CWA and Qwest Corporation d/b/a as CenturyLink QC

Benefits for Those Hired or Re-Hired On or After January 1, 2009

Wages and Working Conditions Agreement Between Qwest Corporation and the Communications Workers of America
AFL-CIO
October 7, 2012 – October 7, 2017

AGREEMENT

BETWEEN

Qwest Corporation &
Communications of Workers of America

Effective **October 7, 2012**

CenturyLink

CWA District 7

IBEW Local 38

Benefits for those hired or rehired on or after January 1, 2009.

There are certain distinctions between groups of employees within the Qwest Bargaining Unit that have been created since 1989 to conform to legal requirements created by acquisitions by US WEST of other companies and the later acquisition of U S WEST by Qwest and the subsequent acquisition of Qwest by CenturyLink. One other distinction is in regards to Benefits (Short-Term Disability, 401k Plan and the Pension Plan). In 2008, three distinctions were made for those employees who were hired or rehired after December 31, 2008:

- **Pension Plan**. Those employees who were active employees as of December 31, 2008 accrue pension credit under the traditional defined benefit provisions of the Qwest Pension Plan. Those who are were hired or rehired on or after January 1, 2009 accrue pension credit in the Qwest Pension Plan under the Account Balance Formula

- **401k Savings Plan**. Those employees who were active employees as of December 31, 2008 have a higher contribution and match rate than those who are were hired or rehired on or after January 1, 2009.

- **Short Term Disability Plan**. Those employees who were active employees as of December 31, 2008 accrue pension credit under the traditional Short Term Disability benefit provisions, while those who are were hired or rehired on or after January 1, 2009 are on a separate defined Plan.

401(k) Savings Plan	401(k) Savings Plan benefits will be the same for eligibility, participation, and provisions based on **TOE date which differs between those hired or re/hired prior to 12-31-2008 and those hired or re/hired** after 12-31-2008. Eligibility is based on GLS date.
Greater Length of Service (GLS)	Same as Company Service Date. The GLS Letter of Agreement and subsequent LoAs govern the application of GLS for various plans, eligibility and vesting provisions, among others.
Healthcare Plan	Healthcare Plan benefits, will be the same for eligibility, participation, plan design and employee contributions as for LQ Occupational Employees. Eligibility is based on GLS date.
Illness	Wage replacement for incidental illness absences is based on the length of service as measured by the TOE/**GLS** date.
Pension	Pension Plan Benefits will be the same for eligibility, participation, and provisions based on **TOE date which differs between those hired or re/hired prior to 12-31-2008 and those hired or re/hired** after 12-31-2008.

	Eligibility is based on GLS date
Short Term Disability (STD)	STD benefits will be the same for eligibility, participation, and provisions based on **TOE date which differs between those hired or re/hired prior to 12-31-2008 and those hired or re/hired** after 12-31-2008. Eligibility is based on GLS date
Work Assignments, and Scheduling	The TOE date will be used for such things as determining Selection and "seniority" among other represented employees for such things as, but not limited to, bidding for weekly work tours; work assignments; selection and scheduling purposes, including the scheduling of paid time off, subject to the provisions of this Collective Bargaining Agreement.

Savings Plan (401k)/ROTH

Eligibility

Regular Full-Time Employees, Regular Part-Time employees (Part-Time Seasonal and Part-Time) and TERM Employees shall be eligible to participate in the CenturyLink Union 401(k) Plan and such participation shall be based on his or her actual wages.

Effective January 1, 2009, occupational employees may make Roth 401(k) contributions on an after-tax basis. For 2008, the pre-tax contributions limit for before-tax and Roth 401(k) is $15,500.

Those Hired or Re-Hired On or After January 1, 2009 All other represented employees who are hired, rehired or transferred into the Qwest/CWA bargaining unit on or after January 1, 2009 and an Active Employee of Qwest Corporation and who elect to participate in the CenturyLink Union 401(k) Plan and who make Pre-Tax Contributions, After Tax Contributions and/or Roth Contributions for a pay period, shall be eligible for a Matching Contribution by the Employer in the following order: the Pre-Tax Contributions will be matched first, then After Tax Contributions and Roth Contributions matched last. Catch-Up Contributions made pursuant to the Plan shall not be eligible for a Matching Contribution by the Employer.

The Matching Contribution formula for these employees will be:

a) a 100% Matching Contribution on the first one percent (1%) of Elective Deferrals (Pre-Tax Contributions, After Tax Contributions and/or Roth Contributions) of the Participant's Compensation made during each pay period by such Participant, plus
b) a 50% Matching Contribution on the next five percent (5%) of Elective Deferrals (Pre-Tax Contributions, After Tax Contributions and Roth Contributions) of the Participant's Compensation made each pay period by such Participant; provided, however, that the total Matching Contribution allocation for any such Participant for any pay period shall not exceed 3.5% of such Participant's Compensation for that pay period. The maximum

allocation of Matching Contributions for the Plan Year for such a Participant is equal to 3.5% of the dollar limit under the Internal Revenue Service (IRS) Code section 401(a)(17) for the Plan Year.

In other words: If a non-grandfathered Participant Defers This Percent:	The Matching Contribution Will Be This Percent:
1%	1.0%
2%	1.5%
3%	2.0%
4%	2.5%
5%	3.0%
6%	3.5%

The Pension Plan

Eligibility

Those employees were hired or re-hired prior to January 1, 2009 and who receive a regular and stated compensation from the Company as a regular full-time, regular or seasonal part-time, an Incidental Employee and a regular Term employee. Regular Part-Time employees (Part-Time Seasonal and Part-Time) shall be eligible to participate in the Qwest Pension Plan on a prorated basis, as provided by the terms of such plan. This includes those who transferred into the Qwest unit from another CenturyLink property.

The difference in the Plan from those who hired or re-hired prior to January 1, 2009 is how Pension credits are accrued and portability. Those in the traditional defined Pension Plan earn Pension Credits with almost 40% of the value of the Pension occurring the employee's final 5 years. Those hired or re-hired on or after January 1, 2009 accrue the Pension under an Account Balance Formula (ABF).

Eligibility for a Deferred Vested legacy CenturyLink Pension

Those who transfer into Qwest from another CenturyLink property fall into one of two categories on Pensions. Those who were not covered by a Union contract saw their pensions frozen in 2010. Those who were part of a legacy CenturyLink property that was union represented still had active pensions.

In both instances, if the employee was vested in the Plan in place, then they retain full rights to that pension under that Plan as a vested participant and will not lose what was accrued. Upon transferring into Qwest, employees will begin to accrue Pension credit.

Account Balance Formula (ABF) Each active Occupational Employee hired or rehired after December 31, 2008 will earn a benefit under the Account Balance Formula (ABF). Compensation Credits equal to three percent (3%) of the employee's eligible compensation (as defined by the Plan document) will be calculated annually in accordance with the ABF.

Employees will become vested in the benefit upon the completion of three (3) years of employment. Upon separation from employment, if the three (3) year vesting period is satisfied, an employee is eligible to receive their account balance as prescribed by the Plan document, including a lump sum.

SURVIVOR

ABF Lump Sum. Your beneficiary may elect, within the period described below, to be paid the amount of the lump sum benefit payable under the ABF. The lump sum is based solely on this formula. If the beneficiary is the spouse, the annuity will be paid unless the spouse elects a lump sum within 180 calendar days after the Participant's death, or 60 calendar days after receiving the pension election forms, if later. If a non-spouse is the beneficiary and no election is made within 180 days after the Participant's death or 60 calendar days after notification, if later, the lump sum will be paid.

In general, the annuity survivor's benefit can also be paid as a lump sum instead of a monthly annuity. If a spouse is the beneficiary, the annuity will be paid unless the spouse elects a lump sum distribution within 180 calendar days after the Participant's death, or 60 calendar days after receiving the pension election forms, if later. If a non-spouse is the beneficiary and no election is made within 180 calendar days after the Participant's death or 60 days calendar days after notification, if later, the lump sum will be paid.

If you did not name any beneficiary or your beneficiary predeceases you, your pre-retirement benefits will be paid to your surviving spouse, or if there is no surviving spouse, to your estate.

ABF FAQs

Q. How are my interest credits calculated?

A. Each January your account balance is credited with an Interest Credit based on the Treasury Rate equal to 3% of the compensation (wages, overtime and commissions that were considered to be taxable income, including deferrals to a 401(k) plan or other pre-tax benefits).. The Treasury Rate is the average of the 30-year Treasury Interest rates in effect during August through December of the Prior year. Interest Credits will continue to be applied to the year-end balance under the ABF until the employee terminates employment and elects to receive their pension benefit.

Example: 2009 total annual compensation	$ 45,000.00
Compensation credit (3% of compensation)	$ 1,350.00
Interest credit on 2009 Compensation Credit	58.19
Plus 2010 compensation credit	$ 1,500.00
Account balance as of 12/31/10	$ 2,908.19

Q. Do I receive Compensation Credits if I terminate employment before the end of the year?
A. Yes. You receive compensation credit through the date you terminated employment.

Q. Does part-time employment affect my ABF benefit?

A. Yes. The ABF formula is based on actual earned eligible compensation. PCS is not used in the calculation.

Q. Do the interest rates affect the amount of my lump sum under the ABF?

A. No. The ABF computes the value of a lump sum on the annuity starting date. This lump sum amount is not affected by interest rates.

Q. Do interest rates affect the amount of my age 65 monthly single life annuity under the ABF?

A. Yes. Your age 65 monthly single life annuity under the ABF is calculated at your Annuity Starting Date. The applicable interest rates and the applicable Mortality Table at the employees Annuity Starting Date are used in the conversion of the ABF lump sum to the monthly annuity. Higher interest rates produce a larger monthly annuity amount and lower interest rates produce a lower monthly annuity amount.

Disability

Type of Disability Benefit	Definition
STD	An illness or injury, supported by objective medical documentation*, that prevents you from performing the normal job duties of your regular job or any other job to which you may be assigned (with or without modifications)
LTD	An illness or injury, supported by objective medical documentation, that prevents you from performing the duties of your last Company assigned job.

The Qwest Short Term Disability Plan is an ERISA -governed Plan. The Long Term Disability Plan is coverage purchased by the employer and provided to the employees under the terms and conditions negotiated as part of an overall contract. Both fall under the provisions of Addendum 10. As such the administration of the STD Plan is not subject to the grievance and arbitration process. Any disputes or challenges to the denial of benefits must be filed in accordance with the claims and appeals procedure provided under each of the Plans and identified in the Summary Plan Descriptions (SPDs).

CenturyLink Disability - Denial and Appeals Process

On the eight day of illness absence, the employee will be provisionally approved for benefits under the CenturyLink Short Term Disability Plan. There is then a 21 day deadline from the first day of absence for QDS to receive the required objective medical documentation. No denials will be issued before day 21 other than those denials sent because an employee is not eligible for

STD benefits. No denials are sent until all the new medical information received on or before day 21 has been reviewed.

An employee is allowed 5 business days after the final date of the initial period that the original STD was approved for to request an extension of the original STD time period and to submit additional medical information to support that request.

There is a Health Benefit Coordinator, appointed by CWA, who work with CDS and who is available to assist both active members and retirees with these issues:

Sean Morrow, Qwest Health Benefits Coordinator
Spokane, WA
509-623-0555
Sean.Morrow@centurylink.com

STD Benefits for Employees Hired or Rehired After December 31, 2008

Those employees hired or rehired on or after January 1, 2009 who incur an approved on-the-job injury or illness claim, such employees are eligible to receive STD Benefits equal to 70% Base Pay wage replacement (with either a "before-tax" or "after-tax election by the participant). The base-pay rate means the employees regular wages or salary rate plus average night differentials, if applicable. Overtime, bonuses, commissions, sales incentives, "at risk" pay and differentials are not included. Sales employees covered under a "leveraged compensation plan" are eligible for a 70% base pay wage replacement benefit based on their Average Hourly Rate (AHR).

Upon attaining one (1) year of service from date of hire or rehire, Occupational Employees, except as identified below with respect to CSA and CSSA job titles, shall be eligible to participate in the Qwest Disability Plan. Employees eligible to receive Short Term Disability (STD) benefits shall receive seventy percent (70%) base wage replacement for approved STD absences for the applicable coverage period, in accordance with and subject to the provisions of the Qwest Disability Plan.

Upon attaining two (2) years of service from date of hire or rehire, Occupational Employees in the CSA and CSSA titles shall be eligible to participate in the CenturyLink Disability Plan. Employees eligible to receive Short Term Disability (STD) benefits shall receive seventy percent (70%) base wage replacement for approved STD absences for the applicable coverage period, in accordance with and subject to the Provisions of the Qwest Disability Plan. (See contract Reference Guide, Appendix 1, pages 127 – 131)

STD FAQ's

Q. Who is eligible for the 70 % Short-Term Disability (STD) payments?

A. Eligibility for STD is discussed at length in the Qwest Disability Plan, and any questions regarding eligibility would be resolved based upon the Qwest Disability Plan. If the employee is unable to work due to a Disability that lasts longer than 7 consecutive

calendar days (partial or full days), STD starts on the eighth consecutive calendar day. At a minimum, an individual must be a Regular, Term, or Part-Time employee with at least 1 year of service and a minimum EWW of 20 hours in order to be eligible for STD. However, an employee may be eligible for payments if they have an accepted on-the-job injury under worker's compensation.

Incidental employees, leased workers, independent contractors, or occasional employees, are not eligible for STD coverage. Additionally, any employee must satisfy other requirements of the CenturyLink Disability Plan to be eligible for payments. All employees with at least 1 year of TOE, excluding incidentals and those employees in the titles of Center Sales Associate (CSA) and Center Sales and Service Associate (CSSA), are eligible for STD. Employees in the titles of CSA and CSSA become eligible for STD after obtaining 2 years of TOE.

Q. How does the employee report a disability?

A.

1. They would contact their supervisor on the first day of absence to report thei disability.
2. The would contact the 3rd party administrator, CenturyLink Disability Services at 800-729-7526, press the option for "disability", on or before the 4th calendar day of their absence – or on the 1st day of a relapse. Their supervisor can report the employee's disability if they are unable to do so. If the employee's absence is due to an on-job injury or illness, they should contact both CDS and Unicall at 866-864-2255.

   Failure to report their absence to the 3rd party administrator may result in denial of STD benefits unless such failure is shown to have been unavoidable.

Q. What is the benefit amount?

A. The benefit payments an employee is eligible to receive depend on the following factors as they apply on the 8th consecutive calendar day of disability:

- The cause of the employees medical condition, illness or injury (on-job injury of off-job illness/injury)
- The employees base pay rate (normal take-home pay if the employee has an on-job injury or illness covered by Worker's Compensation).
  - Normal take-home pay means gross base pay. Deductions, including but not limited to garnishments, 401(k) contributions, United Way, Union dues and flexible spending accounts contributions shall not be excluded from Normal Take Home Pay. Disability pay will be increased/decreased if the employees base pay rate is changed while receiving benefits.
- The employees average hours of work not including overtime.
- Other sources of disability income (see "offsets")

Under the plan, on-job injury or illness means an injury or illness that arises our of and in the course or scope of employment with the Company and has been accepted

by a claims manager as a compensable Worker's Compensation claim under the program of the employee's respective state.

Disability Payment Benefits for Approved on-job injury or illness claims

For employees hired or rehired on or after January 1, 2009 who incur an approved on-the-job injury or illness claim, such employees are eligible to receive STD Benefits equal to 70% Base Pay wage replacement (with either a "before-tax" or "after-tax election by the participant). The base-pay rate means the employees regular wages or salary rate plus average night differentials, if applicable. Overtime, bonuses, commissions, sales incentives, "at risk" pay and differentials are not included. Sales employees covered under a "leveraged compensation plan" are eligible for a 70% base pay wage replacement benefit based on their Average Hourly Rate (AHR).

Short-term disability benefits can last up to 52 weeks (364 days). The employee may be eligible for extended benefits if they have had two (2) or more unrelated disabilities.

Workers Compensation and Your Disability Pay

If the employee is receiving non-taxable Worker's Compensation pay, their STD benefits will be the difference between the Comp benefits plus any other benefits the employee may receive (e.g., social security disability) and 100%, 70% or 60% of their base pay or normal take home pay (based on the payments schedules)

The following examples shows how STD benefits are calculated at 60% of normal take-home pay, assuming they are disabled due to an on-job injury or illness and are receiving Worker's Comp:

Regular Pay	$2076.00	WC	$1200.00
Taxes	-$ 601.81	STD	+ $ 876.00
Normal Take Home Pay	$1474.19	Total Base Pay	$2076.00
		STD	$ 876.00
		Taxes	- $ 270.32
		STD Net Pay	$ 605.68
		Worker's Comp	$1200.00
		STD Net Pay	+ $ 605.68
		Total net pay (take home pay before adjustments)	$1805.68
		Take home pay before adjustments	$1805.68
		Normal take home pay	- $ 480.25
		Excess take home	$ 331.49

		pay	
		STD	$ 876.00
		Adjusted STD	- $ 480.25
		STD benefit	$ 395.75
		STD benefit	$ 395.75
		Taxes	- $ 114.69
		STD net benefit	$ 281.06
		Worker's Comp	$1200.00
		STD net benefit	$ 281.06
		Total net pay	$1481.06

Q. Is STD counted against the Family Medical Leave Act (FMLA) 12-week requirement?

A. To the extent the employee is eligible; an approved STD absence is also counted as FMLA time. If STD is denied and the absence is only covered under worker's compensation, FMLA does not run concurrently.

Q. What are Rehabilitation Benefits ("work hardening") and when do they apply?

A. Rehabilitation Benefits (RB) are intended for employees who are disabled from working their full tour for a temporary period up to 150 days. With CenturyLink Disability Services' (CDS) approval of an appropriate RB plan, an employee may work part of his / her normal tour and be paid for the remainder. The goal is to allow the ill / injured employee a gradual return to a full work schedule. Generally, RB will not exceed three (3) weeks. Any entitlement time taken during a RB plan must be pre-approved through QDS and must be taken in full-day increments; it cannot be used to 'supplement' a partial day schedule.

Q If an employee takes vacation while on RB is the entire day coded as vacation or just the RB portion of the day.

A. The entire day is coded as vacation. In addition, QDS is notified when an employee is not maintaining their RB schedule.

Q. What constitutes a relapse to a disability?

A. Absence within 13 weeks of the return to work from disability, if the absence is for a related reason. Any unrelated absence is considered a separate case; if it extends beyond the 7 calendar days of incidental absence, it becomes a new disability case.

Q. Are STD absences counted under the Occupational Employee Performance Plan (OEPP)?

A. It depends. If the employee is FMLA eligible and the entire absence is covered by FMLA, do not count the absence as an occurrence. If the employee is not FMLA eligible because he/she (1) does not yet qualify for FMLA, or (2) has already exhausted his/her FMLA entitlement, the STD will count as 1 occurrence, 1 day.

Q. Can an employee or the Union file a grievance over denial of benefit payments?

A. No. The Benefits Plans and their administration are not subject to grievance or arbitration. Each of the Plans contracts has an appeal procedure, which an employee may pursue. An appeal over a denial of a STD payment requires a written appeal to the CenturyLink Appellate Committee.

Q. What if the employee's physician disagrees with CDS about the length or nature of the disability or the proposed treatment plan?

A. The employee may continue the absence under an FMLA Illness Leave, if eligible. The employee is encouraged to have the treating physician contact CenturyLink Disability Services to discuss the disability or to provide requested information. Such contact usually resolves the issue for STD. If not, either an Assessment of Abilities Evaluation or a separate medical opinion, paid for by the Company, may be sought.

Q. Does management have to know the employee's medical condition or diagnosis?

A. No. Such information is confidential, unless the employee chooses to discuss it. However, the manager has to know if an employee is on an approved disability absence or is certified for FMLA in order to determine if the absence is excused or follow-up is appropriate with the employee.

Q. An employee was on Short-Term Disability (STD) for several weeks, and then returned to work. **Within** 13 weeks the employee was on STD again. What is the maximum benefit period?

A. If the second absence is for a **related** reason and the return to work was on a normal (not RB) basis, the second absence is considered a relapse. The maximum benefit period is 52 weeks for both absences.

Q. What if an employee returns to work from STD and within 13 weeks is on STD again, for an **unrelated** reason?

A. This counts as 2 separate cases and the maximum benefit period is a total of 78 weeks within a 24 consecutive month period.

Q. If an employee relapses within 13 weeks of returning to work is he/she paid for the first day of absence?

A. Not necessarily. Payment for a relapse on the first day is only approved when it falls within 2 weeks of returning to work on a normal basis. A relapse between 2 and 13 weeks of the return means incidental illness wage replacement for the first 7 calendar days, then STD, if appropriate.

Q. If an illness leads into an approved short term disability (STD) during a time that a Regular Part-Time (RPT) or Seasonal Part-Time (SPT) employee is **not scheduled to work**, does the employee get paid?

A. Yes, even though RPT and SPT employees only get paid for the first seven calendar days if they are scheduled to work, when an illness extends into the eighth calendar day and is approved as an STD, the employee will be paid based on their individual EWW.

Q. If a RPT or SPT employee is on an approved STD and the scheduled hours are reduced to zero, what impact does that have on the STD payments the employee may be receiving?

A. Even when a RPT or SPT employee's hours are reduced, including "zero scheduled", the employee will continue to be paid based on his/her individual EWW for all time the employee remains in an approved STD status. The level of payments will be determined by the appropriate benefit schedule based on the employees TOE.

Long Term Disability (LTD) Benefits

Eligibility

There is no distinction made because of an employee's hire or re-hire date for LTD benefits. When an employee's STD benefits expire, they are removed from the payroll and may apply for LTD. Regular Full-Time Employees, Regular Part-Time employees (Part-Time Seasonal and Part-Time) and TERM Employees who were eligible and approved for STD and have received the maximum STD payments available under the Plan and who continue to meet the definition of disabled (An illness or injury, supported by objective medical documentation, that prevents an employee from performing the duties of their last Company assigned job) are eligible for LTD payments.

LTD does not cover:

- The disability of any former employee who becomes disabled after termination from employment;
- The disability of any former employee who is terminated from the payroll for any reason other than expiration of STD benefits provided by the Plan;
- Successive or future disabilities – if you received LTD benefits and these benefits are discontinued for any reason.
- Disabilities caused or contributed to by,
    - The employees commission of a felony;
    - Intentionally self-inflicted injury, while sane or insane;
    - Military Service;

- War or any act of war, declared or undeclared; or
- Active participation in a riot, insurrection, rebellion, or other civil commotion.

Filing an LTD Claim

The Company or its representative will send the employee a packet for LTD benefits approximately 90 days before the end of the STD period. An employee must apply for LTD benefits within 90 days following their termination of employment or else the employee will forfeit their LTD benefit. The period of time during which you receive LTD benefits won't be included in determining you TOE/GLS or for Pension credited service.

The employee and their approved provider should complete the appropriate sections of the LTD application forms and return them within 90 days from the expiration of their STD. LTD benefits will begin once the employees application is approved they've met all other LTD requirements:

- The employee continues to be disabled as defined in the "disability definitions.
- The individual continues to seek proper care and treatment from an approved provider, and follow a recommended treatment plan.
- You provide documentation supporting your disability to the plan administrator at least annually or upon request. Documentation must support your disability claim and include objective medical findings, diagnosis and any other treatment or management of the condition(s).
- You report for medical and/or psychological examinations at the request of the Plan administrator for the purpose of monitoring your condition.
- You apply for Social Security Disability Insurance Benefits (SSDIB) when eligible or at the plan administrators request and meet the additional requirements outlined in the "social security disability insurance requirements.
- You reimburse the Company for any overpayment of disability benefits that occurs for any reason including, but not limited to, a Social Security Disability Insurance Benefits (SSDIB) award received for a period during which you also received LTD benefits from this Plan.

If you fail to satisfy these requirements, your LTD benefits may be denied, reduced or discontinued. If an LTD claim is denied, in whole or in part, you are entitled to a review.

Independent Medical Evaluation Process – Short Term Disability & Medical Restrictions
Independent File Review Process – Long Term Disability
If an individual has any concern regarding a decision of disability eligibility, the employee has the option of filing an appeal. The matter in question may be resolved by providing additional information, utilizing the IME/IFR process, etc. If the issue remains unresolved, the formal appeal time limits may have been protected.

Independent File Review Process – Long Term Disability Cases

For the purposes of this Agreement, the following Guidelines shall apply to LTD claims once the employee has already gone through the Administrative Review Process:

1. The employee receives notification that the adverse decision is upheld through the Administrative Review process.
2. The employee may request a third level Independent File Review (IFR) by a third party. This may be at the request of the employee or through the Union assisting the employee.
3. A letter is sent from The Standard (insurance provider) acknowledging receipt of the request within approximately two business days of receipt of the request.
4. Within approximately five business days of receiving the employee's request, The Standard will send a copy of the claim file to the Third Party Reviewer/Vendor.
5. The Third Party Reviewer/Vendor reviews the medical documents and pertinent medical data which includes a quality peer review for professional accuracy in addition to contacting the employee's treating physician. This process will take approximately ten business days.
6. The Standard receives information back from the Third Party Reviewer/Vendor and re-reviews the file to determine if the IFR assessment alters Standard's determination.
7. The Standard may conduct additional medical and/or vocation analysis including the use of an IME if needed, based on the IFR.
8. If the claim decision is upheld, The Standard notifies the employee of the outcome. If the claim decision is altered, the claim is reopened for approval determination and the employee is notified.
9. Notwithstanding any other provisions in this Letter of Agreement, The Standard shall not be bound solely by the IME/IFR process but may be a factor in reconsidering its decision. As such, nothing in this Letter of Agreement shall alter the terms and conditions or other requirements required of The Standard under the fully insured plan.

Benefit Amount

The LTD Plan pays a benefit which, when added to all other sources of disability income, will equal 60% of your base pay rate or your "Normal Take-Home Pay" if you are receiving non-taxable workers compensation payments. In either event, your benefit will be based on your Base Pay Rate in effect immediately prior to your termination from employment.

LTD benefits are paid once a month for the preceding month (for example, July's benefits are paid on August 1). If an LTD benefit is due for a partial month, the payment will be pro-rated and paid with the next month's benefit, if possible under payroll deadlines. If a payroll deadline has already passed, the partial month's benefit will be paid with the first full month's payment.

Special Rule

Under certain circumstances, you may be eligible for a higher LTD benefit amount. To be eligible for this increased benefit, you must be:

- A disabled, occupational, non-salaried participant.
- Working at a job that pays less than 60% of your Base Pay Rate (or Normal Take-Home Pay if appropriate); and
- Eligible for LTD benefits under this Plan.

LTD Payments Offset by Other Benefits

Your LTD benefits are reduced dollar-for-dollar for any "offsetting benefits" – disability benefits you receive from other sources such as workers compensation or similar payments for on-job disabilities; SSDIB payments (only your initial monthly SSDIB and not any benefits paid to your family are considered nor any future SSDIB cost-of-living increases) and Pension Payments.

If You Recover From Your Disability

You have no special re-employment rights or any guarantee of re-employment if you later recover from your disability. LTD payments will stop if you are no longer disabled as defined by the Plan. If you become disabled again, that disability isn't covered under the plan and no benefits will be paid.

Maximum LTD Payment Period

Provided you remain disabled, the Plan provides LTD benefits until you reach age 65 – or past that age if you become disabled after age 61 – as shown below:

Age at Termination of Employment	Maximum LTD Period
61 or younger	To age 65
62	3 ½ years
63	3 years
64	2 ½ years
65	2 years
66	1 ¾ years
67	1 ½ years
68	1 ¼ years
69 or older	1 year

Medical Coverage Choices for Both Qwest Active Employees and Pre-Medicare Eligible Retirees

Eligibility

Regular Full-Time

Regular Part-Time employees (Part-Time Seasonal and Part-Time) with an "equivalent work week" of thirty (30) or more hours shall be eligible to participate, on the same basis as Regular Full-Time employees, in the Qwest Health Care Plan, Group and the Life Insurance Program Plan, and the Long Term Care Plan. Regular Part-Time (Part-Time Seasonal and Part-Time) with an "equivalent work week" of more than twenty (20) hours but less than thirty (30) hours shall be eligible to participate in the Health Care Plan (medical, dental and vision) at premium contribution rates equivalent to one-hundred fifty percent (150%) of a Regular Full-Time employee.

An Incidental employee who works more than twenty (20) hours per week may participate in the Qwest Health Care Plan, which covers active employees for healthcare (medical, dental, vision and spending accounts) coverage only (not for vision, dental or spending accounts):

a) Beginning in the first calendar month after he or she completes one hundred eighty (180) sixty (60) consecutive days on the Company's payroll; and

b) Provided that he or she pays the full cost for coverage elected by the employee at premium contribution rates equivalent to one hundred fifty percent (150%) of the premium contribution rate of a Regular Full-Time employee.

Regular TERM employees A Regular Term employee is one who is employed for a specific project with the definite understanding that his or her employment will terminate upon completing the project. A Regular Term employee shall be further classified as either "Full-Time" or "Part-Time". Regular Term Full-Time employees shall have the benefits and entitlements of Regular Full-Time employees. Regular Term Part-Time employees shall have the benefits and entitlements of Regular Part-Time employees.

A former employee who is rehired by the Company and receives health care benefits as an eligible retiree under the CenturyLink Retiree and Inactive Health Plan will no longer be eligible to continue to receive retiree healthcare (medical, vision, dental or spending accounts) coverage while actively employed. They will receive employee healthcare in accordance with their employment status (fulltime/part time/incidental). Retiree healthcare coverage may resume upon the employee's termination from active employment.

Employees and Pre-Medicare eligible Retirees have three (3) healthcare plan options:

- A Preferred Provider Organization (PPO) plan;
- A Consumer Driven Healthcare Plan (CDHP); and
- A High Deductible Healthcare Plan (HDHP).

These Plans share the same provided services, i.e. office visits, surgeries, hospitalization, etc.

However, the premiums, deductibles and co-pays differ. Employees and Pre-Medicare eligible Retirees can opt for any of the Plans during the annual Open Enrollment period.

Non-smokers pay a lower premium. To qualify, you must certify that no one in the household uses tobacco products.

There is an additional surcharge for active employees who cover their working spouse or domestic partner under the CenturyLink Healthcare Plans when that spouse or domestic partner has access to healthcare at their place of employment. If an employee's spouse enrolls in their employers insurance they may take Centurylinks's coverage as secondary and not have to pay surcharge.

Health Care – Active Employees/Pre-Medicare Eligible Retirees

There were some changes to the current PPO plan and a new option for workers was added called the Consumer Directed Health Plan (CDHP). The designation of the terms "PPO", "HDHP" or "CDHP" refer to Plan Design only. The current provider networks are United Healthcare and Blue Cross Blue Shield.

Plan Comparisons

	PPO				CDHP	
	Current Plan In-Network	Out-of-Network	New Plan In-Network	New Plan Out-of-Network	In-Network	Out-of-Network
Deductible						
Employee only	$300	$600 ea individual to a max of $1,800	$500	$1,500	$1,500	
Employee + spouse/DP	$600		$1,000	$3,000	$2,250	
Employee + children	$600		$1,000	$3,000	$3,000	
Employee + family					Employee may use company contributions to employee HRA to pay deductible amounts	

	PPO				CDHP	
	Current Plan In-Network	Out-of-Network	New Plan In-Network	New Plan Out-of-Network	In-Network	Out-of-Network
Company funded contributions to employees HRA's	n/a		n/a			
Employee only					$1,000	
Employee + spouse/DP					$1,500	
Employee + children					$1,500	
Employee + family					$2,000	

Out-of-Pocket Maximum includes Deductible	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Employee only	$1,000 excludes deductible	$3,500 excludes deductible	$3,900 includes deductibles and copays	$5,700 includes deductibles and	$2,000	$2,500
Employee + spouse/DP	up to a maximum of	up to a maximum of	$7,800 includes deductibles and copays	$5,700 includes deductibles and copays	$3,000	$3,750
Employee + children	$3,000	$7,000 excludes deductible	$7,800 includes deductibles and copays	$5,700 includes deductibles and copays	$3,000	$3,000
Employee + family	$1,800	$1,800	$7,800 includes deductibles and copays		$4,000	$5,000
Also there is an additional Pharmacy co-pay maximum					Employee may use company contributions to employee HRA to pay deductible amounts	Employee may use company contributions to employee HRA to pay deductible amounts

Plan Coverage	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Coinsurance (after deductible)	90%	60%	80%	60%	80%	60%
Office Visit	$25 copay	60% after deductible	$25 copay	60% after deductible	80% after deductible	60% after deductible
Office visit lab, Xray, surg Tray, etc.	$25 copay or 100% if associated with an office visit	60% after deductible	$25 copay or 100% if associated with an office visit	60% after deductible	80% after deductible	60% after deductible
	PPO				**CDHP**	
	Current Plan In-Network	Current Plan In-Network	New Plan In-Network	New Plan Out-of-Network	In-Network	Out-of-Network
Specialist Office	$30 copay	60% after	$40 copay	60% after	80% after	60% after

visit		deductible		deductible	deductible	deductible
Outpatient Services Surgery	90% after deductible	60% after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Hospitalization Svcs room & board/surgical services	90% after deductible	60% after deductible	80% after deductible	60% after deductible	90% after deductible	60% after deductible
Urgent Care Urgent Care Services	90% after deductible	60% after deductible	$35 copay	60% after deductible	80% after deductible	60% after deductible
Emergency room coverage – Emergency Care services	90% after deductible; not paid if not an emergency	60% after deductible	80% after deductible; not paid if not an emergency	60% after deductible	80% after deductible	60% after deductible
Obesity Surgery	Not covered	Not covered	Covered when using a bariatric resource services center of excellence	Not covered	80% after deductible	Not covered
Occupational Therapy	$20 copay 60 visit limit combined with speech therapy; autism spectrum disorders not covered	60% after deductible; 60 visit limit combined with speech therapy; autism spectrum disorders not covered	80% after deductible; autism spectrum disorders covered	60% after deductible; autism spectrum disorders covered	80% after deductible; autism spectrum disorders covered	60% after deductible; autism spectrum disorders covered
	Current Plan In-Network	Out-of-Network	New Plan In-Network	New Plan Out-of-Network	In-Network	Out-of-Network
Preventative Care **Well child** **Well man** **Well woman**	$25 copay $25 copay $25 copay	60% after deductible; 60% after deductible 60% after deductible	100% 100% 100%	Not covered Not covered Not covered	80% after deductible	60% after deductible
Retail Rx2 90	$25 copay	60% after	$10 copay	60% after	80% after	60% after

days Generic		deductible		deductible	deductible	deductible
Brand name formulary	$80 copay	60% after deductible	$80 copay	60% after deductible	80% after deductible	60% after deductible
Brand name non-formulary	$140 copay	60% after deductible	$140 copay	60% after deductible	80% after deductible	60% after deductible
HRA Wellness Incentive	n/a	n/a	$500 annually	$500 annually	$500 annually	$500 annually
	PPO				**CDHP** In-Network	Out-of-Network
One time HRA Contribution By Company to Join CDHP Plan	n/a	n/a	n/a	n/a	$1,000	$1,000

Notes:

Wellness – employees can earn up to $500 annually for completing various wellness activities. Spouses/DPs and children may participate in wellness programs, but they would not be eligible for incentives.

- $100 annual HA completion (wellness) credit – paid through payroll
- $100 annual biometric testing credit – paid through payroll
- $300 annual fitness club membership reimbursement

Annual credits/reimbursements are prorated and paid monthly. If the employee is on the CDHP Plan, that reimbursement is put into their Healthcare Reimbursement Account. If they are on the PPO plan, they are given monthly gift/ cash cards.

Those programs that are administered by Highmark/UHC (subject to HIPPA restrictions) are:

- Biometric screening: Annual $100 incentive
- Personal Health Report
- Health coaching/progams (e.g., smoking cessation, weight loss programs, etc.)
- Disease management (e.g., diabetes, heart disease, etc.)
- Wellness communications
- 24-hour Nurse Line
- Wellness Coaching
- Wellness website

Those that are administered internally by CenturyLink are:

- Enrollee and dependent/s (if applicable) enrolled in the medical plan that are smoke-free and tobacco free
- this is so the Company can confirm and the employee will receive the non-smoking discount for medical benefits
- Fitness Club Membership - $300 year (requires monthly participation - 'show me')
- Onsite wellness budgets
- SLT Reports (by regional area)
- Targeted/customized onsite wellness programs
- Company sponsored mammogram/prostate screenings (available in limited locations. Done by vendors and subject to HIPPA)

- Annual Flu Shot Campaign (company paid)

The wellness online portal and program was rolled out in the 2nd quarter 2013. Again - the following incentives received in points or wellness dollars each year up to $500 will be included:
• $100 annual HA completion (wellness) credit – paid through payroll
• $100 annual biometric testing credit – paid through payroll
• $300 annual fitness club membership reimbursement
• Behavior modification programs such as weight loss, smoking cessation, etc.

Copays (medical and prescription), deductibles and amounts over R&C now apply toward out of pocket maximum. They do not count toward the out of pocket maximum under the current Plan.

Mandatory prescription mail order (no coverage for maintenance prescription drugs after 2 fills at retail).

Out of pocket maximums, per the requirements of the ACA, must be combined. The current Plan has an out of pocket maximum of $1,000 (which excludes deductibles) up to a maximum of $3,000 for medical and a pharmacy out of pocket maximum of $1,800 for a total of $2,800 to $4,800 based on dependent status.

All **out of network services** are subject to reasonable and customary (R&C) charges. Any amounts above R&C do not apply towards the annual deductible or out of pocket maximum.

The No-Network Plan continues. Under the current Plan, if the employee or retiree does not have a network provider within a 30 miles radius of the home zip code, they are covered under the In-Network options. That does not change under the new Plan. Under the previous Plan, coverage was based on 90% of R&C. It is now based on 100% of R&C.

Out of Pocket (OOP) Maximum

Regardless of which plan an employee chooses, once the out of pocket maximum is reached the plan pays 100% of all medical expenses.

Preventive Care

Preventive care as out lined by the Affordable Care Act is paid at 100% with no deductible or co-pay required if you use a network provider. This generally includes the following:

1. Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
2. Alcohol Misuse screening and counseling
3. Aspirin use to prevent cardiovascular disease for men and women of certain ages
4. Blood Pressure screening for all adults
5. Cholesterol screening for adults of certain ages or at higher risk
6. Colorectal Cancer screening for adults over 50
7. Depression screening for adults
8. Diabetes (Type 2) screening for adults with high blood pressure
9. Diet counseling for adults at higher risk for chronic disease

10. HIV screening for everyone ages 15 to 65, and other ages at increased risk
11. Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza (Flu Shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
12. Obesity screening and counseling for all adults
13. Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
14. Syphilis screening for all adults at higher risk
15. Tobacco Use screening for all adults and cessation interventions for tobacco users.

Preventive Care for Women

Preventive Care for Women as out lined by the Affordable Care Act is paid at 100% with no deductible or co-pay required if you use a network provider. This generally includes the following:

- Preconception and prenatal care
- Gestational diabetes screening _for women 24 to 28 weeks pregnant (or anytime if at high risk)
- Contraception and contraception counseling- including many FDA approved contraceptive prescriptions, methods and sterilization procedures. Tier 1 contraceptives on the UHC Prescription Drug List (PDL) will be available without cost-share.
- Breastfeeding support, supplies (including equipment) and counseling- while pregnant and postpartum.
- Human papilloma virus (HPV) DNA testing - for women 30 and older
- Annual STI counseling and HIV screening and counseling
- Interpersonal and domestic violence screening and counseling

Active Employee Premiums (Retiree Premiums are Outlined in Retiree Healthcare)

There will be new employee contribution rates beginning in 2014. Premiums will now be paid every two weeks instead of bi-monthly as they had been. CenturyLink uses a 26 payroll period year versus the 24 payroll period year that Qwest utilized.

Premiums are set on a sliding scale based on income. Employees making less than $30,000 and between $30,000 and $50,000 will be charged reduced rates.

Seasonal Part-Time employees and Incidental employees will have health care coverage during times of the year in which they are not scheduled to work. Since they have no earnings during non-scheduled times, their bi-weekly employee premium for health care goes into arrears. Upon returning to work and earnings to deduct from, the arrears payments will be deducted from employees' pay checks until the arrears have been satisfied.

Below are the Premium rates that will be paid for active employee coverage that are locked in for the term of the contract.

2014

	Bi-Weekly Contribution Non-Smoker				Bi-Weekly Contribution Smoker			
2014 Net Medical Contributions	**Employee**	**EE+Spouse**	**EE+Children**	**EE+Family**	**Employee**	**EE+Spouse**	**EE+Children**	**EE+Family**
PPO								
Less than $30,000	$19.44	$37.12	$35.67	$59.06	$36.99	$72.21	$66.39	$111.71
$30,000 but less than $50,000	$21.66	$40.23	$38.73	$63.70	$39.21	$75.32	$69.45	$116.35
$50,000 but less than $70,000	$23.88	$43.34	$41.80	$68.34	$41.43	$78.43	$72.52	$120.99
$70,000 but less than $100,000	$26.10	$46.45	$44.86	$72.97	$43.65	$81.54	$75.58	$125.62
HDHP								
Less than $30,000	$6.12	$14.51	$13.37	$24.55	$17.47	$41.54	$37.07	$65.18
$30,000 but less than $50,000	$7.67	$16.95	$15.77	$28.19	$21.22	$43.98	$39.47	$68.82
$50,000 but less than $70,000	$9.41	$19.49	$18.18	$31.83	$22.96	$46.42	$41.88	$72.46
$70,000 but less than $100,000	$11.15	$21.83	$20.58	$35.46	$24.70	$48.86	$44.28	$76.09
CDHP								
Less than $30,000	$5.92	$14.51	$13.37	$24.55	$21.41	$45.49	$40.48	$71.02
$30,000 but less than $50,000	$7.67	$16.95	$15.77	$28.19	$23.16	$47.93	$42.88	$74.66
$50,000 but less than $70,000	$9.41	$19.39	$18.18	$31.83	$24.90	$50.37	$45.29	$78.30
$70,000 but less than $100,000	$11.15	$21.83	$20.58	$35.46	$26.61	$52.81	$47.69	$81.93

2015

	Bi-Weekly Contribution Non-Smoker				Bi-Weekly Contribution Smoker			
2015 Net Medical Contributions	**Employee**	**EE+Spouse**	**EE+Children**	**EE+Family**	**Employee**	**EE+Spouse**	**EE+Children**	**EE+Family**
PPO								
Less than $30,000	$21.24	$50.04	$46.62	$84.78	$38.79	$85.13	$77.34	$137.43
$30,000 but less than $50,000	$26.48	$57.37	$53.84	$95.71	$44.03	$92.46	$84.56	$148.36
$50,000 but less than $70,000	$31.71	$64.70	$61.05	$106.64	$49.26	$99.79	$91.77	$159.29
$70,000 but less than $100,000	$36.95	$72.02	$68.28	$117.57	$54.50	$107.11	$99.00	$170.22
HDHP								
Less than $30,000	$10.45	$29.52	$26.83	$51.99	$24.00	$56.55	$50.53	$92.62
$30,000 but less than $50,000	$14.56	$35.27	$32.50	$60.57	$28.11	$62.30	$56.20	$101.20
$50,000 but less than $70,000	$18.66	$41.02	$38.16	$69.14	$32.21	$68.05	$61.86	$109.77
$70,000 but less than $100,000	$22.77	$46.76	$43.83	$77.72	$36.32	$73.79	$67.53	$118.35
CDHP								
Less than $30,000	$10.45	$29.52	$26.83	$51.99	$25.94	$60.50	$53.94	$98.46
$30,000 but less than $50,000	$14.56	$35.27	$32.50	$60.57	$30.05	$66.25	$59.61	$107.04
$50,000 but less than $70,000	$18.66	$41.02	$38.16	$69.14	$34.15	$72.00	$65.27	$115.61
$70,000 but less than $100,000	$22.77	$46.76	$43.83	$77.72	$38.26	$77.74	$70.94	$124.19

2016

	Bi-Weekly Contribution Non-Smoker				Bi-Weekly Contribution Smoker			
2016 Net Medical Contributions	Employee	EE+Spouse	EE+Children	EE+Family	Employee	EE+Spouse	EE+Children	EE+Family
PPO								
Less than $30,000	$24.70	$67.98	$62.11	$119.52	$41.58	$101.72	$91.65	$170.15
$30,000 but less than $50,000	$33.69	$80.57	$74.51	$138.30	$50.57	$114.31	$104.05	$188.93
$50,000 but less than $70,000	$42.68	$93.16	$86.91	$157.08	$59.55	$126.90	$116.45	$207.71
$70,000 but less than $100,000	$51.68	$105.75	$99.32	$175.85	$68.55	$139.49	$128.86	$226.48
HDHP								
Less than $30,000	$16.27	$48.46	$43.86	$86.51	$29.30	$74.45	$66.65	$125.58
$30,000 but less than $50,000	$23.33	$58.34	$53.59	$101.25	$36.36	$84.34	$76.38	$140.31
$50,000 but less than $70,000	$30.38	$68.23	$63.31	$115.98	$43.41	$94.22	$86.10	$155.05
$70,000 but less than $100,000	$37.44	$78.10	$73.05	$130.71	$50.47	$104.09	$95.84	$169.78
CDHP								
Less than $30,000	$16.27	$48.46	$43.86	$86.51	$31.16	$78.25	$69.93	$131.20
$30,000 but less than $50,000	$23.33	$58.34	$53.59	$101.25	$38.22	$88.13	$79.66	$145.93
$50,000 but less than $70,000	$30.38	$68.23	$63.31	$115.98	$45.28	$98.02	$89.38	$160.66
$70,000 but less than $100,000	$37.44	$78.10	$73.05	$130.71	$52.33	$107.88	$99.12	$175.39

2017

	Bi-Weekly Contribution Non-Smoker				Bi-Weekly Contribution Smoker			
2017 Net Medical Contributions	Employee	EE+Spouse	EE+Children	EE+Family	Employee	EE+Spouse	EE+Children	EE+Family
PPO								
Less than $30,000	$29.09	$88.79	$80.19	$159.40	$45.26	$121.11	$108.49	$207.91
$30,000 but less than $50,000	$42.27	$107.24	$98.35	$186.92	$58.43	$139.56	$126.65	$235.42
$50,000 but less than $70,000	$55.44	$125.69	$116.52	$214.44	$71.61	$158.01	$144.82	$262.94
$70,000 but less than $100,000	$68.63	$144.13	$134.70	$241.94	$84.79	$176.45	$163.00	$290.44
HDHP								
Less than $30,000	$22.83	$69.66	$62.91	$125.07	$35.31	$94.56	$84.75	$162.50
$30,000 but less than $50,000	$33.16	$84.14	$77.17	$146.66	$45.64	$109.04	$99.00	$184.09
$50,000 but less than $70,000	$43.50	$98.61	$91.42	$168.25	$55.98	$123.52	$113.26	$205.68
$70,000 but less than $100,000	$53.84	$113.08	$105.69	$189.83	$66.33	$137.98	$127.52	$227.26
CDHP								
Less than $30,000	$25.68	$78.38	$70.78	$140.70	$39.95	$106.92	$95.75	$183.51
$30,000 but less than $50,000	$37.31	$94.65	$86.81	$164.99	$51.58	$123.19	$111.79	$207.80
$50,000 but less than $70,000	$48.94	$110.93	$102.85	$189.28	$63.21	$139.47	$127.82	$232.09
$70,000 but less than $100,000	$60.57	$127.22	$118.90	$213.55	$74.84	$155.76	$143.87	$256.36

Spousal Surcharge

Active employees whose spouse earns more than $30,000.00 per year and works for an employer other than CenturyLink and who has access to a qualified group plan where they work, will be required to pay a working spouse surcharge of $100.00 per month if they chose to have their spouse or domestic partner covered under the Company Healthcare Plans.

Employees will not have to pay a spousal surcharge if:

1. The employee earns $30,000 or less per year.
2. Employees who earn more than $30,000 per year if his/her spouse or domestic partner does not have access to an employer-sponsored health plan that meets ACA affordability and minimum value standards (a "qualified plan").

3. If the employee's spouse or domestic partner works for CenturyLink.

Retirees will not be charged a working spouse surcharge for coverage under the Plan even if their spouse or domestic partner has access to a qualified Plan.

A "Qualified Plan" is a group health plan and does not include a private plan, a military plan or a government plan. It must comply with the Affordable Care Act which means the spouse or domestic partner's premium contribution can be no greater than 9.5% of the spouse or domestic partners W2 wages and the plan must cover at least sixty percent (60%) of health care costs.

No Network Areas

No Network areas are referred to "Virtual Networks" and are designed to provide members with benefits in areas where there are no network providers. In areas without Network Providers the member may have to pay for services up front and be reimbursed. After paying the required co-pay, deductible, your co-insurance pay for 80% of covered expenses.

Waiver of Healthcare Coverage Rebate

Active employees may elect to waive medical coverage (including prescription drug coverage) under CenturyLink and receive an annual waive medical rebate of $750.00 paid evenly over 26 pay periods. ($28.85 per pay period)

To waive coverage and receive the rebate you must complete the enrollment process and make an affirmative election to waive medical coverage during the enrollment period. You will NOT be eligible for the rebate if you are covered under another CenturyLink employee or retiree's medical record as a covered dependent.

There is no rebate if the employee waives Dental and Vision coverage. Employees can waive healthcare coverage and still participate in either the Dental Plan and/or the Vision Plans and pay the premium(s). Employees cannot have the Company apply the healthcare rebate in lieu of the premium(s) for Denatl and/or Vision coverage.

Coordinating Medical Claims

If you have coverage under more than one group health plan in addition to your CenturyLInkl Plan, the CenturyLink Plan, together with payments from any other group health plans, will never pay more than what you would have received if your CenturyLink coverage was your only health plan.

If the CenturyLink Plan is your primary (the first to pay), benefits will be paid as if no other health plan exists.

If the CenturyLInk Plan is secondary (the second to pay), benefits will be reduced by the benefits paid by the primary plan. Benefits from your CenturyLink Plan will be used to the extent that,

when benefits from both plans are added together , the total is not more than what the CenturyLink Plan would have paid if you had no other coverage from another health group plan.

CDHP FAQs

Q. Can I choose to have claims paid from my Healthcare FSA first rather than my HRA?

A. All eligible claims are paid first form the HRA (medical and prescription expenses only) If there are out of pocket costs for you, the claim will be submitted to your FSA and you will be reimbursed. You do not have the option to change the order of claims payments. If a claim is eligible medial/prescription expense, it falls under the medical plan and would be paid from the HRA.

Q. When I exceed my $2,000 HRA balance (family coverage) in the CDHP, how does the plan work?

A. You will receive an annual HRA allocation based on the coverage level you elect (employee only, employee + spouse/domestic partner, employee + child (ren) or family). A $2,000 allocation is provided to employees who enroll in the CDHP plan and elect family coverage. All eligible expenses (up to the allowable amount) are paid from the HRA first. The deductible under the CDHP is equal to your HRA allocation plus your member responsibility. For you family coverage, your network deductible is equal to $3,000 ($2,000 HRA and $1,000 Member Responsibility) Once the HRA is exhausted, the participant is responsible for the next $1000 at the full cost. If you contributed to an FSA you may use those dollars to cover that $1,000.

Once you have net the total amount you are responsible for 20% of the cost of services until you have met you out of pocket maximum.

Q. What happens to any leftover HRA dollars at the end of any calendar year?

A. Any money left in the HRA at the end of the plan year rollover to the next year provided you enroll in the CDHP the following year.

Q. Are prescription costs included in my deductible and out of pocket maximum?

A. Yes. Prescription expenses apply toward the deductible and out of pocket maximum just like any other medical expense under CDHP.

Q. Once I reach my out of pocket maximum does the plan pay for 100% of eligible expenses?

A. Yes. The plan will pay 100% of eligible expenses in-network or what is deemed reasonable and customary out of network once the participant has met the out of pocket maximum.

Q. What is reasonable and customary?

A. Reasonable and Customary (R & C) is the average fee being charged in a geographic area for a particular service. Any charge above the R & C amount are not covered by the plan and do not apply to the deductible or out of pocket maximum.

However if you are enrolled in a Flexible Spending Account, that account can be used to pay any amount above the R & C.

Prescription Drug FAQ's

Q. What is a Prescription Drug List (PDL)?

A. A PDL is a list that places commonly prescribed medications for certain conditions into Tiers. Some medications on the PDL may not be covered under the plan.

Q. What are Tiers?

A. Prescription Drugs Tiers are price categories. There are normally 3 or 4 tiers. Medications in tier 1 are the lowest cost. Tier 2 and 3 have a minimum and maximum cost based on a percentage of the cost.

Q. When do medications change tiers?

A. Determination for Drugs to change Tiers happens twice a year, normally in January and July. The medication may also change Tiers when a brand named drug becomes generic. The generic is evaluated and may move into a different tier at the time of evaluation.

Q. If the medication I am taking changes tiers will I be notified?

A. Yes. Normally you will receive notification that your drug is changing from one tier to another.

Q. What is the mandatory mail order prescription plan?

A. The Prescription Drug Plan requires that anyone on a maintenance prescription to use the mail order program. The plan does provide for 2 retail prescription fills before there is a penalty for not using mail order. Mail order will provide a 90 day supply while retail will only provide a 30 day supply.

Dental Benefits are the passive PPO Network (%'s, services, etc.) the same as the PPO Network

Basic Option		**Enhanced Option**
Passive PPO Network	**PPO Network**	**Out-of-Network**
Annual Benefit Maximum	$1,000/person (does not include oral	$2,000/person (does not include oral surgery or orthodontia)

	surgery)		
Annual Deductible	$25/person for General Care and Major and Restorative; no deductible for Diagnostic, Preventive or Oral Surgery	$50/person for General Care and Major and Restorative (does not include Orthodontia); no deductible for Diagnostic, Preventive or Oral Surgery	
Diagnostic and Preventive (cleanings, exams & X-rays)	Plan pays 100% up to maximum allowable amount	Plan pays 100% up to reasonable and customary (R&C); two visits per year	
General Care (fillings, root canals and periodontics)	Plan pays 50% up to maximum allowable amount	Plan pays 80% up to maximum allowable amount	Plan pays 80% up to reasonable and customary (R&C)
Major and Restorative (crowns, dentures and bridges)	Plan pays 50% up to maximum allowable amount	Plan pays 50% up to reasonable and customary (R&C)	
Oral Surgery	80%, no deductible or limit	80%, no deductible or limit	
Orthodontia **(Adult and child(ren))**	Not covered	Plan pays 50% up to reasonable and customary (R&C) after $50 lifetime orthodontia deductible (separate from annual deductible)	
Orthodontia Lifetime Benefit Maximum	N/A	$1,500 (separate from annual individual benefit maximum)	
Administrator	MetLife — Group Number: 305522, Phone Number: **888-356-4191**		

Dental benefits are based on MetLife's maximum allowable amount. MetLife's maximum allowed payment is determined by the lesser of:

- the participating dentist's submitted fee; or
- the MetLife participating dentist maximum fee as set by provider contracts.

Participating dentists base their fees on pre-negotiated contracts with the network.
Reimbursement from non-participating dentists is based, in part, on the average fee submitted by participating dentists. Benefits are limited based on what MetLife determines to be Reasonable and Customary charges.
If you use a dentist participating in the PPO or Network, you will not be billed for the remaining balance over the maximum allowable amount

Vision Benefits

Service	VSP Doctor and Affiliate Providers	Open Access Provider
Eye Exams (once every plan year)	Plan pays 100% after $20 copayment	VSP reimburses you (after $20 copayment) up to a maximum of $45
Lenses: **Single Vision** **Lined Bifocals** **Lined Trifocals** **Lenticular (one every plan year)**	Pays 100% after $40 copayment1 (Includes polycarbonate lenses for child(ren) under the age of 19)	VSP reimburses you (after $40 copayment) up to: $45 $65 $85 $125 (Does not include polycarbonate lenses for child(ren))
Lens Options	Member pricing on any non-covered lens options (i.e., progressive lenses, high-index lenses, etc.)	No discounts available
Frames (one pair every other plan year)	Plan pays 100% of VSP allowable amount up to $130 after $40 copayment;1 you will receive a 20% discount on the charges over the VSP allowable amount.3	VSP reimburses you (after $40 copayment) up to a maximum of $47
Contacts (contact lenses may be chosen once every plan year instead of eyeglass frames and lenses)	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.	VSP reimburses you up to $105 for contact lens exam (fitting and evaluation) and contacts
Laser Eye Surgery2	Discounted rates available. The VSP doctor will coordinate referrals for qualified candidates to participating VSP Laser Surgery Centers. The maximum you will pay is: PRK: up to $1,500 per eye LASIK: up to $1,800 per eye Custom LASIK: up to $2,300 per eye (using wavefront technology only — other technologies not covered under Custom LASIK)	No discounts available
Administrator	Vision Service Plan (VSP) Group Number: 30016605, Phone Number: **800-877-7195**	

Flexible Spending Accounts (FSA)

Summary of each account type.

Traditional Health Care FSA	Limited Purpose Health Care FSA For HDHP Plan Participants Only!	Dependent Day Care FSA
Use money you contribute in this account to reimburse a range of eligible out-of-pocket health care expenses not covered by a medical, prescription drug, dental or vision care plan, including deductibles, copayments, coinsurance and over-the-counter medications (with a prescription).	Use money you contribute in this account to reimburse ONLY eligible out-of-pocket dental and vision care expenses not covered by other plans, including deductibles, copayments and coinsurance (excludes Medicare).	Use money you contribute in this account to reimburse eligible out-of-pocket day care expenses for the care of… child(ren) under age 13 who live with you; an incapacitated spouse; or a dependent parent so that you (and your spouse, if you are married) can work or attend school full-time.
You may contribute between $150 and $2,500 a year in this account.	You may contribute between $150 and $2,500 a year in this account.	You may contribute between $150 and $5,000 a year per family in this account.
You make contributions during the calendar year and may use them to reimburse expenses incurred from January 1, 2014 to March 15, 2015. To use HRA carry over money you must first use current year FSA first	You make contributions during the calendar year and may use them to reimburse expenses incurred from January 1, 2014 to March 15, 2015	You make contributions during the calendar year and may use them to reimburse expenses incurred from January 1, 2014 to March 15, 2015.

Life Insurance

Plan	Benefit
Employee Basic Life Insurance Provides benefits in the event of your death	1x eligible pay (Base Pay + Target Incentive Pay) rounded up to the next higher $1,000 up to $2,000,000 maximum. See **Know About Imputed Income** later in this Guide if your Basic Life benefit is over $50,000.

Employee Supplemental Life Insurance Provides benefits in addition to Basic Life Insurance in the event of your death	1x, 2x, 3x, 4x, 5x, 6x, 7x or 8x base pay rounded up to the next higher $1,000 up to $2,000,000 maximum **Statement of Health/Evidence of Insurability (EOI) is required if:** You are not enrolled currently and elect any coverage option; You are currently enrolled and increase your coverage more than one tier (for example, increasing coverage from 4x to 5x base pay); or You increase your coverage to any amount above 2x eligible pay.
Employee Basic Accidental Death & Dismemberment Insurance (AD&D) Provides benefits in addition to Employee Basic Life Insurance if death is due to a covered accident. Pays partial benefits for accidents resulting in paralysis or loss of a limb(s), eyesight, speech or hearing that occur within 365 days of a covered injury.	1x eligible pay (Base Pay + Target Incentive Pay) rounded up to the next higher $1,000 up to $2,000,000 maximum
Employee Supplemental Accidental Death & Dismemberment Insurance (AD&D) Provides benefits in addition to Employee Basic AD&D Insurance if death is due to a covered accident. Pays partial benefits for accidents resulting in paralysis or loss of a limb(s), eyesight, speech or hearing that occur within 365 days of a covered injury.	1x, 2x, 3x, 4x, 5x, 6x, 7x or 8x eligible pay (Base Pay + Target Incentive Pay) rounded up to next higher $1,000 up to $2,000,000 maximum
Business Travel Accident Provides benefits for accidental loss of life or limb, or for permanent paralysis when traveling on Company business or during the relocation process.	3x eligible pay (Base Pay + Target Incentive Pay) rounded up to next higher $1,000 up to $500,000 maximum
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