# CenturyLink
## Vision Benefits

### TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTRODUCTION</strong></td>
<td>3</td>
</tr>
<tr>
<td><strong>CLAIMS ADMINISTRATORS</strong></td>
<td>4</td>
</tr>
<tr>
<td>Vision Service Plan</td>
<td>4</td>
</tr>
<tr>
<td>CenturyLink Employee Resource Center (ERC)</td>
<td>4</td>
</tr>
<tr>
<td><strong>COMMON FEATURES OF THE HEALTH CARE PLANS</strong></td>
<td>5</td>
</tr>
<tr>
<td>Your Eligibility</td>
<td>5</td>
</tr>
<tr>
<td>Dependent Eligibility</td>
<td>5</td>
</tr>
<tr>
<td>Coverage Level</td>
<td>6</td>
</tr>
<tr>
<td>If Both You and Your Spouse/Domestic Partner Work for the Company</td>
<td>7</td>
</tr>
<tr>
<td>When Coverage Begins</td>
<td>7</td>
</tr>
<tr>
<td>What Coverage Costs</td>
<td>7</td>
</tr>
<tr>
<td>Pre-Tax Premium Payment Plan</td>
<td>7</td>
</tr>
<tr>
<td>How to Enroll</td>
<td>7</td>
</tr>
<tr>
<td>Changing Your Coverage</td>
<td>7</td>
</tr>
<tr>
<td>Midyear Changes to Enrollment</td>
<td>8</td>
</tr>
<tr>
<td>Special Enrollment Period</td>
<td>8</td>
</tr>
<tr>
<td>Qualified Status Changes</td>
<td>9</td>
</tr>
<tr>
<td>Legal Marital Status</td>
<td>9</td>
</tr>
<tr>
<td>Domestic Partner Status</td>
<td>9</td>
</tr>
<tr>
<td>Number of Dependents</td>
<td>9</td>
</tr>
<tr>
<td>Employment Status</td>
<td>9</td>
</tr>
<tr>
<td>Dependent Status</td>
<td>9</td>
</tr>
<tr>
<td>Residence</td>
<td>9</td>
</tr>
<tr>
<td>Required Documentation for Qualified Status Changes</td>
<td>10</td>
</tr>
<tr>
<td>If You Waive Coverage</td>
<td>10</td>
</tr>
<tr>
<td>Leaves of Absence</td>
<td>10</td>
</tr>
<tr>
<td>If You Become Disabled - Premiums</td>
<td>11</td>
</tr>
<tr>
<td>Continuation of Coverage during Family and Medical Leave (FMLA)</td>
<td>11</td>
</tr>
<tr>
<td>Re-enrollment after an FMLA Leave</td>
<td>11</td>
</tr>
<tr>
<td>If You Die</td>
<td>11</td>
</tr>
<tr>
<td>Health Care Benefits at Retirement</td>
<td>11</td>
</tr>
<tr>
<td>Premiums for Retirees</td>
<td>12</td>
</tr>
<tr>
<td>When Coverage Ends</td>
<td>12</td>
</tr>
<tr>
<td>When a Dependent is No Longer Eligible for CenturyLink Health Care Coverage</td>
<td>12</td>
</tr>
<tr>
<td><strong>VISION PLAN FEATURES</strong></td>
<td>14</td>
</tr>
<tr>
<td>Procedures for Using the Plan</td>
<td>14</td>
</tr>
<tr>
<td>Benefit Authorization Process</td>
<td>14</td>
</tr>
<tr>
<td>How to File a Claim</td>
<td>14</td>
</tr>
<tr>
<td>If You Receive Covered Health Services from a VSP Member Doctor</td>
<td>14</td>
</tr>
<tr>
<td>If You Receive Covered Vision Services from a Non-Member Doctor</td>
<td>15</td>
</tr>
<tr>
<td>Payment of Benefits</td>
<td>15</td>
</tr>
<tr>
<td><strong>CENTURYLINK VISION PLAN COVERAGE</strong></td>
<td>16</td>
</tr>
<tr>
<td>VSP Provider Benefits</td>
<td>16</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>16</td>
</tr>
<tr>
<td>Glasses</td>
<td>16</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>16</td>
</tr>
<tr>
<td>Laser Vision Correction Discounts</td>
<td>16</td>
</tr>
<tr>
<td>To Request Benefits</td>
<td>17</td>
</tr>
<tr>
<td>Non-VSP Provider Benefits</td>
<td>17</td>
</tr>
<tr>
<td>Non-VSP Provider Schedule of Benefits</td>
<td>17</td>
</tr>
<tr>
<td>Professional Fees</td>
<td>17</td>
</tr>
<tr>
<td>Materials</td>
<td>17</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>17</td>
</tr>
</tbody>
</table>
MADISON RIVER UNION EMPLOYEES VISION COVERAGE

VSP Provider Benefits
Eye Exam
Prescription Glasses Discounts
To Request Benefits
Non-VSP Provider Benefits
Non-VSP Provider Schedule of Benefits
Professional Fees

VISION SERVICE NOT COVERED

FORMAL INFORMATION ABOUT THE PLAN

Statement of ERISA Rights
Questions and Appeals – What To Do First
How to Appeal a Claim Decision
Appeal Process
Appeals Determinations
Pre-Service and Post-Service Claim Appeals
Voluntary External Review Program
Subrogation – Third Party Liability
Facility of Payment
Recovery of Payments
Benefits Not Transferable
Release of Medical Information
Participants’ Rights
Privacy Complaints/Issues
COBRA – Health Coverage Continuation
Right to Continuation of Coverage
COBRA – Length of Continued Coverage
COBRA – Notice and Election Rules
COBRA – When Coverage Ends
Notice of Unavailability of COBRA
Plan Name and Type
Plan Amendments
Interpretation of the Plan
Examinations Under Oath
Plan Year
Plan Financing
Plan Administration
Claims Administrator
Plan Sponsor
Adopting Employers
Plan Administrator and Agent for Service of Legal Process
Plan Privacy Officer
INTRODUCTION

We are pleased to provide you with this Summary Plan Description (SPD). This SPD describes your benefits, as well as your rights and responsibilities, under the Vision Service Plan (VSP). Participating employees include regular full-time employees.

The employee benefit programs described in this summary are an important part of your total compensation package. Your benefit program has been designed to assist you in maintaining good health and financial security for you and your family.

You are encouraged to review this information carefully and keep it for future reference. Every effort has been made to ensure that this summary accurately reflects the provisions contained in the plan document. Since this is only a summary of the Plan, it does not cover all details found in the official plan document. Should any discrepancy exist between the summary and the Plan, the official Plan document is the controlling document and is binding upon all parties.

Although CenturyLink intends to continue the benefit plans outlined in this booklet, it reserves the right to amend, change, or terminate any plans, plan provisions or benefits at any time for any reason to the extent permitted by law. This means the plan may be discontinued in part or in its entirety, modified to provide different benefits, different levels of benefits, or a different cost sharing between the company and employees; or changed in any other way. If there are any changes made in the future, you will be notified.

January 1, 2010 is the date changes were most recently made to your coverage under the plan.
CLAIMS ADMINISTRATORS

Vision Service Plan 
- Vision care claims
  Web Address: www.vsp.com

CenturyLink Employee Resource Center (ERC) 
- Contact for all other claims questions.
  E-mail: erc@centurylink.com

(800) 877-7195  TDD (800) 428-4833

(888) 722-4372
COMMON FEATURES OF THE HEALTH CARE PLANS

This section provides an overview of the CenturyLink vision plan.

Your Eligibility
You are eligible for vision coverage described in this summary on the first day on which you are:

- A full-time non-represented employee, or
- An employee covered by a collective bargaining agreement that provides for participation in this Plan, and you are employed by a participating employer.

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

- A part-time, casual or temporary employee, or an individual who is not classified by the Company as an employee, 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 Eligibility
You may also cover your eligible dependents when you enroll in the health plans. The Company reserves the right to require supporting financial and/or legal documentation to confirm eligibility at any time. Your eligible dependents include:

- Your spouse and unmarried children. Children include:
  - your natural children;
  - your legally adopted children including children you are in the process of adopting. In the case of a pending adoption, the effective date is the placement date in the home;
  - stepchildren and children for whom you are the legal guardian that live with you in a parent-child relationship except when attending school as described below.

- Your domestic partner provided you certify 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.

- Your unmarried children who are nineteen (19) years of age or older, but younger than twenty-five (25) years of age, who are dependent upon you for at least fifty percent of their support and who are full-time students at an accredited educational institution (including trade or vocational schools). Verification of full-time student status is required twice per year, spring and fall semesters (summer break is allowed). It is your responsibility to contact the Employee Resource Center (ERC) when your dependent no longer meets the qualifications of a full-time student as defined by the institute of learning.

- Michelle’s Law provides for continuation of dependent coverage for college students who
would otherwise lose eligibility because of a reduction in their full-time status for a medically necessary leave of absence from school itself. The law applies to almost all insured and self-insured group health plans that cover dependents and use student status to determine eligibility. The law prohibits a group health plan from terminating a college student’s health coverage on the basis of the student taking a medically necessary leave of absence from school or changing to part-time status. The leave of absence or reduction in hours must be medically necessary and must commence while the eligible student is suffering from a serious illness or injury and would otherwise lose coverage under the plan. Contact the ERC if you believe your dependent may qualify.

- Children of your qualified domestic partner who reside with you in a parent/child relationship and who otherwise meet the criteria above for unmarried stepchildren/foster children. You may cover any or all of your eligible dependents according to the rules of each plan; however, no one may be a dependent of more than one employee under the benefit plans.

- Children may also be covered when an eligible employee is required by a qualified medical child support order (QMCSO), as defined in the Omnibus Budget Reconciliation Act of 1993 (COBRA 93), to provide coverage. The effective date of coverage is the date indicated on the QMCSO. A copy of the procedure governing QMCSO determinations are available upon request free of charge.

- In certain cases, unmarried dependent children who are totally disabled may remain covered under the vision plan after the normal age 19 (or 25) limit. During the extended coverage period, you must provide more than one-half of the child’s support. You must submit an application for coverage to the ERC that includes written documentation of your child’s total disability. You may be required to provide proof of your child’s continued total disability annually.

To qualify for this extended coverage under the vision plan, the disabled child must be enrolled in a CenturyLink vision plan no later than the following time:

- If your child is totally disabled when you first become eligible for CenturyLink’s vision coverage, then you must enroll the child for vision coverage when you are first eligible to enroll, if your child is older than the normal age 19/25 age limit at that time. Your child’s vision coverage will start on the date CenturyLink approves the application. If your child is under the normal age 19/25 limit when you first become eligible for vision coverage, then you must enroll the child for coverage before the disabled child reaches the normal age 19/25 age limit.

- If you child becomes totally disabled after you first become eligible for CenturyLink’s vision coverage, then you must enroll the child for CenturyLink’s vision coverage before the normal age 19/25 age limit.

If you drop the disabled child’s CenturyLink vision coverage after the normal age 19/25 age limit, then you may not later reenroll the disabled child for coverage.

**Coverage Level**

You can choose one of the following coverage levels for your vision plan:

- Employee Only
- Employee & Spouse/Domestic Partner
- Employee & Child(ren)
- Employee & Family
**If Both You and Your Spouse/Domestic Partner Work for the Company**

If both you and your spouse/domestic partner or dependent child work for CenturyLink and are eligible for health care coverage through the Company, you may elect to be covered as individuals, or you can choose to cover yourself as the employee and your spouse/domestic partner/dependent child as a dependent under the medical, dental or vision plans.

A person cannot be covered both as an employee and as a dependent. Only one of you may cover other eligible dependents. In other words, "double coverage" is not allowed. This applies to coverage you may have available through this plan and any other CenturyLink sponsored health plan, including coverage through any retiree, survivor or collectively bargained plan.

If you decide to be covered as individuals, amounts that would otherwise count toward meeting family deductible and out-of-pocket maximum limits will be treated on an individual basis. In other words, you will be treated as two unrelated families, and your individual health care expenses will not count toward satisfying your dependent's family deductible or out-of-pocket maximum.

**When Coverage Begins**

If you enroll within 31 days of when you are first eligible, then your coverage will start coincident with your date of hire. For example, if you are employed full-time on March 14 and you complete your enrollment (either online or by completing and returning the required enrollment form to Benefits within 31 days) you will be covered for benefits as of March 14.

If you fail to enroll within 31 days of eligibility, your coverage will be waived and you will not be eligible to participate, except for a qualified status change (or eligibility for special enrollment) until the next open enrollment period with coverage effective the following January 1. (See the “If You Waive Coverage” section later in this guide).

**What Coverage Costs**

The vision plan is a self-insured plan. That means that CenturyLink pays the claims expense, not an insurance company. The coverage costs that you and the Company share are based on the actual dollar amount of claims paid by the plan.

The cost of vision care coverage for the employee and dependents is deducted from the employee’s pay on a pre-tax basis. The ERC can provide you with information about costs of your coverage options when you are enrolling or changing your coverage.

**Pre-Tax Premium Payment Plan**

If you pay your monthly premium for health coverage with pre-tax dollars, you save money by reducing the tax impact on your take-home pay. Contributions are deducted from your pay before federal and in most states, state income and employment taxes are calculated. This means that your taxable pay (your earnings minus your pre-tax contributions) is smaller, so you pay less in taxes.

**How to Enroll**

You are required to enroll online within 31 days of when you first become eligible for benefits. To enroll, log on to Benefits Online on the CenturyLink intranet and make your benefit selections.

**Changing Your Coverage**

Each fall, you will have the opportunity to change your health options and/or your dependent coverage. This is called the open enrollment period. Any changes you make at that time will
become effective the following January 1, and will be irrevocable for that calendar year, unless you have a qualified status change as outlined below:

**Midyear Changes to Enrollment**
Internal Revenue Service regulations allow you to start or stop participation or to change your contribution midyear if these changes are because of, and consistent with a qualified status change, as described below.

Except for changes resulting from a change in your residence, you may change only the coverage related to your new status. That is, if you have a new baby you can add the baby to your dependent coverage but you cannot switch to a new medical plan option. You must report this change to Benefits within 31 days (90 days for adding a newborn or adopted child) following the qualifying event or no change can be made until the next open enrollment period to be effective the following January 1.

**Special Enrollment Period**
An eligible employee and/or dependent who did not enroll for coverage when first eligible or during an open enrollment period may enroll for coverage during a special enrollment period.

A special enrollment period is available if the following conditions are met:

(a) the eligible employee and/or dependent had existing health coverage under another plan when last eligible to enroll in the plan, and

(b) coverage under the prior plan was terminated as a result of loss of eligibility (including, without limitation, legal separation, divorce or death), termination of all employer contributions, or in the case of COBRA continuation coverage, the coverage was exhausted.

A special enrollment period is not available if coverage under the prior plan was terminated for cause or as a result of failure to pay premiums on a timely basis. Coverage under this plan is effective only if Benefits receives a properly completed enrollment application within 31 days of the date coverage under the prior plan terminated.

Special enrollment also is available for an eligible employee and/or new dependents following the birth (or adoption or placement for adoption) of a child or marriage. Coverage under this plan is effective only if Benefits receives a properly completed enrollment application within 31 days (90 days for newborn or adopted child) of the date of birth, adoption, placement for adoption, or within 31 days for marriage.

Effective April 1, 2009, special enrollment is also available for an eligible employee and/or eligible dependent if the eligible employee or eligible dependent lost coverage under a Medicaid Plan under Title XIX of the Social Security Act or under a State Child Health Insurance Plan under Title XXI of the Social Security Act. Coverage under this Plan is effective only if Benefits receives a properly completed enrollment application within 60 days after the date on which the prior coverage was terminated.

To submit a change, send a completed enrollment/change form to:

CenturyLink Employee Resource Center
Mail Stop; KSOPKR0101
5454 W. 110th Street
The effective date of the change is the qualifying event date. If the change is due to special enrollment following birth, adoption, or placement for adoption of a child, the effective date of the change is the date of birth, adoption, or placement for adoption.

**Qualified Status Changes**
The Company reserves the right to require supporting legal documentation to confirm the status change at any time. Qualified status changes include the following:

**Legal Marital Status**
Any event that changes an employee’s legal marital status, including marriage, divorce, death of a spouse, legal separation or annulment.

**Domestic Partner Status**
Any event that causes the employee’s domestic partner to satisfy or cease to satisfy the requirements for coverage.

**Number of Dependents**
Any event that changes the number of an employee’s dependents, including birth, death, adoption or placement for adoption.

**Employment Status**
Any event that changes the employment status of an employee or his or her spouse or dependent, including termination, commencement of employment, a strike or lockout, the commencement or return from an unpaid leave of absence, a change in worksite, or any other event that effects an individual’s eligibility for coverage under the plan.

**Dependent Status**
Any event that causes the employee’s dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or student status.

**Residence**
A change in the place of residence that affects an individual’s eligibility for coverage under the Plan.

**Note:** If you cancel your spouse’s coverage during annual open enrollment in anticipation of divorce and a divorce later occurs, your divorce may be a qualifying event. If your spouse notifies The ERC within 60 days of the final divorce date and can establish that you canceled their coverage in anticipation of divorce, COBRA coverage may be available to your spouse beginning the first of the month following the final divorce. (But not for the period between the date your spouse’s coverage was ended at open enrollment and the date of the divorce).

Remember, the benefit changes you make must be consistent with your qualified status change. For example, if you have a new baby you can add the baby to your current medical plan or increase your health care or dependent care FSA, but you cannot switch to a new medical plan option.
Required Documentation for Qualified Status Changes

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Documentation Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage</td>
<td>Marriage certificate (no marriage licenses)</td>
</tr>
<tr>
<td>Domestic Partner</td>
<td>Domestic partner certification form</td>
</tr>
<tr>
<td>Divorce</td>
<td>Divorce decree signed by a judge and filed by the court</td>
</tr>
<tr>
<td>Legal separation</td>
<td>Legal separation document signed by a judge and filed by the court</td>
</tr>
<tr>
<td>Death of a dependent</td>
<td>Dependent’s death certificate</td>
</tr>
<tr>
<td>Add a child (newborn)</td>
<td>Birth certificate or birth announcement</td>
</tr>
<tr>
<td>Add a step-child</td>
<td>Proof of residency with employee</td>
</tr>
<tr>
<td>Add an adopted child</td>
<td>Placement for adoption court document</td>
</tr>
<tr>
<td>Add a foster child, grandchild, niece/nephew or any</td>
<td>Legal guardianship document. Legal document filed with the court.</td>
</tr>
<tr>
<td>other child with whom the employee has a parent child</td>
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<td>(child must live in the home with the employee)</td>
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</tr>
<tr>
<td>Add a child – QMCSO</td>
<td>QMCSO</td>
</tr>
<tr>
<td>Employment status</td>
<td>Certificate of loss of coverage. If certificate was not provided, then</td>
</tr>
<tr>
<td></td>
<td>a letter from the prior plan sponsor or governmental agency is sufficient.</td>
</tr>
<tr>
<td>Loss of coverage</td>
<td>Certificate of loss of coverage. If certificate was not provided, then</td>
</tr>
<tr>
<td></td>
<td>a letter from the prior plan sponsor or governmental agency is sufficient.</td>
</tr>
<tr>
<td>Residence</td>
<td>Address has been changed in SAP. If the address doesn’t affect the plan</td>
</tr>
<tr>
<td></td>
<td>employee is currently enrolled in, no change is allowed.</td>
</tr>
<tr>
<td>Spouse’s/Domestic Partner’s open enrollment</td>
<td>Confirmation of benefits statement from spouse’s/domestic partner’s</td>
</tr>
<tr>
<td></td>
<td>employer. Proof of open enrollment period (dates).</td>
</tr>
<tr>
<td>Dependent full-time student status</td>
<td>Copy of the dependent’s current class schedule.</td>
</tr>
</tbody>
</table>

If You Waive Coverage

If you have vision coverage through another group plan and you do not wish to be covered by CenturyLink's vision plan, or if you fail to enroll within 31 days of when you are first eligible, you will not be able to participate, except for a qualified status change (or eligibility for special enrollment), until the next open enrollment period with coverage effective the following January 1.

Your decision to waive coverage means that you may not elect coverage for your dependents either.

Leaves of Absence

You may be eligible to continue your health coverage in accordance with Human Resources policies and procedures while you are on an approved leave of absence. For an approved extended military leave, this means the entire length of the leave provided coverage is not available through another source.

If applicable, you will be required to make a monthly contribution for your benefits coverage. The amount of the contribution is the same amount as for active employees, except that your contributions will be made on an after-tax basis while you are on unpaid leave. Contact The
ERC for more detailed information.

Upon your return from approved military leave, if you did not elect to continue coverage during your leave, you still have the right to be reinstated in the Plan, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

If You Become Disabled - Premiums
If you become disabled and begin receiving monthly benefits under the CenturyLink Long Term Disability Income Plan (LTD), you and your covered dependents are eligible for continued coverage under the medical, dental and vision plans. Contact the ERC for information on other benefits that are available if you become disabled. The health coverage may continue until you are no longer receiving LTD benefits. If LTD benefits are terminated and later reinstated, we will reinstate benefit coverage, but not for a period of more than one year prior to the LTD reinstatement date. In addition, retroactive premiums will need to be paid on a post-tax basis.

Continuation of Coverage during Family and Medical Leave (FMLA)
The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to a total of 12 weeks of unpaid, job-protected leave during any 12-month period to eligible employees for certain family and medical reasons. This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them.

For the duration of an FMLA leave, the Company must maintain your health coverage. You may continue the Plan benefits for yourself and your eligible dependents on the same terms as if you had continued to work. You must pay the same contributions toward the cost of coverage that you made while working.

If you fail to make the payments on a timely basis, the Company, after giving you written notice, can end the coverage during the leave if payment is more than 30 days late.

However, if a payment is more than 30 days late, the Company, after giving you written notice, can end the coverage during your leave.

Re-enrollment after an FMLA Leave
If any or all of your coverage ends while you are on an FMLA leave, you can re-enroll for coverage when you return to work from the FMLA leave.

You and any dependents will be considered timely enrollees if you re-enroll within 31 days from the date you return to work. Any waiting period will be applied as if there had been no break in coverage.

If You Die
If you die while an active employee, your family members may be allowed to continue their current CenturyLink vision coverage for up to six months, at no cost, thereafter your family may purchase coverage through COBRA for up to 36 months. Additional information regarding vision benefit continuation is described in this summary.

If you are eligible for retiree vision at the time of your death, your surviving spouse and/or dependent children may be eligible for continued coverage. Refer to the retiree healthcare SPD of your legacy company for additional details.

Health Care Benefits at Retirement
If you go from full-time active to retirement status, you and your eligible dependents may be eligible for retiree healthcare. Refer to the retiree healthcare SPD of your legacy company for
additional details.

**Premiums for Retirees**
The ERC can provide you with information about costs of your coverage options. The Company reserves the right to increase premiums for retirees at any time (including after retirement) and for any reason.

**When Coverage Ends**
Generally, unless a bargaining agreement states otherwise, your coverage under the health plans terminates on the last day of the month during which you cease to be an eligible participant. This occurs when:

- Your employment terminates (unless you terminate employment due to disability, or retirement and you are eligible for continued coverage as previously discussed);
- You are no longer a regular full-time employee and become a part-time, casual or temporary employee;
- You are not actively at work for any reason other than an approved leave of absence;
- You fail to make your required contribution;
- You become covered under any other health plan to which the Company contributes; or the plans terminate, whichever occurs first.

Coverage under the vision plan terminates on the day an employee is not actively at work due to a work stoppage (strike). Employees who lose medical, dental or vision coverage due to a work stoppage are eligible for COBRA benefits.

In the case of coverage under another Company health plan, benefits terminate coincident with the effective date of the new plan.

Coverage for your enrolled family members will end when your coverage ends (except in the case of your death and/or if you were retirement eligible prior to dying). Coverage for your eligible dependents ends on the last day of the month during which they cease to meet the Plan's eligibility requirements. For example your children's coverage will end on the last day of the month following the date they marry, or reach the Plan's age limits.

When coverage under the health care plans end for you or your enrolled dependents, in most cases continued coverage is available under a federal law known as COBRA (see elsewhere in this summary).

Nothing in this summary says or implies that participation in the CenturyLink benefit plans is a guarantee of continued employment with the Company, nor is it a guarantee that benefit levels will remain unchanged in future years.

**When a Dependent is No Longer Eligible for CenturyLink Health Care Coverage**
When a dependent is no longer eligible to participate in the health care plans, you must submit a Health Care Enrollment Change form to the ERC within 31 days of the event. If you notify the ERC within 31 days of your dependent's ineligibility, then CenturyLink will stop your salary reduction contributions for that dependent coverage as soon as is practicable. If you do not submit a change form within 31 days, coverage will be terminated effective the last day of the
month your dependent is no longer eligible. All claims incurred and paid after eligibility ends will be reversed and you will be responsible for paying those costs to the providers. You will be billed for any claims that shouldn’t have been paid and cannot be reversed. Any overpayment of premiums deducted from your paycheck will not be refunded.
VISION PLAN FEATURES

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

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

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

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

When you use a non-member doctor, you should pay the doctor his/her full fee. You will be reimbursed by VSP in accordance with the non-member provider reimbursement schedule listed under Non-VSP Provider benefits.

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

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

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

Certain Plan benefits require prior authorization by VSP before such Plan benefits are covered. VSP’s prior authorization determinations are based upon criteria developed by Optometric and Ophthalmic consultants and approved by VSP’s Utilization Management Committee and Board of Directors. If you would like more information regarding VSP’s criteria for authorizing or denying Plan benefits, contact VSP Customer Service Department at 1-800-877-7195.

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

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

**If You Receive Covered Vision Services from a Non-Member Doctor**

When you obtain services from a non-member doctor or out-of-network provider, you are responsible for requesting payment from Vision Service Plan through the Claims Administrator. You must file the claim in a format that contains all of the information required as described below.

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

You must submit a request for payment of benefits within 24 months after the date of service. However, you should pay the full bill and send your itemized statement of charges along with a claim form to:

Vision Service Plan  
P.O. Box 997105  
Sacramento, CA  95899-7105.

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

**Payment of Benefits**

Vision Service Plan, the Claims Administrator, will make a benefit determination as set forth below. Benefits will be paid to the VSP member doctor. Benefits will be paid to you when using a non-VSP member doctor.
CENTURYLINK VISION PLAN COVERAGE

This section is a summary of expenses covered by the CenturyLink Vision Plan (excludes Madison River union employees).

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

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

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

- **Lenses**: are available each calendar year. The VSP member doctor will order the proper lenses if needed. The doctor also verifies the accuracy of the finished lenses.
- **Frame**: is available once every two consecutive calendar years. If you select a frame that costs more than the amount allowed by the plan, there will be an additional charge. You will receive a $130 allowance towards any frame of your choice plus 20% off any amount over the allowance.

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

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

Medically necessary contact lenses are covered in full when a VSP member doctor secures proper approval. Medically necessary contact lenses may be prescribed by a VSP doctor for certain conditions. A VSP doctor must receive prior approval for medically necessary contact lenses.

**Laser Vision Correction Discounts**
Laser vision correction discounts are available for people who are nearsighted, farsighted or have a stigmatism, and who wear glasses or contacts. By using participating VSP doctors you receive on average a 15% discount off laser surgery or an additional 5% off the center's promotional price.
To Request Benefits
Once you have made an appointment with a member doctor, the doctor will verify benefit coverage on your behalf prior to rendering service. If you need to locate a member doctor in your area or wish to verify your level of coverage prior to your appointment, call VSP at (800) 877-7195 or visit the web site at www.vsp.com.

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

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

Non-VSP Provider Schedule of Benefits
If you obtain services from a non-member provider, VSP will reimburse you the following:

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

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

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

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

This section is a summary of expenses covered by the former Madison River Union Employees Vision Plan.

**VSP Provider Benefits**

If you use the services of a VSP member doctor, the plan will pay covered vision care services as follows:

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

**Prescription Glasses Discounts**
- **Lenses**
  20% discount when a complete pair of glasses is purchased.

- **Frames**
  20% discount when a complete pair of glasses is purchased.

- **Contacts**
  15% discount off the contact lens fitting and evaluation exam. This additional exam ensures proper fit of your contacts.

**To Request Benefits**

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

**Non-VSP Provider Benefits**

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

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

**Non-VSP Provider Schedule of Benefits**

If you obtain services from a non-member provider, VSP will reimburse you the following:

- **Professional Fees**
  Eye examination, up to $46, after a $20 copayment
VISION SERVICE NOT COVERED

The vision plan does not pay benefits for the services listed below. It is not meant to be an exhaustive list of the services not covered. It is your responsibility to confirm the availability of coverage by calling VSP Customer Service before services are received.

- Orthoptics or vision training and any associated supplemental testing.
- Non-prescription lenses.
- Two pairs of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this plan which are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eye. These services, if medically necessary, may be covered by the medical plans.
- Warranties, insurance and similar programs.
- Non-prescription sunglasses.
- Expenses in excess of eligible expenses.
- Services or supplies that are not covered vision services under the plan.
- Charges for any claim received by the Claims Administrator more than 24 months from the date of service.
- Any treatment, service or supply that would have been covered had the individual obtained coverage required by law, i.e., coverage required under state workers’ compensation or motor vehicle insurance laws. An individual who has not complied with such legal requirements will not be eligible for any benefits for that illness, injury or condition, including any re-injury, aggravation, etc.
- Any treatment, service, or supply provided to a member for whom the member would not be held financially responsible in the absence of coverage.
- Any treatment, service or supply that was received as a result of the following:
  (a) Violent conflicts. This includes participation in an insurrection, war (whether or not declared), military service, any civil disturbance, riot, piracy, highjacking, or any and all acts incident to such events. "Participation" does not include being at the scene of such an event in the performance of your duties for the Company.
  (b) Law violations. This means attempting to violate or violating criminal or motor vehicle laws, except where the violation was unwitting, unpremeditated, and without actual (as opposed to implied) criminal intent.
- Any treatment, service or supply that is received as a result of an accident, illness or injury arising out of or related to employment or self-employment for wage or profit.
- Any treatment, service or supply which was or would have been covered had the individual obtained coverage by or through any government, including, to the extent permitted under
present or future federal law, Medicare, or which was or would have been covered had the individual obtained coverage or taken advantage of any program offered by any government agency, i.e., Veterans Administration.

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

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

- Interest, finance charges, local or state sales taxes.
FORMAL INFORMATION ABOUT THE PLAN

This section summarizes the legal information about the CenturyLink health care plans.

Statement of ERISA Rights
The health care plans are subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). The Employee Retirement Income Security Act of 1974 (ERISA) affords you with certain legal protection under the plans the Company provides.

As a participant in the Vision Plan component of the CenturyLink, Inc. Welfare Benefit Plan No. 512, certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA) provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator’s office and other specified locations, such as work sites, and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Rom of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, 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 materials 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 your claim for benefits 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 costs 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.

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 the Health Insurance Portability and Accountability Act (HIPAA), 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, Pension and Welfare Benefits 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 publication’s hotline of the Employee Benefits Security Administration.

Questions and Appeals – What To Do First
CenturyLink believes that most claim issues, such as a denied claim, can be addressed informally if promptly and objectively raised with the appropriate Claims Administrator, and that the best time to solve a problem or answer a question is when it first arises, not days, weeks or months later.

Participants who have had a claim denied, have questions or complaints, etc., may informally contact the Claims Administrator before requesting a formal appeal. If the Claims Administrator cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in “How to File a Claim” on page 10 you may appeal it as described below, without first informally contacting the Claims Administrator.

If you first informally contact the Claims Administrator and later wish to request a formal appeal in writing you should contact the Claims Administrator and request an appeal. If you request a formal appeal, a representative will provide you with the appropriate address of the Claims Administrator. The address of the Claims Administrator is also provided in the back of this Summary.

The Claims Administrator’s telephone number is shown in the front of this summary. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

To the extent permitted by law, completion of the claims review procedures described in this summary are a mandatory precondition that must be complied with prior to the commencement of a legal or equitable action by a person claiming rights under the Plan.

How to Appeal a Claim Decision
If you disagree with a pre-service or post-service claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient’s name and the identification number from your ID card.
- The date(s) of medical service(s).
- The provider’s name.
• The reason you believe the claim should be paid.
• Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

**Appeal Process**
A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon written request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

**Appeals Determinations**

**Pre-Service and Post-Service Claim Appeals**
You will be provided written or electronic notification of the decision on your appeal as follows:

• For appeals of pre-service claims (as defined in “How to File a Claim”), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the health care provider of the decision within 15 days from receipt of a request for review of the first level appeal decision.

• For appeals of post-service claims (as defined in “How to File a Claim”), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days from receipt of first level appeal decision.

The Plan Administrator has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

Please note that the decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

**Voluntary External Review Program**
If a final determination to deny benefits is made, you may choose to participate in the voluntary external review program. This program only applies if the decision is based on either of the following:

• Clinical reasons.
• The exclusion for experimental, investigational or unproven services.
The external review program is not available if the coverage determinations are based on the explicit benefit exclusions or defined benefit limits.

The Plan waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit a benefit dispute to the voluntary external review program, and any statute of limitations or other defense based on timeliness is tolled during the time that your participation in the program is pending. You may elect to submit a benefit dispute to the voluntary external review program only after exhaustion of the appeals process. You will be provided, upon request, sufficient information relating to the voluntary external review program to enable you to make an informed judgment about whether to submit a benefit dispute to the program. Your decision as to whether or not to submit a benefit dispute to the voluntary external review program will have no effect on your rights to any other benefits under the plan and information about the applicable rules, your right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process. Finally, no fees or costs are imposed as part of the voluntary external review program.

Contact the Plan Administrator at 1-888-722-4372 for more information on the voluntary external review program.

**Subrogation – Third Party Liability**

Subrogation is the substitution of the Plan in the place of a Covered Person with reference to the Covered Person’s rights of recovery, including but not limited to a cause of action, lawful claim, demand or right from a Third Party. Immediately upon providing any Benefit to or on behalf of a Covered Person, the Plan shall be subrogated to and shall succeed to all of the Covered Person’s rights of recovery, under any equitable or legal theory based in whole or in part upon injuries or illnesses resulting in eligible expenses for which the Plan has paid benefits, from Third Parties. The Plan’s right of subrogation is limited to the benefits that the Plan provided or is obligated to provide to or on behalf of the Covered Person as a result of the injuries and/or illnesses.

In addition to the Plan’s right of subrogation and in consideration of the Benefits provided by the Plan to or on behalf of a Covered Person, the Plan shall have an independent right to be reimbursed completely by Covered Persons and Third Parties for Benefits that the Plan provides to Covered Persons.

The Plan’s rights of subrogation and reimbursement shall include recovery from any of the following persons, whether an individual or entity, in this section referred to individually as a “Third Party” and collectively as “Third Parties”:

- Any person alleged to have caused a Covered Person to suffer an injury or illness.
- Any person who is or may be obligated to provide Benefits or payments to a Covered Person, including but not limited to Benefits or payments pursuant to underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowner’s or other compensation coverage), other insurance carriers or third party administrators.
- Any person who is liable to a Covered Person under any theory of liability, whether in law or in equity.

The Plan’s rights of subrogation and reimbursement shall not be affected, reduced or eliminated
by the make-whole doctrine, comparative fault, regulatory diligence, the common fund doctrine or any other doctrine or theory of equitable defense.

In consideration of the Benefits provided by the Plan Administrator to or on behalf of a Covered Person, each Covered Person agrees as follows:

- The Covered Person will cooperate with the Plan in a timely manner to protect the Plan’s rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by the Plan Administrator,
  - signing and/or delivering such documents as the Plan Administrator or its agents reasonably request to secure the Plan’s claim for subrogation and/or reimbursement,
  - responding to requests from the Plan Administrator or its agents for information about any injuries or illnesses,
  - appearing at depositions and in court, and
  - obtaining the consent of the Plan Administrator or its agents before releasing any Third Party from liability.

- The Covered Person’s failure to cooperate in a timely manner to protect the Plan’s rights to subrogation and reimbursement shall be deemed a breach of contract, and may result in the termination of Benefits and/or the institution of legal action against the Covered Person.

- The Plan Administrator has the sole authority and discretion to resolve all disputes regarding the interpretation of the Plan and provisions of this SPD.

- Without the Plan Administrator’s express written consent the Plan’s rights to subrogation and reimbursement shall not be reduced by any court costs or attorney’s fees. Further, the Plan shall not be required to participate in or pay the court costs of any proceeding through which the Covered Person pursues a claim based in whole or in part on any injury or illness or to pay the attorney’s fees for any attorney hired by the Covered Person in connection to such proceedings.

- Regardless of whether the Covered Person has been fully compensated or made whole, the Plan may recover the 100% of the proceeds of any full or partial recovery that the Covered Person obtains, whether such recovery is in the form of a settlement (either before or after any determination of liability) or judgment to the extent of benefits paid by the Plan. The proceeds available for recovery by the Plan shall include, but shall not be limited to proceeds for medical costs or for other items such as lost wages, damages for pain and suffering and punitive damages. The Plan’s right of recovery comes first even if the Covered Person is not paid for all of the Covered Person’s claims for damages or if the payment is received by the Covered Person is for damages other than medical expenses.

- If the Plan makes an overpayment to a Covered Person, the Plan Administrator may consider the overpayment to be Benefits advanced to the Covered Person and withhold future payments of Benefits until the overpayment has been collected or the Plan has otherwise been reimbursed in full for the overpayment.

- If the Covered Person or the Covered Persons authorized agent, including but not limited to the Covered Person’s attorney, receives any funds to which the Plan has a right of recovery, the Covered Person or the Covered Person’s authorized agent will hold the funds separately and alone and serve as a constructive trustee with respect to the funds. The Covered Person’s failure to hold such funds in trust shall be deemed a breach of contract, and may
result in the termination of Benefits and/or the institution of legal action against the Covered Person.

- The Plan shall be entitled to recover from a Covered Person reasonable attorney's fees incurred by the Plan or its agent to collect any funds which the Covered Person recovered from a Third Party and to which the Plan has a right of recovery.

- The Plan Administrator may set off the value of benefits paid, advanced or considered advanced by the Plan Administrator against any future Benefits payable by the Plan, to the extent the Covered Person receives payments to which the Plan has a right of recovery.

- The Covered Person will neither accept a settlement that does not fully compensate or reimburse the Plan without the express written approval of the Plan Administrator, nor undertake any other action that could prejudice the Plan's rights of subrogation or recovery.

- The Covered Person will assign all of the Covered Person's rights of recovery against Third Parties to the Plan, to the extent of the Plan's rights of recovery against the Covered Person or the Third Parties increased by reasonable costs of collection.

- The Plan's right of recovery shall be considered as a first priority equitable lien arising automatically against Third Parties, including but not limited to tortfeasors from whom the Covered Person is seeking recovery, to be paid before the payment of the Covered Person's claims.

- The Plan's right to recovery shall not be reduced by the Covered Person's negligence or under any theory of comparative fault.

- The Plan Administrator may, at its option, undertake all necessary and appropriate actions to preserve the Plan’s rights to subrogation and reimbursement, including but not limited to filing suit in the Covered Person's name. However, such actions shall not obligate the Plan Administrator or the Plan to pay to the Covered Person any recovery that the Plan Administrator or the Plan might obtain unless such recovery exceeds the Plan’s right of recovery. Further, the Plan Administrator shall not be obligated to pursue any rights, independently or on behalf of the Covered Person.

- If the injury or illness giving rise to the Plan’s right of subrogation or reimbursement involves a minor child, the provisions of this section shall apply to the parents or legal guardian of the minor child.

- If the injury or illness giving rise to the Plan’s right of subrogation or reimbursement involves the wrongful death of the Covered Person, the provisions of this section shall apply to the personal representative of the deceased Covered Person.

The failure of a Covered Person to complete any of the steps listed above shall not affect the Plan’s rights to complete subrogation and reimbursement or prevent the creation of a constructive trust or first priority equitable lien discussed in this section.

**Facility of Payment**

Your health care plans may repay any benefits that were paid by another group insurance plan on your behalf, but should have been paid by your plans. These repayments will count as your benefits under the health plans. To the extent it repays the other plan, your plan will be relieved from any liability regarding your benefits.
Recovery of Payments
If your benefit is overpaid for any reason, the plan has the right to recover the excess amount from the person or organization receiving benefits.

The plan reserves the right to recover any amounts due it under these provisions by any means, including reducing future benefit payments or taking appropriate legal action.

Benefits Not Transferable
The right to receive benefits under the health care plans is not assignable or transferable to any other party. Any attempted assignment or transfer will not be binding on the plans.

Release of Medical Information
By accepting benefits from the health care plans you authorize the Claims Administrator to examine any medical records needed to process claims.

You also authorize any provider of care, governmental agency, peer review organization or insurance carrier to release medical records directly to the Claims Administrator. Information will be kept confidential whenever possible. Under certain circumstances this information may be disclosed to other parties with your authorization or as required by state or Federal law.

Participants’ Rights
You and your covered dependents as participants will have the rights set forth in the Plan or its insurer’s HIPAA Notice of Privacy Practices for Protected Health Information and any other rights and protections required under the HIPAA. The Notice may periodically be revised by the Plan or its insurer.

Privacy Complaints/Issues
All complaints or issues raised by you or your covered dependents in respect to the use of their PHI must be submitted in writing to the Plan’s appointed Privacy Officer. A response will be made within 30 days of the receipt of the written complaint. In the event more time is required to resolve any issues this period can be extended to 90 days. You must receive written notice of the extension and the resolution of their complaint. The Privacy Officer shall have full discretion in resolving the complaint and making any required interpretations and factual determinations. The decision of the Privacy Officer shall be final and be given full deference by all parties.

COBRA – Health Coverage Continuation
Please note your rights to health care benefits continuation as described in this section are provided as required by law. The federal law that gives you this right is the Consolidated Omnibus Budget Reconciliation Act (COBRA) and its amendments. If the law changes, your rights will change accordingly. If you have any questions about your rights to purchase continued health care under COBRA, please contact the Employee Resource Center.

In most cases when your Company health care coverage ends, you and your dependents who were enrolled in the Plan at the time coverage is lost have the right to purchase continued coverage for a period of time.

Under COBRA, participants may continue all or part of the medical, dental, and vision coverage that they had immediately before coverage is lost. To continue coverage, COBRA participants must pay the full monthly cost (employer plus employee contributions) of coverage. A two percent administration fee will also be charged.
The health plans available through COBRA are the same as plans offered to active employees and their families. If benefits change for these groups, benefits will also change for COBRA participants. COBRA coverage is generally not available to individuals who become covered under another group health insurance plan or Medicare after electing COBRA.

Although COBRA laws do not apply to a domestic partner and his or her dependent children, the Company has elected to provide parallel continuation coverage provisions. Therefore, any references herein to COBRA will also apply to the domestic partner and his or her dependent children.

To apply for COBRA benefits or find out what your monthly costs would be, contact the Employee Resource Center

**Right to Continuation of Coverage**

You have the right to COBRA continuation coverage if you lose coverage under the Plan as a result of your termination of employment (for reasons other than gross misconduct) or a reduction in your hours of employment causing you to lose eligibility for coverage under the Plan.

Your spouse has the right to COBRA continuation coverage under the Plan if your spouse loses coverage as a result of any one of the following events:

- You terminate employment or have a reduction in your hours of employment that causes your coverage to end.
- You die
- You and your spouse divorce or legally separate.

**Note:** Your spouse has the right to request COBRA from CenturyLink within 60-days of the final divorce. The event will be treated as if the spouse was never removed from the plan. For example, employee removes the spouse during Open Enrollment 2009. Their divorce is not final until August of 2010. The spouse’s COBRA start date would be September 1, 2010 providing the spouse enrolled in COBRA.

Your covered dependent children also have the right to COBRA continuation coverage under the Plan if your dependent children lose coverage as a result of any of the following:

- You terminate employment or have a reduction in your hours of employment that causes your coverage to end.
- You die
- You and your spouse divorce or legally separate
- Your dependent child is no longer an eligible dependent under the Plan.

These events that result in a loss of coverage are called “qualifying events.” You, your covered spouse, and your covered dependents that are eligible to elect COBRA continuation coverage are called “qualified beneficiaries.”

**COBRA – Length of Continued Coverage**

The event that causes coverage to end (the COBRA qualifying event) determines how long you
or your family members qualify for continued coverage under COBRA.

- You (the employee) may purchase up to 18 months of COBRA benefits for yourself and your covered dependents if you have lost coverage because of a reduction in work hours or termination of employment (except in cases of dismissal due to gross misconduct).

- However, if you became entitled to Medicare within 18 months before losing coverage on account of termination of employment or a reduction in your hours, then your family members may receive up to 36 months of COBRA benefits.

- Your spouse and/or dependent children may purchase up to 36 months of COBRA benefits up to age 65, if coverage is lost because: you or your spouse divorce legally or separate; you become entitled to Medicare; or you die.

- A child who ceases to be your eligible dependent may purchase continued coverage for up to 36 months.

- If Social Security determines you and/or your eligible dependent(s) are disabled within the first 60 days of COBRA continuation, then the COBRA eligibility period may be extended an additional 11 months — for a total of 29 months. A larger premium for COBRA coverage may be charged during this 11-month extension for disability.

If your dependent(s) are continuing health coverage under one COBRA provision, and another qualifying event occurs during the initial 18 months of COBRA continuation then, the COBRA coverage period will be counted from the date of the first event. The maximum number of months of COBRA coverage will be determined by the event with the longest coverage period. Only one period applies; the different coverage periods are not added together.

- If you (the employee) are on approved military leave protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA) you and your dependents will have the continuation health coverage rights described herein with all references to an 18-month period replaced with a 24-month period, or, if earlier, until you (the employee) fail to report back to work or apply for reemployment within the required time period after completion of uniformed service. Further, you may have an extended COBRA election period. If you believe this applies to you contact the CenturyLink Employee Resource Center.

COBRA – Notice and Election Rules
The Plan Administrator will send notice to you and your dependents stating your right to the continuation of coverage under COBRA following your termination of employment or to your dependents following your death.

To elect COBRA when coverage ends due to divorce, legal separation or loss of eligibility by a dependent, you or your dependent(s) must notify the Plan Administrator within 60 days of the qualifying event. Send your written notification to the Employee Resource Center (ERC), Mail Stop KSOPKR0101, 5454 W. 110th Street, Overland Park, KS 66211. For questions, call the ERC at 1-888-722-4372.

You may elect continued coverage up to 60 days from the later of the date you are notified of your COBRA eligibility or the date your group coverage ends. If you or your dependents fail to elect COBRA continuation coverage within 60 days your COBRA eligibility will terminate.

For other qualifying events, you will be notified within fourteen (14) days (following the end of the month in which your coverage is terminated) that continued coverage is available. Upon
notification, the Plan Administrator will send you a more detailed explanation of your COBRA rights and an application form.

If you elect COBRA continuation coverage with the 60 days as described above, you then have 45 days from the date you submit your application to make your first payment. Payment must be made retroactive to the termination date of coverage. Claims are not paid until the first payment is received by the Company.

**COBRA – When Coverage Ends**

COBRA continued health care coverage will end in any of the following circumstances:

- The required premiums are not paid on time. Payment, in good funds, is due on the first day of the month preceding the next coverage month. (For example, June 1st payment is due for the month of June.) If payment is not received by the end of the month for which coverage is purchased, your continuation coverage will terminate as of the end of the last month for which payment was made and will not be reinstated.

- The maximum COBRA coverage period expires.

- The Company terminates all group health insurance for all employees.

- Coverage is obtained under Medicare after electing COBRA.

- Coverage is obtained under another group medical, dental or vision insurance plan after electing COBRA. If the new group plan has a limitation or exclusion that affects an individual with a pre-existing condition, COBRA coverage for that individual may continue until the COBRA period would otherwise expire, or earlier, if the plan limitation or exclusion is satisfied.

Also, if you are on an extended COBRA continuation due to determination of disability by Social Security, your coverage will end if you are determined to have recovered. You must notify the ERC within 30 days after Social Security determines that you are no longer disabled. The Plan Administrator will send you notification when COBRA coverage is terminated.

**Notice of Unavailability of COBRA**

If the Plan Administrator receives notice from you or your dependents that a qualifying event, second qualifying event or Social Security disability determination has occurred, and the Plan Administrator determines that you or your dependents are not eligible for COBRA (or not eligible for additional COBRA), the Plan Administrator will provide a notice of unavailability of COBRA to you or your dependents. This notice will be sent within 14 days after receipt of your notice.

Under federal law, the cost of COBRA continuation coverage is reduced in some cases. The premium reduction is available to certain individuals who experience a qualifying event relating to COBRA continuation coverage that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with March 31, 2010, or a reduction in hours during the period beginning with September 1, 2008 and ending with March 31, 2010 that is followed by a termination of employment on or after March 2, 2010 and by March 31, 2010. If you qualify for the premium reduction, you need only pay 35% of the COBRA premium otherwise due to the plan. This premium reduction is available for up to 15 months. If your COBRA continuation coverage lasts for more than 15 months, you will have to pay the full amount to continue your COBRA continuation coverage.
**Plan Name and Type**
The name of the Plan, of which this booklet summarizes, is the CenturyLink Vision Plan. The plan is a component of the CenturyLink, Inc. Welfare Benefits Plan No. 512 which is an umbrella Section 125 cafeteria plan providing for pre-tax contributions for health premiums.

**Plan Amendments**
The Company reserves the right at any time, to terminate, modify or amend, in whole or in part, any or all of the provisions of the plans. The Vice President, Human Resources is empowered to amend these plans or any benefit under these plans at any time by a written instrument signed by that Vice President.

**Interpretation of the Plan**
The Plan Administrator, see below, or any other fiduciary designated by the Plan Sponsor, maintains the full, final and exclusive authority, in its sole and absolute discretion, to interpret the provisions of the plans, to determine such factual issues as come before it, to determine the application of any plan provision to specific fact situations and claims, and to determine eligibility (or continuing eligibility) for benefits under the plans.

The Plan Administrator’s decision governing the meaning, effect, or application of any plan provision, or the relevant facts underlying or involved in a claim, will be final and binding on the plan and the covered person.

**Examinations Under Oath**
The Plan Sponsor may require the covered person (or any individual regularly residing in the household) to give a statement under oath in any circumstances in which it believes it is necessary to the investigation or processing of any claim or the consideration of any appeal of a denied claim.

The examination will be recorded by a professional reporter, and the Plan Sponsor and the covered person may request an official transcript at their own expense. Any refusal to allow such an examination shall allow the Plan Sponsor, in its sole discretion, to refuse further processing (including suspending or terminating benefit payments) or consideration of any pending or future claim or appeal for benefits.

**Plan Year**
The Plan Year is considered to be January 1 through December 31.

**Plan Financing**
All benefits paid from the plan are paid from general assets of the Company, CenturyLink.

**Plan Administration**
The Plan is administered under a contract with Vision Service Plan.

**Claims Administrator**
Vision Service Plan
P. O. Box 997105
Sacramento, CA 95899-7105
(800) 877-7195

**Plan Sponsor**
CenturyLink
C/O Human Resources
Adopting Employers
A list of adopting employers can be obtained on request to the Company’s Corporate Benefits Department.

Plan Administrator and Agent for Service of Legal Process
Administrative Committee,
C/O Benefit Administrator
CenturyLink
Human Resources
805 Broadway
Vancouver, WA  98660
(360) 905-7972

Plan Privacy Officer
CenturyLink
Linda Holzman
805 Broadway
Vancouver, WA  98660
(360) 905-7345