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VIA E-MAIL

Q-242
R-004

November 14, 2011

To: All Locals Representing Legacy Qwest Employees
All Retiree Chapters Representing Legacy Qwest Retirees

From: Reed Roberts, Assistant to the Vice President
Brenda Roberts, Administrative Director
Jay Boyle, CWA Representative

Subject: Follow-up 2012 Qwest Retiree Premiums

As a follow up to Q-234/R-003 (November 7, 2011 re: 2012 Qwest Retiree Premiums) and in response to the many, many questions we are getting from the Locals and the retirees, please review the following information.

How are the premiums determined?

CenturyLink, like Qwest, is self-insured. Blue Cross and the other Administrators handle and/or process the claims that are then paid by the company based on the provisions of the negotiated Plan(s).

What portion of the costs are borne by the company and what portion is borne by the active employees and retirees is determined in bargaining.

Actual costs vary depending on which "pool" you look at. For example, pre-Medicare eligible represented retirees are in a different "pool" than the Medicare eligible retirees. Then there is the "pool" of the pre-1991/ERO retirees which are separate from everything else. Then there is the active represented employee "pool" and the non-represented "pool".

The actual costs for each "pool", minus the negotiated employer contributions, are then used to determine the premiums for the following year.

Historically, for the past 20 years, the contractual Health and Wellness Advisory Committee goes over the previous year's costs as part of the pre-enrollment review process to ensure there are no disputes.

In short, until CenturyLink came into the picture, we had complete transparency.

This review for 2012 Open Enrollment was to have begun at the HWAC's September 2011 meeting in Vancouver, WA. During that meeting, it became apparent that CenturyLink was unaware of and unprepared to meet their contractual obligations

regarding this process. Despite repeated commitments toward transparency, no information was provided including the rates they ultimately published for 2012 open enrollment.

What does the contract say regarding retiree healthcare?
Retiree healthcare is subject to 2 provisions of the current contract: Addendum 10 – Benefits and the Retiree Healthcare Letter of Agreement (attached).

Addendum 10 addresses General Plan Matters and Benefit Plan Grievance and Arbitration and describes the process to be used in the issue of disputes. Since it is subject to the grievance and arbitration procedure, the Letter of Agreement RE: Permissible Mobilization Activities Over Grievable Issues applies.

The Retiree Healthcare Letter of Agreement is what determines healthcare and who pays for what for those who retire(d) on or after January 1, 1991. Without this letter, CenturyLink would have kicked our Medicare eligible retirees to the curb at the same time they kicked the non-represented retirees to the curb.

While CenturyLink has no legal obligation to bargain for the already retired, the Retiree Healthcare Letter of Agreement addresses Retiree Healthcare on a going- forward basis and ties it to the negotiated Plan for active represented employees.

Our dispute is "that no change shall be made without the consent of the Union in the Plans which would reduce or diminish the benefits or privileges thereunder for the employees within the bargaining unit."

"Any claim that the duty to give notice or to offer to bargain has been violated, or that a change in the Plans has resulted in such benefits or privileges being diminished or reduced, may be taken up as a grievance and, if necessary, submitted to arbitration, in accordance with Article 16 of this Agreement. In any such case, the terms of any proposed change in the Plans shall not be subject to arbitration, and any decision or action of the Company shall be controlling, unless shown to have been arbitrary or in bad faith, and only the question of bad faith or arbitrary action shall be subject to the grievance procedure or arbitration." (Section A10.4)

As outlined in Addendum 10, CWA has challenged these actions as changes which "reduce or diminish" the negotiated benefits through actions CWA regards as "arbitrary and in bad faith".

Until we've actually reviewed all the data with our actuary, none of us can actually understand, let alone explain, where these current rates came from or what they're based on.

Opt-In or Opt-Out?

The most asked question we've received is whether a retiree could opt out in 2012 and opt back in to the Qwest Retiree Plan the following year. That answer is yes.
If the premiums change after open enrollment, can I change my option?

The second most asked question is whether employees or retirees could later change their option if the employer is found to be wrong in its determination of the premiums. That

answer is no. Once you've made your choice, you are locked in for that Plan year. Considering CenturyLink's posture, we do not believe that they will change course until and unless they are compelled to, so the odds of this being resolved within the next few weeks are not likely.

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Attachment

C: District 7 RMC
Staff

Attachments

ADDENDUM 10

BENEFITS

For information on the Qwest Pension Plan, the Qwest Savings and Investment Plan ("QSIP"), the Qwest Health Care Plan, the Qwest Disability Plan, and the Qwest Group Life Insurance Plan, employees should consult each Summary Plan Description ("SPD"), which can be found on the Qwest benefits website. Additionally, upon request of the employee, the Company will provide the employee with a paper copy of the Summary Plan Description.

GENERAL PLAN MATTERS

Section A10.1 Selection of Administrators: The Company will review with the Union the criteria to be used in the selection of a Plan Administrator or Administrators or any insurance company with which the Company contracts for insurance or administrative services to provide the benefits of the Plan prior to the selection thereof. The Company will notify the Union of any such selection and the reasons for such selection. In the event of a change in the Plan Administrator or Administrators or any insurance company, the Company will notify the Union of any such change at least sixty (60) calendar days in advance. The selection by the Company of a Plan Administrator or Administrators or any insurance company shall be conclusive and shall not be subject to any grievance procedure or arbitration under this or any other agreement between the Company and the Union.

Section A10.2 Governmental Approval: All changes negotiated in collective bargaining regarding the provisions of the respective Plans are contingent upon and subject to continued approval of the Plans as necessary by the Internal Revenue Service as qualified and any such approval as may be necessary by the United States Department of Labor or any other applicable governmental authority.

BENEFIT PLAN GRIEVANCE AND ARBITRATION

Section A10.3 Except as provided in Section A10.4, there shall be no bargaining during the life of the Agreement upon changes in any of the following employee benefit plans ("Plans") as in effect on the date of this Agreement or as amended in accordance with Section A10.2: pension, savings, health care, short term and long term disability, life insurance and long term care.

Section A10.4 During the term of this Agreement, if the Company proposes to amend any of the Plans in a manner that would affect the benefits or privileges thereunder for employees in the bargaining unit, it will, before doing so, notify the Union of its proposal and afford the Union a period of sixty (60) calendar days for bargaining on said proposal; provided, however, that no change shall be made without the consent of the Union in the Plans which would reduce or diminish the benefits or privileges thereunder for the employees within the bargaining unit. Any claim that the duty to give notice or to offer to bargain has been violated, or that a change in the Plans has resulted in such benefits or

privileges being diminished or reduced, may be taken up as a grievance and, if necessary, submitted to arbitration, in accordance with Article 16 of this Agreement. In any such case, the terms of any proposed change in the Plans shall not be subject to arbitration, and any decision or action of the Company shall be controlling, unless shown to have been arbitrary or in bad faith, and only the question of bad faith or arbitrary action shall be subject to the grievance procedure or arbitration.

Section A10.5 Nothing in Sections A10.1, A10.2, A10.3, and A10.4 shall be construed to subject the Plans or their administration (including, without limitation, matters of eligibility) to grievance or arbitration, but such matters may be subjected to the claims and appeals procedure provided under each of the Plans and HMO contracts. Except as provided in Section A10.4, neither the provisions of this Addendum, or the provisions of Part B of the Memorandum of Understanding, their interpretation, nor the performance of any obligation hereunder shall be subject to arbitration. ***(pages 236 and 237)***

October 12, 2008

Mr. Reed W. Roberts
Administrative Director to the Vice President
Communications Workers of America - District 7
8085 East Prentice Avenue
Greenwood Village, CO 80111

RE: Retiree Health Care

Dear Mr. Roberts:

This letter will confirm our agreement regarding retiree health care and the provisions surrounding retiree health care caps. The parties agree that this letter replaces and supersedes all prior letters concerning Retiree Health Care.

A. The Company shall determine before the start of each year the total expected cost for each Coverage Category for eligible former Union represented employees retiring on or after January 1, 1991 (except employees who retired under the 1992 ERO). The cost to the Company for each eligible former Union represented employee retiring on or after January 1, 1991 (except employees who retired under the 1992 ERO) and their eligible dependents (commonly referred to as "Occupational Post-1990 Retirees") shall not exceed the Company Retiree Health Care Annual Cost Cap detailed below for each Coverage Category. Eligible Occupational Post-1990 Retirees will be responsible to pay premiums (commonly referred to as "Retiree Premiums") equal to the amount by which the total expected annual health care costs for each Coverage Category exceed the Company Retiree Health Care Annual Cost Cap. The Company Retiree Health Care Annual Cost Cap is outlined in the table below.

   The Company will pay expected annual health care costs up to the Company Retiree Health Care Annual Cost Caps by direct payment

and/or payments and/or reimbursements made from the Company sponsored trust funds or other Company sources. Retiree Premiums for the expected costs that exceed the Company Retiree Health Care Annual Cost Cap will apply for eligible Occupational Post-1990 Retirees beginning January 1, 2009 in order to maintain health care coverage under the Qwest Health Care Plan. The Company, in its sole discretion, reserves the right to blend the Coverage Categories into commonly grouped coverage tiers when calculating Retiree Premiums. Administratively, the Retiree Premiums may be collected in monthly installments and will be communicated during the Annual Enrollment period each Fall for the upcoming plan year.

Coverage Category (Eligible as defined by the Plan)	**Company Retiree Health Care Annual Cost Cap***
Eligible Non-Medicare Adult excluding dependent child(ren)	$6,250 per retiree $6,250 per spouse
Eligible Child(ren) (incl. student and handicapped)**	$2,070 maximum
Eligible Medicare-eligible Adult excluding dependent child(ren)	$2,570 per retiree $2,570 per spouse
Waived Coverage	$0

**** Company Retiree Health Care Annual Cost Cap includes medical and dental costs.***

***** Eligible Child(ren) (incl. student and handicapped) Company Retiree Health Care Annual Cost Cap is based on a child(ren) unit. The unit may include one or multiple eligible children but the maximum cap amount applied is $2,070 regardless of the number of children covered. In other words, if one eligible child is covered or if two or more eligible children are covered, the Company Retiree Health Care Annual Cost Cap is $2,070 in both examples.***

In the event the annual expected health care costs (as shown in Section A above) for any Coverage Category for any available benefit plan option (including buy-down plan options, if any) are below the above stated Company Retiree Health Care Annual Cost Caps, the Retiree Premiums will not reduce below zero dollars ($0).

B. For employees who retire on or after January 1, 1991, the Plan shall provide benefits equivalent to the average actuarial value of the benefits provided from time to time under the Qwest Health Care Plan for active occupational employees, and the Company shall continue to have the right to amend such benefits subject to negotiations. This paragraph will apply to employees who retired under 1992 ERO only to the extent it is consistent with the 1992 ERO health care commitment.

C. For eligible active and future retired employees, there shall be no lifetime maximum on the amount of benefits available from the Plan during the life of this Agreement.

D. With respect to individuals retiring on or after January 1, 1991, effective January 1, 1996, the Company will cap the Medicare Part B reimbursement at the 1995 rate of forty eight dollars and ten cents ($48.10) per month. Effective January 1, 2009, the Company will no longer provide the previously referenced Medicare Part B reimbursement of forty eight dollars and ten cents ($48.10) per month in this Section D to any Occupational Post-1990 Retiree or dependent retiring on or after January 1, 1991 (except employees who retired under the 1992 ERO). ***(pages 159 and 161)***