CenturyLink

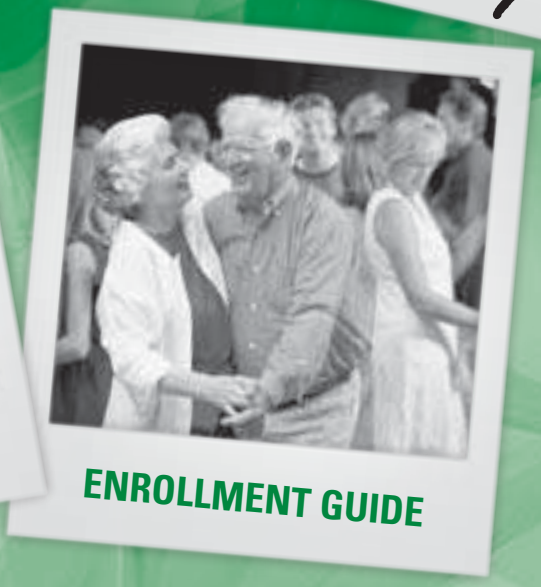
Benefits

Benefits

for Your

Lifestyle

2016 BENEFITS ANNUAL



ENROLLMENT GUIDE

ENROLLMENT BEGINS NOVEMBER 9 AND ENDS NOVEMBER 20, 2015

LEGACY QWEST PRE-1991 INCLUDING:
Retirees • COBRA Participants • Inactive Participants

CenturyLink®

AE16-Ret-PRE91

What's Inside

CenturyLink Retiree and Inactive Health Plan

Special Note for COBRA or Inactive Participants

Some references and benefit options in this document apply
only to Legacy Qwest Pre-1991 Retirees.
For more information, refer to the CenturyLink Health and Life Benefits website
or contact the CenturyLink Service Center for Health and Welfare Benefits.

Information in this Guide applies to Non-Medicare Eligible and Medicare Eligible retirees and their dependents.

How to know which information in this Guide applies to you and/or your dependents:

- Information on pages that have a GRAY HEADER (instead of green) and a gray background applies **ONLY** to Medicare Eligible participants and their Medicare eligible dependents.

Medical & Prescription Drug Options for Medicare Eligible Participants ONLY

- Information on pages with a regular green header applies to **BOTH** Non-Medicare eligible participants and Medicare eligible participants and their dependents.

Medical & Prescription Drug Options

Enrollment Checklist

Review and learn about your 2016 Plan benefit under the CenturyLink Retiree and Inactive Health Plan ("the Plan"). Use these resources for help:

- ❑ **This Guide** – for Annual Enrollment basics
- ❑ **Your Annual Enrollment Worksheet** – to review your current coverage and 2016 benefit options
- ❑ **The CenturyLink Health and Life Benefits website www.centurylinkhealthandlife.com** – to find:
  - information on your benefit options and premiums
  - links to vendor websites
  - printable copies of Summary Plan Descriptions (SPDs) and Summary of Material Modifications (SMMs)

Starting November 9, 2015 – Enroll.

- ❑ Online at **www.centurylinkhealthandlife.com**
- ❑ On the phone – call the CenturyLink Service Center at **800-729-7526**
  M–F, 7:30 a.m. to 5:30 p.m. Mountain time

Enroll by the deadline – November 20, 2015.

Here's what happens if you don't:

- ➤ You will default to your current medical/prescription drug, dental and/or life insurance benefit options (shown on your Annual Enrollment Worksheet), if available.
- ➤ Your **Annual Enrollment Worksheet** will serve as your **2016 Confirmation of Enrollment** statement if you don't make changes. You will not receive a Confirmation of Enrollment as you have in past years.

Medicare Eligible

If you are Medicare eligible and enrolling in the UnitedHealthcare Medicare Advantage benefit option, you must timely complete an individual enrollment form before your coverage can be effective. This form will be sent to you from the CenturyLink Service Center at the end of Annual Enrollment and must be returned to the CenturyLink Service Center no later than **December 18, 2015**.

The CenturyLink Service Center for Health and Welfare Benefits

(referred to in this Guide as the "Service Center")
If you have questions during Annual Enrollment, contact the Service Center through Web Chat while logged into **www.centurylinkhealthandlife.com** or call **800-729-7526** M–F, 7:30 a.m. to 5:30 p.m. Mountain time.

NOTE To request a paper copy of this document and/or to enroll by phone, call the Service Center at **800-729-7526**.

2016 Reminders

Here is a list of reminders regarding your CenturyLink benefits effective January 1, 2016.

Medical Reminders

In addition to the option you have available as your Guaranteed Coverage Commitment, if you are Medicare eligible, you are offered two additional benefit options under the Plan for your consideration. These benefit options are not part of the Guaranteed Coverage Commitment.

- **UnitedHealthcare Group Medicare Advantage Preferred Provider Organization (PPO)**
- **Health Reimbursement Account (HRA) (for individual Medicare plans or policies)**

NOTE Your Pre-1991 CenturyLink Health Care Option has not changed under the "Retiree Health Care Commitment" or "Guaranteed Coverage" as defined by the Retiree and Inactive Health Plan, ("the Plan"). Learn more about all your Health Care Options in the Medical & Prescription Drug Options section of this Guide.

Health and Welfare

What Happens to Your Benefits if You Return to Work for a Supplier on Assignment to the Company After you Retire or Leave Employment

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

Dependent Social Security Numbers Required

The Medicare Secondary Payer provisions of the Social Security Act require all employers to provide eligibility data with the Centers for Medicare & Medicaid Services (CMS). This means the Plan must provide CMS with Social Security numbers of all covered retirees and dependents. If you have covered dependents whose numbers are not on file with the Plan, please contact the Service Center to provide this information.

If you have a Same-Sex Spouse enrolled in medical coverage, you will no longer be subject to imputed income effective July 1, 2015.

NOTE Certain states applied this change retroactively to January 1, 2015. You will receive a W-2 for the 2015 plan year if you were subject to imputed income for any part of the 2015 calendar year. 2015 W-2s will be mailed in late January 2016.

Medical & Prescription Drug Options

Your CenturyLink 2016 Annual Enrollment Worksheet will show the following four options:

1

Company Plan
(current CenturyLink Company plan option still available to both Medicare eligible and non-Medicare eligible participants) referred to as "Retiree Health Care Commitment" or "Guaranteed Coverage."

Medicare Parts A **and** B are required.

2

UHC Group Medicare Advantage PPO
(UHC MA PPO)
(option for Medicare eligible only participants)
Requires timely completion of an enrollment form for each Medicare eligible person.

Medicare Parts A **and** B are required.

3

HRA Plan option
(Option for Medicare only participants.)
No CenturyLink Medical/Prescription Drug benefits provided. Instead, subsidy dollars will be placed in an account to reimburse you for Medicare policy premiums only.

Medicare Parts A **and** B are required.

4

No Coverage
(for both Medicare eligible and non-Medicare eligible participants who do not want any CenturyLink medical coverage options or the subsidy dollars)

NOTE If you enroll in one of the first 3 options and cancel that coverage during the Plan year, you will **default to the No Coverage** option for the remainder of the year, unless you experience a Qualified Life Event (QLE). The Medicare Advantage Option requires timely completion of a **disenrollment form** when cancelling. You will be able to make a new election during the next Annual Enrollment period. Enrollment and disenrollment forms are provided by and returned to the CenturyLink Service Center.

MEDICARE ELIGIBLE

If you and your dependents are **all** Medicare eligible, you must enroll in the same CenturyLink benefit plan option. All Medicare eligible persons enrolling in the UHC MA PPO plan MUST timely complete the enrollment form/process individually. If you are enrolling in an *individual* policy outside of CenturyLink for the HRA benefit option, you must complete that carrier's enrollment process as well.

NON-MEDICARE ELIGIBLE

If you or your dependents are NOT Medicare eligible yet, you can make separate elections for Medicare and non-Medicare family members. The non-Medicare person may remain in the CenturyLink Company plan option or No Coverage option, while the Medicare eligible person may select from all three Medical plan options.

NOTE If the non-Medicare eligible family member becomes Medicare eligible during the plan year, that participant must enroll (and complete forms, if applicable) in the same CenturyLink benefit plan option that the Medicare eligible family member is already enrolled in.

MEDICARE PART-B REIMBURSEMENT

If you are currently receiving Medicare Part-B reimbursement, your reimbursement will continue regardless of which benefit option you choose at the standard Medicare Part-B premium amount unless you submit documentation that you pay an income-adjusted Medicare Part-B premium amount.

2016 CenturyLink Medical

Refer to your Annual Enrollment Worksheet to determine what plan you are eligible for under the Guaranteed Coverage Commitment.

	UnitedHealthcare Group Medicare Advantage Plan*	Pre 91 Retiree Plan		
	Your In- and Out-of-Network Costs	**Plan 1 & Plan 2**	**Plan 3**	**Plan 4**
Annual Out-of-Pocket Maximum (Medical Only)	$1,000	$1,000	$1,000	$250
Deductible	$0	1% of Pension/$150 max	1% of Pension/$150 max	$100
Coordination of Benefits with Medicare	UnitedHealthcare (UHC) handles on your behalf	Claims must be submitted to Medicare Part A or B first, then to UHC for Coordination with Pre 91 Retiree Plan 1 & Plan 2	Claims must be submitted to Medicare Part A or B first, then to UHC for Coordination with Pre 91 Retiree Plan 3	Claims must be submitted to Medicare Part A or B first, then to UHC for Coordination with Pre 91 Retiree Plan 4
Medical Benefits:				
Primary Care Physician Office Visit	$5	20% after deductible	20% after deductible	10% after deductible
Specialist Physician	$10	20% after deductible	20% after deductible	
Preventive Services	$0	Not Covered	Not Covered	
Emergency	$65	$0	$25	
Hospital Co-pay Per Admit	$0	$0	$0	
Outpatient Services	$0	$0	$0	

*** The UnitedHealthcare Group Medicare Advantage Plan is available to Medicare Eligible Participants ONLY.**

Continued on the next page ➥

NOTE Your medical coverage is separate from your dental coverage. See the ***Dental*** section for information on your dental options.

2016 CenturyLink Medical

Refer to your Annual Enrollment Worksheet to determine what plan you are eligible for under the Guaranteed Coverage Commitment.

	UnitedHealthcare Group Medicare Advantage Plan*	Pre 91 Retiree Plan		
	Your In- and Out-of-Network Costs	**Plan 1 & Plan 2**	**Plan 3**	**Plan 4**
Additional benefits and programs not covered by Medicare:				
Hearing Aids	Plan pays up to $500 (every 3 years)	Not Covered	Not Covered	Not Covered
NurseLine℠	Speak with a registered nurse (RN) 24 hours a day, 7 days a week	Not Available	Not Available	Not Available
Vision Services – Eye Exam	$10	Not Covered	Not Covered	Not Covered
Routine Eyeglass Allowance (every 2 years)	$135			
Fitness Program	Stay active with a basic membership at a participating location at no extra cost to you			
Prescription Drug Benefits Retail (30-day supply)				
Tier 1 (Preferred Generic)	$7 co-pay	20% after deductible ***Prescription receipts must be submitted to the medical plan for reimbursement.***		
Tier 2 (Preferred Brand & Non-preferred Generic)	$15 co-pay			
Tier 3 (Non-preferred Brand)	$40 co-pay			
Tier 4 (Specialty)	$40 co-pay			
Coverage Gap	Full Coverage			
Prescription Drug Benefits Mail (90-day supply)				
Tier 1 (Preferred Generic)	$14 co-pay	$3 co-pay	$0 co-pay	$2 co-pay
Tier 2 (Preferred Brand & Non-preferred Generic)	$30 co-pay			
Tier 3 (Non-preferred Brand)	$80 co-pay			
Tier 4 (Specialty)	$80 co-pay			

*** The UnitedHealthcare Group Medicare Advantage Plan is available to Medicare Eligible Participants ONLY.**

Additional Health Care Benefit Options

(for Medicare Eligible Participants ONLY)

These are additional benefit options you can elect instead of coverage under the Guaranteed Coverage Commitment. Refer to the comparison charts for additional information.

UnitedHealthcare Group Medicare Advantage Preferred Provider Option (PPO)

This PPO option includes benefits such as:

- Services from any provider who participates with Medicare. Your benefits are the same regardless if in- or out-of-network providers are used.
- Medicare is assigned to this Plan option when enrolled, so any coordination with Medicare is automatically done for you.
- You share the cost of services by paying co-payments or co-insurance for some services. Many services are covered at 100%.
- This Plan option provides prescription drug coverage, but you must use the in-network pharmacies in order to receive cost savings.

Contact UnitedHealthcare for additional information regarding this benefit option.

NOTE If you are Medicare eligible and enrolling in the UnitedHealthcare Medicare Advantage benefit option, you must timely complete an individual enrollment form before your coverage can be effective. This form will be sent to you from the CenturyLink Service Center at the end of Annual Enrollment and must be returned to the CenturyLink Service Center no later than **December 18, 2015**.

Health Reimbursement Account (HRA) – combined with an Individual Policy

- You are waiving coverage in CenturyLink group medical plan benefits each year you elect this option.
- You purchase the individual Medicare and prescription drug policy directly from the insurance carrier(s) ("carrier") of your choice – pay the insurance premium directly to them – and then receive reimbursement for the premium from your HRA.
- The HRA provides you with Company-subsidized dollars to help you purchase the individual plans/policies that CenturyLink does not offer!
- The HRA account is credited annually, on January 1st of each year, by CenturyLink in the amount of $3,600. Unused dollars are forfeited at the end of each year, December 31.
- The HRA is part of the CenturyLink group health plan, but the individual plan/policy you choose is not.
- In order for your individual Medicare medical policy to be in effect for January 1, 2016, you must enroll with them between October 15 and December 7, 2015. For assistance, call OneExchange at **888-825-4252**.

NOTE If you select one of these health care benefit options and you later want to change options, or return to the coverage you had under the Guaranteed Coverage Commitment, you will be required to wait until the next Annual Enrollment period. If you are cancelling the Medicare Advantage Option, you must timely complete a disenrollment form.

About Medicare

Medicare health insurance is provided by the U.S. federal government. Generally, you become eligible for Medicare on the first of the month in which you turn 65. You may be eligible for Medicare benefits at an earlier age if you have permanent kidney failure or have certain disabilities. If you or your dependents are eligible for Medicare, or will be this year, please review the following information carefully. There are three parts of Medicare that apply to you.

1 Medicare Part A

Medicare Part A covers most inpatient hospital services, skilled nursing facility services, certain home health services and hospice care. Medicare does not cover 100% of these services. Generally, it is available at no cost to you.

2 Medicare Part B

Medicare Part B covers doctor services, outpatient hospital services, certain home health services, medical equipment and supplies and other health services and supplies. Medicare does not cover 100% of these services.

If you are a Legacy Qwest ERO 92 Retiree, the Plan will reimburse the premium you pay for this coverage for you and your dependents who are not Class II dependents.

NOTE If you are enrolled in the HRA option, Medicare Part B does not come from your HRA subsidy. If you are receiving the Medicare Part B reimbursement, you may opt out. Contact the Service Center for details on how to opt out.

3 Medicare Part D (Medicare Prescription Drug Coverage)

Medicare Part D covers the cost of certain prescription drugs for eligible seniors and individuals with disabilities. The cost of this coverage depends on the Medicare Part D plan you select. **However**, if you enroll in either the Guaranteed Coverage benefit option or UHC Medicare Advantage PPO benefit option, you do not need to enroll in Medicare Part D because prescription drug coverage is included in these benefit options, as defined by the Plan.

If you elect the HRA benefit option, you may need to enroll in a Medicare Part D plan, depending on which type of individual Medicare medical plan/policy you elect on your own.

For more information about Medicare benefits, see the ***Medicare & You*** handbook at:

- **www.medicare.gov**; or
- call **800-MEDICARE** [633-4227] and ask to have a copy mailed to you. TTY users should call **877-486-2048**.

Dental Plan Benefit Option

The Plan benefit option available to you is indicated on your Annual Enrollment Worksheet.

It Pays to Use Network Dentists

You may receive services from any provider under your Plan benefit option, but you may pay less out-of-pocket costs if you receive care from MetLife network providers (in the Preferred Dentist Program). If you receive services from a non-network provider, you may pay more out-of-pocket costs and you may need to complete and submit claim forms to receive benefit payments.

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

Preventive and Diagnostic Care Services
(such as cleanings, oral exams and X-rays)

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

All Other Services

You pay according to a schedule of allowances. Review the schedule of allowances in the applicable Summary Plan Description to determine the out-of-pocket expenses you must pay. Call MetLife for details about covered services.

For questions or benefit information, visit the MetLife website at **www.metlife.com/mybenefits** or call **888-356-4191**.

You will not receive an ID card from MetLife for your dental Plan coverage. Simply tell your dentist that you are covered by MetLife through CenturyLink. You may print an ID card from the MetLife website.

Retiree Life Insurance

PLAN	BENEFIT
RETIREE BASIC LIFE INSURANCE Automatic and Company-paid	For eligible retirees, CenturyLink provides Retiree Basic Life Insurance coverage that pays a $10,000 benefit to your designated beneficiary(ies) upon your death.
RETIREE SUPPLEMENTAL LIFE INSURANCE *(if applicable)* You pay the cost	If you continued Retiree Supplemental Life Insurance coverage after your retirement, you may continue coverage to age 65 provided you pay your monthly premium contributions in a timely manner. Coverage ends on the last day of the month in which you turn age 65, but you can apply to convert your coverage to an individual policy. Contact MetLife for details.

Retiree Supplemental Life Insurance

If your coverage is terminated due to non-payment or insufficient payment, you will not be allowed to re-enroll. Once coverage is terminated, it cannot be reinstated. The Service Center will inform you of your right to appeal that determination.

Important Notes If You Have Retiree Supplemental Life Insurance

- You may cancel or decrease coverage at any time by calling the Service Center. You may not enroll, re-enroll or increase coverage during your retirement.
- You may convert your Retiree Supplemental Life coverage, if applicable, according to the laws of the state of Washington where the policy is issued. Conversion is not automatic and you must apply for the converted life coverage through MetLife. Call **877-275-6387** to request a conversion application if you experience a qualified loss in coverage. **MetLife must receive your completed application and premium for conversion within 31 days from the date your retiree supplemental life coverage terminates.** Applications MetLife receives after the 31-day period will be denied.

REMEMBER: To report a death, contact the Service Center at **800-729-7526** and press option "3." It is very important to contact the Service Center as soon as possible as this can impact benefits under the CenturyLink Retiree and Inactive Health Plan, the CenturyLink Life Insurance Plan, and/or the CenturyLink Combined Pension Plan.

Beneficiary Reminder

Please confirm that you have designated beneficiaries for all of your CenturyLink Life Insurance Plan coverage by going to **www.centurylinkhealthandlife.com** or calling the Service Center at **800-729-7526**.

The Service Center is the record keeper of beneficiary designations.

Refer to the SPD for specific beneficiary information including how benefits are paid if no beneficiary is living on the date of your death or you have not elected a beneficiary.

Refer to the ***Helpful Resources*** section of this Guide for instructions on how to access SPDs and SMMs for detailed information.

Paying for Your Supplemental Life Insurance Coverage (if applicable)

CenturyLink makes it easy to pay for your Supplemental Life Insurance benefits.

Your 2015 benefit payment election will continue in 2016 unless you make a change or reach age 65 in 2015 and your Retiree Supplemental Life terminated at the end of the month in which you turned age 65. If you do not have an automatic payment plan in place for your Supplemental Life Insurance premiums, then your premiums are due on the first day of each month for the current month's benefit coverage.

Pay on time with direct debit.

You can avoid worries and concerns about non-payments or insufficient payments by setting up direct debit. Contact the Service Center for more information.

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

There are three ways to pay your benefits premium.

1 Check or Money Order

- You will receive a billing statement each month. Your first statement for 2016 will arrive in December 2015. Here's what to do if you do not receive your statement:
  1. Call the Service Center at **800-729-7526**;
  2. Select the **If you are a former employee** option;
  3. Select the **medical, dental & life** option; then
  4. Press ***0** to speak with a representative.
- Your premium for each month is due on the first day of the month. Submit your premium payment to the address listed on the statement.
- If you submit more than one month of premium payment at a time, your additional payments will be held as a credit in your account.
- Payment should be sent to: CenturyLink, P.O. Box 0597, Carol Stream, IL 60132-0597.

Continued on the next page ➥

Paying for Your Supplemental Life Insurance Coverage (if applicable)

2 Deductions from Your Pension Check

This applies only if you are currently receiving a pension check from CenturyLink and the amount of your check will cover the amount of your benefits premium payment.

- To request your benefits premium payment be deducted from your pension check:
  1. Call the Service Center at **800-729-7526**;
  2. Select the **If you are a former employee** option;
  3. Select the **medical, dental & life** option; then
  4. Press ***0** to speak with a representative.
- If you elect to pay premiums through your monthly pension check, deductions for 2016 premiums are paid in arrears. For example, the January contribution will be deducted from your February pension check.
- You may change your payment option at any time during the year.

3 Direct Debit

- You can enroll in direct debit by visiting the CenturyLink Health and Life Benefits website:
  1. Go to **www.centurylinkhealthandlife.com**;
  2. From the home page, use your computer mouse to roll over the **Health and Life Benefits** tab at the top of the screen;
  3. Under **Take Action**, click on **Billings and Payments**;
  4. Under **Current Ongoing Payment Method**, select **Change**; then
  5. Select **direct debit** and follow the prompts to enroll.
- You can also call the Service Center at **800-729-7526** to request a direct debit form. Fill out the form and return it to the address shown on the form.
- Direct debit deductions occur on the first of each month or the next business day if the first falls on a weekend or holiday. Payment is for the current month of coverage.

Be sure to make timely payments!

If your premium payments are not received by the Service Center in a timely manner, the payments may be cashed due to the delay in updating records internally. In this case, you will receive a refund for the untimely payment and your coverage will not be reinstated, except as may be determined upon a written appeal made by you to the Plan. Please note that checks that are returned or direct debit requests that are refused due to insufficient funds are not re-deposited.

How to Enroll Online

1. Go to **www.centurylinkhealthandlife.com** and **Log On**.
   *(See the next page of this guide: **If you forgot your User ID or password.**)*
2. Once you are logged in, select **Make Your Annual Enrollment Elections** to start enrolling.
3. You will be taken to a step-by-step page with helpful enrollment resources.
4. Click **Enroll in Your Benefits** then **Enroll Now**.
5. Review your choices and associated premiums to make your elections.
6. After you have made your elections, click **Complete Enrollment**.*
7. Look for the **Completed Successfully!** message and print a copy for your records by following the instructions below. You will **not** receive a final Confirmation of Enrollment Statement in the mail as in prior years.

* NOTE If enrolling in the UnitedHealthcare Medicare Advantage option, your enrollment is not final until you complete the enrollment form, which will be sent to you from the CenturyLink Service Center within two days. This form must be returned to the **CenturyLink Service Center** by December 18, 2015, in order for that coverage to be effective for 2016. The coverage effective date is January 1, 2016. Failure to return the form will result in you remaining in your 2015 medical plan option until your Medicare Advantage form has been processed.

- If you are using the site for the first time, click on **Register as a New User** and follow the prompts to set up your User ID and password. Store this information in a safe and secure place.
- If you're not a first time user, enter your **User ID** and **Password**.

The average time to complete your online enrollment is 30-45 minutes.

No Changes?

If you did not make any changes, your Annual Enrollment Worksheet will serve as your Confirmation of Enrollment Statement. You may use the following instructions to print a copy of your 2016 elections through December 31, 2015.

1. Log on **www.centurylinkhealthandlife.com**.
2. Click on the **Health and Insurance** tab.
3. Click on the blue tile labeled **View Pending Coverage Costs (effective Jan. 1, 2016)**.
4. To change from annual cost to monthly cost, select **Monthly**.
5. To print, click on the **Print** icon on the top right side of the screen.
6. Keep a copy of this page for your records.

How to Enroll Online *(continued)*

If you forgot your User ID or Password:

Click **I Forgot My Password** and enter the correct information. First, **confirm your identity**... then **reset your password**. You'll receive your log on information via email if you have a valid email address on file. If not, your log on information will be mailed to the address on file.

NOTE It can take up to 10 business days to receive this information by mail.

Have questions along the way?

Web Chat
Chat with a representative about any of your Health and Welfare Benefits questions by visiting the CenturyLink Health and Life Benefits website at **www.centurylinkhealthandlife.com** and selecting **Home/Contact Us/Enroll in Your Benefits**. Click on **Chat** or **Contact Us** on the dark gray bar at the top of the page.

Phone
If you need to talk with a Customer Service Representative, call **800-729-7526** M–F, 7:30 a.m. to 5:30 p.m. Mountain time. You may experience longer than usual call wait times during the Annual Enrollment period.

CenturyLink Health and Life Benefits website
www.centurylinkhealthandlife.com

A trusted source to:

- Compare Plan deductibles and coinsurance.
- Find out if your doctor or other medical provider participates as an in-network or out-of-network provider.

How to Enroll By Phone

Service Center representatives will be available to answer your questions or help with your enrollment. You must call **800-729-7526** before Friday, November 20 at 5:30 p.m. Mountain time to complete your enrollment.

Helpful Resources

BENEFIT OPTION	PHONE	ONLINE
Health Care		
CenturyLink Service Center for Health and Welfare Benefits	**800-729-7526** M–F, 7:30 a.m. to 5:30 p.m. Mountain time	The CenturyLink Health and Life Benefits website: **www.centurylinkhealthandlife.com**
Retiree Medical/ Prescription Drug Plans	UnitedHealthcare: **800-842-1219**	**www.myuhc.com**
UnitedHealthcare Group Medicare Advantage Preferred Provider Option (PPO)	**877-886-7313** NOTE Do not enroll through this number. Enrollment is completed through the CenturyLink Service Center.	N/A
Health Reimbursement Account (HRA)	**800-729-7526** and select the HRA option	**www.centurylinkhealthandlife.com**
Dental Plans	MetLife: **888-356-4191**	**www.metlife.com/mybenefits**
Health Care Advocacy Services Free assistance with health and life claims and accessing health care services if enrolled in health care benefits through CenturyLink	CenturyLink Service Center for Health and Welfare Benefits: **800-729-7526**	**www.aonhewittadvocacy.com**
Retiree Life Insurance		
Retiree Life Insurance	CenturyLink Service Center for Health and Welfare Benefits: **800-729-7526**	The CenturyLink Health and Life Benefits website: **www.centurylinkhealthandlife.com**
Life Insurance Administrator MetLife is the issuer of CenturyLink's Retiree Life Insurance	Metropolitan Life Insurance Company 200 Park Avenue, New York, N.Y., 10166 **800-638-6420**	

Additional Services Provided by MetLife

Estate Resolution Services are provided at no additional cost to retirees who are covered by the CenturyLink Supplemental Life Insurance Plan through MetLife. If you are eligible to receive these Estate Resolution Services and you or your spouse/domestic partner (for the Will Preparation Service) or you or a beneficiary (for the Probate Service) would like to speak with a representative from Hyatt Legal Plans or get the name of a Plan attorney whom you can speak with about these services, please call **800-821-6400**.

Helpful Resources

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

For Health and Life Benefits

Online

Contact the Service Center:

- Log on to **www.centurylinkhealthandlife.com.**

Follow these steps:

1. From the home page, go to **Your Profile** and click on **Personal Information**.
2. On the **Personal Information** page, under **Addresses**, click on **Change** next to **Permanent Address**.
3. You will then be routed to a page that will allow you to update your permanent address.

Phone

Contact the Service Center:

- Dial **800-729-7526** and press **option 2** and then **option 1** for the Medical, Dental and Life benefits.

For Pension Benefits

Online

Contact the Service Center:

- Visit the retiree website at **https://ctl.mypenpay.com**;

OR

- Submit your information in writing to:

  Retiree Service Center
  Attention: CenturyLink
  P.O. Box 24989
  Jacksonville, FL 32241

  Your written request must include your name, first five digits of your Social Security number, complete old address, complete new address, signature and date.

Phone

Contact the Service Center:

- Dial **800-729-7526** and press **option 2** and then **option 3** for pension information.

When you need more detailed information about Plan specifics, review your SPDs and SMMs located on the CenturyLink Intranet and the Health and Life Benefits website. If you would like a paper copy of these materials, please contact the Service Center to request one. Please be advised that mailing time can take up to two weeks.

Adding Dependents During Annual Enrollment

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

1. Add your newly eligible dependents during your online enrollment by following the prompts or by contacting the Service Center. A Dependent Verification packet will be sent to you automatically in December 2015. Follow the instructions outlined in the packet and **respond by the deadline**.
2. Plan coverage for your newly eligible dependents will become effective January 1, 2016, **EXCEPT**, if validation is required and verification forms are not received by the Service Center by the deadline, your dependents will be removed retroactively from coverage and you will be required to reimburse the Plan for any claims paid while the previously suspended dependents were ineligible under the Plan.

Ending Coverage for Dependents During Annual Enrollment

You may remove dependents from your Plan coverage during Annual Enrollment by following the prompts during your online enrollment or by contacting the Service Center. COBRA will not be offered for dependents removed during Annual Enrollment.

During the year, if dependents no longer meet eligibility requirements for coverage, you are required to contact the Service Center **within 45 days** to terminate their coverage. You must notify the Service Center and coverage will end for the affected individuals retroactively to the end of the month in which the event occurred. You will be responsible for any claims paid after eligibility ended.

If You Have a Qualified Life Event and Need to Make Changes Before 2016

If you make changes during Annual Enrollment and have a subsequent change to your coverage before the end of December 2015 because of a QLE (for example, you add a spouse to your coverage), your 2015 changes/enrollment will not automatically be applied to 2016, so you will need to update **BOTH** your 2015 and 2016 coverage by contacting the Service Center.

What Happens to Your Benefits if You Return to Work Directly for the Company as an Active Employee or Work for a Supplier on Assignment to the Company After You Retire or Leave Employment

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

NOTE *If you had VEBA Life Insurance, that coverage will not be impacted.*

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

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

Once your employment or assignment ends, you may resume your retiree health care, basic and supplemental life insurance coverage, if applicable, in accordance with the terms of the Plan by calling the 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).

If this applies to you and you have questions regarding coverage, call the CenturyLink Service Center at **800-729-7526** M–F, 7:30 a.m. to 5:30 p.m. Mountain time.

A Note About Privacy

Keeping your personal information secure is of primary importance to CenturyLink. That's why we, along with the benefits administrators, have implemented various security measures and policies to help reduce the risk of unauthorized processing or disclosure of your personal information. You can also help by keeping confidential your User ID and password for accessing the CenturyLink Health and Life Benefits website. Please keep this information safe and don't share it with anyone. Never use your Social Security number as your password. Together, we can make sure your personal information stays safe and secure. Please be advised that using an email that is not secured may increase your risk of unauthorized disclosure.

This Is a Summary of Material Modifications (SMM)

This document is intended to serve as a "Summary of Material Modifications" (the "SMM") pursuant to the requirements of Section 104 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This SMM notifies you of certain changes to the CenturyLink sponsored Plans (the "Plan"). Please keep this SMM with your Summary Plan Description for the Plan for future reference. This document summarizes only certain provisions of the Plan. If there is any conflict between the terms of the Plan documents and this SMM, the terms of the Plan documents will govern. The Company has reserved to the Plan Administrator the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan.

Coverage Is Not Advice

Plan coverage is not health care advice. Please keep in mind that the sole purpose of the Plan is to provide payment for certain eligible health care expenses – not to guide or direct the course of treatment for any employee, inactive retiree or eligible dependent. If your health care provider recommends a course of treatment, be sure to check with the Plan to determine whether or not that course of treatment is covered under the Plan. However, only you and your health care provider can decide what the right health care decision is for you. Decisions by a claims administrator or the Plan Administrator are solely decisions with respect to Plan coverage and do not constitute health care recommendations or advice.

The Company's Reserved Rights

This document summarizes certain provisions of the CenturyLink Health Care Plan, the CenturyLink Life Insurance Plan and the CenturyLink Disability Plan (collectively referred to as the "Plan"). For specific employee benefit Plan information, refer to the respective official Plan Documents, including the applicable Summary Plan Description and Summaries of Material Modifications, if any. If there is any conflict between the terms of the official Plan Documents and this document, the terms of the official Plan Documents will govern. The Plan Administrator has the authority, discretion and the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan, to supply omissions and resolve conflicts. Benefits and contribution obligations, if any, are determined by CenturyLink in its sole discretion or by collective bargaining, if applicable.

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

The Plan Administrator, may adopt, at any time, rules and procedures that it determines to be necessary or desirable with respect to the operation of the Plan.

Right to Amend and/or Discontinue and Make Rules

The Company and its delegate, the CenturyLink Plan Design Committee, each has reserved the right in its sole discretion, to change, modify, discontinue or terminate the Plan and/or any of the benefits under the Plan and/or contribution levels, with respect to all participants classes, retired or otherwise, and their beneficiaries at any time without prior notice or consultation, subject to applicable law, specific written agreement and the terms of the Plan Document and with respect to the Health Plan, the written agreement specific to Legacy Qwest Pre-1991 Retirees and Legacy Qwest ERO '92 Retirees. The CenturyLink Employee Benefits Committee, as the Plan Administrator, may adopt, at any time, rules and procedures that it determines to be necessary or desirable with respect to the operation of the Plan. The Plan Administrator has the authority, discretion and the right to interpret and resolve any ambiguities in the Plans or any document relating to the Plans.

Notice of "Exempt" Retiree Medical Plan Status

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

Important Note Regarding Your Annual Enrollment Elections

By electing to participate in the Plans (the CenturyLink Health Care Plan, the CenturyLink Life Insurance Plan, CenturyLink Business Travel Accident Insurance Plan, the CenturyLink Disability Plan, or if applicable, CenturyLink Retiree and Inactive Health Plan), by your submission of information, you have agreed to be bound to and by the provisions of each of the Plans and their administrative practices, including, but not limited to with respect to the recovery of over and underpayments, terms and conditions for eligibility and Benefits. You certify that the submission of information by you in this enrollment process is true and accurate to the best of your knowledge, unless you submit changes as instructed; you agree that you'll submit new information timely as changes occur. You understand that if you are found to have falsified any document in support of a claim for eligibility or reimbursement, the Plan Administrator may, subject to and as may be permitted under the requirements of law, without anyone's consent, terminate your and/or your dependent(s) coverage, and the Claims Administrator may refuse to honor any claim you or your dependent(s) may have made or will make under the Plans if applicable. You understand that you are liable and bear the full financial responsibility for the misappropriation of Plan funds through the filing of false documentation under any of the Plans; You certify that you or your dependent(s) are eligible to enroll in a benefit option, including voluntary or supplemental coverages. Please refer to the applicable Plan document or SPD for details about eligibility for coverage or call the Claims Administrator – limitations may apply including but not limited to, being actively at work in order to be eligible for coverage. You understand that it is your responsibility to confirm your eligibility to enroll in a benefit option, including voluntary or supplemental coverages; enrolling in and paying for coverage for which you are ineligible will not entitle you to Benefits; you understand that it is your responsibility to terminate benefit coverage once you or your dependent(s) become ineligible.

For specific employee benefit plan information, including terms and conditions for eligibility, limitations and Benefits refer to the respective Plan Documents, including the applicable Summary Plan Description and Summaries of Material Modifications, if any. If there is any conflict between the terms of the Plan Documents and this correspondence, the terms of the Plan Documents will govern.

CenturyLink Plan Trust Information Update – No Action is Required

CenturyLink Investment Management Company ("CIM") is the investment fiduciary for the assets held in various trusts for the following Plans: CenturyLink Combined Pension Plan; Qwest Occupational Health Care Plan; Carolina Telephone And Telegraph Company Sickness Death Benefit Plan; CenturyLink Dollars and Sense Plan 401(k) Plan; and the CenturyLink Union 401(k) Plan, (collectively referred to as the "Plan"). CIM is claiming an exemption from registration as a Commodity Pool Operator for the Plans. The Commodity Futures Trading Commission requires that we provide the following information to Plan participants in order to meet the exemption requirements. This disclosure does not affect your benefit in any way and does not require any action on your part.

As part of the investment strategies utilized by the Plans, CIM and/or its investment managers, may engage in commodities futures trading for the above named Plans. The Plans are not construed as commodity pools and CIM has not registered with the Commodity Futures Trading Commission ("CFTC") as a Commodity Pool Operator by claiming an exclusion in accordance with CFTC Rule 4.5(a)(4).

Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

Please contact the Member Services of your Claims Administrator for more information.

Women's Health and Cancer Rights Act

- This notice is provided to you in compliance with the federal law entitled the Women's Health and Cancer Rights Act of 1998 (the "Act"). The Plan provides medical and surgical benefits in connection with a mastectomy. In accordance with the requirements of the Act, the Plan also provides benefits for certain reconstructive surgery.
- In particular, the Plan will provide, to an eligible participant who is receiving (or who presents a claim to receive) benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and treatment of physical complications associated with all the stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.
- As with other benefit coverages under the Plan, this coverage is subject to each medical benefit option's annual deductible (if any), required coinsurance payments, benefit maximums, and copay provisions that may apply under each of the benefit options available under the Plan.
- You should carefully review the provisions of the Plan, the medical benefit option in which you elect to participate, and its SPD and SMM (if any) regarding any applicable restrictions. Contact the Claims Administrator of your medical benefit option for more information.

Health Insurance Portability and Accountability Act (HIPAA)

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

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

What Is a Qualified Medical Child Support Order (QMCSO)?

A QMCSO is a court order that mandates that one parent is obligated to provide coverage under an employer's group health plan to a minor child at that parent's expense. This allows your minor child to be enrolled in a group health plan anytime throughout the year. The child remains enrolled in the plan until a new court order removes the QMCSO or the child becomes ineligible for coverage under the plan's terms (for example, the child reaches age 26 or the parent is no longer eligible). A National Medical Support Notice (NMSN) is issued by a state agency instead of a court but is equivalent to a QMCSO. Typically, a custodial parent will obtain a QMCSO or NMSN as part of a child support arrangement.

- If you have a QMCSO, you must send a copy of it to the Service Center.
- If you have currently waived coverage under the Plans, and the QMCSO requires your dependent children to be covered, you will be automatically set up with default coverage (the "Retiree Health Care Commitment" or, "Guaranteed Coverage" Medical and Dental Plan) depending on the court order.

If you have questions regarding a QMCSO, where to send your QMCSO or whether you have one on file, contact the Service Center at **800-729-7526**.

If You Voluntarily Elect to Drop Coverage

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

Continuation of Coverage

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of employment. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

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

If you have any questions about COBRA or the Plan, please contact the Service Center at **800-729-7526**.

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

NOTE This is an updated notice.

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272**).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2015. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447
ALASKA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 907-465-3347 Phone (Anchorage): 907-269-6529
ARIZONA – CHIP
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-855-432-7587 Phone (Maricopa County): 602-417-5437

COLORADO – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: http://dch.georgia.gov/ – Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507

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Legal and Important Required Notices

IDAHO – Medicaid and CHIP
Medicaid Website: healthandwelfare.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588
INDIANA – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949
IOWA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570
LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 225-342-4902
MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741
MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120
MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
NEVADA – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

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Legal and Important Required Notices

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462
RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA – Medicaid
Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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