In the Matter of the Arbitration Between:

AT&T MOBILITY

and

COMMUNICATION WORKERS OF AMERICA

Interest Arbitration
National Health Care Benefits

Hearings Held: September 9, 10, and 11, 2008
Before Richard I. Bloch, Esq.

Appearances:

For the Company:
Glen A. Glass, Esq.
T. Michael Payne, Esq.
Russell K. Jensen, Esq.
Glenn J. Smith, Esq.
Stephen J. Sferra, Esq.

For the Union:
John L. Quinn, Esq.
Tessa A. Warren, Esq.

OPINION

Facts

At issue in this case is the quantum of cost-sharing of Health and Welfare benefits applicable to the AT&T Mobility's (formerly Cingular, referred to herein as "Mobility" or "Company") 44,000 CWA bargaining unit members. In a 2004 Settlement Agreement, the Company and Union agreed to a range of benefits provisions codified in the "National Bargained Benefit Plan for Employees of Cingular Wireless" ("NBBP"). According to the terms of the Settlement Agreement, the Bargained Plan was to remain in effect until 11:59 p.m. on December 31, 2008. Prior to that time, the parties agreed to meet for the purpose of negotiating a successor plan. Failing agreement, the matter would be, (and has been), submitted to arbitration.

Paragraph VIII provides the jurisdiction of the Arbitrator as well as the mechanism to resolve an impasse over the terms of a new bargained plan:

> VIII. If the Parties cannot reach agreement on a new or subsequent Bargained Plan in the areas listed in (a) below, only, then they will take these issues to mediation under the supervision of the Federal Mediation and Conciliation Service (FMCS) at a mutually agreed upon location and time. This process will last no longer than ten (10) business days. If there is still no agreement through the mediation process, the Parties will go to arbitration under the American Arbitration Association (AAA) for resolution of the issues. The arbitrator will have no jurisdiction over plan design and will be limited to the issues as listed in (a) below. The arbitrator will be limited in his/her decision to accept either Party's last offer or he/she will be limited to a compromise between those two positions. The arbitrator's decision will be final and binding on the parties. Expenses for the mediator and/or arbitrator will be equally shared between the Parties. Each party will be responsible for their own expenses associated with bargaining, mediation and arbitration.
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> a. Areas subject to the mediation and arbitration process described above include, for each of the plans covered in the Bargained Plan: plan eligibility; contribution amounts; co-pay amounts; co-insurance amounts; out of pocket maximum amounts; lifetime maximum amounts; annual maximum amounts; deductible amounts; Medicare Part B reimbursement; and any other fees, penalties or payments required of employees and retired employees who participate in the plans.

The specific task at issue is to allocate the cost elements of the NBBP between the Company and its bargaining unit employees. The amount to be borne by the employee will be short-handed, throughout this Opinion, as the "Employee Cost Share".[1] The standards for the decision itself, which have also been established by

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[1] "Employee Cost Share" is the percentage of total amount of medical costs paid by employees, on the average, under the existing plan. Those costs include premiums, contributions, co-pays, and

the parties,[2] include the admonition to the Arbitrator to utilize "reasonably accepted standards of arbitral jurisprudence and his own professional judgment,"[3] as well as the following benchmarks:

1. Comparisons of the health care benefits, benefit cost structures, and employer and employee benefit cost sharing of the Company with those of employees of other employers performing the same or similar services, both inside and outside of the Wireless Industry;
2. Comparisons of the overall compensation presently received by Bargaining Unit Employees with the overall compensation presently received by employees of other employers performing the same or similar services, both inside and outside the Wireless Industry;
3. Past health care benefit cost increases incurred by the Company during the term of the NBBP Agreement, and future health care benefit cost increases reasonably projected to be incurred during the term of the successor agreement;
4. Terms of the past collectively bargained agreements between the Parties relative to health care benefits, benefit cost structure and employer and employee benefit cost sharing;
5. Business, economic and competitive factors affecting the Wireless Industry and the Company's wireless business, including those factors reasonably projected to affect the industry and the Company's business during the term of the successor agreement;
6. Stipulations of the Parties;
7. The duration of plan benefits and labor agreements between the parties and within the industry;
8. Such other factors, not confined to those listed in this Section IV, which are normally or traditionally taken into consideration in the determination of the issues submitted to final offer

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deductibles, for example, stated either as dollars or percentages. The remainder of the total benefit cost is paid by the company. There are two components to these costs: (1) amounts paid as employee contributions for participation in the Plan; and (2) "out-of-pocket" ("OOP") payments by employees made on an as-used basis, including co-pays for office visits or prescription drugs, deductibles, and co-insurance required by the Plan. (Co. Ex. 9, p.2).

[2] The parties stipulated to an "Interest Arbitration Proposed Case Management Document" that set forth a series of factors to be applied.

[3] *Id.*

> settlement through voluntary collective bargaining, mediation, fact-finding, or other impasse resolution procedures in the private sector.

The Arbitrator has carefully considered these standards in reviewing the respective proposals and reaching the conclusions set forth below.

Union Position[4]

The union, for its part, contends, in essence, that the current system is not broken and, therefore, needs no fixing.[5] The Union recognizes that current benefits under the existing agreement are strong and relatively less costly than elsewhere in the industry. However, says the Union, massive shifting of healthcare costs to employees will not assure reduced healthcare costs in the long run, nor will it necessarily improve the Company's competitive position in the industry.[6] Good health benefits, it is argued, serve to protect and retain employees, ultimately benefiting the company; the retention of high-value employees will yield better customer service.

The recent dramatic escalation of healthcare costs is slowing, says the CWA, and the existing Mobility Plan has been efficient over its term and remains so, beating national trends by substantial margins. And, the Union claims, a smaller share of employees, are opting to participate in the healthcare plan.[7] Similarly, the

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[4] Full text attached as Appendix "B".
[5] Union Brief, p. 22.
[6] Union Brief, p. 7.
[7] *See* Union Exhibit 8: Over the past three years, the number of enrollees, as a percentage of the total workforce, has trended downward. 87.7% were enrolled in 2005. That figure had dropped to 81.6% in 2007.

proportion of enrollees that select family coverage is shrinking in favor of single coverage.[8] These factors portend a lower overall cost for the Company, it is argued.

Consistent with its position that few modifications are appropriate, the Union final offer includes limited incremental increases to premium contributions (8%, 2%, 2% and 2% in years 2009-2012, respectively), as well as certain provisions designed to protect the Company in the event of substantial health plan cost increases,[9] and certain amendments to out-of-pocket expenses. The Union also proposes a Joint Health Care Committee and Total Health Management program.[10] In the overall, the Union vigorously urges the Arbitrator to adopt its final offer, as more reasonably responsive to the needs of both bargaining parties.

Employer's Position[11]

The Company maintains it is essential that it achieve a healthcare plan with a cost-share allocation that is at least in parity with its competitors. The Employer argues its Employee Cost Share under the AT&T Mobility Plan is significantly disproportionate to the wireless industry and to employers nationally. Additionally, it claims the current median wages for mobility's bargaining unit employees are highly competitive with the wireless industry.[12]

As its final offer, the Company proposes to freeze incumbent employees at the current Cost Share for one year. As such, the current 11% contribution would

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[8] *Id.*, Slide 6.
[9] *See*, for example, ¶D of CWA's Final Offer, attached as Appendix "B".
[10] *Id.*, ¶5 and 6.
[11] Full text attached as Appendix "A"
[12] Company closing brief, p. 2. *See* Company Ex. 2-7.

remain, effective January 1, 2009. Thereafter, incumbents would pay 20%, effective January 1, 2010; 23% on the anniversary date in January 2011; and 26% as of January 1, 2012. Employees hired on or after January 1, 2009, would enter the workforce on a flat 4-year plan at 26% (with annual indexing). On a blended Cost Share basis, says the Company, the 4-year plan will continue to trail the industry in general, although it will closely approximate the Cost Share of AT&T's closest competitor, Verizon Wireless, over the 4-year term of the new agreement.

Analysis

The Arbitrator has carefully reviewed the detailed and extensive presentations by both parties. Generally, there is no cause to question the overall accuracy of the respective submissions. Indeed, in many respects the parties themselves are not at odds either as to the data or the assumptions to be drawn therefrom. The Union, for its part, puts substantial weight on the fact (which is reasonably supported by the evidence) that the Company has been thriving in this concededly competitive environment, and that it can afford to maintain, in the future, without question, a relatively generous benefit. And, the Union notes, with some justification, that imprudent increases in health care costs to employees may well result in their declining to sign up for coverage or to leave the workforce entirely. Surely, there is merit to the Union's observation that an attractive benefit package will better serve to retain an experienced workforce.

From a utilization standpoint, as well, the Plan has proven efficient, according to the record. In 2005, 88.9% of healthcare costs were incurred in-network; by

2007, however, 90.7% of such costs were incurred in-network. Doctors' office visits fell from 5.2 per employee, per year in 2005, to 4.7 in 2007. Emergency Room visits decreased, as well, as did out-patient facility charges.[13] On the average, the cost per employee for health benefits has decreased, says the Union. In 2005, the average cost per employee was $7,521; in 2007, it was $7,513. During all this time, co-insurance remained unchanged. While the Company's net benefit cost increased over a two-year period from 2005 to 2007 – 3.46%, this was a favorable factor when compared to a national average of 13% during the same period.[14]

Management, for its part, stresses the need to maintain its competitive stance in the industry; it sees the need to even the playing field and gain ground on its non-union competitors by implementing progressive adjustments that will ultimately place them in better parity.

Paragraphs 1 and 2 of the Case Management document refer to comparing cost and compensation levels industry-wide and elsewhere.[15] Some initial comments are in order concerning comparisons in this case. First, it is reasonable to conclude, for reasons discussed below, that employee Cost Share at AT&T Mobility is, if not "disproportionate," at least relatively more favorable for these bargaining unit employees than other industry employees. The difficulty in being more precise on that comparison, as will be noted, is that it is difficult to make firm conclusions as to the ultimate comparability of the competitors' packages, on a cost basis. AT&T Mobility and Verizon clearly dominate the industry, maintaining a combined 60% of

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[13] Union Exhibit 8, Slides 7 and 8.
[14] *Id.*, Slide 11, Tr., p. 314.
[15] See p.3, *supra*.

wireless customers.[16] Those two companies are the most profitable in the field, with widely diversified products including voice, data, and video services over wireless or LAN line networks.[17] But AT&T is alone in maintaining an organized workforce, and the competitors cited on the record, Verizon Wireless, Alltel Wireless, Sprint, U.S. Cellular, T-Mobile and Cricket, vary substantially in size and market share, among other things.[18] Nowhere in the record is there evidence reflecting actual comparative cost sharing figures as among the companies cited for comparison. The materials that approach those figures are those submitted as a JP Morgan survey[19], which purport to show dramatic variances between AT&T and its various competitors. The methodology set forth in the testimony supplied by the Company[20] is described as follows:

> JP Morgan ... [compares] the "actual Cost Share under a particular company's Health and Welfare benefit plan, based on actual benefit and claims experience for that company, to the estimated Cost Share under a different company's plan design, assuming the same claims experience. JP Morgan performs these studies by running the actual claims experience of the identified company through the plan design parameters of the Health and Welfare benefit plan of one or more comparator companies.[21]

In the JPO Morgan model, AT&T employees experienced about half the cost sharing under the AT&T program than *they* would have had they been under the Verizon and Sprint models, incurring outlays of $817, which amounted to about an 11% Cost

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[16] The next closest competitor has 16%. See Union Exhibit 1, Slide 6.
[17] Union Exhibit 1, slides 3-4. *See, also,* Tr., p. 227-8.
[18] *See* Co. Ex. 2 & 9 .
[19] *Id.*
[20] See Stipulated Testimony of Geoffrey Kuhn, Co. Ex. 9.
[21] *Id.*,p.2

Share. [22] Under the Verizon and Sprint plans, on the other hand, AT&T employees would have paid in excess of $1,700, amount to a 23% Cost Share.[23]

These figures, however, have built in limitations for comparison purposes. They demonstrate comparative Cost Shares between and among companies, but those figures are hypothetical, relying not on actual sharing data, but on figures derived from the assumption that AT&T employees would in all cases make similar decisions and choices of coverage, notwithstanding the potentially varying plans[24], availability of alternative services and the demographics of the particular work forces, all of which could inject meaningfully different claims experience in a given work force.[25] Nevertheless there is reason to conclude that, even given some imprecision in these figures, the AT&T package is likely superior, in terms of employee cost-sharing burden, than those of the competitors in the industry; the Union does not seriously dispute that fact.

It may be said, with some greater confidence, that median wages are above average. Indeed, wage surveys submitted in evidence[26] demonstrate, among other things, that, whether based on Retail Sales,[27] Customer Service Representatives[28] or Cell Site Technicians,[29] AT&T Mobility wages are highly competitive.

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[22] The AT&T employees experienced outlays of $817, which amounted to about an 11% Cost Share.
[23] Alltel, U.S. Cellular and Cricket were more expensive for the employees, but the firms are not reasonably comparable.
[24] For example, the existing Mobility POS Plan has a $35 Inpatient hospital co-pay; the payment under Verizon's PPO Plan is $200. There is a $1,000 per person maximum on Prescription Drug OOP's ($2,000 family) under Mobility's plan; Under Verizon's plan, there is no maximum. See Co. Ex. 25.
[25] One notes, as well, that, for survey purposes, the JP Morgan report utilized blended and averaged amounts across all plan options in those cases where multiple plans were offered. Co. Ex. 9, p. 4.
[26] *See* the Industry wage surveys submitted as Co. Ex. 11. *See, also,* Co. Exs. 5, 6 and 7.
[27] Co. Ex. 5.

The Company proposes an overall Cost Share that escalates from the current 11% level to 26% over a four-year period. There would be no increase for calendar year 2009. Thereafter, monthly premiums, which are indexed as a percentage of the total cost of the benefit plan, increase in a fashion that contributes to an annual Cost Share for incumbent employees as follows:

Effective January 1, 2010 – 20%
Effective January 1, 2011 – 23%
Effective January 1, 2012 – 26%

New hires would be subject to a flat four-year plan at 26%.[30] As a result of the graduated Cost Share increases (to the 26% level) and the two-tier cost allocation for new hires, the effective Cost Share over the term of the agreement is 21%.

The Union proposes increased premium contributions of 8%, 2%, 2% and 2% over the four years. Setting the increases on a percentage basis, the Union notes, helps to counter the tendency of a flat dollar design to erode the relative value of the health care package.[31]

A careful review of all the evidence persuades the Arbitrator that some adjustment of these respective positions is in order. The Union's proposal, which is properly characterized as essentially unchanged from the *status quo*, and which arguably results in reduced costs for employees over the 4-year contract term, is not reasonably responsive to the current trends of escalating health care costs. Even

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[28] Co. Ex. 6.

[29] Co. Ex. 7.

[30] In this manner, New Hires and Incumbents will be at the same Cost share, and under the same benefit plan upon expiration of the successor agreement.

[31] But a dollar comparison is, nevertheless, enlightening. The current single employee premium contribution is $15. Under the Union's approach, it would increase slightly in years one, two, three and four to $16.20, $16.52, $16.85 and $17.19. The Company's plan would raise the $15 contribution in years two, three and four to $34, $54 and $75.

assuming a slowing in the cost escalation, that proposal is not supported by the evidence. On the other hand, the Union is correct in noting that the health care costs are only one element in the economic picture. Economic equivalence cannot be obtained, and should not be sought, solely at the expense of employee health care.

In rejecting portions of the positions the Arbitrator regards as untenable on both sides, the comparisons of health care benefits and overall compensation, as referenced in Paragraphs 1 and 2 of the Settlement Agreement, have been reviewed and taken into consideration, as discussed earlier. Paragraphs 3 and 4 are also highly relevant to these particular parties in the context of this particular dispute and are repeated here for ease of reference:

> Past health care benefit cost increases incurred by the Company during the term of the NBBP Agreement, and future health care benefit cost increases reasonably projected to be incurred during the term of the successor agreement;
>
> Terms of the past collectively bargained agreements between the Parties relative to health care benefits, benefit cost structure and employer and employee benefit cost sharing;

Health care benefit costs have increased over the term of the past agreements. Moreover, because of the flat dollar structure of the Cost Share mechanism, the employer's burden of the shared costs has increased. These facts, taken together with the comparisons industry-wide, strongly suggest the need for adjustment. The Union offer does not adequately address this, as noted above. At the same time, the economic terms of the past Collective Bargaining Agreement itself suggest a more tempered adjustment than is represented by the Employer's final offer in this case. Consideration of those elements lead one to the conclusion that (1) meaningful adjustments in Cost Share over the term of the next agreement are appropriate; and (2) the adjustment should be implemented on a more gradual slope than that proposed here by the Employer.

Both parties are agreed on at least two important aspects of the new agreement. First, there should be a two-tier scale for new employees (but they differ as to the terms) and, secondly, the term of the Agreement should be four years. These elements will, together, contribute to a more equitable Cost Sharing arrangement and to continued stability in the overall collective bargaining relationship.

The Company notes that ¶7 of the NBBP grants to the Arbitrator jurisdiction over not only the medical benefits but also over the cost allocation elements of the other benefit plans in the NBBP. It suggests that its proposals in these areas serve to simultaneously promote additional cost controls while maintaining superior coverage for employees. But Mobility also observes, properly, that these bevy of "minor terms" of the NBBP Plan were not addressed "in any significant detail"[32] at the hearing. Under the circumstances, it would be foolhardy to attempt to fabricate a mix that seeks to incorporate these unexamined elements to somehow approximate the desired end result. The alternative is to address one's self primarily to the terms of the overall Cost Sharing objective – as did the parties at the hearing – setting forth those parameters and, with the exception of certain specified elements of the Plan, leaving additional elements unchanged from the current plan. In short, the Award in this case is intended to modify only those elements specifically set forth below.

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[32] Co. Final Offer, p. 4.

AWARD

1. Term

The parties are agreed, and the Arbitrator concludes, that a four-year term is appropriate.

2. Premium Contributions/Cost Sharing

1. The conclusion is that the maximum Cost Share applicable to Incumbent Employees shall be as follows:

Effective Jan. 1, 2009 – 11%
Effective Jan. 1, 2010 – 14%
Effective Jan. 1, 2011 – 17%
Effective Jan 1, 2012 – 20%

Premium contribution levels for 2009 shall remain unchanged. Premium contribution rates of 7%, 10% and 13% for years 2010, 2011 and 2012, respectively, are to be indexed as a percentage of the total cost of the benefit plan. Employee Deductibles and Out of Pocket Maximums referred to below are to be indexed as a percentage of wages, with dollar maximums. There shall be no change as to those not referenced below.

2. The flat rate applicable Cost Share to employees hired after January 1, 2009 shall be 20%, indexed as a percentage of the total cost of the benefit plan, with premium contributions and other items specifically detailed below to be indexed as in 1, above.

3. Part time employees working less than 20 hours a week will pay full premium costs; more than 20 hours per week, 50% of full cost.

4. Office Visits – Preventive – 100% Company Paid. Deductible waived.
Sickness – 90% after deductible.

5. Diagnostic Tests – 90%, after deductible.

6. Emergency Room 90%, after deductible.

7. Hospital Co-pay – 90%, after deductible.

8. Prescription Drug coverage.

- Retail Co-pays (30 day supply): Generic - $8; Formulary - $17; Non-formulary $35
- Mail Order Co-pays (90 day supply); Generic - $17; Formulary - $35; Non-formulary - $70

Other requests for modifications are denied.

Richard I. Bloch, Esq.

December 15, 2008

HEALTH AND WELFARE BENEFITS PLAN
FOR BARGAINED EMPLOYEES OF AT&T MOBILITY

Current Employees remain in their current health and welfare benefit plans for 2009. Benefits outlined below reflect New Hires changes effective in 2009 and for Current Employees in 2010.

	MEDICAL BENEFITS
Plan	**AT&T Medical Plan – Alternative Provisions**
Eligibility	Date of hire
EE Class	Regular Full-Time and Regular Part-Time
Enrollment Window	31 days
Full Time EE Contribution Per Month **Monthly Premiums are indexed at the percentages listed. The dollar amounts are estimates of the employee monthly premiums.** **Actual dollar amounts are calculated by applying the stated percentage to the premium equivalent rate that varies from year to year.**	**<u>Current Employees</u>** Remain in the Cingular Wireless Health and Welfare Benefits Plan for Bargained Employees for 2009. Effective 2010: | | <u>2010</u> | <u>2011</u> | <u>2012</u> | Employee: 7% / 10% / 13% Dependent: 7% / 10% / 13% Estimated Contributions: (<u>2009*</u> / <u>2010</u> / <u>2011</u> / <u>2012</u>) Employee: $15 / $34 / $54 / $75 Employee +1: $30 / $65 / $101 / $142 Family: $40 / $96 / $149 / $210 Note: Contribution amounts subject to annual adjustment based on new premium equivalent rates. *2009 is actual contribution for current employees. **<u>New Hires with 6 months or more of Net Credited Service</u>** Employee: 13% Dependent: 13% Estimated Contributions: (<u>2009</u> / <u>2010</u> / <u>2011</u> / <u>2012</u>) Employee: $59 / $64 / $69 / $75 Employee +1: $112 / $121 / $131 / $142 Family: $165 / $179 / $194 / $210 Note: Contribution amounts subject to annual adjustment based on new premium equivalent rates. **<u>Newly Hired Employees with less than 6 months of Net Credited Service</u>** Employees and Dependents pay 100% of the cost of coverage.
Part Time EE Contributions	Based on Scheduled hrs/week: 20 hrs > 50% of full cost < 20 hrs = 100% of full cost
Working Spouse Contribution	N/A
Coinsurance	<u>Network/ONA:</u> 90%, after Deductible <u>Non-Network:</u> 60%, after Deductible Note: Annual deductible does not apply to Network preventive care

Appendix "A"

HEALTH AND WELFARE BENEFITS PLAN
FOR BARGAINED EMPLOYEES OF AT&T MOBILITY

<table>
<tr><th></th><th>MEDICAL BENEFITS</th></tr>
<tr><th>Plan</th><th>AT&T Medical Plan – Alternative Provisions</th></tr>
<tr><td>Annual Deductible
(Deductibles are either a percentage of base salary or a dollar amount as listed whichever is lower. For example, an employee who makes $27,000 annually who has single coverage would pay a deductible of $270 not $500.)</td>
<td>
<u>Network/ONA *:</u>
<table>
<tr><th rowspan="2">Tier</th><th colspan="2">Annual Deductibles</th></tr>
<tr><th>% of Base Wages</th><th>Maximum</th></tr>
<tr><td>Employee</td><td>1%</td><td>$500</td></tr>
<tr><td>Employee +1</td><td>2%</td><td>$1,000</td></tr>
<tr><td>Family**</td><td>3%</td><td>$1,500</td></tr>
</table>
(integrated Med/Surg, Rx, MH/SA)

*Note: Non-Network amounts will automatically be adjusted accordingly to remain at 3x Network maximum amounts.
** Note: No plan benefits paid for any participant until Family Annual Deductible is satisfied.

Items that <u>do</u> <u>not</u> count toward the Deductible include:
• Personal Choice Drugs
• Amounts that exceed Eligible Expense
• Monthly Contributions
</td></tr>
<tr><td>Annual
Out of Pocket Maximum (OOP)
(Out Of Pocket maximums also are a percentage of base salary or the dollar amount listed, whichever is lower. For example, an employee who makes $27,000 annually who has single coverage would have an OOP of $1,080 not $2,000.)</td>
<td>
<u>Network/ONA *:</u>
<table>
<tr><th rowspan="2">Tier</th><th rowspan="2">% of Base Wages</th><th colspan="2">Maximum</th></tr>
<tr><th>< or = $50K</th><th>> $50K</th></tr>
<tr><td>Employee</td><td>4%</td><td>$2,000</td><td>$2,500</td></tr>
<tr><td>Employee +1</td><td>6%</td><td>$3,000</td><td>$4,000</td></tr>
<tr><td>Family</td><td>8%</td><td>$4,000</td><td>$5,300</td></tr>
</table>
(integrated Med/Surg, Rx, MH/SA)

*Note: Non-Network amounts will automatically be adjusted accordingly to remain at 3x Network maximum amounts.

Items that <u>do</u> <u>not</u> count toward the OOP include:
• Personal Choice Drugs
• Amounts that exceed Eligible Expense
• Monthly Contributions
</td></tr>
<tr><td>Office Visit
(Preventive care is paid at 100% by the Company.)</td>
<td>
<table>
<tr><th></th><th><u>Network/ONA</u></th><th><u>Non-Network</u></th></tr>
<tr><td>Preventive</td><td>100% Company paid, Deductible waived</td><td>No Benefit</td></tr>
<tr><td>Sickness/ Illness</td><td>90%, after Deductible</td><td>60%, after Deductible</td></tr>
</table>
</td></tr>
<tr><td>Emergency Room</td>
<td><table><tr><th><u>Network/ONA</u></th><th><u>Non-Network</u></th></tr><tr><td>90%, after Deductible</td><td>60%, after Deductible</td></tr></table></td></tr>
<tr><td>Urgent Care Center</td>
<td><table><tr><th><u>Network/ONA</u></th><th><u>Non-Network</u></th></tr><tr><td>90%, after Deductible</td><td>60%, after Deductible</td></tr></table></td></tr>
<tr><td>Hospital</td>
<td><table><tr><th><u>Network/ONA</u></th><th><u>Non-Network</u></th></tr><tr><td>90%, after Deductible</td><td>60%, after Deductible</td></tr></table></td></tr>
</table>

HEALTH AND WELFARE BENEFITS PLAN
FOR BARGAINED EMPLOYEES OF AT&T MOBILITY

	MEDICAL BENEFITS
Plan	**AT&T Medical Plan – Alternative Provisions**
Lifetime Maximum	Network/ONA: None Non-Network: $1,000,000 lifetime maximum per participant
COB	• Non-duplication of benefits. Company plan benefits are offset by primary plan benefits, "benefit-less-benefit". • Order of payment for dependent children: Determined based upon which parent has the birthday earlier during calendar year. "Birthday Rule".
Survivor	If eligible for Company subsidized coverage, then 12 months company extended coverage (CEC) concurrent with COBRA, then 100% of full cost for life or remarriage.

Prescription Program	**PRESCRIPTION DRUG BENEFITS**
Plan	**AT&T Medical Plan**
Brand Restriction	If generic is available and brand is purchased, pay generic coinsurance amount plus cost difference between brand and generic
Annual Deductible	Integrated with Med/Surg, & MH/SA
Out of Pocket Maximum (OOP)	Integrated with Med/Surg, & MH/SA Note: Personal Choice purchases and Brand penalties do not accrue to the max OOP.
Retail (up to a 30-day supply per Rx or refill)	Note: Copay escalators do not apply
Generic	$8, after Deductible
Formulary	$17, after Deductible
Non-formulary	$35, after Deductible
Personal Choice	100% participant-paid
Mail Order (up to a 90-day supply per Rx or refill)	Note: Copay escalators do not apply
Generic	$17, after Deductible
Formulary	$35, after Deductible
Non-formulary	$70, after Deductible
Personal Choice	100% participant-paid

	MENTAL HEALTH BENEFITS
Plan	**AT&T Medical Plan**
Deductible	Integrated with Med/Surg, & MH/SA
Out of Pocket Maximum	Integrated with Med/Surg, & MH/SA
Coinsurance	**Inpatient** Network/ONA: 90%, after Deductible Non-Network: 60%, after Deductible **Outpatient** Network/ONA: 90%, after Deductible Non-Network: 60%, after Deductible
Limitations	**Inpatient** Any combination of Network, Non-Network and ONA Benefits for Mental Health and/or Substance Abuse services is limited to 30 days per Covered person per calendar year. **Outpatient** Any combination of Network, Non-Network and ONA Benefits for Mental Health and/or Substance Abuse services is limited to 50 visits per Covered person per calendar year.

	SUBSTANCE ABUSE BENEFITS
Plan	**AT&T Medical Plan**
Deductible	Integrated with Med/Surg, MH/SA, & supplemental medical
Out of Pocket Maximum (OOP)	Integrated with Med/Surg, MH/SA, & supplemental medical
Coinsurance and copayments	**Inpatient** Network/ONA: 90%, after Deductible Non-Network: 60%, after Deductible **Outpatient** Network/ONA: 90%, after Deductible Non-Network: 60%, after Deductible
Limitations	**Inpatient** Any combination of Network, Non-Network and ONA Benefits for Mental Health and/or Substance Abuse services is limited to 30 days per Covered person per calendar year. Substance abuse courses are limited to two courses of treatment per lifetime per Covered person. **Outpatient** Any combination of Network, Non-Network and ONA Benefits for Mental Health and/or Substance Abuse services is limited to 50 visits per Covered person per calendar year.

HEALTH AND WELFARE BENEFITS PLAN
FOR BARGAINED EMPLOYEES OF AT&T MOBILITY

	EMPLOYEE ASSISTANCE PLAN
Plan	**AT&T Employee Assistance Plan**
Eligibility	Date of hire
EE Class	Regular Full-Time and Regular Part-Time
Cost	100% Company Paid
Design	Provides one assessment/referral consultation per person, per issue at no charge to patient
Survivors	None

	DENTAL BENEFITS
Plan	**AT&T Dental Plan**
Eligibility	Date of hire
EE Class	Regular Full-Time and Regular Part-Time
Full Time EE Contribution	Employee: 0% Dependent: 35% For 2009 * : Participant Contributions Employee $0 Employee +1 $11 Family $22 * Note: Contribution amounts subject to annual adjustment based on new premium equivalent rates.
Part Time EE Contributions	Based on Scheduled hrs/week: 20 hrs > 50% of full cost < 20 hrs = 100% of full cost
Annual Deductible	Network/Non-Network $25 per Individual/per year
Annual Maximum	Network/Non-Network $1,300 per Individual
Diagnostic & Preventive	Network/Non-Network Preventive: 100%, Deductible waived
Minor Restorative	Basic restorative: 80%, after Deductible
Major Restorative	Major restorative: 50%, after Deductible
Orthodontia	50%, after Deductible Network: $1,600 per Individual lifetime maximum Non-Network: $1,400 per Individual lifetime maximum
COB	• Priority of Payment. For dependent children the priority of payment is determined based upon which parent has the earlier birthday during the calendar year. "Birthday Rule". • Formula when secondary. After determining benefits payable, the Plan pays remainder of allowable medical expenses left unpaid by primary plan, to not exceed "100% of allowable expense".
Survivor	12 months company extended coverage (CEC) concurrent with COBRA, then 100% of full cost for life or remarriage.

	VISION BENEFITS
Plan	**AT&T Vision Plan**
Eligibility	Date of hire
EE Class	Regular Full-Time and Regular Part-Time
Full Time EE Contribution	Employee: 0% Dependent: 35% For 2009 * : Participant Contributions Employee $0 Employee +1 $2.00 Family $4.50 * Note: Contribution amounts subject to annual adjustment based on new premium equivalent rates.
Part Time EE Contributions (Shall not be less than FT contr.)	Based on Scheduled hrs/week: 20 hrs > 50% of full cost < 20 hrs = 100% of full cost
In Network	100% after $15 copay for exam, lenses, and frames
Contact Lens Allowance	$150 Allowance
Frame Allowance	$105 Retail
2nd Pair Benefit	Employee and Dependent: • $30 copay • Lenses – once every 24 months • Frames – once every 24 months
Frequency: EE	• Exam – once every 12 months • Lenses – once every 12 months • Frames – once every 24 months
Frequency: Dependent	• Exam – once every 12 months • Lenses – once every 12 months • Frames – once every 24 months
Non-Network Allowance	• Exam - $28 • Lenses – $30 - $80 • Frames – $30 • Contacts - $150
COB	• Priority of Payment. For dependent children the priority of payment is determined based upon which parent has the earlier birthday during the calendar year. "Birthday Rule". • Formula when secondary. After determining benefits payable, the Plan pays remainder of allowable medical expenses left unpaid by primary plan, to not exceed 100% of allowable expense".
Survivor	None; COBRA available

HEALTH AND WELFARE BENEFITS PLAN
FOR BARGAINED EMPLOYEES OF AT&T MOBILITY

	MEDICAL PLUS BENEFITS
Plan	**AT&T CarePlus – A Supplemental Medical Plan**
Eligibility	Date of hire
EE Class	Regular Full-Time and Regular Part-Time
Employee Contributions (FT & PT)	Participant Contributions Employee $1 Employee +1 $2 Family $2 Note: Contribution amounts are subject to annual adjustment.
Benefits	Coinsurance Services at Approved Facilities covered at 100% Benefit Maximum Unlimited Enrollment Annual
COB	• Priority of Payment. For dependent children the priority of payment is determined based upon which parent has the earlier birthday during the calendar year. "Birthday Rule". • Formula when secondary. After determining benefits payable, the Plan pays remainder of allowable medical expenses left unpaid by primary plan, to not exceed 100% of allowable expense.
Survivor	None; COBRA only

	FLEXIBLE SPENDING ACCOUNTS
Plan	**AT&T Flexible Spending Account Plan**
Dependent Care Spending Accounts	
Eligibility	Eligible first day of the month following enrollment.
EE Class	Regular Full-Time and Regular Part-Time
Maximum	$5,000
Minimum	$100
Health Care Spending Accounts	
Eligibility	Eligible first day of the month following enrollment.
EE Class	Regular Full-Time and Regular Part-Time
Maximum	$10,000
Minimum	$100
Survivor	None

HEALTH AND WELFARE BENEFITS PLAN
FOR BARGAINED EMPLOYEES OF AT&T MOBILITY

	LIFE INSURANCE
Plan	**AT&T Group Life Insurance Plan**
Eligibility	Date of hire
EE Class	Regular Full-Time and Regular Part-Time
Eligible Dependent	Spouse/RDP Child up to age 23 regardless of full-time student status Disabled Dependent if covered and disabled to limiting age
Enrollment Window	Date Of Notification (DON) + 31 days
Life Event	31 days for all life events (add new dependent with EOI)
Basic Life Insurance Benefit	Company Paid 1x covered comp $7 million max (Basic + Supp) Reduction schedule post age 65
Supplemental Life Insurance Benefit	EE paid Up to 6x covered comp (supp and AD&D) $7 million max (Basic + Supp)
Accelerated Death Benefit	Yes – 75% max
AD&D	Basic: 1X annual basic pay; ER paid Supp: 1x-6X annual basic pay
Seatbelt Incentive	Yes
Dependent Benefit Amount	Employee paid Spouse/RDP (life and AD&D): $10K, $25K-$150K in $25K increments; smoker/nonsmoker rates Child Life and AD&D: $1.5K, $3K, $5K, $10K, $15K,
LTD Coverage	Basic Life (not AD&D) continues for 3 years Supplemental Life: EE paid; max 3 years but not beyond age 65 Dependent to end of month in which STD ends
Portability upon termination	Not Basic Life and AD&D Supp can be ported Not Spouse and Child Life or AD&D
Conversion upon termination	Basic Life, not AD&D, may be converted Spouse and Child Life, not AD&D
Survivor	None

HEALTH AND WELFARE BENEFITS PLAN
FOR BARGAINED EMPLOYEES OF AT&T MOBILITY

	LONG-TERM CARE
Plan	**AT&T Consolidated Group Long-Term Care Plan**
Eligibility	Date of hire
EE Class	Regular Full-Time and Regular Part-Time
Cost	Employee paid
Spouse/RDP	Yes, EOI
Parents	Yes, EOI
Parents-in-Law	Yes, EOI
Retired Employees	May continue if enrolled at time of retirement
Class IIs	Not eligible
Sponsored Children	Not eligible
LTD	May continue if enrolled at time of LTD
Nursing Home Coverage	Yes
Comprehensive Coverage	Yes

	ADOPTION ASSISTANCE PROGRAM
Plan	**AT&T Adoption Reimbursement Plan**
Eligibility	Eligible date of hire
EE Class	Regular Full-Time and Regular Part-Time
Maximum	Up to $5,000 in eligible expenses
Spouse Adoption	Covered

	TUITION REIMBURSEMENT PLAN
Eligibility	No change to current
EE Class	No change to current
Maximum (same for FT & PT)	No change to current
Reimbursement for classes:	No change to current

CWA-AT&T Mobility Health Plan Arbitration

Changes below to be effective 1/1/2009 unless otherwise noted.

1. Employee Eligibility and Contributions:

A. For employees hired on and after January 1, 2009: employees with less than 6 months of service: pay 100% of the premium (i.e., an access only plan).

B. Employees with 6 months and more of service: current monthly premium contributions will be increased as follows:

Effective January 1, 2009: 8%
Effective January 1, 2010: 2%
Effective January 1, 2011: 2%
Effective January 1, 2012: 2%

C. Part-time employees will pay the same premiums as full time employees who are paid the same base pay rate.

D. Beginning in 2010 and in each subsequent year, in the event total annual health plan cost increases are projected to exceed 9%, then the Joint Health Care Cost Containment Committee will meet to discuss options for plan design changes and contribution changes to mitigate the increases. The Committee will have three months to determine ways to address the cost increases.

- If the Joint Committee is unable to agree to modifications to mitigate the changes, then the total amount of cost increases in excess of 9% will be allocated among the employer and employees with the employer responsible for 85% and employees responsible for 15% of the excess.

E. For any employee, during the term of the agreement, in no event will monthly contributions exceed 125% of the current monthly contributions.

F. Beginning in 2010, if the increase in total annual health care costs falls below 2%, then employees' monthly contributions will be reduced proportionally.

2. Maintain current Medical Benefits as outlined in Attachment I of the 2004 Settlement Agreement, with some modifications:
   - Provisions for annual deductible, coinsurance, and annual out of pocket maximum (listed on page 1 of 9) remain as in the current plan.
   - Office Visit Copays = $20 (from $15, as listed on page 1 of 9)

Appendix "B"

- Emergency Room Copay remains as in the current agreement (page 1 of 9)
- Urgent Care Center remains as in the current agreement (page 2 of 9)
- Hospital Copay = $125 (from $35, as listed on page 2 of 9)
- Lifetime Maximum provisions remain the same (page 2 of 9)
- COB provisions remain the same (page 2 of 9)
- Survivor coverage provisions remain the same (page 2 of 9)
- Retiree eligibility remains the same as in Attachment II
- Mental health and substance abuse benefits remain as in the current agreement (page 3 of 9)
- Prescription Drug Coverage as noted below:
  - Retail Copays (30 day supply): Generic - $8; Formulary - $17; Non-formulary - $35
  - Mail Order Copays (90 day supply): Generic - $17; Formulary - $35; Non-Formulary - $70
  - Smoking Cessation drugs covered in the Formulary classification

3. All other benefits as proposed in CWA's 6/30/08, 6:10 proposal. This includes:

- employee assistance plan (page 4 of 6/30 proposal)
- dental benefits (page 5)
- vision benefits (page 6)
- Medical Plus benefits (page 7)
- Flexible Spending Accounts (page 7)
- Life Insurance (page 8)
- Long Term Care (page 9)
- Adoption Assistance (page 9)
- Tuition Reimbursement Plan (page 9)

4. HMO and/or EPO Coverage will be made available in areas where the bargained POS plan is not available. Employees may submit recommendations for HMOs to be offered to the Joint Committee. In areas where the bargained-for POS plan is available, the company will contribute to the HMO up to the amount it contributes to the POS plan coverage and the employee will pay the difference in monthly contribution, if any. In areas where the POS plan is not available, the employees will pay the same monthly contribution required for the POS plan, as described in item 1 above.

5. The Parties agree to establish a Joint Health Care Committee, as follows:

a. The Committee will review and monitor plan performance in the areas of cost, access to providers, quality of care delivery and customer satisfaction. The Committee will discuss and make recommendations on ways to control health care costs, including possible new Plan designs that may be used to help control costs, and make joint recommendations to the bargaining chairs for consideration by the Company and the Union.

b. The Committee may make vendor recommendations for the Company to consider; however, the selection of vendors is solely the responsibility of the Company.

c. The Committee will review availability of HMO and EPO plans in areas where the POS plan does not provide adequate access and make recommendations for HMOs and EPOs for those areas. In addition, the Committee will review recommendations for HMOs and EPOs sent by employees to the Committee. The Committee's goal will be to expand options for cost effective quality care for employees in POS areas and to assure adequate access to affordable coverage in non-POS areas.

d. The Committee shall meet at least quarterly, unless agreed to be changed by representatives serving on the Committee, but in no event shall they meet less than once every six (6) months.

e. The Committee will discuss options and opportunities to work together to achieve legislative changes to assure universal health coverage, including guaranteed coverage for workers and retirees age 55 and over. Opportunities could include joint letters and/or lobbying visits to Members of Congress.

f. Should there be legislative changes related to health care that impact the Bargained Plan, such changes will be reviewed by the Parties. If it is necessary to adjust or modify the Bargained Plan to remain in compliance with the law, the Parties shall meet to discuss the modifications prior to implementation. Those portions of the Bargained Plan not impacted by law will remain in force unless mutually agreed upon by the Parties to make adjustments to the Plan. Should the legislative changes result in cost savings to the company as a result of benefit changes, the parties will meet to discuss the distribution of the plan savings.

g. For the District 3, District 6 and Puerto Rico contracts, one full time union-appointed benefit liaison, to be paid by Company. For the contract covering all other CWA Districts (the "orange" contract), two full-time union-appointed benefits liaisons shall be appointed by the union and paid by the Company. These individuals are charged with assisting bargaining unit members who are having trouble understanding and accessing their medical and other health benefits and with helping members in resolving problems with insurance administrators.

6. Through the Joint Committee, the Company and the Union will implement a Total Health Management program effective January 1, 2010.

a. The goal of the THM program will be to assure moderate medical trend rates over time. This goal will be achieved through reduced medical utilization as a result of improvements in care coordination, treatment compliance with medical guidelines, patient safety, quality care, the overall health of members. The THM program will include the following components at a minimum: chronic condition management and health promotion/wellness.

b. Participation in the THM program will be based on involvement in one of the qualifying activities listed in items 6d or 6e below for each category. Participation will be strongly encouraged for employees and their spouses/domestic partners using the following incentive:

c. Employees and/or the spouses/domestic partners who participate in one of the listed activities will have their monthly health plan contributions waived for 6 months following completion of one of the qualifying activities described below.

d. Category 1: Employees and spouses/domestic partners suffering from a chronic illness (e.g. diabetes, heart disease, COPD, asthma, hypertension) and are designated by the chronic condition management vendor as eligible to participate in the chronic condition management program will have five qualifying activities from which to choose. Those activities will be:

- Complete the chronic condition management telephonic assessment and complete one follow-up call with a nurse case manager working for the chronic condition management vendor supporting the THM.
- Actively participate for at least 4 consecutive months in the chronic condition management program protocols, telephonic patient coaching calls, and comply with all medical treatment (i.e. take medications, check-ups, regular tests) recommend by the participant's physician related to the chronic condition.
- Based on the chronic condition management guidelines and protocols receive a designation from the chronic condition management vendor as having successfully completed or "graduated" from the chronic condition management program.
- Following completion or graduation from the formal chronic condition management program, demonstrate compliance with

recommended follow-up calls and protocols recommended by the chronic condition management vendor's nurse case manager.

- Demonstrate compliance with chronic condition specific treatments and protocols, such as – having annual check-ups, monitoring glucose levels, measuring cholesterol levels, others as deemed appropriate by the chronic condition management vendor and the participates physician.

e. Category 2: Employees and their spouses/domestic partners who are not identified as eligible for participation in the chronic condition management program will have six health promotion/wellness qualifying activities from which to choose. These activities are listed below:

- Fully complete the on-line Health Risk Assessment offered through the THM.

- Support good health through accessing timely preventive health care. This can be done by completing age/gender specific preventive health screening tests such as – colorectal cancer screening, Pap smear, cholesterol testing, PSA, and others as deemed appropriate by a physician.

- Have a complete annual physical exam and follow recommendations of the physician for getting health screenings and tests.

- Demonstrate participation in a regular exercise program (at least 3 months) that is progressively improving some aspect of overall health.

- Complete a tobacco cessation program offered through the THM.

- Complete a weight management program offered through the THM.

f. Role of the Joint Health Care Committee: Joint partnership of the union and the company in the oversight of the total health management program will assure its success. The Committee will be responsible for designing and overseeing a member/employee education program with the goal of encouraging participation. In addition, the Committee will: set benchmarks and review and monitor utilization trends; track partipation rates in the THM programs; advise union and company bargainers and leadership and members/employees about results; propose modifications to the THM program in order to improve participation rates and results or to take advantage of new initiatives.