

2007 Benefit Changes/AT&T

The 2005 bargaining with AT&T revised benefits effective January 1, 2007. Below are examples of revisions for your reference. Complete information can be found in the 2005 Collective Bargaining Agreement and will be provided in the revised Summary Plan Descriptions to be provided by the Company. Coinciding with the negotiated benefit changes the Company has instituted vendor and administration changes.

The Dependent Audit period is ending. The Dependent Audit was to verify the eligibility of dependents covered under the Plan. Correspondence is being mailed to confirm dependent status, request additional information if necessary and dependent denials, including the appeal process.

State Disability and changes in disability administration

AT&T eliminated self insurance in some states and members will be required to file claims with AT&T and the State Disability (SDI) for disability payments. AT&T will offset the amount of pay by the amount SDI pays, starting from the first day of disability, so it will be important for members to file their claims promptly. SDI payments are usually received within two weeks after a properly completed claim is received. The SDI benefits are based upon the state in which you work in. Below is a list of the states and the amounts of pay provided, calculated on a per week basis:

State Disability Weekly Benefits*

California - \$840 per week
Hawaii - \$437 per week
New Jersey - \$488 per week
New York - \$170 per week
Rhode Island - \$607 per week
Puerto Rico - \$113 per week

- Please note the weekly maximums may be updated periodically by each state.

Your SDI benefits are taxable only if you receive Disability Insurance benefits in place of Unemployment Insurance (UI) benefits. In this case, your SDI benefits are considered a substitution for your UI benefits, which are taxable.

Information, including phone numbers and web sites will be provided when a disability claim is called in. Information will also be mailed to the member after the claim is called in, with state specific information included. The AT&T disability guide may be viewed at: <http://intranet.sbc.com/benefits/>

Short Term Disability and Accident administration vendors changed to Sedgwick.

This change includes the elimination of the 050 disability reporting form used previously. AT&T will require medical releases signed (either provided in the mailing of the disability guide or can be signed at your doctor's office). Medical information **must** be received within the first 14 days of a disability or pay will be stopped. This first 14 days of pay without medical information will be referenced as **conditional pay**. Disabilities begin on the 8th calendar day of an illness and previously weren't reported until that day.

Disabilities may be reported prior to the 8th calendar day now, but the first day of disability is still the 8th calendar day and when the 14 days of “conditional pay” starts.

FMLA administration is changing with the elimination of Aon and the rolling calendar year. Effective in January 2007 the calendar year accounting method will be instituted.

Rules governing the change per AT&T: The law requires that an employee have at least 12 months of service and work at least 1250 hours in the 12 months preceding the request for FMLA. As a result of the payroll transition from IPAY to eLink a business decision was made to assume that all employees who had at least 12 months of service prior to the 1/1/07 conversion would have worked the 1250 hours required for FMLA eligibility. This is a one time event. As the year progresses and employees' time is reported in eLink, that time reporting will begin to have an impact on determining FMLA eligibility.

AT&T has details on FMLA at: <https://intra.att.com/fmla/>

Vendor Changes, see attached for complete list of vendor changes. These were consolidations to vendors already in place with SBC.

Continuation of Care

- If a member is assigned to a new carrier while under treatment for a catastrophic or serious illness, applying for the Continuation of Care (Transitional Care) may cover the issue of retaining treatment under their current physician even though that physician is not a participant in the newly assigned network
- A member needing consideration for Continuation of Care must apply through the **new** carrier before the first of the year.

Prescriptions will now be issued by Caremark, effective January 1, 2007. All members should have received a “welcome package” from Caremark this week, with new member ID cards, contact information, mail order forms and the preferred drug list included.

AT&T mailed notifications Medco would no longer bill for mail order medications.

Anyone refilling **must** make payment arrangements before medication will be shipped.

Notification was made via telephone by Medco to members last week that effective January 1, 2007 they would not be handling their prescriptions.

New Medical ID cards should be received before January 1, 2007. BCBS in Georgia is the exception. An administration change has them concerned the cards won't be received prior to January 1, 2007, but they are mailing information to all members this week to use as proof of coverage if they need medical attention before the new cards are received.

Debit Account information was mailed to any retiree paying premiums for supplemental life insurance, OCC or health care coverage. The Company's response: We have identified issues with the OCC billing. Our intent was to bill monthly for OCC for participants that have contributions for other health benefits (i.e. Medical, Dental, Life). And to bill yearly for participants with only OCC contributions. We were unaware that some participants paid their OCC contributions via their pension check. However, there was a problem and all participants with an OCC contribution received a monthly billing statement. We are in the process of correcting the participants that should be monthly and those where the contribution should be deducted from their pension check. Participants will receive notification regarding the issue in early January. We are in the process of resolving the issue so that all the retirees can receive accurate notification and pension deductions and billing statements. During this clean-up no participants will have their coverage dropped.

AT&T Benefits Vendors

Effective 1-1-2007 unless otherwise noted

Benefit Plans

	Current Vendor	New Vendor
Health Benefits		
Eligibility / Enrollment	Convergys/SHPS	Hewitt
Medical	Aetna	Aetna
	BCBS Horizon	BCBS Horizon, BCBS IL, Well Point BCBS GA
	CIGNA	CIGNA
	UHC	UHC
Rx	Medco	Caremark
Flexible Spending Accounts	SHPS	SHPS
MH/CD	UBH	UBH
Employee Assistance Programs	Magellan	ValueOptions
Advocacy and Treatment Education	Consumer's Medical Resource	Consumer's Medical Resource
Third party medical reviews	MCMC	MCMC
Med. Part B reimbursement	Convergys/Acordia	Hewitt/State Street
Adoption	Ceridian	Hewitt
Welfare Benefits		
Dental	Aetna	CIGNA
Vision	Cole	Cole
Life Insurance	MetLife	MetLife
Long Term Care	MetLife	Metlife
Short Term Disability / LTD/Workers' Comp	MetLife	Sedgwick (Workers' Comp changes effective 11-1-06)
Legal Services	Hyatt Legal Svcs.	Hyatt Legal Svcs.
Work and Family	Ceridian	Lifecare
Retirement Benefits		
Pension Recordkeeping	Aon	Aon
Pension Checkwriting	Citibank	Citibank
Savings / SOP's	Fidelity	Fidelity
Survivor Benefits	MetLife	Fidelity
Other		
401(k) Pension-Retiree	Acordia	Acordia

August 16, 2007

744363

Medical Plan Changes effective January 2007

*Previous benefits through December 31, 2006

Healthcare Contributions:

The caps on Company contributions for health coverage under the AT&T Corp. Postretirement Welfare Benefits Plan will be modified from separate amounts based on age and coverage level to a single amount equal to \$9,000 for each Post 3/1/90 Occupational Retiree and Post 3/1/90 LTD beneficiary. In effect, contributions from these participants will only be required when the average cost of the Plan per retiree/LTD beneficiary exceeds \$9,000. Please note: contributions will not be required for the Point of Service and Traditional Indemnity medical options for the period January 1, 2006 through April 4, 2009, even if the average cost of the Plan exceeds \$9,000.

Deductibles:

Point of Service Option:

In-Network: no deductible

Out-of-Network: \$470 Individual; \$940 Two-Person; \$1,410 Family

Previously \$450 Individual; \$900 Family

Co-Payments and Coinsurance Amounts:

Point of Service Option – In Network:

		*Previous
Physicians Office Visit	\$ 20	\$10
Emergency Room (non-admittance)	\$ 75	\$40
Per Hospital Admission	\$200	New

Point of Service Option – Out-of-Network:

		Previous
Emergency Room (non-admittance)	\$ 75	\$40 co-pay
Per Hospital Admission	\$200	\$150

Out-of-Pocket Maximum Amounts (does not include deductibles):

Point of Service Option – In Network:

		Previous
Individual Maximum	\$1,000	\$750 per person
Family Maximum	\$3,000	

Point of Service Option – Out-of-Network:

Individual Maximum	\$2,500
Family Maximum	\$5,000

Lifetime Maximum:

Point of Service Option – Out-of-Network:

		Previous
Lifetime Maximum	\$500,000	\$1 M

Cost Differential Appeal Process:

The Company will establish an appeal process for Plan participants who purchase a prescription at an out-of-network retail pharmacy in an emergency situation when a network retail pharmacy is not available. The appeal process will provide that a Plan participant will be reimbursed for the difference in costs between network and out-of-network retail if it is determined that the Plan participant had no reasonably available alternative when purchasing the prescription and a true emergency existed.

Non-Participating Retail Pharmacy:

For out of network retail prescriptions, the participant will pay the greater of the applicable network retail co-payment or the balance remaining after the plan pays 75% of the network retail cost of the prescription drug.