For AT&T retirees and eligible dependents on Medicare: Planning your health care coverage for 2015

BACKGROUND

Q: What is happening to my AT&T group retiree health care coverage and when?
A: Effective December 31, 2014, you and your eligible dependents who are Medicare eligible will see their AT&T group retiree health care coverage end. However, effective January 1, 2015 it will be replaced by an individual health care policy that you select through a private (i.e., non-government) Medicare exchange operated by Aon Hewitt.

ELIGIBILITY

Q: Whom does this impact?
A: If you’re a Medicare eligible AT&T retiree, who received an enrollment kit from Aon Hewitt, then you and your eligible dependents are impacted.

Q: What if my spouse or other eligible dependent are not eligible for Medicare?
A: They will continue to receive coverage under the AT&T group retiree plan just as they did in 2014.

Q: Do my dependent and I have to elect the same plan from the private Medicare exchange?
A: No. You can each choose the plan that best suits your health needs and financial circumstances.

MONTHLY PREMIUM PAYMENT

Q: Will my monthly individual insurance premium in 2015 health care coverage be higher than my current AT&T group retiree health care coverage?
A: It depends on which plan you choose and the premium associated with that plan. However, AT&T has confirmed that for 2015 it will be subsidizing a similar level of the insurance premium cost as it did in 2014, only now via a Health Reimbursement Account (“HRA”).

Q: Who pays for the coverage that I choose through the Aon Hewitt exchange?
A: You are responsible for paying your monthly individual insurance premium. However, for 2015 AT&T is funding an HRA for you and your eligible dependents to help offset the cost.

The full annual HRA amount will be credited to your HRA account on January 1, 2015. HRA funds can only be used to pay for your monthly individual insurance premiums and eligible out-of-pocket expenses. The specific amount of your HRA subsidy is provided during your personalized education session with Aon Hewitt.

Q: What constitutes an “eligible out-of-pocket expense” that can be reimbursed via my HRA?
A: You will be receiving an HRA plan document from Aon Hewitt detailing the list of eligible out-of-pocket expenses, but IRS Publication 502 provides a list of generally accepted expenses including: health care insurance premiums (for the Aon Hewitt exchange as well as Medicare Part B), copays (e.g., A $30 copay for a doctor’s office visit), coinsurance (i.e., your portion of an unpaid health care bill), items typically not covered under health plans (e.g., vision care, dental care, acupuncture, chiropractic care, hearing aids, etc.)

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Q: Do my eligible dependents and I receive separate HRA accounts?
A: Yes. You and your eligible dependents will each receive your own HRA accounts. Further, the amounts can be shared between individuals (i.e., one spouse can get reimbursed from the other’s account).

Q: I was paying for my share of my AT&T group retiree health care coverage through deductions from my pension check every month. How will I pay now?
A: You have two options for paying your monthly individual insurance premiums. One, you can set up an automatic deduction from your checking or savings account. Two, you can pay by check.

Q: How do I get reimbursed from my HRA account?
A: Some plans offer an “auto-reimbursement” feature wherein your monthly individual insurance premiums only (and Part D prescription premiums, if applicable) will be automatically reimbursed to you from your HRA account. For other eligible expenses like copays, you will need to file a claim with the HRA administrator. Make sure to ask your Aon Hewitt benefit advisor if your plan includes the auto-reimbursement feature.

Q: Am I still eligible for an HRA account if I don’t purchase coverage through the Aon Hewitt private exchange?
A: No. In order for you and your eligible dependents to receive your HRA, you each must purchase medical OR prescription drug coverage through the Aon Hewitt exchange.

Q: Do I lose my HRA funds that are unused at the end of the year?
A: No. Any unused HRA funds in 2015 will “roll over” to your HRA account in 2016.

Q: Since AT&T is putting this money into an account for me, is it taxable income?
A: No. It is a pre-tax account and the reimbursements are not considered taxable income.

Q: Will I still receive the separate subsidy from AT&T for Medicare Part B premiums?
A: No. Your only subsidy from AT&T will be your HRA.

**COVERAGE OPTIONS**

Q: Currently, AT&T group retiree health care coverage generally pays the balance of my health care costs after Medicare pays first. Will this change in 2015?
A: Yes, it will change, but how drastic the change is depends on which plan which you choose. There are two general plan types and multiple options within these types:

Option 1 is what’s known as Medicare Part C, or Medicare Advantage, and is a type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. If you’re enrolled in a Medicare Advantage Plan, Medicare services (and in some cases, prescription drug services) are covered through the plan and aren’t paid for under “Original Medicare”. Your Aon Hewitt advisor can explain the variety of Medicare Advantage options and differences, but they include Preferred Provider Organizations (“PPO”) and Health Maintenance Organizations (“HMO”) options. Please see our Definitions section for a more complete explanation of Medicare Advantage and these types of managed care plans.

Option 2 is what’s called a Medigap plan (also known as a “Medicare supplement” plan). Medicare would remain your primary coverage and the Medigap plan you choose would be your secondary (and supplemental coverage) that typically pays for the balance of your health care costs (over and above your deductibles and copays). Your Aon Hewitt advisor can explain the variety of Medigap options and differences.

Q: I want as little as possible to change in 2015. Which plan should I choose?
A: While a straightforward question, it’s one that you need to pose to your Aon Hewitt benefit advisor. It requires a side-by-side comparison of, among other things:
- The monthly individual insurance premium (after factoring in the HRA).
- The extent to which services are covered under your AT&T group plan in 2014 vs. the plan(s) you’re considering in 2015.
- The annual out-of-pocket maximum (or “worst case” out of pocket costs) this year vs. 2015.
- Whether your can continue to receive care from your same doctor(s) and at what cost.

**TIPS FOR MAKING THE BEST DECISION**

We at the Voyage Financial Group know that this is a significant, if not daunting, change for many AT&T retirees. However, with change comes the opportunity to choose the right plan for you and your eligible dependents. Your decision will likely come down to a few factors, including your current health, your prescribed medication list, your doctors, and your interest in being covered for dental and/or vision services.

Additionally, you should factor in your financial circumstances, your family...
Your medical history, your willingness to accept risk, and your lifestyle (e.g., Do I regularly travel outside my geographical area? Do I partake in high-risk activities?).

The following is a list of questions we believe you should review and - if they are appropriate to your situation - ask your Aon Hewitt benefit advisor. It’s also recommended that you take notes of your conversations with the advisor and document names, times and dates.

QUESTIONS EVERYONE SHOULD ASK

• Which plan(s) provides me with the same medical, dental, vision and prescription coverage that I have in 2014? If not exactly the same, which one comes closest? What are the similarities? Differences?

• Retaining my doctors is very important to me. Which plans do my doctors accept?

• What is my worst-case scenario for out-of-pocket costs for 2015, including monthly premiums, coinsurance, copays, non-covered expenses, etc.

• Does the plan(s) I’m considering have an auto-reimbursement feature where my monthly individual insurance premiums (and Part D, if applicable) are automatically reimbursed to me via my HRA account.

• Under what, if any, circumstances can the insurance plan(s) I’m considering deny coverage for a pre-existing condition?

• Additionally, what if I choose a Medicare Advantage plan during the initial enrollment for 2015 and then want to move to another Medicare Advantage or Medigap plan during a future enrollment? What does this involve?

• If my health diminishes during 2015, will I be subject to a “pre-existing condition” qualification if I want to stay with or change plans in 2016 and beyond?

• What information will I receive between now and the end of the year so that this will be a smooth transition on January 1, 2015?

• Who do I contact after January 1, 2015 if there is a problem? Aon Hewitt or the insurance company?

For those considering Medigap (aka, Medicare Supplement) plans

• Are my 2015 Medigap premiums affected by factors like my age and current medical conditions? What about after 2015?

• Has there been a price increase in the Medigap plan I’m considering during the past 3 years? If so, how much?

• Is this first enrollment for 2015 considered my “Medigap Open Enrollment Period” and, as such, can I purchase ANY Medigap policy without restriction and at the same price as those with good health?

• After the 2015 Medigap Open Enrollment Period, it appears that if I want to switch my Medigap plan I could be subject to medical underwriting guidelines and a potential price increase. Is that correct? If so, should I look at my Medigap selection in 2015 as a one-time decision?

• Other than dental, vision, hearing aids, long-term care, and private-duty skilled nursing care, what else is not covered by Medigap plans?

For those who are planning to travel or move

• I spend the winter months in Florida (or elsewhere). Which plans best cover me both here and there? If more than one, what are the similarities and differences?

• What is my coverage for the plan(s) I’m considering if I travel outside the United States? Are there limits to this coverage?

• I am planning to move next year. Will I be able to change plans in the midst of the plan year after I move? If so, will I be able to move mid-year from a Medicare Advantage plan to a Medigap plan without a pre-existing condition policy?

For those planning surgery in 2015

• I’m going to be having elective surgery in 2015 (a planned one-time occurrence), but otherwise I’m in good health. Which plan will allow me to utilize my surgeon of choice while incurring the smallest amount of out-of-pocket expenses for the surgery?

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For those with ongoing, serious health conditions

• For example: I have End Stage Renal Disease, or ESRD. Can I join a Medicare Advantage plan or must I stick to a Medigap plan?

• Will AT&T continue to offer CarePlus?

• Will AT&T also continue to offer cancer treatment through Cancer Centers of America as well as second opinions from the Cleveland Clinic?

For those who take multiple prescriptions

• Can you please confirm that AT&T's current retiree prescription drug program through CVS is ending on December 31, 2014?

• I understand from medicare.gov that if I select a Medicare Advantage plan that includes prescription coverage, I DO NOT need to enroll in Medicare Part D. Can you please confirm this?

• I've read that AT&T will be providing catastrophic prescription coverage. If so, what is it and who pays for it?

For veterans with coverage through the VA or who are using the TRICARE health care program

• Is there any situation under which I should enroll in a plan through the Aon Hewitt exchange?

For those who live in Wisconsin, Massachusetts or Minnesota

• I know that my state offers a Medicare SELECT plan, which generally costs less than other Medigap policies. How does it limit my health care choices? Do these plans still qualify for the HRA subsidy from AT&T?

THE FOLLOWING IS A RESOURCE OF DEFINITIONS TO HELP YOU UNDERSTAND MANY OF THE TERMS, ABBREVIATIONS AND ACRONYMS ON AON HEWITT'S WEBSITE.

MEDICARE

Part A - Medicare covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) considered medically necessary to treat a disease or condition.

In general, Part A covers:
• Hospital care
• Skilled nursing facility care
• Nursing home care (as long as custodial care isn’t the only care you need)
• Hospice
• Home health services

Part B - Medicare covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) considered medically necessary to treat a disease or condition.

In general, Part B covers:
• Clinical research
• Ambulance services
• Durable medical equipment (DME)
• Mental health - Inpatient, Outpatient, Partial hospitalization
• Getting a second opinion before surgery
• Limited outpatient prescription drugs

Part C - Medicare Advantage - is a type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you’re enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren’t paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Part D – Medicare Prescription Drug Coverage - Optional benefits for prescription drugs are available to all people with Medicare for an additional charge. The coverage is offered by insurance companies and other private companies approved by Medicare.

These plans (sometimes called “PDPs”) add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) Plans, and Medicare Medical Savings Account (MSA) Plans.
CMS Ratings for prescription drug plans - Medicare uses information from member satisfaction surveys, plans, and health care providers to give overall performance star ratings to plans. A plan can get a rating between 1 and 5 stars. A 5-star rating is considered excellent.

MEDICARE ADVANTAGE (Part C) NETWORK TYPES

HMO – Health Maintenance Organization - In HMO Plans, you can't get your health care from any doctor, other health care provider, or hospital. You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except emergency care, out-of-area urgent care, or out-of-area dialysis).

In some plans, you may be able to go out-of-network for certain services, usually for a higher cost. This is called an HMO with a point-of-service (POS) option.

In most cases, prescription drugs are covered in HMO Plans. Ask the plan. If you want Medicare prescription drug coverage (Part D), you must join an HMO Plan that offers prescription drug coverage.

HMO-POS - a Medicare Advantage Plan that is a Health Maintenance Organization with a more flexible network allowing Plan Members to seek care outside of the traditional HMO network under certain situations or for certain treatment.

A Member may pay some additional fees for using the POS (out-of-network) option.

PPO – Preferred Provider Organization - A Medicare PPO Plan is a type of Medicare Advantage Plan (Part C) offered by a private insurance company.

In a PPO Plan, you pay less if you use doctors, hospitals and other health care providers that belong to the plan's network. You pay more if you use doctors, hospitals and providers outside of the network.

In most cases, prescription drugs are covered in PPO Plans. Ask about this. If you want Medicare prescription drug coverage, you must join a PPO Plan that offers prescription drug coverage. If you join a PPO Plan that doesn't offer prescription drug coverage, you can't join a Medicare Prescription Drug Plan (Part D).

PFFS – Private Fee-for-Service - A Medicare PFFS Plan is a type of Medicare Advantage Plan (Part C) offered by a private insurance company. PFFS plans aren't the same as Original Medicare or Medigap. The plan determines how much it will pay doctors, other health care providers, and hospitals, and how much you must pay when you get care.

Some things to know about Medigap policies:

• You must have Medicare Part A and Part B.

• You pay the private insurance company a monthly premium for your Medigap policy in addition to the monthly Part B premium that you pay to Medicare.

• A Medigap policy only covers one person. If you and your spouse both want Medigap coverage, you each will have to buy separate policies.

You can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat you. Not all providers will.

If you join a PFFS Plan that has a network, you also can see any of the network providers that have agreed to always treat plan members. You also can choose an out-of-network doctor, hospital or other provider, who accepts the plan's terms, but you may pay more.

SNP – Special Needs Plans - Medicare SNPs are a type of Medicare Advantage Plan (like an HMO or PPO). Medicare SNPs limit membership to people with specific diseases or characteristics, and tailor their benefits, provider choices and drug formularies to best meet the specific needs of the groups they serve.

Generally, you must get your care and services from doctors or hospitals in the Medicare SNP network (except emergency or urgent care, such as care you get for a sudden illness or injury that needs medical care right away, or if you have End-Stage Renal Disease (ESRD) and need out-of-area dialysis). Medicare SNPs typically have specialists in the diseases or conditions that affect their members. And, all SNPs must provide Medicare prescription drug coverage.

MEDIGAP

Medigap – Medicare Supplement Insurance Plans - sold by private companies, can help pay some of the health care costs that Original Medicare doesn't cover, like copayments, coinsurance, and deductibles.

Some Medigap policies also offer coverage for services that Original Medicare doesn’t cover, like medical care when you travel outside the U.S. If you have Original Medicare and you buy a Medigap policy, Medicare will pay its share of the Medicare-approved amount for covered health care costs. Then your Medigap policy pays its share.

A Medigap policy is different from a Medicare Advantage Plan. Those plans are ways to get Medicare benefits, while a Medigap policy only supplements your Original Medicare benefits.

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Any standardized Medigap policy is guaranteed renewable even if you have health problems. This means the insurance company can’t cancel your Medigap policy as long as you pay the premium.

Policies sold after January 1, 2006 aren’t allowed to include prescription drug coverage. If you want prescription drug coverage, you can join a Medicare Prescription Drug Plan (Part D).

Medigap policies generally don’t cover long-term care, vision or dental care, hearing aids, eyeglasses, or private-duty nursing.

Medigap policies are standardized:

Every Medigap policy must follow federal and state laws designed to protect you, and it must be clearly identified as “Medicare Supplement Insurance.” Insurance companies can sell you only a “standardized” policy identified in most states by letters.

All policies offer the same basic benefits but some offer additional benefits, so you can choose which one meets your needs.

In Wisconsin, Massachusetts and Minnesota, Medigap policies are standardized in a different way. Copy http://www.medicare.gov/supplement-other-insurance/compare-medigap/compare-medigap.html to your browser to see how their policies compare.

Medigap covers coinsurance only after you’ve paid the deductible (unless the Medigap policy also pays the deductible).

Medigap “Select” Plans - Medigap “Select” offers the same benefits as above EXCEPT for nationwide coverage. Select plans generally limit your hospital network and may limit your choice of doctors. If you go outside of your “Select” network, Medigap is not responsible to cover your costs (except in case of emergency). The major benefit of “Select” policies is that its premium is generally less expensive for the same coverage.

### Medigap Benefits

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<th>Plan</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>F*</th>
<th>G</th>
<th>K</th>
<th>L</th>
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* Plan F also offers a high-deductible plan. If you choose this option, this means you must pay for Medicare-covered costs up to the deductible amount of $2,140 in 2014 before your Medigap plan pays anything.

** After you meet your out-of-pocket yearly limit and your yearly Part B deductible, the Medigap plan pays 100% of covered services for the rest of the calendar year.

*** Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don’t result in inpatient admission.

Plan F “Innovative” – includes benefits not contained in other standardized Medigap plans. They include, subject to limitations: Access to nurse-advice telephone service, an annual physical exam, preventive dental care, routine vision care and routine hearing exam.

Plan F “High” – this high-deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,140 deductible. Benefits do not begin until out-of-pocket expenses exceed $2,140. Out-of-pocket expenses for this deductible are expenses that ordinarily would be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.