Annual Enrollment 2011

October 2010
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Getting smarter about your benefits is the first step to getting the most from them.

Start by reviewing this communication, which contains changes, updates and reminders related to your 2011 benefits.

Your annual enrollment period runs from Oct. 4–15. Before then, take the time to read this information carefully and share it with your family so that your choices keep up with your changing needs.

Distributed to active bargained employees of legacy AT&T CWA, associated nonmanagement nonunion employees, LOA or STD recipients, survivors of active employees and COBRA participants

Contents

This document was written to make it easier to read. So, sometimes it uses informal language, like "AT&T employees," instead of precise legal terms. Also, this is only a summary, and your particular situation could be handled differently. More specific details about your benefits, including eligibility rules, are in the summary plan descriptions (SPDs), summaries of material modifications (SMMs) or the plan documents. Except for the changes described in this document, the plan documents always govern, and they are the final authority on the terms of your benefits. AT&T reserves the right to terminate or amend any and all benefits plans, and your participation in the plan is neither a contract nor a guarantee of future employment.

Health Care Reform: What We Know

As a result of the recently passed health care legislation, there are changes to your benefits for 2011. The federal government is still in the process of issuing the regulations and guidance necessary for AT&T to determine all of those changes; however, the following changes are already known:

- You can enroll any eligible dependent for medical coverage and CarePlus coverage (if eligible) up to age 26. (See page 6.)
- You can no longer be reimbursed for nonprescribed over-the-counter drugs from your health care flexible spending account or health reimbursement account. (See page 13.)
- Lifetime limits will be eliminated under the AT&T medical plans.
- Certain annual limits on essential benefits will be lifted.

Watch for additional information later this year.

Online Enrollment

Each year, you have the opportunity to review your benefit options and make enrollment decisions. Most of the information you need is available on the AT&T Benefits Center website.

This communication covers key plan changes effective Jan. 1, 2011, and provides updates and reminders for your benefits annual enrollment.

Your two-week enrollment period begins at 7 a.m. Central on Oct. 4 and ends at 7 p.m. Central on Oct. 15. You will need to log on to the AT&T Benefits Center website and enroll for your 2011 benefits during this time.

Your Enrollment Checklist

Review Recent Materials. In addition to this communication, you should have received a postcard or News Now messages with your enrollment dates and information.

Evaluate Your Options. It is very important that you check your assigned coverage and your available coverage options during your enrollment period because they may have changed. There are also other changes and information you need to know.

Check Your Medical Coverage Status. Depending on your home ZIP code, you will be assigned either point-of-service or traditional indemnity coverage. This distinction can significantly change the cost of your medical coverage.

Elect to Participate in a Flexible Spending Account. A health care flexible spending account (FSA) is a savings tool designed to help you offset the cost of eligible health care expenses for you and your dependents. A dependent care FSA is another savings tool designed to help you offset the cost of daycare or elder-care expenses. You will find more information about these tools on the Your Benefits section of HROneStop.

Review Your SPDs and SMMs. These are the legal documents that contain the full details on your benefits plans and programs, including eligibility requirements. They are located on the AT&T Benefits Center website under Health and Insurance > Overview > Plan Information.

Check Out Enrollment Tools and Resources. AT&T and your benefits administrators partner to provide information, tools and calculators on their websites to help you estimate costs and make informed enrollment decisions.

- **Your Benefits Section of HROneStop | hronestop.att.com**
  This site contains information about the benefits AT&T offers along with links to benefit vendors and other general information.
- **AT&T Benefits Center website | resources.hewitt.com/att**
  When you want to view your personalized health and welfare benefits information, log on to this website. It is your go-to source for benefits enrollment, and features:
  - Health-Plan Comparison Charts
    These help you compare your options during annual enrollment by providing high-level snapshots of coverage and costs.
  - Tools and Calculators
    This section has a variety of resources to help you make your benefits decisions, including links to finding network providers and a medical expense estimator.

Your medical claims administrator is changing to UnitedHealthcare in 2011. This can change your assigned coverage.

See page 7 for more information.

Even if you have an FSA this year, you must enroll again to participate in 2011.

If you have a **change-in-status event** that requires you to make a change to your coverage between now and the end of the year, you will need to go to the AT&T Benefits Center website and make two separate elections. First change your coverage for the rest of 2010. Then update your elections for 2011.

Stay Current on Eligibility

Tip for a Quick Enrollment

When you go online to enroll, **be sure to have the Social Security numbers** of your dependents handy. You'll be prompted to enter them if they are not already on file with the AT&T Benefits Center.

Adding or Removing a Dependent From Coverage

Annual enrollment is your opportunity to enroll your dependents in coverage for next year. Making changes to your dependent coverage is easy. Simply follow the online directions to enroll or remove dependents for 2011.

You Can Enroll Any Eligible Dependent for Medical Coverage Up to Age 26

As a result of the health care legislation that was passed earlier this year, you will be able to enroll eligible dependents in your medical plan (and CarePlus, if eligible) up to the age of 26.

Proof of Eligibility for Dependents

If you add a dependent to coverage, you will be required to provide proof of eligibility. The exception is if you simply add new or different plans for currently enrolled and approved dependents.

Newborn or Newly Adopted Child

New baby on board? Remember to visit the AT&T Benefits Center website within 31 days of birth or placement and enroll the child to ensure coverage beginning on your child's birthday or placement date.

Your child's Social Security number is not needed at the time you enroll. Once you receive this information, contact the AT&T Benefits Center so eligibility information can be updated.

Removing Ineligible Dependents

If your dependent becomes ineligible to participate in a company-sponsored health plan, you are required to remove that person from coverage by notifying the AT&T Benefits Center either online or by phone.

Continuing coverage for an ineligible dependent is considered benefits fraud and can result in disciplinary action up to, and including, dismissal. You also may be responsible for repaying any benefits received by the ineligible dependent. AT&T reserves the right to audit the eligibility of any dependent at any time.

Imputed Income and Legally Recognized Partners and Domestic Partners

The Internal Revenue Code requires AT&T to include the cost of benefits for a legally recognized partner or domestic partner and that partner's children as income to you unless they qualify as tax dependents. Therefore, if you enroll your partner or your partner's children in coverage, income may be imputed to you. This imputed income amount is subject to Medicare and Social Security taxes, as well as federal and state income tax.

Important Changes and Reminders for 2011

New Medical Claims Administrator for 2011

In 2011, UnitedHealthcare (UHC) will be the claims administrator for your company-sponsored medical plan, and the UHC Choice Plus network will be your network if you enroll in the POS option. If however, you are enrolled in the Traditional Indemnity option, the UHC Options PPO network will be your network.

If you plan to enroll in the POS option for 2011, you should go out to myuhc.com/groups/att and click on the Find a Physician. Then follow the instructions to make sure your doctors are in the network. If your providers are not currently in UnitedHealthcare's network, talk to them about joining. They can contact UnitedHealthcare's National Credentialing Center by phone at 877-842-3210. Or by visiting www.unitedhealthcareonline.com, selecting "New User" in the upper right-hand corner and following the prompts.

Transition of Care May Apply to You

If you are enrolled in a non-HMO type coverage option and your claims administrator is changing in 2011, the following transition of care guidelines may apply, so please review them carefully.

If you or a covered family member is undergoing medical treatment and/or planning for surgical services that will continue beyond Dec. 31, 2010, and you enroll in the POS option for 2011, you will need to verify that your treating provider also is a member of the UnitedHealthcare Choice Plus network to receive the highest level of coverage under the plan. If your provider is not in the network, contact UHC at 877-506-7221 to apply for transition of care benefits after you have enrolled.

Check Out The Great Tools on myuhc.com

On **myuhc.com/groups/att** there is a Site Demo link that will walk you through many of the tools and resources that will be available to you beginning in 2011.

You and your provider must complete a transition of care application form and submit it for consideration. Requests must be received by Jan. 31, 2011, to find out whether you meet the criteria for transition of care benefits. Once approved, you will receive written confirmation from the carrier.

Health conditions that qualify for transition of care for the period of Jan. 1 – March 31, 2011, include the following:

- End-stage renal disease (ESRD) and dialysis (applied to the physician or other provider or dialysis center)
- Nonsurgical cancer therapies, including chemotherapy and radiation
- Pregnancy, regardless of trimester, through postpartum follow-up visit
- Symptomatic AIDS
- Transplants (solid organ and bone marrow)
- Conditions where federal law requires transition of care

If your treating provider is not a member of the UnitedHealthcare network and if your application is not approved for transition of care benefits, your claims for 2011 services will be paid at the non-network level of benefits, which will result in higher out-of-pocket expenses.

This article is not intended to address HMO-type medical coverage options. Contact your HMO-type coverage provider for its specific rules related to the use of network providers.

Pay Attention to Your Point-of-Service or Traditional Indemnity Coverage Options

Depending on your home ZIP code, you'll be assigned either point-of-service (POS) or traditional indemnity (TI) coverage.

This is especially important for your 2011 enrollment period because your claims administrator is changing to UnitedHealthcare and your assigned coverage may be different for 2011. You can visit the AT&T Benefits Center website to view your coverage during your enrollment.

Assigned TI Coverage?

If your home ZIP code is outside the network service area, you'll be assigned TI coverage. With TI coverage, you can use any providers (doctors, hospitals, etc.) you wish. You also have the option of enrolling in POS coverage. Participants may choose to do so because some services under POS coverage have lower costs. Before you make the decision to switch, you should:

- Check the network providers listed.
- Find out where they are located.
- Understand that you might need to travel farther to receive care.

If you choose to enroll in POS coverage, you must then always use network providers or risk paying higher costs. If you select POS coverage, you cannot change back to TI coverage during the calendar year unless you experience certain change-in-status events.

Network Providers Can Change During the Year

Although providers may move in or out of the network during the year, you can't change your medical enrollment midyear unless you experience a change-in-status event. The best way to ensure that your doctor is in the network is to check with the provider before you receive service. You also may contact your claims administrator for verification.

HMO-Type Medical Coverage Options

You may be eligible to participate in an HMO-type medical coverage option. HMO-type options are generally offered by home ZIP code, and their availability is subject to change annually. Though you may be currently enrolled in an HMO-type option, there's no guarantee that it will be offered in 2011. If your current option is not offered in 2011, you will be enrolled automatically in the option listed on the Enroll in Your Benefits page, unless you select another available option during annual enrollment.

Also be aware that the level of benefits — as well as the contribution amounts and provider networks — offered by an HMO-type option can change yearly. If you're considering enrolling in an HMO-type option for 2011, you should carefully review the level of coverage the option offers.

QUICK QUIZ:
Preventive or not?

When you visit a health care provider, the services you receive will be considered either preventive or nonpreventive. See if you can determine in the following scenarios whether the care received would be considered preventive or nonpreventive.

SITUATION 1

A woman visits her network doctor for her annual mammogram.

Answer: This is considered preventive care because her visit is part of a routine annual exam and has not been prompted by any sort of previous diagnosis.

SITUATION 2

A woman goes to her network doctor for a mammogram and is asked to return for another one because there were questionable results on the first test.

Answer: The first visit is considered preventive. The follow-up visit is not. The second mammogram and any additional tests would be considered treatment for an existing condition. The woman would be responsible for paying this cost out of pocket if she had not met her annual deductible. If she had already, she would be responsible for paying 10 percent of the eligible charges.

Choosing the Option That's Right for You

To determine which option is best for you, go to the Enroll in Your Benefits page of the AT&T Benefits Center website. Your health plan comparison chart or the Medical Expense Estimator can be found in the Tools and Calculators section. Note the differences in coverage levels and costs when comparing your options.

HMO-Type Medical Coverage and Eligible Dependents

Generally, dependents such as your spouse or child will be eligible for HMO-type options if they are eligible for coverage under your non-HMO-type options. However, certain HMO-type options may require additional information or may not provide coverage for such dependents as legally recognized partners (LRPs), disabled dependents, etc. Call the HMO-type option's service center directly (not the AT&T Benefits Center) to determine if it will allow these types of dependents to be eligible for coverage. Phone numbers are listed on your health plan comparison chart. When you call, have your reference number handy. You can find it in the Group ID field. Also, be sure to tell the service representative that you are an AT&T participant.

Not all coverage details about the 2011 offerings will be listed on your comparison chart. For more information, call the HMO-type option's service center directly (not the AT&T Benefits Center).

Network Preventive Care Services Are Covered at 100 Percent

Eligible preventive care services are covered at 100 percent *as long as you receive care from network providers.* There is no coverage if you receive these services from a non-network provider. (If you have TI coverage, the plan picks up 100 percent of eligible preventive care expenses whether you use network or non-network providers.)

Preventive care services include routine wellness screenings and exams, while nonpreventive services are considered treatment or diagnosis for an existing illness, injury or condition.

Examples of preventive care:

- Annual routine physicals
- Pap smears
- Cholesterol screenings
- Some immunizations
- Mammograms
- Well-baby and well-child care

This isn't a comprehensive list. For more information on what services qualify as preventive care, contact your claims administrator.

There may be limits on how often you can receive preventive care treatments and services. And depending on the situation, services might be considered preventive or nonpreventive. Always consult with your health care provider to clarify the type of service you're receiving. This will help you understand your potential out-of-pocket expenses.

Get Extra Protection With CarePlus

There may be a time when you or your family needs medical treatments that aren't covered by your health plan. CarePlus is there for times like these.

CarePlus is a supplemental medical program that provides financial protection against the high cost of certain forms of medical treatments that are not generally covered by AT&T medical plan options. Enrollment in a separate medical plan is not necessary to sign up for CarePlus, and you'll have the opportunity to enroll in CarePlus during your annual enrollment period. Participation costs are minimal — just $1 per month for individuals and $2 per month for those covering dependents. Services must be preapproved by UnitedHealthcare before you obtain care, except for those services designated not to require preapproval.

Program highlights include:

- 100 percent reimbursement for approved procedures by network providers.
- Coverage for emerging treatments for cancer and other severe, life-threatening diseases.
- Complementary and alternative medicine.

In addition, your CarePlus plan covers:

- Professional air ambulance service coverage of up to $15,000 to transport a patient to the appropriate facility where an approved CarePlus covered procedure is to be performed when it is deemed necessary by the claims administrator.
- Second opinions covered through the e-Cleveland Clinic via the Internet or by phone.

For more information on CarePlus, call UnitedHealthcare at 877-261-3340. Customer service representatives are available from 7 a.m. to 7 p.m. Central time. You can find the same information in your CarePlus SPD and SMMs on the AT&T Benefits Center website.

Check it out

If you sign up for CarePlus, you'll also have access to the eCleveland Clinic, which is part of the Cleveland Clinic, one of the largest health-referral institutions.

The eCleveland Clinic MyConsult program gives you and any eligible dependents access to request a second medical opinion from some of the country's leading medical experts on more than 600 life-threatening and life-altering diagnoses without waiting weeks for an appointment or the expense and hassle of traveling. Cleveland Clinic experts review your medical records and diagnostic tests and render an opinion that includes treatment options or alternatives and recommendations.

For more information about the eCleveland Clinic MyConsult program, visit http//eclevelandclinic.org/att.

Not available in North Dakota or Guam.

Prescription Drug Copayments

Don't forget to look up your prescription drug copayments for 2011 when reviewing your enrollment information.

These can be found on the enrollment website along with your health plan comparison charts (see Tools and Resources section). Prescription drugs range in price depending on the type (generic or a preferred or nonpreferred brand) and where you choose to purchase them (network retail pharmacy, non-network retail pharmacy or mail order program).

Health Reimbursement Accounts

You can use your health reimbursement account (HRA) to reimburse yourself for the monthly contributions you make through payroll deduction to participate in the plan if you elect to make those contributions on an after-tax basis.

If you elect — or are defaulted to — before-tax contributions, you cannot be reimbursed for your monthly contributions.

You will have the opportunity to elect to make those contributions on either a before- or after-tax basis during annual enrollment.

If you were hired or rehired on or before Aug. 8, 2009, you may be eligible for a health reimbursement account (HRA) as long as you enroll in a company-sponsored health plan (non-HMO-type option). You can use the funds available in your account to reimburse yourself for eligible medical, dental and vision services and prescription drug expenses that are not covered by your medical plan.

In late January, you will receive a letter from SHPS, the HRA claims administrator, to let you know that the HRA amount for 2011 has been added to your account (see chart below for amounts) and is available for reimbursement for eligible out-of-pocket expenses. After you've incurred an eligible expense, to reimburse yourself, you'll simply fill out a claim form from the program's administrator (SHPS) and mail it in along with proof of the expense. SHPS will reimburse you via check or direct deposit (your choice). Your enrollment status on Jan. 1, 2011, (individual, family, active or retired) will determine the amount available in your HRA. Your account will be credited as follows:

2011 HRA Amounts

Individual coverage:	$600
Family coverage:	$900

If You Had an HRA in 2010

Any unused funds from 2010 will carry over to 2011 for your use, regardless of whether you continue to participate in your company-sponsored health plan (non-HMO-type option).

If you are eligible for 2011 HRA funds, they will be added to your existing account balance. if you don't enroll in your company-sponsored health plan (non HMO-type option) for 2011, you will not be eligible for the 2011 HRA funds.

To be reimbursed for any eligible expenses incurred during 2010, you must file claims by March 31, 2011.

Over-the-Counter Drugs No Longer Covered Under Health Reimbursement Accounts and Flexible Spending Accounts

New Restrictions for 2011

As a result of the recent federal health care legislation, over-the-counter drugs will no longer be eligible for reimbursement starting in 2011 unless you have a prescription. This includes medications such as cold and flu medicine, pain relievers and allergy drugs.

Remember to Consider Your Expenses Carefully

The health care FSA is still a great way to save money on eligible health care expenses for you and your dependents, but don't forget to consider this change when you are calculating how much to set aside for 2011.

Women's Health and Cancer Rights Act of 1998 — Annual Notice

As required by the Women's Health and Cancer Rights Act of 1998, your AT&T company medical program provides benefits for mastectomy-related services, such as:

- Reconstruction and surgery to achieve symmetry between breasts.
- Prosthesis.
- Complications resulting from a mastectomy (including lymphedema).

Coverage may be subject to applicable annual deductibles, copayments and coinsurance.

Medicare Enrollment Is Your Responsibility

It is your responsibility to enroll in Medicare when you first become eligible as a result of age or disability. You must also stay enrolled in Medicare parts A and B in order to receive the highest level of benefits.

If you or your dependents are eligible and you are not an active employee of an AT&T company, call the AT&T Benefits Center to learn more about any actions you may need to take during this enrollment period.

For more information on steps you must take at retirement, review the AT&T Retirement Checklist located in the Your Benefits section of HROneStop, in the right-hand column under Benefits Tools & Resources. You should also refer to your SPDs and SMMs for complete retirement, Medicare and benefit eligibility rules.

Planning for Retirement

If you are considering retirement in 2011, contact the AT&T Benefits Center before making your annual enrollment decisions because the benefits and the contributions you pay (if any) may change when you retire or become eligible for Medicare.

Medicare Enrollment

Annual enrollment is a good time to consider your Medicare options if you are considering retirement. You and your Medicare-eligible dependents *must* enroll in Medicare parts A and B when you first become eligible for Medicare as your primary coverage. Typically this occurs when you stop working for an AT&T company. However, in some circumstances, such as end-stage renal disease, or ESRD, Medicare can become your or your dependent's primary coverage even while you are actively working. If you have questions about whether Medicare should be your primary coverage, check with Medicare and your medical benefits claims administrator.

You should be aware of how your retiree medical plan choices or Medicare eligibility impacts your plan options. As a result, if you drop or do not elect Part B coverage, you will be responsible for paying the full amounts that Part B would have paid and your out-of-pocket expenses will be significantly higher.

Call the AT&T Benefits Center if:

- You or an eligible dependent will become eligible for Medicare by turning age 65, and you plan to retire. (Do this two to three months before the event.)
- You or a covered dependent becomes Medicare eligible as a result of disability.
- You would like to learn more about how becoming Medicare eligible can impact your benefit choices, monthly contributions and how claims will be paid by the AT&T plan.

Enroll in Medicare Part B on Time and Maintain Your Coverage

When you are Medicare eligible, it's important that you enroll in Medicare parts A and B and remain enrolled in them in order to receive the highest level of benefits under your AT&T medical coverage. When you become eligible for Medicare, your AT&T medical plan becomes your secondary coverage once you are no longer working and in some instances, when you are still working. This means that Medicare parts A and B will provide payment for your eligible claims first, and then your AT&T medical plan coverage will pay secondary for any eligible claims.