.

MetLife, Zurich, and Standard allow for Life Insurance, AD&D, and Disability coverage to continue for a certain period of time when you are on an approved Leave of Absence. Please contact the CenturyLink Service Center for more details.

- Regular part-time, Seasonal part-time, Regular term part-time, or incidental to Regular full-time or Regular Term full-time: Health, Life, AD&D, BTA, and FSA coverage is effective the date the employee is reclassified provided the 30-days of employment requirement has been met (this change will affect your premium deduction).
- Employees who work 20 hours a week or less to 21-29 hours a week: this change will affect your medical contribution.
- Rehired Employee. Coverage is effective on the 31st day after the rehire date.
- Rehired Retiree. Coverage for active Benefits is effective the first of the following month after the re-hire date for retirees.

Dependents

- Common-law marriages. Coverage is effective the date of the event following receipt of an *approved* notarized affidavit of marriage, if notification was given **within 45 days** of the date the affidavit was notarized.
- Domestic Partner and Children of a Domestic Partner. Coverage is effective the date of the event following receipt and approval of an affidavit of domestic partnership, ***if received within 45 days of the event.*** For Children of a Domestic Partner, coverage begins on the date a Child of a Domestic Partner is acquired ***provided the child is enrolled within 45 days.*** If not enrolled within this 45-day period, the child cannot be added until the next Annual Enrollment Period or next applicable Qualified Life Event. The Child(ren) must qualify as the Domestic Partner's Dependent(s) for federal tax purposes. Domestic Partners and their children are not eligible to participate in the Health Care and Dependent Day Care FSAs for reimbursement.

- Coverage for other Dependents will become effective prior to completion of the verification process. Any individuals who are determined to be ineligible, or for whom proof of coverage is not received timely, will be removed from coverage retroactively to the date they were added, and you will be responsible for any health care claims that were incurred during the ineligible period. Payroll adjustments will be processed in accordance with the payroll schedule or as soon as administratively possible. You will be responsible for any premium deductions retroactive to the event date. Any retroactive balance will process based on the current premium deduction plus one retroactive premium deduction until the retroactive balance has been satisfied (reduced to \$0).
See the *Dependent Certification* section above for more details.

CHANGING YOUR HEALTH CARE COVERAGE—QUALIFIED LIFE EVENTS (QLE)

Generally, your benefit option choices under the Health Plan (medical, prescription drug, dental, vision, Health Care and Dependent Day Care FSAs) and access to EAP will remain in effect for the full Calendar Year and can be changed only during the Annual Enrollment Period.

However, you can make limited changes during the year if you experience a Qualified Life Event (QLE). The benefit changes you request must be consistent with the type of Qualified Life Event change you experience.

If you are making a change to your coverage elections as a result of a Qualified Life Event (as defined by the IRS), coverage for you or your eligible Dependents will be effective either the day of the event, or the first day of the calendar month following your notification to the CenturyLink Service Center, provided notification is given **within 45 days** of the change. If you are removing a dependent, coverage ends on the last day of the month in which the event date occurred.

Qualified Life Event Reminder:

If you experience a Qualified Life Event such as marriage, adoption or birth, or losing other coverage, you must contact the CenturyLink Service Center at www.centurylink.com/healthandlife (if actively employed) or www.centurylinkhealthandlife.com or contact the CenturyLink Service Center at 800-729-7526 within 45 days of the event in order to change your coverage elections. **If you miss the 45-day window, you will not be able to make changes until the next Annual Enrollment.**

Remember, you must add and validate your newborn or adopted child to your coverage, even if you already have family coverage, within 45 days of birth or adoption to cover your Child under the Plan.

Please note: If you are an Employee who wishes to provide coverage for your biological Children who are under an issued QMCSO, see QMCSO information above in this SPD.

Life Insurance Changes. You may also make changes to your Supplemental, Spouse/Domestic Partner, and Dependent Child Life Insurance coverage at any time during the year, provided that you meet the appropriate evidence of insurability (EOI) provisions, if applicable. Please refer to the *Life Insurance SPD* for additional details.

Effect of Changes in Eligibility Status

You will retain your coverage history relating to Plan limitations whenever you are covered by the Plan in any capacity. For example, if both the employee and spouse/domestic partner are covered, any orthodontia expenses incurred by Dependents who are covered by the husband as a Dependent will be carried over for those Dependents if they are later covered by the wife as her Dependents.

Qualified Life Events

The following changes in your family situation are Qualified Life Events and may provide an opportunity for you to modify your benefit choices. All of the following should be reported to the CenturyLink Service Center (***within 45 days of the QLE***):

- Your marriage or divorce;
- Birth or adoption of a Child;
- Death of a Dependent (deaths should be reported to the CenturyLink Service Center by selecting the option “To Report a Death”)
- Start or end of your Spouse/Domestic Partner’s employment impacting your previous coverage or need;
- Work status changes for you or your Spouse/Domestic Partner (for example, part-time to full-time, full-time to part-time, and starting or returning from an unpaid leave of absence, etc.);
- Significant changes in the health care coverage or cost provided by your Spouse/Domestic Partner’s employer;
- Learning that your coverage under another employer’s plan does not permit you to receive CenturyLink’s waived medical rebate credit;
- 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 limit;
- You or your Spouse/Domestic Partner gain or lose eligibility for coverage;

- Spouse/Domestic Partner becoming a Full-time Student (Dependent Day Care FSA only)

The Plan Administrator also has the discretion to recognize other changes allowed by the Internal Revenue Service (IRS). CenturyLink may require documentation of a Qualified Life Event prior to processing a change in coverage election.

If you do not notify the CenturyLink Service Center within 45 days (or 60 days if the event is subject to Children's Health Insurance Program (CHIP) from the date of the qualifying status change, you will not be allowed to make changes until the next Annual Enrollment period. Additionally, if the QLE was a COBRA event, your Dependent will lose the opportunity to elect COBRA if you do not notify the CenturyLink Service Center within 60 days of the QLE. See the *Required Notice and Disclosure* section of this SPD for more information.

Report Change of Status Due to Qualified Life Event--Gain in Eligibility

To qualify for a change in your benefit option choices, you must contact the CenturyLink Service Center ***within 45 days of the Qualified Life Event change***. Changes to your coverage are generally effective on the date of the QLE (including Legal Guardianship and QMSCOs on date of order). **Note:** Even if you already have dependent coverage, **you must add** your new dependent to your coverage within 45 days of the QLE. ***Changes to coverage due to a Qualified Life Event received more than 45 days after the Qualified Life Event will not be accepted*** and your coverage will remain the same.

Report Change of Status Due to Qualifying Life Event--Loss in Eligibility

Changes in your coverage elections due to a loss of your Dependents' eligibility, reported within 45 days of the Loss will be effective as of the first day of the month following the event effective date. However, please note:

- Coverage will be dropped retroactively for an ineligible Dependent if you contact the CenturyLink Service Center **after** 45 days of the Qualified Event
- COBRA: If you fail to notify the CenturyLink Service Center ***within 60 days of the change***, the Dependent losing eligibility and coverage will not be eligible to continue coverage through COBRA. **You will be responsible for any repayment of claims incurred and paid by the carrier after your Dependent retroactively loses eligibility**
- You must report the death of **any** covered dependent as soon as possible

Consistency Rule. Any change in your decision for coverage due to a Qualified Life Event must be consistent with the Qualified Life Event. For example, if you divorce you may only drop your former Spouse/Domestic Partner; with respect to coverage for your Children in this situation, you may add your Children if you did not previously cover them under the Plan or you have a QMCSO to add them.

Depending on the reason for your change of status, you can make the following coverage changes (for a summary list of changes allowed due to various life events, access the CenturyLink Service Center at www.centurylink.com/healthandlife (if actively working) or www.centurylinkhealthandlife.com):

- **Health Plan Benefit Option.** You can change to a different medical benefit option
- **Health Care FSA.** You can reduce or stop your contributions if you experience certain Qualified Life Events, consistent with such a change. For example, gaining or losing a Dependent, Dependent satisfying or ceasing to satisfy eligibility; however, no change is permitted for Qualified Life Events such as a change in residence or change in cost of coverage. Changes are effective the first of the following month after the QLE
 - If you stop your contributions while an active Employee, expenses incurred up to the date contributions end (typically, the end of the month) can be submitted for reimbursement from your account provided the expenses are submitted within three months after the end of the Plan Year in which the expenses were incurred. Expenses incurred after that date are not eligible for reimbursement
 - You may reduce or avoid forfeiture of unused contributions if you make after-tax contributions to the account during periods you are not on the payroll (see the *Continuation of Coverage* section or *Leave of Absence* section for more information or exceptions)
- **Dependent Day Care FSA.** You can start, stop, or change your contributions if you experience certain Qualified Life Events provided the change in your elections is consistent with such a Qualified Life Event. For example, if you take an unpaid leave of absence, you may only stop your contributions. Changes are effective the first of the following month after the QLE

Health Plan—HIPAA Special Enrollment Provisions

Loss of Other Coverage. 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; or
- Loss of coverage to a class of similarly situated individuals under the other plan (e.g., when the other plan does not cover temporary/contractors).

If your spouse/domestic partner or other dependents have special enrollment rights, you may enroll and make changes to your enrollment in any health plan benefit option available to you based upon your home ZIP code and plan service areas within 45 days

following the qualifying event. For example, if you have Employee Only coverage in a CenturyLink benefit option, and your spouse/domestic partner loses coverage under his/her employer's plan and has special enrollment rights, both you and your spouse/domestic partner may enroll in any of the CenturyLink benefit options available to you, provided you verify your spouse's/domestic partner's eligibility for the Plan.

You may not enroll under special enrollment if you lost the other coverage because you failed to pay the premiums or if you lost the other coverage for cause (for example, you misrepresented something on the application form). You may not enroll your Dependent unless you already are enrolled or are enrolling yourself along with your Dependent.

Adding a New Dependent. If you are covered under the Health Plan, or if you are eligible to be covered but have previously waived coverage for any reason, and if you acquire a new Dependent through marriage, birth, adoption, or placement for adoption, then you may enroll in the Health Plan:

- Yourself
- Your Spouse or Domestic Partner
- Your Dependent Children, whether or not they are recently acquired

You may **not** enroll your Dependent unless you already are enrolled or are enrolling yourself along with your Dependent. The effective date for coverage when you add a new Child is the date of birth, adoption, or placement for adoption. The effective date for coverage when you add a Dependent through marriage is the date of your marriage. However, you must enroll **within 45 days** of the marriage, birth, adoption, or placement for adoption.

Dependent Special Enrollment. Your Spouse/Domestic Partner, who is not enrolled, may enroll for coverage in the event of a birth or adoption of a Dependent provided your Spouse/Domestic Partner is an eligible Dependent and the enrollment occurs **within 45 days** of such birth or adoption. Coverage for your Spouse/Domestic Partner will be retroactive to the date of the birth or adoption provided the Employee timely makes the required contributions to the plan.

Re-Enrollment. If you are terminated (other than retirement) from the Company and then rehired as a regular full-time or regular term full-time Employee, you can enroll again in medical, dental, vision, life insurance, AD&D and FSAs (according to your payroll status and benefit eligibility), same as any newly hired employee. See the *Eligibility* and the *When Coverage Begins* sections in this SPD.

WHEN HEALTH PLAN COVERAGE ENDS

Your health care coverage usually ends when your employment with the Company ends as described below. However, there are several other situations that will cause your or your Dependent's Health Plan coverage to end. *Refer to 'Changing Your Health Care Coverage—Qualified Life Events' section for additional information.*

In addition, when coverage ends, you or your Dependents may be eligible to continue coverage at your own expense. For more information, see the *Continuation of Coverage* section regarding COBRA.

Ending Coverage for Dependents Who No Longer Meet Eligibility Requirements

If a Dependent covered under the Plan no longer meets the eligibility requirements for coverage, you are responsible for contacting the CenturyLink Service Center **within 45 days** to terminate his or her coverage. In some cases, you may have the opportunity to continue health care coverage for the formerly eligible Dependent under COBRA (as long as you notify the CenturyLink Service Center **within 60 days** of the change). You also have the option of continuing any supplemental life insurance coverage currently in place for your Dependent by converting to an individual policy. See the *Life Insurance SPDs* for more information or access the CenturyLink Health and Life website at www.centurylink.com/healthandlife (if actively employed) or CenturyLink Health and Life Benefits website at www.centurylinkhealthandlife.com for more details.

Note: Divorce or death of a Spouse/Domestic Partner or Child

Coverage will retroactively end on the last day of the month in which the event occurred, regardless of the notification date. In the event of a divorce, you will be responsible for any claims paid that are paid after the ex-spouse is no longer eligible for coverage (the date of the divorce). If applicable, there could be a slight delay in receiving a retroactive credit due to payroll processing. Check guide for language

Your Health Plan coverage will end as described below:

- Termination of employment. Your Health Plan coverage ends on the last day of the month when your employment terminates.
- Death of Primary Participant. Any coverage for the Surviving Spouse/Domestic Partner (and eligible Children) after the death of the Primary Participant (in active or LTD status) is based on what retirement status the Primary Participant would have been eligible for at the time of death as follows:
 - After the 6 months of Company paid Benefits, COBRA coverage will be offered based on the coverage that was continued during the 6 month extension specific to each person. COBRA is offered for an additional 36 months at the COBRA rate (102%). After COBRA coverage, there are no Benefits available through CenturyLink. See the *Continuation of Coverage Under COBRA* section for more COBRA information.

Note: Only Dependents who were enrolled at the time of death are eligible to continue on the extended coverage.

- *In certain circumstances, a Surviving Spouse/Domestic Partner can continue to withdraw Dependent Day Care FSA contributions for Eligible Expenses*

incurred for the remainder of the Calendar Year. Call the CenturyLink Service Center for details.

- If the Primary Participant is **not** eligible for Retiree health care Benefits (Medical and Dental only) on the date of death, then the eligible surviving Dependents will be offered active health care Benefits for 6 months at no charge. After the 6 months of Company paid Benefits, COBRA coverage will be offered for another 36 months at the full COBRA cost (102%) to the surviving Dependents (if elected).
 - The benefit options that can continue during the six month extension for the survivors are only those that the Employee and Dependents were enrolled in at the time of the Employee's death. For example:
 - If the Employee had elected Employee & Family for medical, but waived dental and elected Employee only for vision—then the survivors would only be eligible to continue medical coverage
 - If the Employee had elected Employee & Family for medical, Employee and Spouse/Domestic Partner for dental and Employee and Child for vision—then all survivors would be eligible to continue medical, the Spouse/Domestic Partner could continue dental and the Child could continue vision.
 - The six months of Company paid Benefits can also be waived (but not suspended until a later date) by non-retiree eligible participants.
- **If the Primary Participant is eligible for retiree health care Benefits (Medical and Dental only)** as a Retiree on the date of death (assuming he or she would have retired on that day), then the eligible surviving Dependents will be offered the same Retiree health care Benefits (Medical and Dental only) as would have been available to the Primary Participant as a Retiree. The cost will be the same as for all other Retirees in those same Benefits. *However, if the Dependent(s) is Medicare eligible, group medical coverage is no longer available (only group dental Benefits).* All Medicare eligible Dependents will be able to select individual Medicare policies and may receive a subsidy amount funded in a Health Reimbursement Account, if applicable to the Retiree's Benefits, to help purchase the individual coverage. Contact the CenturyLink Service Center for more details.
 - Survivors may elect to waive the Retiree medical and/or dental benefits until a later date. However, if the Spouse/Domestic Partner elects coverage the Children may either elect coverage or waive coverage, but if the Spouse/Domestic Partner elects to waive, then the Children will also be waived. Note: Survivor may waive retiree benefits until a future QLE or during Annual Enrollment. Survivor may waive coverage two

times without losing rights to future coverage regardless of suspensions made by the employee.

- Spouse/Domestic Partner/Children are not required to be enrolled at the time of the Employee's death (but will need to go through the Dependent Validation process at this time) and can elect the Benefits independently. For example: The Spouse/Domestic Partner could elect medical only and the Children could elect only dental benefits.
- COBRA Benefits will also be offered as a requirement for the 36-month period for plans already enrolled in at the time of death; however, COBRA is only offered at the full cost of COBRA which could be more expensive than just continuing the Retiree Benefits. **Note:** This is typically used to continue the vision Benefits end at time of retirement. If COBRA is elected, the Dependent can enroll in Retiree benefits after the 36 months as long as the employee was retirement eligible.

If the Primary Participant is already a Retiree receiving health care Benefits, the Benefits will be applied as described above for the Primary Participant who would have been Retiree Benefits eligible at the time of death, including the Medicare eligible status information. **Note:** Only Dependents who were enrolled at the time of death are eligible to continue on the extended coverages.

- You are no longer eligible. Your Health Plan coverage ends on the last day of the month in which you no longer satisfy eligibility requirements of the Health Plan
- Nonpayment of contributions or cancellation. Coverage ends on the last day of the month during which you stop paying any required premium contribution or request cancellation of premium contributions if you have a QLE.
- Loss of LTD Recipient status. Coverage ends on the last day of the month during which your long-term disability status ends for any reason including reaching the maximum duration age, unless you also qualify for coverage as an active or retired Employee.
- Leave of absence. Generally, coverage ends on the last day of the month in which the leave begins or on the last day of the previous month if the leave begins on the first day of a month.

Contact the CenturyLink Service Center for more details applicable to your situation.

Other Benefit coverage will end as described below:

All Life and Disability insurance coverage ends on your last day worked.

Coverage Extension

Generally, your health care expenses will no longer be eligible for coverage under the Health Plan after your eligibility ends. However, health care coverage can continue—with approval from the Claims Administrator—in the following situations, as long as your coverage did not end because you failed to pay any required premium:

- If you are receiving care in a covered inpatient facility, facility Benefits can continue for up to 120 days from the date of Admission or until you are discharged, whichever comes first.
- Facility Benefits for inpatient mental or nervous conditions can continue for up to 120 days from the date of Admission or until you are discharged, whichever comes first.
- Facility Benefits for inpatient substance use treatment can continue 120 days or until you are discharged, whichever comes first.
- Home health care, Hospice Care, and Skilled Nursing Facility benefits can continue for up to 120 days from the date of Admission.

Coverage May End or Be Rescinded Retroactively

Generally the Plan will not rescind or revoke coverage on a retroactive basis for a Participant or a Participant's eligible Dependent once the Participant or Dependent is covered. If it is determined that a Participant or a Participant's Dependent is ineligible for coverage or fails to timely pay for coverage, you will be notified that your coverage will terminate prospectively. However, if it is determined that a Participant or a Participant's Dependent has performed an act or practice that constitutes fraud or an intentional misrepresentation of a material fact as prohibited by the terms of the Plan coverage (such as, for example, coverage being continued when the Dependent was ineligible due to divorce or aging out) the Plan's coverage may be rescinded retroactively to the date of the ineligibility. If this is the situation, you will be notified in writing prior to the rescission of the coverage.

LEAVE OF ABSENCE

Contact the CenturyLink Service Center for specific information on continuing your health care coverage while on a leave of absence.

Paid LOA. Your contributions, if any, for the Benefits as stated above will continue to be deducted from your paycheck during your leave, including FMLA. Your Dependent Day Care FSA is terminated since you are not eligible to submit claims for reimbursement for expenses incurred while you are on a leave. Once you return from a LOA, you will need to contact the CenturyLink Service Center within 14 calendar days to re-elect your Dependent Day Care FSA contributions. If you do not contact the CenturyLink Service

Center or you contact them after the 14 calendar day window, your Dependent Day Care FSA will remain ended with a \$0 contribution amount and you will not be able to contribute until the next Annual Enrollment.

Unpaid LOA. Missed or suspended contributions for the continued Benefits may be deducted from your future paycheck(s) when you return to work from your leave or as soon as administratively possible. If you are placed on an unpaid leave, including FMLA, you may be billed directly. If you are billed directly, you will receive an invoice for payment.

If you do not return to active employment with the Company after your LOA has expired or, if you give the Company notice of your intent not to return to active work with the Company before the end of your LOA, your coverage may be continued only under the provision of COBRA, effective on the earlier of:

- The day following the last day of the month in which your LOA ends.
- The day you give notice of your intent not to return to work.

This means that you generally will be responsible for payment of the entire cost of coverage and an administrative fee during the period that Benefits are continued under COBRA. Your period of coverage during Family and Medical Leave will not be counted toward the maximum number of months of coverage you are permitted under COBRA. You will be required to timely make your COBRA election and make the required payment before your Continuation Coverage is effective.

Reinstatement of Health Plan Coverage. If your Health Plan coverage was terminated during your Leave of Absence under the provisions of COBRA either because you failed to pay your portion of the contribution or because you elected not to continue coverage, your coverage under the Health Plan will be reinstated the first day of the month following your return to active employment with the Company if you:

- Return to employment with the Company immediately upon the expiration of your Leave of Absence
- Re-enroll for coverage **within 31 days** of your return to active employment through the CenturyLink Service Center
- Make the required contribution

Note: You will not be required to satisfy any eligibility waiting period when you re-enroll.

Please Note: If you did not continue your Supplemental life insurance while on leave, you may need to complete Evidence of Insurability to reinstate coverage.

Health Care FSAs. Health Care FSA contributions can continue (on an after-tax basis) through COBRA during your Leave of Absence through the end of the Calendar Year, subject to any reduction as a result of a Qualified Life Event or non-payment of

contributions. If monthly contributions are not paid, you cannot receive reimbursement for expenses incurred in that month, nor can you access the funds that were already deducted. See the *FSA SPD* for more information.

Dependent Day Care FSA. You are not eligible to submit claims for reimbursement for expenses incurred while you are on leave. While you are on an unpaid LOA, your dependent day care FSA contributions will be suspended. You will continue to be eligible for reimbursements, provided the expense is submitted before the claim filing deadline (April 30th following the end of the Plan Year) up to the total amount you had contributed before your Leave. See the *FSA SPD* for more information.

Military Leave of Absence

Under a federal law called the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if you are covered under the Health Plan and are absent from employment with the Company due to military service for a period of more than 31 days, you will be deemed to be on an *leave of absence* while performing the military service. You will be eligible to continued coverage under the Health Plan for up to 24 months. If your military service does not exceed 31 days, you will continue to be covered by the Health Plan as a regular, active Employee.

Health Care Benefits. Employees who are called to military duty will continue to receive health care coverage up to 12 months while in the military at active Employee rates, and up to 12 additional months at the full Company rate, if still in military service. Although you will be covered under the Company health care benefits during this 24-month period as if you were an active Employee, if premiums are paid timely (and unless you elect otherwise), this is considered a COBRA Qualifying Event and 18 months of the 24 months will count towards the COBRA 18-month continuation coverage period. However, you will not be charged the full COBRA rates. This means that at the end of the 24 months of benefit coverage, if you are still on military leave, health care coverage under the Company's Health Care Plan (including COBRA) is no longer available.

While you are on military leave, the military benefits for which you are eligible will be primary. However, if your Dependents participate under the Plan while you are on military leave, the Plan coverage is primary; any military coverage for them will be secondary to the Plan.

Note: There is an exception to the forfeiture rules under the Health Care Flexible Spending Account if you are called to active Military duty. Under certain circumstances you are allowed to take a withdrawal of your HCFSA balance. Please see the *Required Notice and Disclosure* section of this SPD.

Reinstatement of Health Plan Coverage. If you are entitled to reinstatement following your military service and you return to active employment, your health coverage and your Dependent's coverage under the Health Plan will be reinstated effective the first day following the end of the military leave period if you and your Dependents were covered under the Health Plan on the day before your absence from employment due to military service (whether or not you elected to continue coverage).

If you return to active employment with the Company during the same Plan Year in which you left, eligible charges you had accumulated towards satisfying Annual Deductibles and Out-Of-Pocket Maximums will be taken into account in determining your Benefits for the Plan Year.

Life Insurance. Employees who are called to military duty will have the following Life Insurance provisions apply:

- Basic and Supplemental Life Insurance for the Employee, Spouse/Domestic Partner and Child(ren) will be terminated beginning with the first day of the military LOA period. Upon return from military LOA, Basic and Supplemental Life Insurance will be reinstated effective with the first day following the end of the military Leave period. Employees may convert their Basic and Supplemental Life Insurance to an individual policy if application is made within 31 days following the leave effective date.
- Basic Accidental Death & Dismemberment (AD&D), Voluntary AD&D, General Business Travel will be reinstated effective with the first day following the end of the leave effective date. Employees may not convert Basic AD&D or Voluntary AD&D benefits.

Disability. Eligibility for Disability benefits will be reinstated effective with the first day following the end of the leave effective date. Please refer to the specific SPD for Disability benefits and applicable waiting periods and benefit coverage.

HOW TO FILE PLAN CLAIMS

This Section provides you with information about how to file claims for medical, dental, vision and flexible spending account services. The claims procedures for the other Benefits (life, disability, etc.) are briefly explained below and set forth in more detail in each of those respective benefit option SPDs.

Claims for Medical Services

- If you receive Covered Health Services from a Network Provider, generally the Network Provider will file the claim for you. UnitedHealthcare and pay these Providers directly.
- If you receive Covered Health Services from an Out-of-Network Provider you may be responsible for filing a claim. Subject to written authorization from you, all or a portion of any Eligible Expenses due may be paid directly to the Provider instead of being paid to you. The Claims Administrator will not reimburse third parties who have purchased or been assigned Benefits by Physicians or other Providers

Release of Records. You will be asked to authorize and direct any Provider who has provided your health care to release all necessary information to the Claims

Administrator. This information is kept confidential. Failure to authorize or provide such information may result in the denial of your claim for health care coverage of such health care under the Health Plan.

Claims for Prescription Drugs

For information on submitting claims for home delivery service or retail prescription drugs, refer to the medical plan benefit options' SPDs which include these Benefits.

Claims for Mental Health and Substance Use Treatment

Claims for mental health care and substance use treatment will usually be filed directly by the mental health/substance use Provider when using In-Network Providers. See your specific medical plan option SPD, which includes this Benefit.

Claims for Dental and Vision

Typically, if you receive services from a Network provider, they will file the claim for you and MetLife or VSP will pay the provider directly. Otherwise, you must submit a claim form to MetLife for the dental services and to VSP for the vision services. Refer to the Dental and Vision SPDs for additional information. However, if you are enrolled in the Health Care FSA, you may be able to pay claims directly from your FSA account. See the *FSA SPD* for more information.

Claims for Health Care and Dependent Day Care Flexible Spending Accounts

Generally, if you participate in the Health Care FSA, as you incur claims during the Plan year, your out-of-pocket medical expenses from UnitedHealthcare, OptumRX, MetLife Dental and VSP Vision will be reimbursed automatically from your Health Care FSA **unless you specify otherwise**. Typically this would be stopped if you have secondary coverage that needs to be coordinated before the FSA amount can be determined. Contact UnitedHealthcare or visit www.myuhc.com to stop automatic reimbursement. (**Note:** If you stop auto payments you must submit a claim form for all Eligible FSA Expenses)

For more information on obtaining reimbursement from your Health Care FSA, see the *Flexible Spending Account SPD*.

Claims for the Dependent Day Care FSA must be filed through UnitedHealthcare either manually or by using your UnitedHealthcare Health Care Spending Card, HCSC. For more information on obtaining reimbursement from your Dependent Day Care FSA, see the *Flexible Spending Account SPD*.

Regardless of how you file your claims, you should keep track of all your expenses as backup for substantiation, if requested.

Claim Forms and Deadlines

If you are filing claims manually, claim forms may be obtained on myuhc.com, InsideLink, or on the Health and Life web site at www.centurylink.com/healthandlife (if actively employed) or www.centurylinkhealthandlife.com. To ensure timely processing of your claims, it is important that you include all the information about your Provider, the type of

service you received, and the diagnosis. It is also important that you attach an itemized statement with your claim form.

Claim Filing Deadlines. Health Care and Dependent Day Care FSA claims must be incurred by March 15th following the end of the plan year, but may be submitted for reimbursement by April 30th following the end of Plan Year.

Claims for Life Insurance

You or your beneficiaries are responsible for filing claims for life insurance Benefits under the Life Plan. Refer to the “Life Insurance SPD” for additional information on the claims and appeals procedures.

Claims for AD&D Insurance

You or your beneficiaries are responsible for filing claims for AD&D insurance Benefits under the AD&D Plan. Refer to the “Life Insurance SPD” for additional information on the claims and appeals procedures.

Claims for Disability Benefits

You are responsible for filing claims for Short Term Disability (STD) and Long-Term Disability (LTD) Benefits under the Disability Plans. Refer to the STD and LTD SPDs for information on the claims and appeals procedures.

The Right to File a Benefit-Related Lawsuit and Deadline. You cannot bring any legal proceeding or action against the Plan, the Plan Administrator or the Company unless you first complete all the steps in the claims and appeal process described in this SPD.

After you have exhausted or completed the claims and appeal procedures and the process 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.

Note: This means that you cannot bring any legal action against CenturyLink, 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 against CenturyLink, the Employee Benefits Committee or the Claims Administrator 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 CenturyLink or the Claims Administrator.

TIMING OF BENEFIT DETERMINATIONS ON HEALTH CLAIMS AND APPEALS

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 in the *Glossary section*;
- 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 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 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: | |

| Post-Service Claims | |
|---|---|
| Type of Claim or Appeal | Timing |
| ■ 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 (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: | 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.

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: | |
| <ul style="list-style-type: none"> ■ if the initial claim is complete, within: | 30 days |
| <ul style="list-style-type: none"> ■ 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 Benefit 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:

- Within 180 days of an adverse decision by the Plan Administrator, or
- The earlier of:

- Within 180 days of the effective date of an election that is later claimed to be erroneous, or
- 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.

This section generally describes the process for the medical plans. Processes for the Dental and Vision may vary as they do not have pre-service claims. See the specific benefit option SPD for more details or contact the Claims Administrator directly.

COORDINATION OF HEALTH CARE BENEFITS

Your Benefits are coordinated with other group plans covering you and your Dependents.

If you, your Spouse/Domestic Partner or an eligible Dependent are covered by any other group medical or health plan – for example, if your Spouse/Domestic Partner has coverage through his or her employer – Benefits from the Health Plan and the other plan will be “coordinated.” Coordination of Benefits can be applied in several different ways. This section describes the COB with the Medical benefit options. See *COB with the Dental and Vision benefit options later in this section.*

If you have duplicate coverage, one of the plans will be designated as the primary carrier and the other as the secondary carrier. The primary carrier pays Benefits under its provisions first, and the secondary carrier pays for any remaining expenses under its provisions. This is called Coordination of Benefits (“COB”).

Benefits coordination provisions under the medical benefit options, is non-duplicative, meaning that the Benefits you receive from the Health Plan, when combined with Benefits from all other group medical or health plans, will not add up to more than the health care Benefits payable under the Health Plan had it been your only plan coverage.

If the CenturyLink medical option is primary (the first to pay), Benefits will be paid as if no other plan exists.

If the CenturyLink medical option is the secondary payer, 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 CenturyLink would have paid if no other plan exists.

Coordination of Benefits is the method used to determine which of your group health care plans (if applicable) has the primary responsibility to provide Benefits, and which group plan pays second. This COB provision generally does not apply to individual policies that are not issued under a group coverage arrangement.

Please Note: The Prescription Drug Program does coordinate with other plans, including Medicare Part D plans. See the *Retiree and Inactive Health Plan SPD* for more information if retiring and Medicare eligible.

How Coordination Works

When you have a health care claim, the plan considered primary pays Benefits first, without regard to any other plans. The plan considered secondary then adjusts its Benefits so that the total paid to Providers is not greater than your incurred charges.

The following guidelines are used to determine which plan is primary:

- Any plan that has no COB provisions will be primary
- The plan covering the Employee - will be primary—unless the patient is also a Medicare beneficiary. In that event, the plan covering the patient as a dependent will pay first if the following are both true:
 - Medicare is secondary to the plan covering the patient as a Dependent
 - Medicare is primary to the plan covering the patient as other than a Dependent)
- If your Spouse/Domestic Partner has other coverage, that coverage is typically primary for the Spouse/Domestic Partner and this Plan is secondary
- If a Dependent Child is covered under both parents' plans, the parent whose birthday comes earlier during the Calendar Year will provide the primary coverage. If both parents have the same birthday, the parent who has been covered longer will provide primary coverage
- In the case of a divorce or separation, any court decree establishing financial responsibility for the Child's health care expenses will determine the primary plan. If there is no decree, the plans will pay in this order:
 - The plan of the custodial parent will pay first

- If the custodial parent has not remarried, the plan of the non-custodial parent will pay second
 - If the custodial parent has remarried, the plan of the stepparent, if any, will pay second and the plan of the non-custodial parent will pay third
 - However, if the court decree states that the parents will share joint custody but does not establish that one of the parents is responsible for the Child's health care expenses, the plans covering the child will pay according to the birthday rule described in this COB section
- If none of the above situations apply, the plan covering the patient as an active Employee (or their Dependent) is considered before the plan that covers the patient as a laid-off or retired Employee (or their Dependent)
 - If none of these situations apply, the plan covering the patient the longest will be primary

In order to administer this COB, the Plan Administrator has the right to:

- Provide or receive information needed to determine Benefits
- Recover excess payments, including payments made because of a third party's wrongful act or negligence. For more information on the Plan's right to recovery, refer to the *Right to Full Restitution* section of this SPD

Coordination with Medicare (if you are no longer actively employed and are in retired status)

Since CenturyLink group health coverage is no longer available to Company retirees who are Medicare eligible, there is no coordination of coverage between CenturyLink and Medicare. As a retiree, Medicare becomes your primary coverage and you can enroll in other individual policies for additional benefits.

Note: If you are unable to qualify for a Medicare supplemental plan on the market, you will remain in a CenturyLink default plan until you are able to obtain a market Medicare plan but no longer than the first day of the month in which you turn 65. This default plan does coordinate with Medicare.

Disabled Employee. When determining if the Plan is primary with respect to Medicare, a disabled Employee means an Employee who is receiving Short-Term Disability Benefits under the Company's Disability Plan.

The Health Plan will be primary, meaning it will pay Benefits before Medicare does, in any of the following instances:

- You are a disabled Employee not suffering from chronic kidney disease
- You are an active or disabled Employee with a disabled Spouse/Domestic Partner or Dependent Child who is under age 65 and not suffering from chronic kidney disease

- You, your Spouse/Domestic Partner or a Dependent Child is under age 65 and suffering solely from chronic kidney disease (for the first 30 months of the disability)
- You are an active or disabled Employee who is over age 65 (or you are an active or disabled Employee with a Spouse/Domestic Partner over age 65)

Note: An individual who is entitled to Long-Term Disability Benefits as a former Employee under the Company's Disability Plan is not considered a disabled Employee who is receiving Short-Term Disability Benefits.

Coordination with Military Benefits

If you are an Employee and go on military leave, your active benefits will continue as stated in the Company policy. (See the *Leave of Absence* section above for Benefit coverage.)

While you are on military leave, your military benefits for which you are eligible will be primary while you are on active duty. However, if your Dependents participate under the Plan while you are on military leave, the Plan coverage is primary; any military coverage you elect for them will be secondary to the Plan.

Coordination with Dental and Vision Benefit Options

Both the Dental and Vision benefit plan options use the standard COB process, meaning that when the CenturyLink Plan pays as secondary, it will pay up to the amount it would have paid had it been primary. This can result in the Benefit amount being paid up to 100%, keeping the Employee whole. Contact the Plan Administrator for more information.

CONTINUATION COVERAGE (UNDER COBRA AND OTHER CONTINUATION COVERAGE)

On April 7, 1986, a federal law titled the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (Public Law 99-272, Title X) (known as "COBRA"), was enacted. This law requires most employers sponsoring group health plans to offer covered Employees, their covered Spouses/Domestic Partners and covered Dependent Children (called "Qualified Beneficiaries") the opportunity to purchase a temporary extension of health coverage (called "Continuation Coverage") at group rates (plus a 2% administrative charge) in certain instances where coverage under the plan would otherwise end (called "Qualifying Events"). This notice is intended to inform you, in a summary fashion, of your rights and obligations under the Continuation Coverage provisions of COBRA. You, your Spouse/Domestic Partner and your covered Dependents, if any, should take the time to read this notice carefully.

Continuation Coverage for the Health Plan is administered by CenturyLink Service Center, which is referred to in this section as the COBRA Administrator.

Certain states provide continuing coverage rights in addition to the federal COBRA rights explained in this SPD. Contact the Plan Administrator or its delegate the Claims Administrator, for information regarding the Continuation Coverage offered by your state.

Eligibility, Qualified Beneficiaries and Qualifying Events

Employees. If you are covered by the Health Plan (including the medical, dental and vision benefit options and the Health Care FSA), you may have a right to Continuation Coverage under the Health Plan if you lose your Health Plan coverage due to the Qualifying Events of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

Spouse or Domestic Partner. If you are the Spouse or Domestic Partner of an Employee and you are covered by the Health Plan, you have the right to purchase Continuation Coverage under the Plan for yourself if you lose group health coverage for any of the following reasons (with the loss of coverage, known as Qualifying Events):

- The death of your *Spouse or Domestic Partner* (who is the Employee)
- A termination of employment by your *Spouse or Domestic Partner* who is the Employee (for reasons other than gross misconduct)
- A reduction in hours of employment of your *Spouse or Domestic Partner* who is the Employee so as to discontinue the Health Plan coverage
- Divorce from the Employee, your Spouse or termination of *your Domestic Partnership*
- Entitlement to Medicare (Part A, Part B or both) by your *Spouse or Domestic Partner*, the Employee (generally this is a secondary Qualifying Event)

Your covered Spouse is a Qualified Beneficiary for purposes of COBRA. *However, while your Domestic Partner is not a Qualified Beneficiary for purposes of COBRA, CenturyLink provides your partner with the opportunity to continue health coverage under terms and conditions similar to COBRA Continuation Coverage as described in this section of the SPD.*

Dependents. In the case of a Dependent Child of an Employee who is covered by the Health Plan, such Child has the right to purchase Continuation Coverage under the Health Plan if the Plan coverage is lost for any of the following reasons (with the loss of coverage, known as Qualifying Events):

- The death of a parent who is covered by a Company-sponsored group health plan
- The termination of employment with the Company by a parent (for reasons other than gross misconduct)

- A reduction in a parent’s hours of employment with the Company so as to discontinue the Company-sponsored group health plan coverage
- Parents’ divorce
- Entitlement to Medicare (Part A, Part B or both) by a parent who is a covered Retiree
- The Dependent ceases to be a Dependent Child as defined under the terms of the Company-sponsored group health plan

The definition of “Qualified Beneficiary” for COBRA purposes also includes a Child born to or to be placed for adoption with a covered Employee during the period of the Employee’s Continuation Coverage. Thus, once the newborn or adopted Child is enrolled in Continuation Coverage pursuant to the Health Plan’s rules, the Child will be treated like all other COBRA Qualified Beneficiaries. The final COBRA regulations indicate this provision only applies to the Child of the covered Employee (or former Employee), not to the Child of other Qualified Beneficiaries.

Your covered Child is a Qualified Beneficiary for purposes of COBRA. *However, while the Children of your Domestic Partner are not Qualified Beneficiaries for purposes of COBRA*, CenturyLink provides them with the opportunity to continue health coverage under terms and conditions similar to COBRA Continuation Coverage as described in this section of the SPD.

Notification Requirements

Please Note: Under COBRA, you or your family has the responsibility to inform the Plan Administrator of a divorce, termination of a Domestic Partnership or a Child losing dependent status under the Plan **within 60 days** of the date of the event or the date on which coverage would end under the Plan because of the event, whichever is later. If one of these events occurs, you **must** notify the CenturyLink Service Center online at www.centurylink.com/healthandlife (if actively employed) or www.centurylinkhealthandlife.com or by calling 800-729-7526, press the applicable options . You may be asked to provide additional information and documentation about the event and the persons involved.

When the COBRA Administrator, the CenturyLink Service Center, is notified that one of these events has happened, each Qualified Beneficiary will in turn be notified of the right to choose Continuation Coverage. Under the law, you have 60 days from the later of (i) the date you ordinarily would have lost coverage because of one of the events described above, or (ii) the date of the notice of your right to elect Continuation Coverage, to inform the COBRA Administrator that you want Continuation Coverage.

Timely Notification Required or Forfeit Continuation Coverage Right. If you or a covered family member does **not** timely notify the Plan Administrator of a divorce, termination of a Domestic Partnership or a Child’s loss of dependent status, you will **lose**

the right to elect Continuation Coverage and your Plan coverage and the Plan coverage of your Dependents will end.

For example, if you and your Spouse/Domestic Partner are divorced effective May 22nd, you must notify the Plan Administrator by calling the CenturyLink Service Center within 60 days (or in this example, by July 21st) to advise that your Spouse/Domestic Partner is no longer eligible.

Electing COBRA and Other Continuation Coverage

To elect Continuation Coverage, you must timely complete your COBRA election. Each Qualified Beneficiary has a separate right to elect Continuation Coverage. For example, the Employee's Spouse/Domestic Partner may elect Continuation Coverage even if the Employee does not. Continuation Coverage may be elected for only one, several or for all Dependent Children who are Qualified Beneficiaries. A parent may elect to continue coverage on behalf of any Dependent Children. The Employee or Employee's Spouse/Domestic Partner can elect Continuation Coverage on behalf of all of the Qualified Beneficiaries.

Things to Consider on COBRA and Other Continuation of Coverage Elections

In considering whether to elect Continuation Coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of and maintenance of Continuation Coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get Continuation Coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 45 days after your group health coverage ends because of the Qualifying Event listed above. You will also have the same special enrollment rights at the end of Continuation Coverage if you get Continuation Coverage for the maximum time available to you.

Type of Continuation Coverage Available and Duration (Under COBRA and Continuation Coverage)

When Continuation Coverage Begins. If you timely elect Continuation Coverage, your Continuation Coverage will begin on the date your Plan coverage would have otherwise ended, but for your election to purchase Continuation Coverage.

Type and Duration. If you elect Continuation Coverage, you are entitled to be provided with Continuation Coverage that is identical to the Coverage being provided under the Plan to similarly situated Employees, Retirees (or their family members).

Up to 18 Months. If you lost medical, dental or vision coverage under the Health Plan because of a termination of employment or reduction in hours, COBRA requires that you

be afforded the opportunity to maintain Continuation Coverage for up to 18 months. You may also have continued access to the employee assistance services.

If you lost coverage under the Health Care FSA, Continuation Coverage may be provided on an after-tax basis until the end of the year in which the Qualifying Event occurred.

Up to 36 Months. In the case of other Qualifying Events, (death, divorce, Dependent ceases to be a Dependent, Medicare Entitlement), Qualified Beneficiaries will be afforded the opportunity to maintain Continuation Coverage for up to 36 months.

Disability Extension of 18-Month Period of Continuation Coverage. An 18-month period of Continuation Coverage may be extended for up to 11 months (for a total of up to 29 months of Continuation Coverage) if the Qualified Beneficiary is disabled (as defined under the Social Security Act) at any time during the 60 days of the 18 month Continuation Coverage period. The Qualified Beneficiary must notify the COBRA Administrator, within 60 days of the later of:

- The date of the disability determination by Social Security Administration;
- The date on which the Qualifying Event occurs;
- The date on which coverage is lost due to the Qualifying Event; or
- The date the Qualifying Beneficiary receives notice of his responsibility to notify the COBRA Administrator of such determination

(and within the initial 18 month Continuation Coverage period). The disability must last at least until the end of the 18-month period of Continuation Coverage for the Qualified Beneficiary to receive the extension. The 29 month period of Continuation Coverage also is available to a disabled Qualified Beneficiary's non-disabled family members who are entitled to Continuation Coverage.

Notice Required. In the event of such a disability, you must notify the CenturyLink Service Center either by writing or calling the CenturyLink Service Center at 1 800-729-7526 and press the applicable options. See the section *If You Have Questions About Continuation Coverage* for the COBRA Administrator's address. You may be asked to provide additional information and documentation about the event and the persons involved. If you or a family member do not timely notify the Plan Administrator of the disability event, you will lose the right to purchase Continuation Coverage for the longer period.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage. Additional Qualifying Events (including, but not limited to, your death; you become divorced; your Dependent Child is no longer eligible; or you become entitled to Medicare (Part A or Part B or both) Benefits as defined under the Social Security Act) can occur for your Dependents while Continuation Coverage is in effect. Such events may extend an

18 month period of Continuation Coverage to 36 months, but in no event will coverage extend beyond 36 months after the loss of coverage due to the initial Qualifying Event.

Notice Required. If a second Qualifying Event occurs during your Continuation Coverage period, you must notify the CenturyLink Service Center within 60 days of that event either by writing or calling the CenturyLink Service Center at 1 800-729-7526. You may be asked to provide additional information and documentation about the event and the persons involved. If you or a family member does not timely notify the CenturyLink Service Center of a second qualifying event, you will lose the right to purchase Continuation Coverage for the longer period.

When COBRA and Other Continuation Coverage Ends

If you do not elect to purchase Continuation Coverage within 60 days of the loss of coverage or within 60 days from the date you receive notice from the COBRA Administrator, whichever is later, your coverage or coverages for which you do not elect Continuation Coverage under the Health Plan benefit option(s) in which you participate will end.

Please Note: If you do not timely elect to purchase Continuation Coverage, your Company-sponsored group health coverage under the Health Plan will end as of the date it was scheduled to end due to the Qualifying Event.

Termination of Continuation Coverage. COBRA also provides that your Continuation Coverage may be terminated for any of the following five reasons:

- The Company no longer provides Company-sponsored group health plan coverage to any of its Employees
- You do not timely pay the premium for your Continuation Coverage within 30 days of the due date (or within any applicable longer grace period)
- You become covered under another group health plan (as an Employee or otherwise) unless that new plan contains any exclusion or limitation with respect to any preexisting condition of the Qualified Beneficiary. The affected Qualified Beneficiary may continue coverage until the preexisting exclusion or limit would otherwise end. (Pursuant to the Health Insurance Portability and Accountability Act of 1996, there are new restrictions on the use of preexisting condition limitations and exclusions, and group health plans are required to give credit to individuals for prior health coverage in certain circumstances for purposes of reducing a preexisting condition limitation or exclusion period.)
- You become entitled to Medicare (Part A or Part B or both) Benefits except that if the covered Employee or Retiree becomes entitled to Medicare, his/her covered family members who are Qualified Beneficiaries may continue coverage for up to a total of 36 months from the date of the Qualifying Event

- Continuation Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled (as defined under the Social Security Act), in which case, coverage will end on the first day of the month that begins more than 30 days after the date of such determination

You do not have to show that you are insurable to purchase Continuation Coverage. However, Continuation Coverage is provided subject to your eligibility for coverage under the Company group health plan. **The Company (and the plan's insurer(s), as may be applicable) reserves the right to terminate your Continuation Coverage retroactively if you or your Dependents are determined to be ineligible.**

Payments Required for Continuation Coverage

Under COBRA, you may have to pay all or part of the premium for your Continuation Coverage. The amount a Qualified Beneficiary may be required to pay may not exceed 102% (or in the case of an extension of Continuation Coverage due to a disability, 150%) of the cost of the group health plan for coverage of a similarly situated plan participant or beneficiary who is not receiving Continuation Coverage. The law also says that, at the end of the 18, 29 or 36 month Continuation Coverage period, you must be allowed to enroll in an individual conversion health plan that is provided under the plan, if one is available. **Note:** UnitedHealthcare does not offer conversion to an individual plan.

First Payment for Continuation Coverage. If you elect Continuation Coverage, you must make your first payment for Continuation Coverage not later than 45 days after the date of your election. **The initial payment must include premiums due for all months from the coverage termination date through the date of your payment.** If you do not timely make your first premium payment for Continuation Coverage in full (i.e., through the month prior to the month in which you make payment), your coverage will be cancelled retroactive to your loss of coverage date. You are responsible for making sure that the amount of your first payment is correct and that it is timely received. You may contact the CenturyLink Customer Service Center by calling 1 800-729-7526 and press the applicable options, or go online at www.centurylink.com/healthandlife (if actively working) or www.centurylinkhealthandlife.com to elect, pay, or confirm the correct amount of your first payment and to ensure it is timely received.

Your Continuation Coverage will be provided for each month's coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage, your coverage under the Health Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for Benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

You will receive monthly billing statements, or you can set your payment plan to electronic fund transfer from your bank.

Please Note: Once your Continuation Coverage terminates for any reason it cannot be reinstated.

If You Have Questions About Continuation Coverage

If you have questions about your rights to Continuation Coverage, you should contact the COBRA Administrator. All questions and correspondence should be directed to the CenturyLink Service Center at 1 800-729-7526.

You also may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

Keep the Plan Administrator Informed of All Address Changes

In order to protect your family's rights, you should contact the CenturyLink Service Center regarding any and all changes in the addresses of family members.

The information provided above is a summary of the law and, therefore, general in nature. The actual COBRA laws and the terms of the Company's official group Health Plan Documents must be consulted with regard to the application of these provisions in any particular circumstance. If you have any questions about COBRA, please contact the CenturyLink Service Center at 1 800-729-7526. If you have a change such as: marital status, a Child loses Dependent status, you experience a change in address, upon a death or you become entitled to Medicare (Part A or Part B or both), please notify the Plan Administrator as soon as possible, but in no event later than 60 days after the event has occurred. The COBRA Administrator is the CenturyLink Customer Service and can be reached at 1 800-729-7526.

ADDITIONAL CONTINUATION OF HEALTH COVERAGE RULES

The Health Coverage Available if you are an LTD Recipient

An LTD Recipient is an individual who is entitled to receive a long-term disability (LTD) benefit under the CenturyLink Disability Plan. Coverage under the Health Plan is available to LTD Recipients as set forth in the Chart below (subject to continued status as "disabled" under the CenturyLink Disability Plan):

| LTD: | Your Medical Coverage Eligibility is: | Your Dental Coverage Eligibility is: | Your Vision Coverage Eligibility is: | Your Life Insurance Coverage Eligibility is: |
|---|---|---|---|---|
| Benefit Coverage for LTD Status, <15 years of service | <p>You are eligible for Company-subsidized medical (the same coverage as actives) for up to a total of 3 years from the beginning of your STD date, or 2 years from your LTD date, subject to the terms of the CenturyLink Retiree and Inactive Health Plan.</p> <p>Upon exhaustion of your Company-subsidized coverage, you will be offered continuation of coverage under COBRA, full cost is paid by you.</p> | <p>You are eligible for Company-subsidized dental (the same coverage as actives) for up to a total of 3 years from the beginning of your STD date or 2 years from your LTD date, subject to the terms of the CenturyLink Retiree and Inactive Health Plan.</p> <p>Upon exhaustion of your Company-subsidized coverage, you are offered continuation of coverage under COBRA, full cost is paid by you.</p> | <p>You are eligible for Company-subsidized vision (the same coverage as actives) for up to a total of 3 years from the beginning of your STD date or 2 years from your LTD date, subject to the terms of the CenturyLink Retiree and Inactive Health Plan.</p> <p>Upon exhaustion of your Company-subsidized coverage, you are offered continuation of coverage under COBRA, full cost is paid by you.</p> | <p>You are eligible for Basic Life Insurance Continuation for up to a total of 3 years from your STD date or 2 years from your LTD date subject to the terms of the CenturyLink Group Life Insurance Plan.</p> <p>Waiver of Premium applies to Supplemental Life Insurance</p> <p>Once life insurance ends, conversion will be offered.</p> |

| | | | | |
|--|--|---|---|--|
| Benefit Coverage for Disability Retiree Status, >15 years of service | You are eligible for Retiree Medical, administered by the CenturyLink Service Center subject to the terms of the CenturyLink Retiree and Inactive Health Plan. | You are eligible for Retiree dental administered by the CenturyLink Service Center, subject to the terms of the CenturyLink Retiree and Inactive Health Plan. | You are offered 18 months of COBRA, full cost is paid by you; disability extension may be available upon timely notice to the Claims Administrator. | Coverage will reduce to \$10,000, subject to the terms of the CenturyLink Group Life Insurance Plan. |
|--|--|---|---|--|

MORE LTD INFORMATION - Disability Extension and Other COBRA Information:

The 18-month COBRA period described in this section may be extended for 11 additional months to 29 months, as explained in the *Disability Continuation* section provided you follow the required procedures and are eligible.

You may also elect to continue dental and vision and Health Care FSA (HCFSA) coverage for you and your covered eligible Dependents for up to 18 months by paying the applicable rate (the HCFSA is available only through the end of the Calendar Year). If you should die before the end of the 18 months of COBRA coverage, your surviving covered eligible Dependents may elect to continue their coverage, at their own expense, for a total of 36 months from the date your COBRA coverage originally began. At the expiration of the 18-month period, medical coverage for you and your eligible covered Dependents may be continued as indicated on the Chart above, but will no longer fall under the provisions of COBRA.

Coverage upon Death. If you should die **before** the end of the 18 months of COBRA coverage, your surviving covered eligible Dependents may elect to continue their coverage, at their own expense, for a total of 36 months from the date your COBRA coverage originally began. If you should die **after** your COBRA Benefits end, medical coverage for your surviving covered eligible Dependents will end on the last day of the month in which your death occurred. They will not be entitled to COBRA Continuation Coverage at that time.

If you should die **after** the 18-month COBRA period but before the end of the 24-month period, medical coverage for your surviving Dependents will end on the last day of the month in which your death occurred.

Life Insurance Coverage for LTD Recipients: Refer to the “Life and AD&D Insurance SPD” for information on when your life insurance Benefits end.

Domestic Partner

If you are a Domestic Partner of an Employee, you will have the right to elect Continuation Coverage for yourself and your covered Dependent Children ("Continuation Beneficiaries"). This Continuation Coverage is administered the same as under COBRA as described above in the *Continuation Coverage Under COBRA and Other Continuation* section.

The covered Employee or Domestic Partner has the responsibility to notify the CenturyLink Service Center of a termination of relationship between an Employee and a Domestic Partner. Continuation Beneficiaries will not have to show that they are insurable to choose Continuation Coverage. They will have to pay the group rate premium for their Continuation Coverage plus any administration fees.

Children of a Domestic Partner will not be eligible to be a Continuation Beneficiary under their own right. They are only eligible for Continuation Coverage if the Domestic Partner is a Continuation Beneficiary.

PLAN INFORMATION

Plan Sponsor and EIN Number

CenturyLink, Inc.
100 CenturyLink Drive
Monroe, LA 71211
EIN: 72-0651161

| Plan | Type of Plan and Administration | Plan Administrator | Send Claims and Appeals to: | Plan # |
|--|---|--|---|--|
| CenturyLink Health Care Plan | Except for the Dependent Day Care FSA, the Health Plan is a Welfare Plan as defined under ERISA Benefit options are Self-funded with third party contract administrator providing health, prescription, dental, vision and EAP | Plan Administrator: CenturyLink Employee Benefits Committee 214 E. 24 th Street Vancouver, WA 98663 | <u>Send Claims and/or Appeals To:</u> For general eligibility appeals: CenturyLink Service Center Claims and Appeals P.O. Box 1407 Lincolnshire, IL 60069-1407 | 512 |
| | Health Care and Dependent Day Care Flexible Spending Account | Plan Administrator CenturyLink Employee Benefits Committee 214 E. 24 th Street Vancouver, WA 98663 | <u>Send Claims & Appeals To:</u> UnitedHealthcare P.O. Box 30432 Salt Lake City, UT 84130-0432 | 512 |
| CenturyLink Disability Plan, which is a component plan of the CenturyLink Welfare Benefits Plan | Welfare Plan as defined under ERISA STD -Self-funded and LTD – insured | Plan Administrator: CenturyLink Employee Benefits Committee 214 E. 24 th Street Vancouver, WA 98663 | <u>Send STD Claims to:</u> CenturyLink Disability Services P.O. Box 14426 Lexington, KY 40512 <u>Send LTD Appeals To:</u> | 513, the plan number for the CenturyLink Welfare Benefits Plan |

| Plan | Type of Plan and Administration | Plan Administrator | Send Claims and Appeals to: | Plan # |
|--|--|---|---|---|
| | | | Standard 900 SW 5 th Ave Portland OR 97204 800-368-1135 | |
| CenturyLink Life Insurance Plan, which is a component plan of the CenturyLink Welfare Benefits Plan | Welfare Plan as defined under ERISA Insured | Plan Administrator: CenturyLink Employee Benefits Committee 214 E. 24 th Street Vancouver, WA 98663 MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100 | <u>Send Claims To:</u> CenturyLink Service Center at 800-729-7526 <u>Send Appeals To:</u> MetLife Corporate Consumer Relations Department P.O. Box 6100 Scranton, PA 18505-6100 | 513 the plan number for the CenturyLink Welfare Benefits Plan |

| Plan | Type of Plan and Administration | Plan Administrator | Send Claims and Appeals to: | Plan # |
|---|--|---|---|---|
| CenturyLink Business Travel Accident Plan and Accident Death and Dismemberment which are both component plans of the CenturyLink Welfare Benefits Plan | Welfare Plan as defined under ERISA Insured | Plan Administrator: CenturyLink Employee Benefits Committee 214 E. 24 th Street Vancouver, WA 98663 Zurich American Insurance Company P.O. Box 968041 Schaumburg, IL 60196-8041 | <u>Send Claims To:</u> CenturyLink Benefit Service Center at 1 800-729-7526 <u>Send Appeals To:</u> Zurich Claims Department P.O. Box 968041 Schaumburg, IL 60196 Attn: ERISA Appeal Committee Specialties Division A&H Special Risk Claims | 513 the plan number for the CenturyLink Welfare Benefits Plan |

Note: Health Care Plan claims, and appeals should be filed with the claims administrators listed in the Health Plan Claims Administrator Information Section depending on the plan benefit option you elected. Claims and Appeals for the Plans listed in the table directly above should be filed with those claims administrators.

Health Plan Claims Administrator Information

Whenever you have a question or concern regarding your Benefits or a claim, please call the Claims Administrator for the benefit option using the telephone number for Customer Service listed on your ID card (for medical claims only) or below.

Note: The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan.

Type of Plan Administration

The Plan Sponsor provides certain administrative services in connection with the Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of Benefits and subrogation; care coordination; and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. The Plan Sponsor also has selected a health care Network of Providers established by UnitedHealthcare Insurance Company and Medica.

The Employee Benefits Committee is the Plan Administrator and a named fiduciary for the Plan. CenturyLink, Inc. is the Plan Sponsor. The Committee has designated the Claims Administrator of each plan benefit option under the Plan as the claim fiduciary.

Person designated as Agent for Service of Legal Process

Process in legal actions with respect to the provisions of the Plan should be directed to the Plan Administrator: c/o CenturyLink General Counsel-Litigation, 930 14th Street, #900, Denver, Colorado 80202 or to the Plan Sponsor's agent for service of legal process: The Corporation Company (CT Corp), 1675 Broadway, Suite 1200, Denver, Colorado 80202.

Source of Contributions under the Health Plan

Benefits under the Plan are paid from the general assets of the Plan Sponsor. Any required Employee contributions are used to partially reimburse the Plan Sponsor for Benefits under the Plan. Also, refer to the *Plan Cost* and *Funding* sections earlier in this SPD.)

Plan Year

The Plan Year shall be a twelve-month period ending December 31.

Benefits under the Plan are furnished in accordance with the Plan Document issued by the CenturyLink Employee Benefits Committee, including this SPD.

Participants' rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA), and the procedures to be followed in regard to denied claims or other complaints relating to the Plan are set forth in the body of this SPD.

Discretionary Authority

The Plan Administrator has the right and discretion to determine all matters of fact or interpretation relative to the administration of the Plan - including questions of eligibility, interpretation of Plan provisions and all other matters. The decisions of the Plan Administrator, and any other person or group to whom such discretion and authority is delegated, such as the Claims Administrators, shall be conclusive and binding on all persons.

Invalid Provisions

In the event any provisions of the Plan Documents may be held illegal or invalid for any reason, such illegality or invalidity will not affect remaining sections of the Plan and the Plan will be construed and enforced as if said illegal or invalid provisions had never been inserted therein.

RIGHT OF FULL RESTITUTION (SUBROGATION) AND REIMBURSEMENT

The Health Plan does not provide Benefits for any accident, Injury or Sickness for which you or your eligible Dependents have, or may have, any claim for damages or entitlement to recover from another party or parties arising from the acts or omissions of such third party (for example, an auto accident). The terms of this entire subrogation and reimbursement provision shall apply, and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the Covered Individual identifies the medical benefits the Plan advanced. The Plan's right of full reimbursement shall not be reduced or limited in any way by the Covered Individual's actual or alleged comparative fault or contributory negligence in causing the injury(ies) or accident for which the Plan advanced medical benefits. In the event that another party fails or refuses to make prompt payment for the medical expenses incurred by you or your eligible Dependents when expenses arise from an accident, Injury or Sickness, subject to the terms of the Plan, the Plan may conditionally advance the payment of the Benefits. See the example below as to how this process might work:

Example:

Mr. Jones is a participant in the CenturyLink Health Care Plan and is involved in a motor vehicle accident where another party is at fault. Mr. Jones is admitted to the hospital, using his CenturyLink Health Care Plan ID card. His claims are paid by his Claims Administrator under the Plan. Once these claims are paid by the Plan, they are electronically sent to Accent, the recovery services administrator. The recovery services administrator contacts Mr. Jones to ask about his treatment at the hospital and is advised of the motor vehicle accident by Mr. Jones, as required by the Plan. The recovery services administrator obtains all the information regarding the accident (auto carrier/attorney/ etc.) and contacts the involved parties putting them on notice of the Plan's interest. The recovery services administrator follows the case until a settlement is made between Mr. Jones and the at fault auto carrier and/or any uninsured/underinsured auto insurance. The Plan is reimbursed for Mr. Jones' hospital claims. This process ensures those claims which are paid by the Plan as the result of a liable third party are captured and returned to the Plan.

Benefits Conditional Upon Cooperation

The Plan's payment of Benefits is conditional upon:

- The cooperation of you and eligible Dependents, or your respective agent(s) (including your attorneys) or guardian (of a minor or incapacitated individual) working on your behalf to recover damages from another party. You may be asked to complete, sign, and return a questionnaire and possibly a restitution agreement

If you or your eligible Dependents, or your agent(s) or guardian (of a minor or incapacitated individual) refuse to sign and return a restitution agreement, or to cooperate with the Plan or its assignee, the Plan and/or its assignee, such refusal and non-cooperation may be grounds to deny payment of any Benefits.

By participating in the Plan, you and your eligible Dependents acknowledge and agree to the terms of the Plan's equitable or other rights to full restitution, reimbursement or any other available remedy. You will take no action to prejudice the Plan's rights to restitution, reimbursement or any other available remedy. You and your eligible Dependents agree that you are required to cooperate in providing and obtaining all applicable documents requested by the Plan Administrator or the Company, including the signing of any documents or agreements necessary for the Plan to obtain full restitution, reimbursement or any other available remedy.

Other Party Liability

If you or your Eligible Dependent is injured or becomes ill due to the act or omission of another person (an "other party"), the Plan Administrator shall, with respect to Services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution, reimbursement, or any other available remedy to recover the amounts the Plan Administrator paid for Services provided to you or your Eligible Dependent from any recovery (defined below) obtained by or on behalf of you or your Eligible Dependent, from or on behalf of the third party responsible for the injury or illness or from your coverage, including but not limited to uninsured/underinsured motorist coverage, other medical coverage, no-fault coverage, workers' compensation coverage, STD coverage, personal injury coverage, homeowner's coverage and any other insurance coverage available.

The Plan Administrator's right to restitution, reimbursement or any other available remedy, is against any recovery you or your Eligible Dependent receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage or other coverages listed above, related to the illness or injury (the "Recovery"), without regard to whether the you or your Eligible Dependent has been "made whole" by the Recovery and without reduction for any attorney fees and costs paid or owed by or on your behalf by you or your Eligible Dependent.

You or your Eligible Dependent is required to:

1. Notify the Plan Administrator in writing of any actual or potential claim or legal action which such you or your Eligible Dependent expects to bring or has brought against

the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,

2. Agree to fully cooperate with the Plan Administrator to execute any forms or documents needed to enable the Plan Administrator to enforce its right to restitution, reimbursement or other available remedies; and,
3. Agree, if requested, in writing, to reimburse the Plan Administrator for Benefits paid by the Plan Administrator from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage or other coverage; and,
4. Provide the Plan Administrator with a lien in the amount of Benefits actually paid. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,
5. Notify Accent Insurance Recovery Solutions (Accent) at 1 888-556-3373 or at www.onlineaccent.com, or fax at 1 402-384-5190 as soon as possible, that the Plan may have a right to obtain restitution, reimbursement or any other available remedy of any and all Benefits paid by the Plan. This also means that if you or your Eligible Dependent goes to the Hospital because of an accident, Sickness or Injury that is the result of the actions of another party, you must inform the hospital staff that the Sickness or Injuries are the result of the actions of another for which that other person may be liable. Generally, the hospital staff notes this information on the report that is submitted to the Plan's Claims Administrator. You will later be contacted by Accent, and you must provide the information requested. If you retain legal counsel, your counsel must also contact Accent; and,
6. Inform Accent in advance of any settlement proposals advanced or agreed to by another party or another party's insurer; and
7. Provide Accent and the Plan Administrator all information requested by Accent and the Plan Administrator regarding an action against another party, including an insurance carrier; this includes responding to letters from Accent on a timely basis; and
8. Not settle, without the prior written consent of the Plan Administrator, or its designee, any claim that you or your eligible Dependents may have against another party, including an insurance carrier; and
9. Take all other action as may be necessary to protect the interests of the Plan.

In the event you or your eligible Dependents do not comply with the requirements of this section, the Plan may deny Benefits to you or your eligible Dependents or take such other action as the Plan Administrator deems appropriate.

If you or your eligible Dependents are eligible to receive Benefits from the Plan for Injuries caused by another party or as a result of any accident or personal Injury, or if

you or your eligible Dependents receive an overpayment of Benefits from the Plan, the Plan has the right to obtain full restitution, reimbursement or any other available remedy of the Benefits paid by the Plan from:

- Any full or partial payment which an insurance carrier makes (or is obligated or liable to make) to you or your eligible Dependents
- You or your eligible Dependents, if any full or partial payments are made to you or your eligible Dependents by any party, including an insurance carrier, in connection with, but not limited to, your or another party's:
 - Uninsured motorist coverage
 - Under-insured motorist coverage
 - Other medical coverage
 - No fault coverage
 - Workers' compensation coverage
 - STD Coverage
 - Personal injury coverage
 - Homeowner's coverage
 - Any other insurance coverage available

This means that, with respect to Benefits which the Plan pays in connection with a Sickness, Injury or accident, the Plan has the right to full restitution, reimbursement or any other available remedy from any payment, settlement or recovery received by you or your eligible Dependents from any other party, regardless of whether the payment, recovery or settlement terms state that there is a separate allocation of an amount for the restitution of medical expenses, the types of expenses covered by the Plan or the Benefits provided under the Plan.

You or your Eligible Dependent's failure to comply with the above shall not in any way act as a waiver, release, or relinquishment of the rights of the Plan Administrator.

Note: The Plan (Health, Life, Disability, BTA/ADD) is subject to ERISA. Certain plans - specifically, the Health Plan and Disability Plan - are self-funded, and for those plans you and your Eligible Dependent are also required to do the following:

1. Ensure that any Recovery is kept separate from and not comingled with any other funds or you or your Eligible Dependent's general assets (for example, your household checking account) and agree in writing that the portion of any Recovery required to

satisfy the lien or other right of Recovery of the plan is held in trust for the sole benefit of the Plan until such time it is conveyed to the Plan Administrator; and

2. Direct any legal counsel retained by you or your Eligible Dependent or any other person acting on behalf of you or your Eligible Dependent to hold that portion of the Recovery to which the plan is entitled in trust for the sole benefit of the Plan and to comply with and facilitate the reimbursement to the Plan of the monies owed it.

Payment Recovery to be Held in Trust

You, your eligible Dependents, your agents (including your attorneys) and/or the legal guardian of a minor or incapacitated person agree by request for and acceptance of the Plan's payment of Benefits, to maintain 100% of the Plan's payment of benefits or the full extent of any payment from any one or combination of any of the sources listed above in trust and without dissipation except for reimbursement to the Plan or its assignee.

Any payment or settlement from another party received by you or your eligible Dependents must be used first to provide restitution, reimbursement or any other available remedy to the Plan to the full extent of the Benefits paid by or payable under the Plan. The balance of any payment by another party must, first, be applied to reduce the amount of Benefits which are paid by the Plan for Benefits after the payment and, second, be retained by you or your eligible Dependents. You and your eligible Dependents are responsible for all expenses incurred to obtain payment from any other parties, including attorneys' fees and costs or other lien holders, which amounts will not reduce the amount due to the Plan as restitution, reimbursement or any other available remedy.

The Plan is entitled to obtain restitution, reimbursement or any other available remedy of any amounts owed to it either from funds received by you or your eligible Dependents from other parties, regardless of whether you or your eligible Dependents have been fully indemnified for losses sustained at the hands of the other party. A Plan representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Plan's equitable (or other) right to obtain full restitution, reimbursement or any other available remedy.

NOTICE OF HIPAA RIGHTS

Important Notice of Your Right to Documentation of Health Coverage

Recent changes in federal law may affect your health coverage under the Health Plan if you are enrolled or become eligible to enroll in health coverage that excludes coverage for pre-existing medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. You are entitled

to a certificate that will show evidence of your prior health coverage. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion. Contact your State insurance department for further information.

You have the right to receive a certificate of your prior health coverage since July 1, 1996. You may need to provide other documentation for earlier periods of health care coverage. Check with your new health plan administrator to see if your new health plan includes coverage for pre-existing conditions and if you need to provide a certificate or other documentation of your previous coverage.

To request a HIPAA certificate contact the CenturyLink Service Center at 1 800-729-7526 press option 1 and then option 1 again.

Keep a copy for your records. You may also request HIPAA certificates for any of your eligible Dependents (including your spouse/domestic partner) who were enrolled under your health coverage.

The information provided above is a summary of the law and, therefore, general in nature. The actual HIPAA law and the terms of the official Health Plan Documents must be consulted in regard to the application of these rules in any particular circumstance. If you have any questions about HIPAA or your special enrollment rights under HIPAA, please contact the Plan Administrator.

Special Enrollment Rights under HIPAA. You may have special enrollment rights under HIPAA. Please refer to the *Changing Your Health Care Coverage—Qualified Life Events* section above in this SPD for more information.

HIPAA Guaranteed-Issue Requirements

HIPAA requires that all health insurance carriers that offer coverage in the individual market accept any eligible individuals who apply for coverage without imposing a pre-existing condition exclusion. However, you may lose this right to avoid having pre-existing condition exclusion apply to you if you have more than a 63-day gap in health coverage. To take advantage of this HIPAA right, you elect COBRA and maintain it (by timely paying the premium) for the duration of your maximum COBRA coverage period, and then apply for coverage with an individual insurance carrier before you have a 63-day lapse in coverage. Since we do not sponsor this other health coverage, you should contact that insurer directly, your independent insurance specialist or the State insurance commissioner for more information.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. You may also obtain the most recent version of the *Notice of Privacy Practices* on InsideLink.

Privacy Officer Designation/Contact Information. The designated Privacy Officer is Linda Gardner, who has designated the HIPAA Compliance Committee or its designee to answer any questions regarding this Notice or the subject addressed in it.

Please forward inquiries to the:

HIPAA Compliance Committee

CenturyLink, Inc.
600 New Century Parkway
New Century, KS 66031
or

E-Mail: askHIPAA@CenturyLink.com

or

Call the CenturyLink Integrity Line at **1 800-333-8938**, Select Option 1
(Personal Health Information or HIPAA issues)

General Information About This Notice. This Notice relates to the use and disclosure of your medical information by the Health Plan.

The term “Plan” as used in this Notice means only the portions of the Health Plan that provide group health Benefits (for example, medical, dental, vision, employee assistance and medical expense reimbursement). HIPAA does not apply to the Disability Plan, the Life Plan or to Worker’s Compensation and those Plans therefore are not subject to HIPAA.

The Plan continues its commitment to maintaining the confidentiality of your medical information for the purpose of your Plan coverage. This Notice describes the Plan’s legal duties and privacy practices with respect to that information.

This Notice also describes your rights and the Plan’s obligations regarding the use and disclosure of your medical information. Your personal doctor or health care provider may have different policies or notices regarding the doctor’s or health care provider’s use and disclosure of your health information created in the doctor’s or health care provider’s office or clinic.

This Notice applies to:

- the portions of the Plan listed above that provide group health Benefits;
- any CenturyLink employee or other individuals acting on behalf of the Plan; and
- third parties performing services for the Plan

The Plan is required by law to:

- follow the terms of the Notice that are currently in effect;
- provide you with specific information about your rights with respect to your medical information;
- maintain the privacy of your medical information; and

- give you this Notice of the Plan’s legal duties and privacy practices with respect to medical information about you; and
- Notify you if there is a breach of your unsecured PHI.

Plan Use and Disclosure of Your Medical Information. The Plan is required by law to take reasonable steps to ensure the privacy of your protected health information (“PHI”). PHI is any information held by the Plan that identifies you, such as your name or address, paired with medical information such as:

- your past, present or future physical or mental health or condition; or
- the provision of health care to you; or
- the past, present or future payment for the provision of health care.

If the Plan needs to amend this Notice due to changes in their operation, then this Notice will be amended and an updated privacy Notice will be made available to you.

The Plan needs to use your PHI in certain ways that are described below in more detail.

- **Use or Disclosure for Treatment.** The Plan may use and disclose your PHI to others to facilitate your medical treatment, which includes the provision, coordination, or management of your health care and can include consultation between one or more of your providers. For example, the Plan may disclose information regarding your prior prescriptions to a pharmacist to determine if a pending prescription will conflict with a prior prescription. For these purposes, the Plan may disclose information to business associates of the Plan.
- **Use or Disclosure for Payment.** The Plan may use and disclose your PHI to others so that the Plan can facilitate proper payment for treatment and services provided to you and includes, but is not limited to, making coverage determinations, claims management, subrogation and recovery, reviews for medical necessity and appropriateness of care, utilization and preauthorization reviews. For example, the Plan may use your PHI to determine your Benefit eligibility or coverage level, to pay a health care provider for your medical treatment or to reimburse you for your direct payment to a health care provider. The Plan may tell a health care provider whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.
- **Use or Disclosure for Health Care Operations.** The Plan may use and disclose your PHI to the extent necessary to administer and maintain the Plan. For example, the Plan may use your PHI in the process of negotiating contracts with third party carriers, for legal services, for internal audits (including fraud and abuse compliance programs), business planning, or for cost management purposes. For these purposes, the Plan may disclose your PHI to business associates of the Plan.

- **Disclosure to CenturyLink.** With respect to your Plan coverage, the Plan may use and disclose your PHI to CenturyLink as permitted or required by the Plan Documents or as required by law. Certain employees of CenturyLink who perform administrative functions for the Plan may use or disclose your PHI for Plan administration purposes.

Any PHI disclosure to CenturyLink by the Plan for other than plan administration purposes will require your written authorization. At no time will PHI be disclosed to CenturyLink for employment-related actions or decisions, except for drug and alcohol test results under certain circumstances.

- **Disclosures to Family or Close Friends.** Under certain circumstances, as described in the HIPAA Methods and Procedures, the Plan may release your PHI to either a family member or someone who is involved in your health care or payment for your care. The HIPAA Methods and Procedures are available on InsideLink under Benefits/Health and Welfare or CenturyLink Health and Life website at www.centurylink.com/healthandlife (if actively working) or www.centurylinkhealthandlife.com on the Internet at www.centurylinkhealthandlife.com.

Your Written Authorization. Generally, the Plan must have your written authorization to use or disclose your PHI in circumstances not covered by this Notice or the laws that apply to the Plan. If you provide the Plan with authorization to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization. However, you understand that the Plan is unable to take back any disclosures already made based on your prior authorization.

Special Situations. The following are examples of when the Plan may disclose your PHI without your written authorization (this list is not exhaustive and there may be other situations when it would be necessary to disclose PHI that are not addressed here):

- **Required by Law.** The Plan may disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding, such as a malpractice action.
- **Public Health Risks.** The Plan may use or disclose your PHI for public health reasons. These reasons may include the following:
 - prevention or control of disease, injury or disability;
 - to report child abuse or neglect;
 - to report reactions to medications or problems with products;

- to notify individuals of recalls of medications or products they may be using;
 - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- **Victims of Abuse, Neglect or Domestic Violence.** As permitted or required by law, the Plan may disclose your PHI to an appropriate government authority if the Plan reasonably believes you are the victim of abuse, neglect or domestic violence. If the conduct does not involve a child, the Plan will make this disclosure only if the victim agrees or when required or authorized by law.
 - **To Avert a Serious Threat to Health or Safety.** The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your PHI in a proceeding regarding the licensure of a Physician.
 - **Health Oversight Activities.** As authorized by law, the Plan may disclose your PHI to health oversight agencies. Such disclosure will occur during audits, investigations, inspections, licensure, and other government monitoring and activities related to health care provision or public benefits or services.
 - **Judicial Proceedings, Lawsuits and Disputes.** The Plan may disclose your PHI in response to an order of a court or administrative tribunal, provided that the Plan discloses only the PHI expressly authorized by such order.

If you are involved in a lawsuit or a dispute, the Plan may disclose your PHI when responding to a subpoena, discovery request or other lawful process where there is no court order or administrative tribunal. Under these circumstances, the Plan will require satisfactory assurance from the party seeking your PHI that such party has made reasonable effort either to ensure that you have been given notice of the request or to secure a qualified protective order.

- **Law Enforcement.** In response to a court order, subpoena, warrant, summons or other legal request, or upon a law enforcement official's request, the Plan may release your PHI to a law enforcement official for certain law enforcement activities. The Plan may also release medical information about you to authorized government officials for purposes of public and national security.
- **National Security and Intelligence Activities.** The Plan may release medical information about you to authorized federal officials for intelligence, counterintelligence and any other national security activities authorized by law.
- **Military and Veterans.** If you are or were a member of the armed forces, the Plan may release your PHI as required by military command authorities. The

Plan may also release PHI about foreign military personnel to the appropriate authority.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement officer, the Plan may disclose your PHI to the institution or officer. This may happen, for instance, if the institution needs to provide you with health care, to protect your health or safety or the health and safety of others or to protect the safety and security of the correctional institution.
- **Organ, Eye and Tissue Donation.** The Plan may release your PHI to an organization that handles organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation. This may happen, for instance, if you are an organ donor or are seeking an organ transplant.
- **Coroners, Medical Examiners and Funeral Directors.** Upon your death, the Plan may release your PHI to a coroner or medical examiner for purposes of identifying you or to determine a cause of death, and to funeral directors as necessary to carry out their duties.
- **Workers' Compensation.** The Plan may release your PHI to comply with workers' compensation or similar programs.

Your Rights. You have the following rights regarding your PHI maintained by the Plan:

- **Right to Request a Restriction.** You have the right to request a restriction or limitation on the Plan use or disclosure of your PHI for treatment, payment or health care operations purposes as set forth above. You also have the right to request a limit on the type of PHI the Plan discloses about you to someone who is involved in your care or the payment of your care. For example, you may ask the Plan not to disclose your PHI to a certain family member or you may ask the Plan to limit your PHI provided to a large case manager who is assigned to you. The Plan is not required to agree to your request. If the Plan does agree, the Plan will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions on the use and disclosure of your PHI, you must complete and submit a written request to the HIPAA Compliance Committee or its designee (i.e. a claims administrator such as United Healthcare). Your written request must specify the following:

- the information you want to limit
- whether you want the Plan to limit the use, disclosure, or both
- to whom you want the restrictions to apply

- **Right to Receive Confidential Communications.** You have the right to request that the Plan communicate with you about your PHI in a certain manner or at a certain location. For example, you may request that the Plan contact you only at work and not at home, or the Plan send written correspondence to a post office box.

To request a specific manner to receive confidential communications, you must complete and submit a written request to HIPAA Compliance Committee or its designee (i.e. a claims administrator such as United Healthcare). The Plan will accommodate all reasonable requests if you clearly state that you are requesting the confidential communication because you feel that disclosure could endanger you. Your request must specify how or where you wish to be contacted.

- **Right to Inspect and Copy Documents Containing PHI.** You have a right to inspect and obtain a copy of your PHI contained in a “Designated Record Set,” for as long as the Plan maintains the PHI.

“Designated Record Set” includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the Designated Record Set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your Designated Record Set. Requests for access to PHI should be made in writing to the HIPAA Compliance Committee or its designee (i.e. a claims administrator such as United Healthcare).

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

- **Right to Amend Your PHI.** You have the right to request that the Plan amend your PHI or a record about you in a Designated Record Set for as long as the PHI is maintained in the Designated Record Set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written

denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a Designated Record Set should be made to the HIPAA Compliance Committee or its designee (i.e. a claims administrator such as United Healthcare). You or your personal representative will be required to complete a form to request amendment of the PHI in your Designated Record Set, and provide the reasons in support of an amendment to your PHI.

- **Right to Receive an Accounting of Disclosures of Your PHI.** You have the right to request a list of the disclosures of your PHI the Plan has made about you, subject to certain exceptions. For example, the accounting need not include PHI disclosures made:
 - to carry out treatment, payment or health care operations;
 - prior to the required compliance date (April 14, 2003);
 - to individuals about their own PHI;
 - based on your own authorization;
 - due to emergency; or
 - disclosures incident to other permissible disclosures.

In order to receive an accounting of disclosures, you must submit a written request to the HIPAA Compliance Committee. Your request must include the following:

- the time period for the accounting, which may not be longer than 6 years and may not include dates prior to April 14, 2003; and
- the form (i.e., electronic, paper, etc.) in which you would like the accounting.

Your first request within a 12-month period will be free. The Plan may charge you a reasonable, cost-based fee for providing you any additional accounting. The Plan will notify you of the costs involved, and you may choose to withdraw or modify your request before you incur any costs.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual requesting is given a written statement of the reasons(s) for the delay and the date by which the accounting will be provided.

- **Right to Receive a Paper Copy of This Notice.** You have the right to receive a paper copy of this Notice, even if you previously agreed to receive this Notice electronically.

In order to receive a paper copy, you must submit a written request to the HIPAA Compliance Committee. You may also obtain a copy of the Notice under InsideLink > Benefits > Important Benefits and Documents or on the CenturyLink Health and Life website at www.centurylink.com/healthandlife (if actively working) or www.centurylinkhealthandlife.com.

Personal Representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action on your behalf. Proof of such authority may take one of the following forms:

- the power of attorney for health care purposes notarized by a Notary Public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Filing a Complaint Against the Plan. If you believe your rights have been violated, you may file a written complaint with the Plan. The written complaint should contain a brief description of how you believe your rights have been violated. You should attach any documents or evidence that supports your belief, along with the Plan Notice of Privacy Practices provided to you, or the date of such Notice. The Plan takes complaints very seriously. You will not be retaliated against for filing such a complaint. Please call the CenturyLink Integrity Line at 1 800-333-8938 and select the HIPAA or Protected Health Information option for additional information. Please send all written complaints to:

HIPAA Compliance Committee
CenturyLink, Inc.
600 New Century Parkway
Gardner, KS 66031
-or-
E-mail: askHIPAA@CenturyLink.com

You may also file complaints with the United States Department of Health and Human Services, which may be contacted at the following address:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
1 800-368-1019

The Plan will not retaliate against you for filing a complaint.

Additional Information About This Notice.

- **Changes to This Notice.** The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

This Notice has been in effect and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to those for whom the Plan still maintains PHI. Any revised version of this Notice will be distributed and made available on InsideLink > Benefits > Important Benefits and Documents within 60 days of the effective date of any material change to the uses or disclosures, the individuals rights, the duties of the Plan or other privacy practices stated in this Notice.

No Guarantee of Employment. Nothing contained in this Notice shall be construed as a contract of employment between CenturyLink and any employee, nor as a right of any employee to be continued in the employment of CenturyLink nor as a limitation of the right of CenturyLink to discharge any of its employees, with or without cause.

No Change to Plan. Except for the privacy rights described in this Notice, nothing contained in this Notice shall be construed to change any rights or obligations you may have under the Plan. You should refer to the Plan documents, including your Summary Plan Description and Summaries of Material Modifications, for complete information regarding any rights or obligations you may have under the Plan.

YOUR ERISA RIGHTS

As a participant in the Health Plan, the Life Plan and the Disability Plan, you are entitled to certain rights and protections under ERISA. (Note: The Dependent Day Care FSA is not subject to ERISA.) ERISA provides that all Plan participants shall be entitled to:

Receive Information About the Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including, if applicable, insurance contracts and a copy of the latest annual report (Form

5500) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration

- Obtain, by writing to the Plan Administrator, copies of documents governing the operation of the Plan, including, if applicable, insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated SPD. The Plan Administrator may request a reasonable charge for the copies
- Receive a summary of the Plan's annual financial report

Continue Group Health Plan Coverage

- Continue health care coverage for yourself and your Dependents, if eligible, if there is a loss of medical, dental or vision benefits and Health Care FSA coverage under the Health Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Health Plan for more information on the rules governing Consolidated Omnibus Budget Reconciliation Act of 1986, as amended, ("COBRA") Continuation Coverage rights
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Health Plan, if you have Creditable Coverage from another group health plan. You should be provided a Certificate of Creditable Coverage, free of charge, from the Health Plan or health insurance issuer when you lose coverage under the Health Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, if applicable or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because

of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these cost and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1 866-444-EBSA (3272) or by going to its Web site at <http://www.dol.gov/ebsa>.

GENERAL ADMINISTRATIVE PROVISIONS

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 and Insurance Policies (as applicable), the Plan Document and Policies shall govern.

Our Relationship with Providers

The relationships between us and Network Providers and the Claims Administrator are:

- Solely contractual relationships between independent contractors
- Not that of agents or Employees

Furthermore, the Claims Administrator shall not be deemed or construed as an employer or Plan Administrator for any purpose with respect to the administration or provision of Benefits under the Plan.

The relationship between us and you is that of employer and Employee, Dependent or other classification as defined in the Plan.

Your Relationship with Providers

The relationship between you and any Provider is that of patient and Provider.

- You are responsible for choosing your own Provider
- You must decide if any Provider treating you is right for you. This includes Network Providers you choose and Providers to whom you have been referred
- You must decide with your Provider what care you should receive
- Your Provider is solely responsible for the quality of services provided to you

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. 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. This applies to all Covered Persons, including Enrolled Dependents whether they have signed the enrollment form.

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 the Claims Administrators have sole and exclusive 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 the Claims Administrator may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the Claims Administrator may, in its sole discretion, offer Benefits for services that would not otherwise be Covered Health Services. The fact that the Claims 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 continues to retain the right, within its sole discretion and authority, at any time to amend, modify, or eliminate any benefit or provision of the Plans or to not amend the Plans at all, to change contribution levels and/or to terminate the Plans, subject to all applicable laws.

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, 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.

CLAIM FOR PAYROLL ADJUSTMENT AND THE DEADLINES

There is a separate claims process if you dispute the deductions from your paycheck for your Plan Benefits.

Reminder to Review Your Paycheck Deductions

- Review your paycheck along with the CenturyLink Benefits and Payroll schedule (available online) to confirm your benefit premium deductions for Health & Welfare including Savings and Spending Accounts. Any questions related to benefit premiums should be directed to the CenturyLink Service Center at 800-729-7526, option 1, option 1 and then option 1 again. Do not contact the CenturyLink Payroll Department as the Payroll staff will be unable to assist you.
- If your benefit premium deductions are not correct or not what you expect you must make a claim to the Plan Administrator in accordance with the claims procedures as soon as possible after the year's payroll deductions begin.

► If your claim is denied, be advised that there is a deadline to file an appeal and if you miss the deadline, your deductions remain in place for the benefit plan year. The time period to make an appeal is the **earlier of:**

- (1) within 180 days of an adverse 1st level 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 appeal is not filed by this deadline it shall be deemed untimely and denied on that basis.

The Required Forum for Legal Disputes. After the claims and appeals procedures are exhausted as explained above, and a final decision has been made by the Plan Administrator, if an Eligible Employee wishes to pursue other legal proceedings, the action must be brought in the United States District Court in Denver, Colorado.

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.

Examination of Covered Persons

In the event of a question or dispute regarding Benefits, the Plan may require that a Network Physician of the Plan's choice examine you at our expense.

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. However, for those benefit options that are insured, the Benefits are subject to State laws and regulations including, but not limited to, State law benefit mandates.

Incentives to You

At various times the Claims Administrator may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not you choose to participate is yours alone, but you should discuss participating in such programs with your Provider. These incentives are not plan benefits and do not alter or affect your Benefits. Contact the Claims Administrator if you have any questions.

Incentives to Providers

The Plan and the Claims Administrator do not provide health care services or supplies, nor does CenturyLink practice medicine. Rather, the Claims Administrator arranges for Providers to participate in a Network. Network Providers are independent practitioners; they are not CenturyLink Employees or Employees of the Claims Administrator, nor is there any other relationship with Network Providers such as principal-agent or joint venture. Each party is an independent contractor.

The Plan arranges payments to Network Providers through various types of contractual arrangements. These arrangements may include financial incentives by the Plan or the Claims Administrator to promote the delivery of health care in a cost efficient and effective manner. Such financial incentives are not intended to impact your access to health care. Examples of financial incentives for Network Providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness
- Capitation is when a group of Network Providers receives a monthly payment for each Covered Person who selects a Network Provider within the group to perform or coordinate certain health services. The Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the health care is less than or more than the payment
- Various payment methods to pay specific Network Providers are used. From time to time, the payment method may change. If you have questions about whether your Network Provider's contract includes any financial incentives, we encourage you to discuss those questions with your Provider. You may also contact the Claims Administrator at the telephone number on your ID card. They can advise whether your Network Provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed

Refund of Benefit Overpayments to You or a Dependent

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 either of the following apply:

- 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 (including Medicare Part B premiums)

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 any Benefits under the Plan, that individual must refund the amount of the excess Benefit payment.

Deadlines for Lawsuit or Civil Action

You cannot bring any legal proceeding or action against the Plan, the Plan Administrator or the Company unless you first complete all the steps in the claims and appeal process described in this SPD.

After you have exhausted or completed the claims procedures and the process 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 CenturyLink, 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 against CenturyLink, the Employee Benefits Committee or the Claims Administrator 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 CenturyLink or the Claims Administrator.

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.

REQUIRED NOTICE AND DISCLOSURE

Consequences of Falsification or Misrepresentation

You will be given advance 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 false, 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.

Continued coverage of an ineligible person is considered to be a misrepresentation of eligibility and falsification of, or omission to, update information to the Plan, which is in violation of the Code of Conduct and may result in disciplinary action, up to and including termination of employment. This misrepresentation/omission is also a violation of the Plan document, Section 8.3 which allows the Plan Administrator to determine how to remedy this situation. For example, if you divorce, your former spouse is no longer eligible for Plan coverage and this must be timely reported to the CenturyLink Service Center within 45 days, regardless if you have an obligation to provide health insurance

coverage to your ex-spouse through a Court Order.

- 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 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 (UHC) may refuse to honor any claim under the Plan or to refund premiums.
- While a court may order that health coverage must be maintained for an ex-spouse/domestic partner, that is not the responsibility of the Company or 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 the 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 and 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*

Plan Determinations Are Not Health Care Advice

Please keep in mind that the sole purpose of the Health 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 Health 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 Health 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 Health Plan coverage and do not constitute health care recommendations or advice.*

Circumstances That May Affect Your Plan Benefits

Under certain circumstances all or a portion of your Benefits under the Plan may be denied, reduced, suspended, terminated or otherwise affected. Many of these circumstances have been addressed elsewhere in this SPD. Such circumstances, in general, include but are not limited to:

- You are no longer in an eligible class of participants or your Dependents are no longer eligible Dependents
- The Plan is amended or terminated
- You attain the maximum benefit limit available under the Plan, such as may apply to certain Health Plan, Disability Plan, Life Plan, AD&D and BTA Benefits
- The expense incurred was not Medically Necessary, was Investigational or Experimental, was specifically excluded, or exceeded the reasonable and customary charge
- There is duplicate health care coverage, or you become eligible for Medicare (Part A, Part B or both), and Plan Benefits are coordinated with the Benefits provided under another group health or dental plan or Medicare
- You misrepresent or falsify any information required under the Plan; you will not be permitted to benefit under the Plan from your own misrepresentation; for example, if you misrepresent who your dependents are for purposes of coverage, or Working Spouse status or tobacco-free status, or if you don't update those statuses
- You have been overpaid a benefit and the Plan seeks a refund/restitution
- If you or your Dependents are entitled to receive Benefits from the Plan for injuries caused by a third party, the Plan has the right to obtain restitution, or by other equitable means, to a repayment of the Benefits paid under the Plan from any part of payments received from your insurance carrier or by any other party, including an insurance carrier
- Your coverage under the Plan is terminated for one of a variety of reasons, for example, failure to pay your employee contribution or a COBRA premium
- Your coverage is rescinded as permitted by law

Qualified Medical Child Support Orders (QMCSO)

The Health Plan complies with all Qualified Medical Child Support Orders ("QMCSO"). A QMCSO is a court order, under State family or child support laws, which may require a parent to enroll his or her children in his or her employer's medical plan. A Child eligible for coverage under the Health Plan pursuant to a QMCSO is a Child of a Primary Participant, including any Child adopted by, or placed for adoption with a Primary Participant. The QMCSO may also require Benefits to be assigned to a Child, to a custodial parent, or to a legal guardian. QMCSOs should be sent to the Plan Administrator (see the *Plan Information* section).

You may receive a free copy of the Health Plan's procedures governing QMCSOs by contacting the CenturyLink Service Center.

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

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs. If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial 1 877-KIDS NOW [534-7669] or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must request coverage within 60 days of being determined eligible for premium assistance.

To see which states have a premium assistance program and for information on special enrollment rights, you can contact either:

U.S. Department of Labor

U.S. Department of Health and Human Services
Employee Benefits Security Administration
www.dol.gov/ebsa
Toll free: 1 866-444-EBSA [3272]

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
Toll free: 1 877-267-2323, Ext. 61565

Women’s Health and Cancer Rights Act Of 1998

This notice is being provided to you in accordance with the requirements of the Federal law entitled the Women’s Health and Cancer Rights Act of 1998 (the “Act”).

The CenturyLink Health Care 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 the following Benefits:

- reconstruction of the breast on which the mastectomy has been performed
- surgery and reconstruction of the other breast to produce symmetrical appearance
- prosthesis and treatment of physical complications associated with all 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 Health Plan, this coverage is subject to the Health Plan's annual deductible (if any), required Coinsurance payments, benefit maximums and Copay provisions that may apply under benefit options of the Health Plan.

You should carefully review the provisions of the Health Plan, the health plan benefit option in which you elect to participate and its SPD regarding any applicable restrictions. If you have any questions regarding this coverage, please contact your health care Claims Administrator by calling the number listed on your ID card.

The Newborns' and Mothers' Health Protection Act (NMHPA)

Under federal law, the Health Plan generally may not 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 delivery by cesarean section. However, the Health Plan may pay for a shorter stay if the attending Provider (the Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn child earlier than the 48 or 96 hours described above.

Also, under federal law, the Health Plan may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Health Plan may not, under federal law, require that a Physician, or other Provider, obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

GLOSSARY OF DEFINED TERMS

Terms that appear in initial capitalization throughout this SPD (for example, Dependent) are explained within the SPD document or below. This section defines many of the terms used throughout this SPD and is not intended to describe benefits. These definitions are periodically updated and subject to change. If you are uncertain about the meaning of a term, contact the Plan Administrator or the Claims Administrator for further clarification. In the event of any discrepancies or conflicts between these

definitions and the Plan Document, the terms of the Plan Document shall govern. Some definitions may be specific to the benefit plan option—see that specific SPD for further details.

Actively at Work. For purposes of the Life and Disability Plans, this generally refers to an Employee's regularly scheduled attendance at the Company's place of business and the Employee's physical ability to reasonably perform the material duties of your own job. Actively at Work includes an Employee's temporary absence from work due to vacation or jury duty. With respect to the Life and Disability Plans, refer to the specific Plan SPD or ask the Claims Administrator (the insurance carrier) directly how this is defined. For example, an Employee is not considered Actively at Work when on an approved leave of absence or entitled to receive Benefits from the Company's disability plans, whether the Employee is receiving pay or Benefits from such plans.

Annual Enrollment Period. A period of time that follows the initial enrollment period, as determined by the Plan provisions and the Plan Administrator, during which Primary Participants may enroll themselves, change coverage, and drop coverage and covered Dependents under the Plan according to verification and certification provisions.

Benefits. Your right to payment for Covered Health Services that are available under the Plan, subject to the terms, conditions, limitations, and exclusions of the Plan. The term "Benefits" also means the payments or services provided under the Plans, as applicable, the CenturyLink Group Life and Business Travel Accident Insurance Plan and the CenturyLink Disability Plan.

Calendar Year. The period starting on January 1st of each year and ending at midnight December 31st of that year.

Child. See the detailed description in the text of this SPD.

Claims Administrator. The entity that has been delegated responsibility for administration of the benefit option to include claims and appeals administration.

Company. CenturyLink, Inc.

Continuous Coverage. The maintenance of continuous and uninterrupted Creditable Coverage by an eligible Employee or Dependent. An eligible Employee or Dependent is considered to have maintained Continuous Coverage if the individual applies for coverage within 63 days of the termination of his or her qualifying coverage.

Covered Person. Either you or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to you and your Dependents throughout this Benefits Summary are references to a Covered Person.

Dependent. The Employee's legal Spouse (including a Common-law Spouse in states where it is recognized and where an affidavit is on file with the Plan Administrator), the Employee's Domestic Partner (where an affidavit is on file with the Plan Administrator), or certain Dependent Children as discussed earlier in the SPD. Generally for a

Dependent to be eligible for coverage under the Plan, the relationship must be established and in some circumstances, the financial support. Common-law spouse is not recognized by MetLife for Life Insurance.

Dependent Day Care Flexible Spending Account. Means the CenturyLink Dependent Day Care Flexible Spending Account (Dependent Day Care FSA), a dependent day care assistance program. Refer to the SPD for the Flexible Spending Account(s) for additional information.

Disability or Disabled. With the respect to an Employee, the term is as defined in the CenturyLink Disability Plan. With respect to a Child, the term is as determined by the Claims Administrator to be indefinitely incapable of self-support and fully dependent on the participant for support.

Employee. An individual employed directly by any Participating Company as a common law employee on a full-time, part-time, seasonal or incidental basis who receives compensation other than a pension, retainer, or fee under contract, except that Employee shall not include any leased employee. An Employee ceases to be an "Employee" on the date on which he is no longer within a covered payroll classification. The determination of whether an individual performing services for the Company is an "Employee" of the Company and the determination of whether an "Employee" of the Company is classified as a member of any classification of employees shall be made in accordance with the classifications used by the Company, in its sole discretion, and not the treatment of the individual for any purposes under the Code, common law, or any other law. The Company has full discretion to determine whether the eligibility requirements set forth herein have been satisfied. If a classification of an individual as ineligible is determined to be incorrect or is revised retroactively, the individual nevertheless will remain ineligible. This ineligible status will apply to all periods prior to the date of determination that the classification was incorrect and should be revised.

Enrolled Dependent. A Dependent who is properly enrolled and eligible under the Plan.

Enrollment Date. The first day of coverage.

Health Care Flexible Spending Account(s). The CenturyLink Traditional and Limited Health Care Flexible Spending Accounts, component plans that provide reimbursement to Primary Participants, who enroll and who are not eligible Retirees for certain health care expenses on a non-taxable basis. See the SPD for the Flexible Spending Account(s) for additional information.

HRA (Health Reimbursement Account). An HRA is an account funded with Company dollars if you are enrolled in a Consumer Driven Health Plan (CDHP). See the *CDHP benefit option SPD* for more information.

HSA (Health Savings Account). An HSA is a personal bank account that you fund and own. You are eligible for an HSA if you elect the High Deductible Health Care Plan

(HDHP) medical benefit option. See the *HDHP benefit option SPD* for more information.

Initial Enrollment Period. The first period of time, as we agree with the Claims Administrator, during which the employee may enroll themselves and their Dependents under the Plan.

Long-Term Disability (LTD) Recipient. An LTD recipient is an individual who after exhausting the maximum payment period of STD benefits, becomes entitled to receive LTD payments under the Disability Plan and LTD Policy.

LTD Benefit Payment Schedule. Health care Benefits end when your LTD benefits end or earlier as described in the “*The Health Coverage Available if you are an LTD Recipient*” section in this SPD. LTD benefit payments begin after the expiration of the maximum payment period of STD benefits, if the participant is otherwise eligible and approved for LTD benefits, and such LTD benefits are paid in accordance with the following schedule:

| Age at which LTD Benefits Commenced | Maximum Payment Period* |
|-------------------------------------|--|
| 61 or younger | to age 65 or 3 years 6 months, whichever is longer |
| 62 | 3 years 6 months |
| 63 | 3 years |
| 64 | 2 years 6 months |
| 65 | 2 years |
| 66 | 1 year 9 months |
| 67 | 1 year 6 months |
| 68 | 1 year 3 months |
| 69 or older | 1 year |

***includes 180 or 270 days of STD benefit (depending on collective bargaining agreement).**

Medically Necessary. Eligible medical and hospital services that the Claims Administrator determines are appropriate and necessary based in its internal standards. In disputed cases, the standard peer review process is used.

For purposes of Mental Health Services, the following Medically Necessary definition applies:

Health care services appropriate in terms of type, frequency, level, setting, and duration to the individual's diagnosis or condition, diagnostic testing, and preventive services. Medically Necessary care must:

- Be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the conditions, procedures, or treatment at issue
- Help restore or maintain the individual's health
- Prevent deterioration of the individual's condition; or prevent the reasonable likely onset of a health problem or detect an incipient problem

Medicare. The federal government's health insurance program under Social Security (Title XVII). Medicare gives health Benefits to people who are age 65 or older, or who are permanently disabled. The program has three parts, Part A, Part B and Part D. Part A generally covers the cost of Hospitals and extended care facilities. Part B generally covers the cost of professional Medicare services. Effective January 1, 2006 Part D covers prescription drugs. All Parts are subject to Medicare deductibles.

Plan or Plans. CenturyLink Health Care Plan; the following are "component plans" of the CenturyLink Welfare Benefits Plan: the CenturyLink Disability Plan, CenturyLink Life Insurance Plan, and CenturyLink Business Travel Accident Plan and other plans described in this SPD. While this SPD has referred to coverage for retirees and LTD Recipients, their health care benefits are provided in accordance with the terms of the CenturyLink Retiree and Inactive Health Plan.

Plan Administrator. The CenturyLink Employee Benefits Committee or its designee as that term is defined under ERISA.

Plan Document. The insurance contracts, amendments and other documents that describe and govern the CenturyLink Health Care Plan; the following are "component plans" of the CenturyLink Welfare Benefits Plan: CenturyLink Disability Plan, CenturyLink Life Insurance Plan, CenturyLink Business Travel Accident Plan and other plans described in this SPD.

Provider. Any person, facility, or other program that provides Covered Services within the scope of the provider's license, certification, registration, or training.

Short-term Disability. As defined under the CenturyLink Disability Plan.

Subscriber. The Primary Participant (who is not a Dependent) on whose behalf coverage under the Plan is provided.

Term of Employment (TOE). Term of Employment (TOE) is a period of continuous employment, as reflected in the Company's official service records and as defined by the Qwest Pension Plan.

Termination of Employment. Termination of employment means separation from employment with the Company for any reason, except death or retirement. Reasons include layoff, leave of absence, reduction of hours, expiration of short-term disability benefits (if not eligible for retirement), strike, or other work stoppage.

Third Party Administrator. An entity appointed by the CenturyLink Employee Benefits Committee to administer the Plan.

Total Disability or Totally Disabled. As defined under the Health Plan, a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex. The Disability Plan has its own specific definitions so please refer to the specific Disability Plan SPD.

Traditional FSA. See definition of *Health Care Flexible Spending Account* above.

Waiting Period. The period of time that must pass before you or your Dependents are eligible for coverage under the Plan.