Our MISSION:
"To maintain a point of contact and information for telephone retirees on health care and other benefit issues."
— AUSWR CO/WY

THE RETIREE GUARDIAN

2015 Issue 4

Newsletter of the retirees of CenturyLink, Qwest, U S WEST and their predecessor companies. www.AUSWR.org

Health care Annual Enrollment here again!

Special to the* Retiree Guardian *by
Deb Conley, CenturyLink Human Resources

Note: See the Annual Enrollment materials for more information and additional items—as that is considered the official Summary Of Material Modifications (SMM) for Annual Enrollment changes.

Health Care Annual Enrollment time is here again! There are NO changes in the benefit plan options (or the Health Reimbursement Account (HRA) subsidy amounts) that are being offered in 2016—and very few changes to the plan benefits as outlined below. Some are enhancements!

If you are still eligible and do not want to change your group plan enrollment election—No action is necessary—you will automatically remain in the same benefit option as you had last year.

For those who remain in CenturyLink group benefit options, the Annual Enrollment dates will be **November 9 through November 20** this year. Changes, as well as the 2016 premium rates, will be explained in detail in your Annual Enrollment materials from CenturyLink. ***Note:*** CenturyLink tries to get Annual Enrollment materials out as soon as possible, but system changes and updates do not allow much advance mailing time.

Post-1990 Non-Medicare Retiree group plans.

(Management—Non-occupational retirees)

The Standard CDHP (consumer-driven health plan), Premium CDHP and Savings HDHP (high-deductible health plan) are still available in 2016. Beginning in 2016, if you have a CDHP HRA balance that can roll over—it will roll over — even if you elect the HDHP benefit option! You must meet the HDHP deductible before the CDHP HRA dollars can be used.

- Out-of-pocket (OOP) Maximums for the **Standard CDHP** Family in-network category is being *reduced* from $7,200 to $6,850.
- Out-of-pocket Maximums (OOP) for the **Savings HDHP** in-network will *increase* to match the Standard CDHP. Single will change from $3,000 to $3,600, and Single+One or more, from $6,000 to $6,850; the out-of-network OOP maximum will increase from $6,000 to $7,200 for single, and from $12,000 to $14,000 for Single+One or more.

Applicable to all three benefit plan options:

- Use of *Premium Network Providers* (where available) will provide a greater coinsurance (85% vs. 80%). Premium providers are always shown at the top of the list when searching for providers on website **www.myuhc.com**.
- Use of *Premium Place of Service Providers* (where available, designated hospital outpatient departments and free-standing network facilities) will provide a greater coinsurance (85% vs. 80%).
- Spine and Joint Solution and Center of Excellence (COE) program provides guidance and education for certain orthopedic surgical procedures. Participants who use these COE centers for surgery receive 100% coverage and travel benefits (if closest COE facility is more than 50 miles away).
- Prior Authorization will be required for determining benefit coverage *prior* to services, tests and/

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INSIDE THIS EDITION—

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or procedure that are medically appropriate and cost-effective.

Pharmacy: Mail order now required for cardiovascular and diabetes medications.

Medicare Eligible retirees with HRA funding:

The HRA subsidy amounts will remain the same for 2016. The Medicare election period for those who are enrolled in the HRA option, and need to make decisions about your Medicare and Prescription drug policies, is **October 15 through December 7, 2015**. You will receive an Enrollment Worksheet from the Service Center that will display your annual subsidy amount.

Pre-91 and ERO '92 retiree plans:

The Company Guaranteed option is still available to both non-Medicare and Medicare-eligible retirees. In addition, the UHC group Medicare Advantage and the HRA are both available to the Medicare-eligible participants. There are no benefit changes in any of these options, and everyone can still "waive" coverage as well.

If you are enrolled in the HRA option, and therefore, in an individual Medicare policy outside of CenturyLink, you will receive any benefit changes or rate changes directly from your carrier.

Note: If you are *enrolling* in the Medicare Advantage option this year, **for the first time**, you must complete an **enrollment form** through the CenturyLink Service Center no later than **December 18th**.
—If you are *disenrolling* from the Medicare Advantage option this year, you must complete a **disenrollment form** through the CenturyLink Service Center no later than **December 18th**.

These are both required by CMS before your desired election can be effective! The Service Center will you send you these forms within 2 days of when you make your election. It is important to make your election early in the Annual Enrollment time period to ensure time for the completion, and turn-around of these forms. You must sign and date the forms, and return them within the deadline for a January 1, 2016 effective date.

Affordable Care Act Update

- As part of the new Internal Revenue Service (IRS) reporting and participant disclosure rules for employer-provided health care coverage, CenturyLink MUST have a Taxpayer Identification Number/Social Security Number (SSN) for all active and retired employees and their eligible covered dependents. In December, the Service Center will conduct a SSN solicitation of all participants without a SSN on file. If you do not have a SSN on file for you or your covered dependents, Please go online during Annual Enrollment to add that information.
- : CenturyLink will provide a 1095-C to each employee enrolled in medical coverage. This can be used as proof to the IRS that you were enrolled in medical coverage as required.
- If you have a Same-Sex Spouse enrolled in medical coverage, you are no longer subject to imputed income as of July 1, 2015.

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

RETIREE ADVOCATES can help you if you have questions or problems AFTER you call the CenturyLink Service Center at 800-729-7526

If you live in:	*Retiree Advocate:*	*Call:*	*E-mail*
Arizona	Kitty Kennedy	520-883-8272	kkennedy404@gmail.com
Idaho or **Montana**	Shirley Moss	208-342-3449	samoss05@q.com
New Mexico	Cassie Kelley	505-298-8666	cassiek@comcast.net
Oregon or **Washington**	Shirley Jones	206-368-8686	benefit65@clear.net
Utah	Byron Lemmon	801-295-4653	bylemmon99@msn.com
ALL OTHER STATES:	Jim Heinze	303-442-1831	jjonrr@ecentral.com

Regional* Retiree Guardian *team:

Regional & Colo/Wyo Editor: Kitty Kennedy, (*kkennedy404@gmail.com)*
Copy editor: Irene Chavira, *(irenec98@msn.com)* ***Copy editor: Eve Mary Verde,*** *(everde@hoglezoo.org)*

AUSWR COLO/WYO:
Barbara Wilcox, (*bmw@mho.com)*
John Rommelfanger, *(jrommel@live.com*
Don Warsavage, (*oldsavage14@gmail.com)*

NWB Qwest—U S WEST association:
Clyde Just, *(cjust6365@centurylink.net)*
Jerry Weldon, *(weld60@msn.com)*
Cindy Hadsell, *(clhadsell@aol.com)*
Editor: Jerry Miller, *(jfpm815@gmail.com)*

Medicare annual Open Enrollment

Medicare 'major' changes for 2016

Excerpts and data as reported by the NYT, October 5, 2015 — and AARP Bulletin

For Post-90 retirees on Medicare, and all others on Medicare, who are not on the company group insurance, this is a reminder that Medicare annual Open Enrollment is **October 15 through December 7**. **This is <u>not the same</u> as CenturyLink Annual Enrollment, as described on Page 1.**

During the annual Medicare Open Enrollment, you can make changes in your Part D Prescription Drug Plan or your Medicare Advantage Plan, or other Medicare Health Plan. Open Enrollment does not apply to Medicare Supplemental Insurance.

For further information see *Medicare & You 2016,* which you should have received recently in the mail, or go to **www.Medicare.gov**. (The Medicare & You 2016 book does not have information on possible Part B increases.

Higher Part B premiums likely in 2016

The trustees of the Medicare trust funds issued their annual report in July, projecting **Part B premium increases in 2016**. An official announcement is expected in mid-October.

By law, the Part B premiums must cover 25% of the Part B expenditures, the other 75% covered by the federal government. If expenditures go up, then Part B premiums go up. We are fortunate that Part B premiums have remained the same since 2013.

But, the amount of any Part B increase would be limited for most of us on Medicare (70% of all Medicare beneficiaries) because of the Social Security 'hold harmless' provision.

The exceptions are shown in the chart below. If there is no COLA, increasing Social Security payments in 2016, as is projected, then the entire Medicare Part B premium increase will be borne by the 30% not protected by 'hold harmless.' In other words, for most of us, the size of our net Social Security monthly payments cannot go down.

For example, if there is no Social Security cost-of-living increase in 2016, then the Medicare Part B premium that is deducted from our Social Security checks would remain at the present rate of $104.90 (for most of us).

The Medicare actuaries also predict an **increase in the annual deductible** — the amount that beneficiaries pay for medical care before Medicare begins to pay. They estimated that the deductible would rise to $223 next year, from $147 in 2015.

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IF Social Security has no Cost-of-living adjustment (COLA) for 2016 – then annual income and Social Security status determines Medicare premiums

Your current status:	***Effect on your premiums:***
You had the standard ($104.90) Part B premium deducted from your monthly Social Security	NO increase in premiums because of the Social Security 'hold harmless' law
You pay higher Part B premiums because you have higher income (over $85,000 for individual)	YES, you will have an increase in premiums even if you receive monthly Social Security benefits
You have Medicare Part B, but you have not started taking your Social Security benefits	YES, premiums will increase because they are not deducted from your Social Security
You signed-up late for Medicare Part B, and you are paying permanent penalties	YES, premiums will increase because the penalties are calculated as a percentage of the higher premium
You are not enrolled in Part B Medicare, and will sign-up next year	YES, you will pay the newer, higher premiums because your are new to Medicare
You have your Medicare Part B paid by your state Medicaid program	No increase —your state pays under the Medicaid or the Medicare Savings Program

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Seventy national organizations, including the Medicare Rights Center, AARP, labor unions and trade associations for health insurance companies, sent letters to congressional leaders in late September, calling for swift action to "mitigate projected increases in Medicare premiums," reminding them that half of all people with Medicare are living on annual incomes of $24,150 or less.

Medicare beneficiaries with annual incomes greater than $85,000 already pay more than the standard premium. The most affluent ones — those with incomes over $214,000 a year — pay premiums of about $335 a month. If there is no cost-of-living adjustment for Social Security, their Medicare premiums next year could exceed $500 a month, according to the annual report of the Medicare trustees, issued in July.

Congress and the White House are seeking ways to hold down Medicare premium increases.

New NOTICE Act benefits Medicare patients under hospital 'observation'

by Barbara Wilcox, Health Care Specialist AUSWR Colorado/Wyoming

Congress overwhelmingly passed, and the President signed into law, the "Notice of Observation Treatment and Implication for Care Eligibility" (NOTICE) Act this summer.

The law requires that Medicare patients who have been under observation in a hospital for 24 hours must be given a written notice that explains that they haven't been admitted to the hospital, the reasons why, and what the financial implications are. Unless the patient is actually admitted to the hospital, his or her care is covered under Medicare Part B Medical Insurance, not Part A Hospital Insurance.

Prescription drugs administered during an observation stay would have to be covered by the patient's Part D Medicare Prescription Drug Plan.

Medicare will not pay for follow-up care in a Skilled Nursing Facility unless the patient has been admitted to the hospital for a 3-day stay (must include three-midnights). Elderly patients are often sent to a Skilled Nursing Facility for Rehab services after an illness or injury, and they can be left with a very large bill if they failed to stay the required days formally admitted to a hospital. The new law will take effect in the summer of 2016, after a rule-making process.

What should you do if you are in a hospital?
You, or a friend or loved one should ask frequently if you have been admitted to the hospital, and if not, why not. Your doctor is the person who makes the decision to admit you, based on your medical condition. If you are not admitted, but are told you will need rehabilitation, ask if you can receive these services at home.

Generally, Home Health Services, for example a visiting nurse, physical therapist, and/or occupational therapist will be paid for by Medicare as long as you meet Medicare guidelines and are home-bound.

If you are in a Medicare Health Plan, such as a Medicare Advantage Plan, then it is your plan that determines exactly how time in the hospital is handled. You should direct questions to your plan. Medicare Health Plans are required to provide benefits at least as good as 'Original Medicare.'

Denver-area Medicare 101 Classes: **Thursday, JANUARY 21, 2016 at 1:30-3:30 p.m. at the Prince of Peace Lutheran Church, 2400 South Colorado Blvd., Denver, CO 80222**

You don't live in the Denver area, and you would like to attend a class closer to home? Please contact me to let me know. If there is enough demand, we may be able to schedule classes in places such as Colorado Springs, Grand Junction or Cheyenne. These classes are geared toward Post-1990 retirees who will be 65 soon, or are going on Medicare for any other reason, such as being on Social Security disability for two years. Anyone interested in Medicare, and how it interfaces with CenturyLink retiree health benefits, is welcome. The classes are a collaboration between AUSWR CO/WY and the State Health Insurance Assistance Program (SHIP) — and they are free of charge. CenturyLink Human Resources personnel are often present to answer questions, depending upon their availability.

For sign up or questions: contact Barbara Wilcox at 303-377-5761 or e-mail: BMW@mho.com

Answers to health care questions

by Barbara Wilcox, Health Care Specialist
AUSWR Colorado/Wyoming

Q. If a Pre-1991 or ERO retiree leaves the company plan to take the HRA offering, and enrolls in a Medicare Advantage Plan, etc., can the retiree go back to the company plan in a subsequent year?
A. Yes. A pre-1991 retiree can always return to the company plan during Annual Enrollment. The 'Phelps settlement' guarantees that the same company plan will always be available to pre-91 retirees. **This applies to Pre-91 and ERO retirees only.** The rules are different for Post-90 Management and Occupational retirees.

Q. What are the rules for enrolling in a Medicare Supplement (Medigap) policy? When can I enroll?
A. Medicare rules, and in some cases state rules, tell you when you can buy a Medigap policy without supplying health information. This is called "Guaranteed Issue," meaning the insurance company selling the policy cannot turn you down or charge you more than the standard price because of health conditions. Guaranteed Issue applies to the following time periods.

 Initial Enrollment Period: When you first go on Medicare, you have six months from the date your Medicare is effective to enroll in a Medigap policy. To avoid a gap in coverage, you should actually enroll as soon as you receive your Medicare card, and ask for it to be effective the same day your Medicare is effective. **Note: In some states Medigap policies are not available to those on disability. Check with your state SHIP program for more information.**

 Special Enrollment Period: There are numerous events which can give you a Special Enrollment Period of 63 days or longer, during which you have Guaranteed Issue to buy any plan you want, including a Medigap plan. These events include the following: 1) You move to another state or out of the coverage area for the plan you are on, 2) The plan you are on terminates because the company stops offering your plan in your area, or for other reasons, 3) You leave a plan because it misled you or otherwise broke Medicare rules., or 4) You are on a company group plan that terminates.

Other circumstances, or special rules may apply in your state, giving you Guaranteed Issue.

You can apply to enroll in a Medigap at any time after you are on Medicare. But, if you aren't in a time period that gives you Guaranteed Issue, the insurer will ask you to fill out a health questionnaire. If your health doesn't meet the plan's guidelines, e.g. because you have a chronic or pre-existing condition, the insurance company can either turn you down entirely, charge you a higher monthly premium, or make you wait six months before they will cover a pre-existing condition.

These rules apply only to Medigap plans. You always can enroll in a Medicare Advantage Plan or a Medicare Prescription Drug Plan during Medicare Open Enrollment each fall, and these plans are required to take you regardless of your health status.

Q. What is the difference between a Medicare Supplement Plan (Medigap) and a Medicare Advantage Plan?
A. They are two different ways of augmenting your basic Medicare coverage. In your basic coverage under Original Medicare, Part A is Hospital Insurance and Part B is Medical insurance. Part B pays for medical care when you are not admitted to a hospital. With both Part A and Part B, you have deductibles and coinsurance to pay when you use the insurance. Both Medigap and Medicare Advantage plans are offered by private insurance companies, which have to adhere to Medicare rules. If you buy either a Medigap or a Medicare Advantage Plan, you have to be enrolled in Medicare Part A and Part B, and you have to pay your Part B premium to the government.

Medigap plans are designed to supplement Original Medicare. Depending on the plan you buy, you pay a monthly premium, and your Medigap will pay the Medicare deductibles and/or the coinsurance for you. For example, a Medigap Plan A will not pay deductibles, but will pay all coinsurance once you have satisfied the deductibles for Part A and Part B. Medigap Plan F will pay all deductibles and coinsurance. You can use your Medigap plan anywhere in the U.S.A., as long as the doctor or provider accepts Medicare. Medigap does not include prescription drugs, and you have to buy a separate prescription drug plan. *See the Q&A above for information on when you should enroll.*

A **Medicare Advantage Plan** essentially replaces your Original Medicare, and take care of your medical needs under a single plan. It covers hospital insurance, medical insurance, and usually prescription drug insurance in a single plan. Most Medicare Advantage Plans are **HMOs**, which means you have to use the plan network's doctors and health facilities; you have no coverage outside of the network except emergency services. Some Medicare Advantage Plans are **PPOs**, which means you can go outside the network, but you will pay higher copays if you do. These plans may or may not charge a monthly premium, but they do charge a copay or coinsurance every time you use the plan. You can enroll or change plans only during the annual Open Enrollment each fall, for the plan you will use the following year.

Verizon retirees take cases to U.S. Supreme Court

By Curtis L Kennedy, Litigation Attorney

Verizon retirees become the first retiree group in the nation to legally challenge — in two separate situations — what they argue are breaches of ERISA fiduciary duty. In both legal cases, the Verizon corporation rid its responsibilities and commitments for retiree benefits through large-scale corporate business transactions.

UNITED STATES COURTS

US 5th Circuit Court of Appeals

The first legal challenge involved the erstwhile corporate spin-off of Verizon's former directories division and creation of Idearc, a company which ultimately twice, went bankrupt. On the last day of the spin-off transaction, Verizon transferred a large group of retirees into Idearc, a situation unwanted by Idearc senior executives -- and the *Murphy* class action was spawned.

The second situation, involving Verizon's jettison of most management retirees out of the federally-protected pension plan into state-regulated insurance annuities, spawned the *Lee* class action.

The *Murphy* case was assigned to the same federal trial court judge who held a two-week separate case trial for Idearc creditors, who fiercely contended the corporate spin-off was nothing but an elaborate fraud. Most unfortunately, both the creditors' case — tried without a jury — and the *Murphy* case (no trial was conducted) resulted in decisions favorable to Verizon.

The *Murphy* case was taken all the way to the U. S. Supreme Court, which tragically, declined to review any aspect of the matter, no doubt because it was the first retiree pension case of its kind. The Supreme Court rarely takes up a civil case of 'first impression,' unless it involves either a matter of constitutional law or issues of federal government versus state government rights.

The *Lee* case, after being rebuffed by appellate judges who decided neither to sign nor publish their rulings, finding there was no legal recourse against Verizon, is now headed to the U. S. Supreme Court.

Two significant legal issues are being presented to the Supreme Court in the *Lee* case. The first legal issue is whether retirees can complain in federal court about mismanagement of about $1 billion of pension funds used, not to pay expenses of the on-going pension plan, but rather used to pay expenses that should have been charged to corporate revenues.

The lower courts have ruled that retirees have no "constitutional standing" to complain in federal court about a violation of the federal law ERISA, unless they were personally, financially harmed by the mismanagement or improper use of pension funds.

Ironically, the constitutional standing issue of harm is now front-and-center before the U. S. Supreme Court in *Spokeo v. Robins*, which is an unrelated case scheduled for oral argument on November 2. A favorable outcome in the *Spokeo* case will necessarily revive a big part of the *Lee* case.

The second legal issue to be presented in the *Lee* case is one (another one) of 'first impression' – whether pension plan sponsors and plan fiduciaries engage in impermissible discrimination under ERISA when jettisoning one large group of retirees out of a healthy pension plan while maintaining the on-going pension plan for all other retirees.

I will give you update reports on the *Lee* case over the next several months.

Curtis L Kennedy

Curtis Kennedy's legal opinion:

CenturyLink pension plan's 'health'

Our Qwest pension plan merged with two other CenturyLink pension plans at the end of 2014. With the merger into one plan, comes questions about the continuation of our pensions. ***Was the merger legal? Why did CenturyLink take this action? Is the strength of the combined pension plan healthy?*** *We turned to Curtis Kennedy for his legal opinion about all the aspects of the CenturyLink pension plan merger.*

by Curtis L. Kennedy, ***Litigation Attorney***

When CenturyLink merged its three pension plans at the end of last year, it was done with IRS approval, and the newly merged surviving pension plan was more than 84% actuarially funded. Thus, there was no violation of either a federal statute or federal regulation. There is no present risk of a termination of the newly-combined pension plan.

CenturyLink named the merged pension plan "CenturyLink Combined Pension Plan." The new governing pension plan document was formally executed and adopted on December 25, 2014, and the massive document is well over 1,000 pages in length. All of the assets of the three previously separate pension plans have been commingled into a single trust, named "CenturyLink Defined Benefit Master Trust."

I have reviewed the current "Pension Trust Investment Policy," and I see nothing out of the ordinary, unlike what I learned about past practices when the Qwest Pension Plan was being operated under former CEO Joseph Nacchio's regime.

One primary public policy reason that federal law allows for pension plan mergers is to enable a financially weaker (perhaps underfunded) pension plan to be combined with a financially superior (perhaps overfunded) pension plan, so that the plan sponsor in control of the separate pension plans does not decide to terminate the financially weaker pension plan. Ergo, pension plan sponsors do not surreptitiously combine two underfunded pension plans. Most often, pension plans are merged in order to reduce huge duplicative administrative costs, and to achieve economy of scale, with a combined larger pool of assets to be collectively invested. Pension plan mergers are common, especially in industries such as telecommunications, where radical changes in technology and loyal customer base have required numerous companies to transform themselves.

For instance, you may recall that effective January 1, 1993, U S WEST merged its two separate pension plans, the non-management and management pensions, into a single pension plan. This was done in order to shore up the declining financial condition of the management pension plan, especially after the huge lump-sum pay-outs were made pursuant to the '5 + 5' early retirement offering for managers during 1990. The merger of pension plans was completely legitimate, and indeed, a very responsible action taken on the part of U S WEST.

ERISA, the federal law that completely governs this situation, specifically permits pension plan mergers, provided that the requirements of Sections 204(g) and 208 of ERISA, (along with applicable regulations) are fully satisfied. In simple terms, the federal law states that a merger of pension plans can take place, so long as immediately thereafter no person's pension plan benefits are either diminished or interrupted. Formal document reviews of the combined CenturyLink pension plans, show that CenturyLink/Qwest retirees have not lost any vested or accrued benefits. There is no present risk of a termination.

Formal document requests and reviews will continue through 2015.

Section 208 of ERISA provides that a pension plan may "merge or consolidate with, or transfer its assets or liabilities to" another plan as long as each participant would (if the plan then terminated) receive a benefit immediately after the merger,

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consolidation, or transfer which is equal to or greater than the benefit he would have been entitled to receive immediately before the merger, consolidation, or transfer (if the plan had then terminated)." 29 U.S.C. § 1058. And, there is a parallel provision of the Internal Revenue Code authorizing pension plan mergers. 26 U.S.C. § 414(l). The federal courts have long recognized that Section 208 of ERISA and Section 414(l) of the Internal Revenue Code expressly authorize the transfer of pension assets and liabilities from one plan to another, so long as (i) the benefits are "at least as good . . . under the new pension plan as under the old one" and (ii) the employer "transfer[s] sufficient plan 'assets' to pay previously promised benefits." *Koch Indus., Inc. v. Sun Co*., 918 F.2d 1203, 1206-07 (5th Cir. 1990).

Numerous federal courts have held that compliance with ERISA's and the Internal Revenue Code's statutory and regulatory regime necessarily forecloses any claim that a pension plan merger violates ERISA's fiduciary standards. E.g., *Blaw Knox Ret. Income Plan v. White Consol. Indus., Inc*., 998 F.2d 1185, 1190 (3d. Cir. 1993) ("[C]ompliance with ERISA's provisions for the funding of merged, transferred or acquired pension plans as set forth in [Section 208] preclude[s] a finding that a fiduciary breach had occurred."); *Sys. Council EM-3 v. AT&T Corp*., 972 F. Supp. 21, 30-31 (D. D.C. 1997) (holding that Section 208 of ERISA provides the specific means by which to challenge a plan merger), *aff'd*, 159 F.3d 1376 (D.C. Cir. 1998).

During the past year, we made several very comprehensive formal document demands for CenturyLink to provide information about the Qwest Pension Plan and the CenturyLink Combined Pension Plan. After carefully reviewing all of the detailed documentation, at this time, I do not see any legal basis to contend that CenturyLink's merger of the pension plans failed to comply with ERISA and federal regulatory requirements. Since the merger, I have not yet seen any evidence that the combining of assets into one pension plan failed to conform to either ERISA Sections 204(g) (anti-cutback provision), 208 or the Internal Revenue Code requirements. To my knowledge, the merger resulted in no reduction in accrued benefits: All U S WEST/Qwest retirees who were entitled to receive monthly annuities are receiving exactly the same pension benefits after the merger as before. During December 2014, the Internal Revenue Service gave CenturyLink a series of "favorable determination letters," reporting that the Qwest Pension Plan complied with Internal Revenue Code requirements. In short, this means the pension plan is entitled to favorable tax treatment, pursuant to Internal Revenue Code Section 401. Prior to the actual merger date, the Qwest Pension expressly contemplated that assets and liabilities might be transferred to and merged with another pension plan.

For instance, Section 11.6 of the Qwest Pension Plan stated:

> 11.6 Plan Merger or Consolidation.
> In the case of any merger or consolidation with, or transfer of any assets or liabilities to, any other plan, each Participant in this Plan must be entitled to receive (if the surviving plan is then terminated) a benefit immediately after the merger, consolidation, or transfer that is equal to or greater than the benefit he or she would have been entitled to receive immediately before such merger, consolidation, or transfer (if this Plan had terminated). Any such merger or consolidation with, or transfer of any assets or liabilities to, any other plan shall be to a plan qualified under Code section 401(a) and shall be subject to the approval of the Plan Design Committee or its designee. In the event of a transfer of Plan assets pursuant to this Section, any corresponding benefit liabilities shall also be transferred.

Because this plan provision is very clear, presently, I see no legal basis to challenge CenturyLink's merger of the pension plans.

The responsibility for overseeing the trust fund has been delegated to the "CenturyLink Investment Management" team. Presently, the U.S. Department of Labor is conducting a "routine audit" (. . . whatever that means. . .), and we will seek more information about the government's inquiry, pursuant to your rights under the Freedom of Information Act, as we've done in the past —and will continue on-going at regular intervals.

Curtis L Kennedy

Don Warsavage's 'Person-to-Person'

"My first management assignment…"

John Shepherd, of Parachute, Colorado, *was a high-potential college graduate, hired by Mountain Bell in the Initial Management Development Program (IMDP). "IMDP'ers" were given multiple training assignments in several departments on their paths to positions in higher-management. John started his career in Greeley, Colorado, back in the 1960's. We thank him for his story.*

John's first assignment was the management of operator services for the towns of Greeley and Fort Collins, Colorado. Back then, the telephone company was the only game in town. The Mountain Bell operator was your only choice to call long-distance. There was no 9-1-1 for emergencies. The operator was your lifeline.

On this particular day, John visited the Fort Collins office, especially to learn about the all-night operation. When introduced to the all-night operator, he was surprised to learn that she'd just come from a party still wearing her party dress. She seemed very young too — maybe not even twenty years old. John thought the all-night operator, being on her own to handle everything, should be a little more mature, more experienced. Recognizing that he didn't know the job very well in those early days, he did raise his concern with the Chief Operator. She said she was not at all worried. John deferred to her experience, and returned to his home in Greeley.

Later that night, the all-night operator, knowing she was the only one left in the building, took off her nice party dress, folded it and carefully set it aside. The very hot day was not cooling off. Around midnight, the air conditioning failed.

The heat began to accumulate in the second floor switchboard room. A boring night with long periods of waiting, and the heat rising, made it all the more uncomfortable. Knowing the door at the end of the room led outside to the roof of the business office next door, the young operator thought if she opened it for a few minutes, it might cool the place off. She could still see the switchboard from over by the door. The switchboard was quiet. Fort Collins customers seemed to have all gone to sleep. She got up, unplugged her headset, and went to the door. When she opened it, the outside air felt so refreshing; she just stepped outside to enjoy it for a minute. She must have gasped or cried out, when a sudden wind gust slammed the door shut, leaving her locked firmly outside —wearing only undergarments.

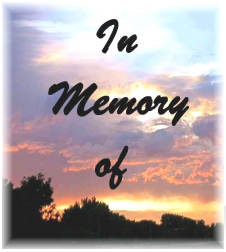
—Tell your stories to Don Warsavage, and he will write them with you —for a future edition of our newsletter. Email Don at: oldsavage14@gmail.com Phone: 303-776-7782

At about 4:00 A.M., one Fort Collins customer became very frustrated as he listened to the repeating rings after he'd dialed 'O.' When his patience finally gave out, he hung up and dialed the local number for the Fort Collins Police Department.

The police arrived at the telephone building to find a young woman, dressed only in her underwear, on top the building shouting for someone to help.

John's home telephone rang at about 6:00 A.M., "You're going to hear about this pretty soon anyway," said the Chief Operator from Fort Collins, as she told the story.

John retired from AT&T in Denver in 1986. He doesn't recall the details, but he's quite sure the all-night operator and the Chief Operator had a heart-to-heart discussion the next day. He does recall that his working relationship with the Chief Operator grew into a very good one after that.



...friends and loved ones we lost

Arizona		
Reynolds	Tamara "Tammy" Witcombe	Tempe
Colorado		
Anderson	Margaret Lillian	Boulder
Aswegan	Larry Lee	Parker
Belich	Lynn	Lakewood
Blacksher	Alvin L "Al"	Denver
Boatright	Jarrel Lee "Boaty"	Denver
Bragg	Gary	Denver
Brouse	Ronald	Denver
Culp	Maxine P	Denver
Davis	Velmer G	Denver
Haggan	Richard Edward	Greeley
Hammond	(Manly) Blake	Denver
Helms	Robert "Mike"	Littleton
Karsten	Donald J	Lakewood
Kinney	Genevieve C "Gussie"	Englewood
Lewis	Cecil J	Longmont
McCaulley	Sally Ann	Ft Collins
McMillan	Bernard "Barney"	Denver
Ming	Robert "Bob"	Evergreen
Pine	Richard "Dick"	Denver
Schade	Alvin L	Pueblo
Stein	Elizabeth S "Betty"	Denver
Montana		
Basinger	Kathleen M "Cookie"	Helena
Kjos	Robert A "Bob"	Helena
Stebbins	David D	Billings
Thares	Alberta Earlene	Helena
New Mexico		
Chagnon	William P "Bill"	Albuquerque
Duff	Glenna O	Albuquerque
Yates	Martha E	Roswell
Utah		
Arnold	Joseph L	Salt Lake City
Brannan	Marlys "Teri"	Salt Lake City
Clark	Paul	Salt Lake City

Thanks for Dick Johnson

We share an enormous loss in our retiree leadership. Dick was there from the start of AUSWR, and he remained generous with his time, giving help and advice to all retirees who turned to him with their benefit questions.

"Dick was one of our original 'Retiree Voice' (now Retiree Advocates) members, and he has served us so well in representing Utah retirees, along with Byron. He was quite the gentleman, and he will truly be missed. May he rest in peace and our thoughts and prayers go out to his wife, Susan, and the family." __Jim Heinze, Ombudsman

Susan is the former *Retiree Guardian* editor for the Utah, Idaho and Montana local pages. Our caring thoughts of comfort go out to her.

***Utah** (continued)*		
Engelhardt	Volker "Willie"	Salt Lake City
Evans	Robert "Bob"	Taylorsville
Gant	Mildred Miller	Salt Lake City
Grant	Irene E	Murray
Hill	Clyde Shelton	Bountiful
Johnson	Richard "Dick" Elmer	W. Valley City
Lowry	Dale Jay	Manti
McLaughlan	Shirley R	Salt Lake City
Mitchell	Jay Ira	West Jordan
Sapp	Anna D	W. Valley City
Tuckfield	Wallace S "Wally"	Sandy
Washington		
Simpson	Thomas	Hamilton
Wyoming		
Bartenhagen	Jack Alfred	Casper
Fleig	Charles F	Cody
Gillen	Alfred	Cheyenne
Holyoak	Wiliam L "Bill"	Morgan
Roh	Evagene "Evie"	Sheridan
Wolfgang	Helen Marie Lytle	Omaha, NE

Bill Alsdorf sends retiree obituaries via email weekly, including more about the retiree. To join the email list, send your request to Bill at his email: **auswr@q.com.** You can send your information about a member who has passed away to Bill —(please include the date and newspaper source of the obituary).

Legal services DONATION for CURTIS KENNEDY for 2016: $_____ .00

AUSWR Colorado/Wyoming Application —PLEASE PRINT—

CHECK ONE: New Member: _____ Annual renewal: _____($5.00) Change _____

Last name: _____ First name: _____
Dual membership: Last name: _____ First name: _____
Mailing address: _____
City: _____ State: _____ Zip code: __ __ __ __ __ - __ __ __ __
Phone: _____ E-mail: _____

I would like to volunteer in the following areas: (you will be contacted —you can check more than one):
Area Rep: _____ Membership: _____ Financial: _____ Legislative: _____ Media Relations: _____
Other (*describe*): _____

I retired from (Name of company): _____ Date: _____
Spouse retired from (Name of company): _____ Date: _____
I own CenturyLink stock: Yes: _____ No: _____

Please mail DUES check for $5 to: AUSWR CO/WY, PO BOX 27027, DENVER, CO 80227-0027

CHANGES TO ADDRESS, PHONE NUMBER OR E-MAIL ADDRESS

If you have a change in your name, mailing address, phone number, or e-mail address, please use this form. **ALSO** on the back page of this newsletter, your membership expiration date is included on the mailing address. If your expiration date is near, use this form to submit your annual dues.

- **IF YOU KNOW** of any prospective members who have not yet joined the Association, please provide them with a copy of this **Membership Application** form, or have them contact John Rommelfanger, Colorado President, at 303-475-8225. A copy of the form also can be printed from our web site at: **www.AUSWR.org. IMPORTANT TAX INFORMATION:** AUSWR CO/WY is an I.R.S. non-profit, tax-exempt organization. However, dues and donations are **NOT DEDUCTIBLE** on your personal tax returns. Records are available via written request at **P.O. Box 27027, Denver, CO 80227.**

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Treasurer-Receipts/Budget: Bill Campbell —303-988-2800 / *wilco751@q.com*
Treasurer-Disbursements: Dale Thompson —303-659-8720 / *daleosa2@comcast.net*
Health Care Specialist: Barbara Wilcox —303-377-5761 / *bmw@mho.com*
Database Manager: Dale Thompson —303-659-8720 / *daleosa2@comcast.net*
E-mail Editor: Bill Alsdorf —303-659-4189 / *balsdorf@q.com*
Newsletter Editor: Kitty Kennedy —520-444-6617/*kkennedy404@gmail.com*
CWA/Legislative Rep: Harvey Hoffman —303-733-1955 / *hehoff@q.com*
CO/WY Retiree Advocate: Jim Heinze —303-442-1831 *jjonrr@ecentral.com*

COLORADO AREA REPS:

To volunteer in your area, contact
John Rommelfanger —303-475-8225

Arvada: Betty Moore—303-936-7917 bluebetty@q.com
Aurora: Pat Finley —303-425-0804 pfinley00@msn.com
Boulder/Longmont: John Rommelfanger —303-475-8225 / jrommel@live.com
Broomfield: Judy Campbell—303-466-5666 jacampbell38@q.com
Castle Rock/Monument: Charley Heard —303-660-9593 / cheard@att.net
Colorado Springs: Ralph Rohrig —719-550-8267 / earoh12@aol.com
Denver East: Ed Arnold—303-321-7766 earnold72@gmail.com
Denver North: Dave Felice —303-880-5150 d2felice@aol.com
Denver Southeast: Robert Wiswell —720-859-7641/ rwiswell@ix.netcom.com
Denver Southwest: Jim Hodges —303-798-3213 / ehodges641@aol.com
Englewood: Ed Payne—303-781-2222
Fort Collins/Loveland: Chuck Rider —970-267-0817 / clmnrider@att.net
Fort Morgan: John Jump—970-867-7221 jjumper143@q.com
Golden: - Vacant
Grand Junction/Durango: Sue Berndt —970-263-9008 / tbandsb@msn.com
Greeley: Chuck Rider—970-267-0817 clmnrider@att.net
Lakewood: Don Hinkley—303-988-0095 dwhinkley@q.com
Littleton (80220—80222): Ed Dinkins —303-794-6625 /ed9603@hotmail.com
Littleton (80223—80225—80227): LaVerne Lanskey303-726-2520/ lalanskey@gmail.com
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Middle Park: - Vacant
Parker/Sedalia: John Rommelfanger —303-475-8225 / jrommel@live.com
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South East Colorado: Wesley Colvin —719-384-2436 / reddbarn@centurytel.net
Thornton/Brighton: Bill Alsdorf —303-659-4189 / balsdorf@q.com
Westminster/Wheat Ridge: Alice M. Peterson --303-424-7609 / allicad@aol.com

WYOMING AREA REPRESENTATIVES:

Casper Area: Gary Overturf —307-527-9005 / ago@tritel.net
Lander-Riverton: Jim Reddon —307-856-6833 / jamesr@bresnan.net
Cheyenne Area: Dorothy Rhoades —307-235-4501 /drhoades36@hotmail.com

ARIZONA REPRESENTATIVE:

Statewide: Kitty Kennedy
—520-444-6617 / kkennedy404@gmail.com

All Other STATE CONTACTS:

John Rommelfanger
—303-475-8225 / jrommel@live.com

To volunteer in your area, contact
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COLORADO & WYOMING Presidents' Messages

by John Rommelfanger, Colorado President

An estimated 140 members attended the 20th annual meeting of the AUSWR CO/WY, held at the Holiday Inn in Lakewood, Colorado, Saturday October 10, 2015. Members were treated with first-hand information from their board of directors concerning membership, financials, benefits and health care. The 'Pledge of Allegiance' started the meeting, followed by housekeeping rules —and then introductions of CO/WY board of directors members, Area Representatives, Past President Jack Beattie and former AUSWR Regional President Mimi Hull. Pat Finley reviewed, and members approved, the 2014 annual meeting minutes. Re-elected to serve another 2-year term are:

- *CO-President AUSWR CO/WY Colorado* John Rommelfanger
- *CO-President AUSWR CO/WY Wyoming* Robert Rucker
- *Vice-President Communications* LaVerne Lanskey
- *Treasurer-Disbursements* Dale Thompson

The leaders for Financials, Membership, and Health care reported their activities. Herb Hackenberg, author of the 1986, *Muttering Machines to Laser Beams: A History of Mountain Bell,* presented information about the Telecommunications History Group. The meeting continued with a Q&A session directed to our panel of 'experts,' including former and current board members. The main point of discussion was about plans for early 2016, when AUSWR CO/WY and NWB leaders will meet with CenturyLink management to discuss retiree benefits going forward. Our membership was treated to music provided by the Cello Quartet "Voice of the Wood," lunch was served, closing remarks and adjournment followed. Special thanks go out to Bill Alsdorf and his crew, who always arrive early and setup tables to welcome members. Last, but not least, Ed Arnold, who has taken many pictures of our meeting in the past, was there again, taking, some great pictures for us to enjoy.

__Rommel

by Bob Rucker, Wyoming President

We continually receive calls from all over our beautiful state from members stating how much our organization means to them —and how the *Retiree Guardian* is not only timely, but provides a life line for many of our members. Remembering that AUSWR CO/WY is a volunteer organization, the dedication shown by these folks is truly amazing.

Gary Overturf, the Casper,Wyoming Area Representative, reports that the information contained in the *Retiree Guardian* is something the members can count on. At this time, there are no questions that haven't been addressed in the *Retiree Guardian*.

Jim Redon, the Lander/Riverton Area Representative, reports that while there have not been many questions from our members this summer, those that were raised have been referred to the board members to be resolved. He also points out that many of the inquiries can be answered by the information contained in the *Retiree Guardian*.

Dorothy Rhoades, the Cheyenne Area Representative, reports that she also attends the Telephone Pioneer meetings in Cheyenne, and receives many inquiries at these meeting from concerned retirees, which she either refers to the information contained in the *Retiree Guardian,* or escalates the issues to the appropriate board member.

Our thanks go out to the above Area Representatives who help make the AUSWR CO/WY organization work for the benefit of our members.

__Bob & Jean Rucker

Editor's Note: Retiree Guardian workers thank the Wyoming folks for the kind words.