

TO: Legacy T Presidents with Members in AT&T

FROM: Ralph Maly, Vice President, C&T

SUBJECT: Health Care for Current Retirees

Every bargaining team at each of the tables made a request to bargain for not only future retirees, but also current retirees. AT&T was very consistent with their response. While they were willing to bargain for future retirees (a mandatory subject of bargaining) they were unwilling to bargain for current retirees (a permissive subject of bargaining). After several months of bargaining it became apparent that AT&T was not going to modify their position on bargaining for current retirees.

We were informed in early June that AT&T wanted to modify the health care plans offered to current retirees so they would save ten percent of their OPEB (Other Post Employee Benefit) liability, a sum that totaled approximately two billion dollars. AT&T informed us that while they were unwilling to negotiate with us on the new plan designs they would allow us to have input and make suggestions that we thought would provide better options for the retirees. Their initial plan designs met the savings criteria established by them.

Through the course of the discussions that ensued we made many suggestions. Some led to changes and some did not. One of our major goals was to ensure that every current retiree (both pre and post 65 Medicare eligible retirees) had access to a no premium plan design option. That goal was achieved. The new cap amount will be \$12,500 per retiree per year. The caps will only apply for pre-65 retirees. The 2010 **projected** average blended cost for all regions including Legacy T is \$12779. If the projected number is correct, the first year's premium for one of the pre-65 options will be as follows. The numbers going across will be single, single plus one and single plus two or more.

| | | | |
|------|---------|---------|---|
| 2010 | \$13.46 | \$24.86 | \$34.86 <u>(THESE ARE ESTIMATES)</u> |
|------|---------|---------|---|

Each year the premiums would be adjusted based on the total dollar amount over the cap of \$12,500. Retirees will be informed of the premium amount when they receive their open enrollment package each year.

AT&T will be notifying retirees, both grandfathered and non-grandfathered, by letter. The letter contains a commitment that these will be the plan benefits for the years 2010-2012 unless changes in the law dictate change. CWA is also getting a written commitment. Grandfathered retirees will not be impacted by any of the changes. Grandfathered retirees are those that retired before 3/1/1990.

Attached is a chart that specifies the benefit options for your current retirees and a question and answer document.

These will be the plan designs that are offered to **CURRENT** retirees. These plan designs will not change since AT&T will not negotiate over the provisions. AT&T will bargain over **FUTURE** retirees.

In the Midwest and West agreements the CWA committee did bargain the creation and funding of Health Care Reimbursement accounts for current retirees. The accounts will receive funding dollars in year one and year two of the contract. The total amount over two years equals \$1000 for singles and \$2000 for families. Health Care Reimbursement Accounts are non-taxable, gain interest and the dollars can roll over between calendar years.

Your bargaining team will also have the option of negotiating offsets for the current retirees.

Questions on Health Care for Current Retirees

1. Will every retiree have a no premium option?

Yes, every retiree – pre 65 and post 65 -- will have a no premium option. For post 65 retirees, retirees will continue with the current plan with changes in the drug plan or they can take a new option. For pre-65 retirees, there is an option of a no premium plan which has deductibles and 10% coinsurance. For the current plan, the cap will apply and a premium will be announced annually. These are the basic plans. There will be regional variation on HMOs.

2. Will I have a choice of plans?

Yes, you will be able to select the ATT offered plan that best meets your needs.

3. Will Grandfathered employees lose their protections?

No grandfathered employees continue with their protections through this agreement. The cut off dates for the each of the grandfathered groups is for those who retired before:

| | |
|----------|----------|
| Legacy T | 3/1/1990 |
|----------|----------|

4. Where will there be HMO options and how will they be costed?

There will likely be a variety of HMOs offered for retirees. HMOs typically bid separately for retirees versus actives. The plan design would not be negotiated, but would be what the HMO offers.

The cost of the HMO will be compared to the least expensive of the plan options separately for pre-65 and post 65 retirees. This is the same process as done today. There would be an overlap for the Option 2 plan which is available to both pre and post 65 employees.

Each of the plans driven by underlying plan rules negotiated by the District or C&T will drive different costs. The result could be for example that an HMO that is offered in Kansas City, MO where we have both Legacy T and Southwest members would have different contributions or one could be free and one would require a contribution.

5. For those plans that have specific provisions for Wellness (typically) no co-pays; how are those provisions applied if the retirees has a plan design that includes deductibles and co-insurance?

Wellness will be covered 100% if a network provider is utilized. That will apply regardless if your plan design uses co-pays or whether you have deductibles and co-insurance. The cost to the plan participant will be zero.

DRUGS

6. Are the RX deductibles per person?

The RX deductibles are for whoever you are insuring. For the \$50 deductible in the current plan, it is \$50 for each individual. For the deductibles that start at \$75.00 in 2010 and escalate over the life of the agreement, it is the same amount whether you are single or whether you are covering one or more dependents.

7. Do all RX co-pays for the three categories of drugs, both mail and retail apply towards the OOP max?

No, Non-Formulary drugs, both retail and mail do not apply to the Rx OOP max. This is consistent with the current plan rules for every agreement except Legacy T and Southeast.

8. Is there any coordination of benefits that comes into play for medicare eligible retirees on Rx benefits?

No

9. The Rx co-pays in option 1 have potential maximum amounts? Is there any intent to modify the co-pays, if so how will that be calculated and how often?

The co-pays would increase annually based on the cost for each of the six categories of drugs. The total costs would be compared to the prior 12 months similar to the example laid out in question ten on average costs for medical. The cost would then be trended forward and then used to calculate the change.

10. How does coordination of benefits with Medicare work for the medical benefits for both Option 2 (deductibles and co-insurance) and Option 3 (co-pays)?

Since Medicare is primary, and AT&T secondary most providers are not going to require a co-pay at the time of the appointment or admission to the hospital or emergency room. What would typically happen is that the co-pay would be applied on the backend and the retiree would be billed. Sometimes the provider is willing to accept the Medicare payment as total payment and in that case the retiree would have no out of pocket expenses.

Option 3 Scenario One: Retiree has an office visit. The cost is \$100. Medicare typically covers medical at 80-20. When the claim is filed, Medicare would pay \$80.00, and when the claim is filed with AT&T they would reduce the \$100 claim with the \$30.00 co-pay. Before Medicare COB, the AT&T plan would be able to pay \$70 and the retiree would be responsible for the remaining balance of \$30.00. Since Medicare's payment is greater than the benefit available under the AT&T plan for these services, no benefit is payable from the AT&T plan. After Medicare and COB the retiree pays \$20 balance. Assumes nothing has been applied toward OOP max.

Option 3 Scenario Two: Retiree is getting diagnostic X-Ray and Lab tests Out-Patient hospital. The cost is \$5000.00.

Claim is submitted to Medicare. Assuming all deductibles for Medicare have been met, Medicare would pay 80% of the \$5,000 or \$4,000. The claim is then submitted to AT&T's third party administrator. AT&T would look at the entire claim before Medicare payment and apply the terms of the plan. So, assuming this retiree is a Southwest Region retiree and assuming the Medicare deductible has been met, AT&T would consider the Out-Patient hospital allowable amount of \$5,000 at 100%. The administrator would reduce the AT&T plan benefit of \$5,000 by the amount paid by Medicare (\$4,000), yielding a payment of \$1,000 from the AT&T retiree plan.

Option 2 Scenario 1: Retiree has an office visit. The cost is \$300.00.

Again, assuming the Medicare deductible has been met, the \$300 office visit would be paid by Medicare at 80% or \$240. The AT&T plan would look at the total claim of \$300.00 and apply the deductible of \$400.00 and would pay \$0. If the retiree had met their deductible, the \$300 claim would be adjudicated at 90%, yielding a net amount of \$270. Subtracting what Medicare paid of \$240 yields a final payment of \$30 from the plan and the balance of \$30 to be paid by the retiree.

Option 2 Scenario 2: Retiree is admitted to the hospital. The cost is \$10,000. The \$10,000 amount is covered by Medicare at 100% after the Part A deductible (\$1,068 for 2009) or \$8,932. AT&T plan would apply the \$400 deductible to the total claim of \$10,000 leaving \$9,600. 10% coinsurance is applied leaving a balance from the plan of \$8,640. Subtract what Medicare pays from the amount payable by the AT&T plan and the net result is no benefit, since Medicare's benefit is in excess of the benefit from the AT&T plan. The retiree pays the difference between \$10,000 and the Medicare benefit of \$8,932 which equals \$1,068.

Option 2 Scenario 3: Retiree is admitted to the hospital.

The cost of the stay is \$100,000. Medicare would pay 100% after the Part A deductible (\$1,068 for 2009) or \$98,932. The AT&T plan would adjudicate the claim prior to Medicare COB applying, and, assuming the AT&T deductible was

already satisfied would produce a benefit of \$99,000 since the OOP Max would now be satisfied. Subtracting what Medicare pays (\$98,932) from the AT&T plan benefit of \$99,000 would result in a net benefit of \$68 from the plan, and the retiree would pay \$1,000.

POST 65

11. What happens when a retiree reaches age 65 in the middle of the year? Do they change at that time to the post 65 plan and do they get a choice?

Turning 65 is considered a change in status event. They will receive a new packet prior to their birth date and they will be allowed to make a new choice.

12. Is Option 2 a viable option for post 65 retirees?

Option 2 is a real option especially for a retiree that has the potential for catastrophic medical expenses. See Option 2, Scenario 3 in question 10.

13. Please provide some more detailed information on the calculation of the average cost and how the yearly cost will be calculated.

The retiree average cost is calculated by adding up the total medical claims, medical premiums and administrative costs for all plan participants in the population that the cap is being applied to using data from July-June. This total cost is divided by the average monthly retiree count for that same period.

This total cost is compared to the previous July-June period and that number is used to calculate the percentage increase. The trend amount is capped at 5%. The next step is to trend the amount forward to capture the remaining eighteen months. That new trended percentage is used to establish the next year's cost. The cap of \$12,500 is then subtracted from the number to get the amount over the cap.

Scenario 1: (This numbers are only for illustrative purposes. Only the cap is a real number). The total cost in the July-June period of 07-08 using the methodology above is \$1.2 billion. During that same period there was a monthly average of 100,000 retirees. The total average cost per retiree is \$12,000.

The total cost in July- June of 08-09 is \$1.5 billion and there was a monthly average of 120,000 retirees. The total average cost per retiree is \$12,500.

The annual difference is \$500 or an increase of approximately 4%. That trend is under the cap of 5%. The next step is to trend the increase forward by changing it from a twelve month trend to an eighteen month to capture the last 6 months of

2009. That calculation is \$12,500 (total cost per retiree for July-June 08-09) and multiplying by the trend forward of 6% for a projected cost for 2010 of \$13,250.

The difference would be figured by subtracting the actual costs from the cap amount \$12,500 (the cap) from \$13,250 for a total of \$750.00.

14. Is the trend rate specific to the calculation of the average cost capped at 5% for 2010, 2011 and 2012?

Yes, the trend is capped at 5% for the average retiree cost that is compared to the cap. For example if the trend is 3%, then that would be what would be used. If the trend increased 8% only 5% of the increase would be applied. See Question 10 above for more detail on how the trend is used in determining the average retiree cost for cap purposes.

15. How is the amount above the cap divided between single and Family?

The percentage that the projected average retiree cost exceeds the cap is applied to the premium equivalent for each tier to develop the contributions associated with the tiers.

Continuing with the example from Question 10, the difference of \$750 is divided by the projected average retiree cost of \$13,250, resulting in a percentage of about 6%. This percentage is then applied to the premium equivalent for each tier to develop the contributions associated with the tiers.

16. What additional factors other than the elimination of the costs for the post-65 retirees impacted the change in the change to the cap from \$9000 to \$12800?

The other factor was the removal of the costs associated with the grandfathered retirees along with the post-65 retirees. The average cost per retiree was then calculated using the methodology outlined in question ten and assuming a 5% trend. The blended cost for all regions was \$12,759. That number was rounded up to \$12,800. The assumption with this cap was that each of the regions and their costs would be bounced against the cap. The forecasted average costs for 2010 for each region are as follows:

| | |
|-----------|----------|
| Southwest | \$14,409 |
| East | \$10,456 |
| West | \$12,560 |
| Midwest | \$12,975 |
| Southeast | \$12,466 |
| Legacy T | \$11,743 |
| Combined | \$12,759 |

17. Why is the cap \$12,500 and not \$12,759

The Management insisted that there be a premium paid for the current plan option. Once Management responded to our request to average the cost of health care for all units, the cap was set at \$12,500 to force a first year premium.

Legacy AT&T

Current Retiree Plan Designs

| | 1 | 2 | 3 |
|---------------------------|------------------------------------|--|------------------------------------|
| | Pre-Medicare Eligible | | Post-Medicare Eligible |
| | Legacy T Plan w/ Blended Cap | Regional Medical Plan (as amended) | Legacy T Plan |
| Medical Components | | | |
| Monthly Contributions | See Note | None | None |
| Deductibles (Network) | None | \$400/\$800 | \$200/\$400/\$600 |
| Coinsurance | None | 10%/50% | None |
| OOP Max (Network) | \$1,000/\$2,000/\$3,000 | \$1,000/\$3,000 | \$1,000/\$2,000/\$3,000 |
| OOP Max Type | N/A | Individual Basis | Individual Basis |
| Copays | | | |
| Office Visits | \$20 | None | 20% |
| Hospital ER | \$75 | None | No Copay/Coins |
| Hospital Admission | \$200 | None | No Copay/Coins |
| Rx Components | | | |
| Contributions | | | |
| | None | None | None |
| | | 2010 - \$75 | 2010 - \$75 |
| | \$50 (retail) per Ind. | 2011 - \$125 | 2011 - \$125 |
| | | 2012 - \$175 | 2012 - \$175 |
| Deductibles | | | |
| | None | None | None |
| | \$1,500/\$3,000 | \$1,500/\$3,000 | \$1,500/\$3000 |
| | (applies to Generic and Formulary) | (applies to Generic and Formulary) | (applies to Generic and Formulary) |
| OOP Max (Network) | | | |
| | Individual Basis | Individual Basis | Individual Basis |
| OOP Max Type | | | |
| | 2010 Actual (Max) | 2010 2011 2012 | 2010 2011 2012 |
| | Retail Generic | \$8 (\$14) | \$10 \$10 \$11 |
| | Retail Formulary | \$26 (\$28) | \$30 \$30 \$33 |
| | Retail Non-Formulary | \$50 (\$56) | \$50 \$50 \$55 |
| | Mail Generic | \$17 (\$28) | \$20 \$20 \$28 |
| | Mail Formulary | \$54 (\$56) | \$75 \$75 \$83 |
| | Mail Non-Formulary | \$108 (\$112) | \$125 \$125 \$138 |

Notes:

Legacy S Cap Option - cap will apply, monthly contributions will be based on plan performance.

Per Capita Costs will be done on a blended basis and only includes those that are subject to the cap.

Cap will be set at \$12,500

Medical components will be consistent with the current Regional Medical Plans. Each region will remain in their current medical plan.

T Pre-65 information based on POS; Post-65 information based on Indemnity

Rx Provisions outlined are a summary. Intent is that T would come into same Rx program as SW Core.

This includes:

3 tier copay structure of Generic, Formulary, and Nonformulary

Retail Non-Network provision of: Greater of applicable Network Retail copay or balance remaining after Plan pays 75% of Network retail costs, after Ded

Mandatory Mail applies after 2nd fill at Retail

Specialty Pharmacy provisions

Personal Choice drugs covered by plan and available for purchase at 100% of discounted rate

This chart includes a summary of benefit plan design descriptions for discussion purposes.

In all cases, the official documents for the Plan govern and are the final authority of the terms of the Plan. If there are any discrepancies between the information in this document and the Plan, the Plan documents will control.