AT&T Ameritech /SBC Retirees

We are AASBCR®

Proudly working on behalf of retirees of the Bell System and successor companies of the New AT&T, located worldwide

First Quarter Newsletter March, 2010

FROM THE PRESIDENT'S DESK, March, 2010

My fellow retirees,

There are several issues that AASBCR® is working with at this time. We are all still waiting to see what our representatives in Washington DC do about the spiraling health care costs. Be assured that AASBCR®, working closely with the National Retiree Legislative Network (NRLN), will continue to fight for retirees.

In that vein, the NRLN has produced a white paper that encourages Congress to pass legislation to provide Americans--especially retirees--with savings on prescription drugs. This legislation: 1) Enables importation of prescription drugs. 2) Enables Medicare to develop formularies and take competitive bids for prescription drugs sold under the Medicare D plans. 3) Staff and fund the FDA to reduce the generic drug approval back log.

AASBCR® is continuing our partnership with the NRLN. The NRLN is our national legislative partner. To that end, AASBCR® is in support of the NRLN 2010 Special Projects. Those projects are -- **Bankruptcy Reform** (to include Retirees' pensions, health care, and other ***earned*** benefits on the list of Corporate Obligations); ***Employee Retirement Income Security Act*** **(*ERISA*)** and **Pension Benefit Guaranty Corporation (PBGC)** legislation needed to protect retirees' benefits. U.S. companies have been bought by other companies (GM, Delta Airlines, etc.) and by Foreign Corporations (Lucent by French Alcatel, Chrysler by Italian Fiat, etc). All companies are vulnerable to bankruptcies and large company takeovers. That includes AT&T. To that end, the AASBCR® board of directors has contributed to these NRLN 2010 special projects and will ask you, our members, where possible to assist. You will see more on this subject

While lamenting the rising costs of retiree benefits, the company has no problem providing Ed Whitacre, as part of a $158 million retirement package, use of AT&T's corporate jets for 10 hours a month. This costs AT&T $20,000 a month. Whitacre now works in Detroit, but his primary residence is in San Antonio. The perk from his AT&T

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package allows for two round-trip flights between the two cities per month, it was reported. Whitacre earns about $1.7 million per year at GM, which gave up its seven corporate jets last year when it filed for bankruptcy.

Again, in April, I will attend the AT&T shareholder meeting and attempt to get our former employer, AT&T, to do the right thing. We are again asking that AT&T provide information to the stockholders to approve or disapprove the compensation of the named executive officers as set forth in the proxy statement's Summary Compensation Table. This "vote" is strictly advisory. It would show that AT&T is open and honest about executive compensation. Sadly, they do not want to do that.

Don't forget the AASBCR® Annual Meeting. It will be held on Thursday, June 10 at noon central time, 1 PM eastern time in Cleveland and Chicago. Conference call-ins will be welcomed.

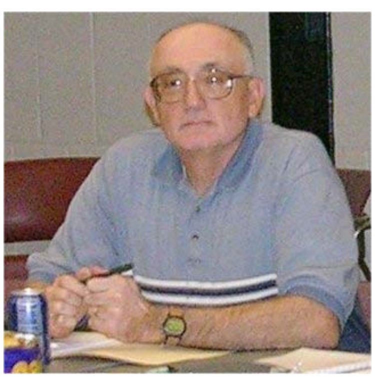
Have a wonderful Easter and spring.

Carole Lovell

March 27, 2010

From the Desk of Ray Sternot, VP-Legislation

By now all of you should be aware that the President has signed the Healthcare bill and it has become law. As I stated in my last newsletter, AASBCR® cannot tell anyone how to assess what Congress finally created. But obviously not everyone is happy with all items in the bill.



In our opinion, the model health bill for retirees should have been about helping companies sustain company sponsored healthcare while not shifting all cost increases to employees or retirees. It should be to protect Medicare by eliminating waste and lowering the cost curve through delivery improvements and better negotiations with and competition among big Pharmaceutical and Insurance companies. It is one than minimizes Government involvement but calls for more competition nationally. Time will tell whether we get that kind of benefit from this recent legislation or changes to it.

But what I do believe that retirees in general got were the following items from the recently passed bill:

a.) The bill makes it against the law for insurance companies to deny you coverage on the basis of a pre-existing condition or illness.

b.) The bill stops insurers from charging exorbitant premiums on the basis of age, health, or gender.
c.) The bill will prevent insurance companies from dropping your coverage when you get sick.

Why is that important? Because, as I said, not everyone is happy with the bill that has passed. In fact, even AT&T has indicated that because of the bill they must now "potentially adjust" their coverage for retirees. So, these changes could prove beneficial in the future to us.

In my last quarter's article, I stated that It was clear that retiree healthcare, as we know it or prefer it to be, is going away because of the increasing costs to companies. (It hasn't been just because of the healthcare bill. It's been happening for a long time now with increased out of pocket costs for many of our retirees.) I also stated that unless something changes, companies will continue to shift costs to retirees and/or eliminate healthcare coverage altogether if allowed to do so. In fact, I stated that the December 26, 2008, EEOC ruling protects companies under the EEOC rules from being sued if they do so.

I also said that because AT&T is healthy, we have not seen our benefits totally stripped. But now even AT&T is considering doing just that to our benefits. In my opinion, blaming the healthcare bill is really being disingenuous. After all, AT&T prior to 2003 didn't get this government tax benefit and they still provided retirees their earned healthcare benefits. The bill just taxes this payment whereas before it contributed directly to their bottom line. And, they still continue to pay our former chairman his pension, travel costs, and healthcare even though he is now Chairman of GM getting a huge salary.

So what can we expect? In my opinion, more pressure by AT&T to pushing additional costs on to retirees or by eliminating benefits in some instances in their entirety and blaming the changes on the recently passed healthcare bill.

As a member and officer within the NRLN and on the legislative team, we are working hard to get our message to the various committees in Congress that retiree healthcare should be protected. I encourage you to view the NRLN's Legislative Agenda at the NRLN website (www.nrln.org) and participate when there is a call to action.

Ray Sternot

Long ago when men cursed and beat the ground with sticks, it was called witchcraft. Today, it's called golf.

State of the Association / AASBCR®

During the past year, several members have made inquires regarding the economic health of the Association. It is my pleasure to report that the patient is in fine health.

Last year, your Officers, ever mindful of the economic times, diligently administered a very aggressive budget and completed the year being 17.5% under budget. Some of the highlights of the year are:

- Membership donations, over and above dues - - $1,360
- Donations to the Jim Kempe (Legal Counsel) Memorial Fund - - $75
- Support of retiree legislative efforts in Washington D.C. in affiliation with the NRLN (National Retiree Legislative Network) - - $5400
- AASBCR® shares of AT&T stock are now at 94 shares, up from the initial purchase of 80 shares, achieved through dividend re-investment
- Investment returns - - $510

Thanks to everyone for your support and contributions.

Chet Przybyslawski
AASBCR® VP/CFO

Opinion... from the Desk of Ray Sternot, VP-Legislation

WHAT IF?

As former AT&T employees, we were conditioned to look ahead and ask ourselves a very basic question: 'What if?' What if a worst-case scenario happened? What would it look like? How would we handle it?

Applying that to retiree healthcare and pension benefits it is clear that we can no longer afford to rely on the paternalistic behavior of our former company. Nor can we be confident that members of Congress will always do the right things for retirees. In fact, we should be extremely concerned when we think we could be one inept CEO away from an employee disaster like Qwest, with Joe Naccio. Quest retirees are now in the process of losing more retiree benefits (survivor insurance). We should be equally concerned with what is happening in Congress with all legislation, not just healthcare. There is extreme uncertainty about what a final Healthcare bill might look like, if it passes at all. There is no knowing what will come of this "reconciliation process". It is anticipated that some House items on retiree benefits will probably be pushed aside because of Senate concerns on how businesses will be impacted. On the positive side some congressmen have said, "Legislation should first do no harm."

However, it's clear not all members of Congress get it. You can meet with them but only if you are one of their constituents. You can write but they don't have to listen or respond because if you aren't in their State or Congressional district, your vote doesn't count. You can complain about greed with banks but there is greed everywhere, including in the legislative and election processes.

There is also complacency among some retirees who look at the situation around them and say, "I'm concerned and sympathetic to this plight but it doesn't impact me." That's what the Delta Pilot Retiree President was thinking when he was talking with the US Air Retiree President after US Air went bankrupt and pensions were at risk. Who would have thought short two years later, with the bankruptcy of Delta Airlines, he would have been in the same situation?

While healthcare has always been provided at the discretion of the companies because it was considered a welfare program not entirely covered under ERISA regulations, assets that support pensions are covered by ERISA but still may not be protected in this changing environment. For example, are the pension assets of Lucent, being taken over by a foreign Company (Alcatel), or Chrysler, being taken over by Fiat, really protected? It's clear that the PBGC (Pension Benefit Guarantee Corporation) does not know the answers to these questions. Things are changing and these changing times need to be addressed.

Retiree groups need to ask the right questions of companies and members of Congress, encourage them to do the right thing, and hold them accountable for their decisions. But retiree groups are all composed of us retirees and, if we don't support a retiree group that will represent our needs as retirees then who will ask the 'what if' questions? Retiree organizations with their limited resources can't do it alone. Like armies, they need troops and supply lines to support the effort. Like anything, planning, doing, taking action takes time, people, organization and continued effort to plan for the 'what if' concerns coming down the road.

So, we hope you will continue to actively support the AT&T, Ameritech & SBC Retiree organization and the associated NRLN in our continued efforts on behalf of retirees. We are a non-profit, all volunteer organization. Our dues go to services that support the continuation of employer sponsored pension and healthcare benefits at a local and national level via our membership in the NRLN. We need our members to tell other non-members about us and just what's at risk.

Remember, if you do nothing, you are at the mercy of others. In many instances, they may not be doing much and, in some case, may be doing more harm than good for retirees. While not perfect, we are here for retirees both in dealing with the company and with Congress. We need your support! Thanks and may we continue to prosper and thrive in retirement.

Ray Sternot

CALL FOR CANDIDATES -- RESULTS

The nomination period for the six AASBCR® board positions ended on February 28, 2010. Following is the Nominating Committee's Final Report.

AASBCR® Nominating Committee
Final Report – 3/12/2010

1) Appoint Nominating Committee – Complete December 4, 2009 by Carole Lovell.
   Nominating Committee Members:
   - Bob Ledvina
   - Carole Lovell
   - Chet Przybyslawski
   - Pat Reichard
   - Joe Zubay
2) Prepare 'Nomination Solicitation Letter' – Complete December 10, 2009 by Nominating Comm.
3) 'Nomination Election Process and Solicitation Letter' approved as submitted by AASBCR® Board at December 10, 2009 regular meeting.
4) Distribute 'Nomination Solicitation Letter' – Posted in December 31, 2009 4th Quarter Newsletter.
5) As of close of nominations for the AASBCR® Board of Directors 2010-2011 term the following candidates were submitted and agreed to accept the nomination:

Office:	**Nominee:**
Membership	Carole Lovell
Legislation	Ray Sternot
Communication	Joe Zubay

CFO/Treasurer . . . . . . Chet Przybyslawski
Secretary . . . . Rich Runge

6) Nominations closed as of close of business February 28, 2010.

Submitted by: Joe Zubay, Nominating Comm. Member

According to the AASBCR® By-Laws, since there are no contested positions, the entire slate is elected by acclamation. They will be installed at the AASBCR® Annual Meeting on June 10, 2010.

AT&T ANNUAL MEETING -- AASBCR® SAY ON PAY – FOURTH YEAR

The AT&T Annual Meeting is on April 30, 2010, in Chattanooga, TN this year. Carole will be there to present our Stockholder Proposal to allow a non-binding vote of the stockholders on Executive Compensation. JoAnn Alix-Gagain will be there to present the Southern New England Retiree Association (SRA) Stockholder Proposal to eliminate Pension Plan Earnings as a source to determine executive bonuses. The following is from the ACER (Legacy AT&T) Newsletter:

Colleagues, Retirees, Employees and Friends,

The AT&T Annual meeting is scheduled for April 30, 2010. Our AT&T Retiree Organizations are sponsoring 2 proposals that deal specifically with the payment of our executives and the management of the pension fund. Please Vote "FOR" these proposals!

Your vote is extremely important. Both of these proposals have fallen short of the 51% margins needed to be considered as approved. We run the risk of them being eliminated from the annual report without your support.

Shareholder proxies are non-binding as per the SEC; but it is an emotional victory to reach that hurdle.

Proposal 4: Exclude Pension Credits from Calculation of Performance-based Pay.

Legacy AT&T adopted this practice in 2003, but the new AT&T has yet to embrace it as policy. Our premise is that the management of pension funds, whether it is profitable or not, should not have any bearing on executive pay. Pension fund performance should not be reflected in the performance of the company. It is misleading to the shareholders.

Proposal 5: Shareholder Advisory Vote on Executive Compensation
This gives shareholders the opportunity to agree or disagree with the established compensation package. It does not in any way

hinder business operation or invalidate employment agreements. It just gives Shareholders the Voice they are entitled to as owners of the company.

If you have not received your information, please read the message below. To review the 2010 Annual Report go to: **http://www.att.com/Common/about_us/annual_report/pdfs/2010_ProxyStatement.pdf**. *The proposals are on pages 20-25. (Get some coffee. This is a very slow load.)*

How to vote your AT&T proxy:

Note: Only AT&T stockholders who held shares at the close of business on March 2, 2010, the record date for the AT&T 2010 Annual Meeting, are eligible to vote their shares at the meeting. Access information (holder account number, proxy access number, control number) was sent by mail to stockholders beginning March 11, 2010. If you have not received your information by March 31, 2010, and you are a registered holder of AT&T, please call 800-351-7221. If you hold your shares through a broker/financial institution and you have not yet received your access information, please contact your broker for instructions.

Health Costs for Surviving Spouses

By Carole Lovell

While we all realize the difficulty of discussing what costs will occur for our family when we pass away, it is a very necessary discussion to have. I have heard some very sad stories.
"Robert retired March 2008 and died in March, 2009. He was 57 years old with no health problems. We have a son attending college and a disabled adult daughter. Our medical insurance coverage went into an account under my name on 4/1/2009. When I signed up for 2010 enrollment, my premium rose to $524.00 a month. Now I get notification that my premium will be over $1400.00 (for 2 healthy people-with no issues) starting 4/1/2010 -- there is no way I can afford this.

I am so disappointed in AT&T, it has not been the way I expected to be treated. Without any warning my phone bill rocketed to $180. I had lost the concession, except it took many phone calls and 2 weeks to find out what was going on. Also when I cancelled his cell phone, and said he had died, the rep said "does that mean he doesn't exist anymore?"!!

All of this on top of my grieving."

AASBCR® cannot change the SPD and the benefits that we receive from AT&T. We can just make sure that these benefits are handled fairly. Please, read your SPD or call the AT&T Benefit Center BEFORE something happens. Have a discussion with your spouse. Make financial preparations. Don't let them find out in such a distressing way.

A REASONABLE SUMMARY OF THE NEW HEALTH CARE LAW
(IN ONLY FIVE PAGES)

It was the best of times - It was the worst of times.
It is the beginning of the new millennium, with health and prosperity for all - The Apocalypse is upon us.
All parties involved in the Great Health Care Debate have spread enough Bovine waste to fertilize US Agra-Business for at least a year – maybe a decade! I've heard of "Lies, Damned Lies, and Statistics". Seems there is a fourth, even worse type of lie – Politics.

The following was distributed to employees by the Cleveland Clinic to explain the changes in the near future.

Patient Protection Act (with changes made by Reconciliation)

Below are the elements of the Patient Protection and Affordable Care Act that may be of interest. This document is based on the Senate version of the health care reform legislation as amended by the House reconciliation bill. There could be further changes and amendments to the reconciliation piece during Senate consideration, and there is a remote chance that the Senate would fail to pass the reconciliation package. Both scenarios would result in changes to the legislation and this summary. Thus, this is not a final document.

Of particular note to us is that there is not a public option present in the legislation. Also absent is the Health Rating Authority Commission, which was the proposal to have a federal rating board.

Individual Mandate
All individuals will be required to have health insurance, with some exceptions, beginning in 2014. Those who do not have coverage will be required to pay a yearly financial penalty of the greater of $695 per person (up to a maximum of $2,085 per family), or 2.5% of household income, which will be phased-in from 2014-2016. Exceptions will be given for financial hardship and religious objections; and to American Indians; people who have been uninsured for less than three months; if the lowest cost health plan exceeds 8% of income; and if the individual has income below the poverty level ($10,830 for an individual and $22,050 for a family of four in 2009).

Guaranteed Issue
Through private market reforms (detailed below) all carriers will be required to have guaranteed issue and guaranteed renewal in order to accommodate the individual mandate beginning in 2014.

American Health Benefit Exchanges
States will create the American Health Benefits Exchanges where individuals can purchase insurance and separate exchanges for small employers to purchase insurance. These new marketplaces will provide consumers with information to enable them to choose among plans. Premium and cost-sharing subsidies will be available to make coverage more affordable.

Access to Exchanges will be limited to U.S. citizens and legal immigrants and subsidies will only be available to those without other coverage or whose share of the premium for coverage offered by an employer exceeds 9.8% of their income. Small businesses with up to 100 employees can purchase coverage through the Exchange.

Although there will not be a public plan option in the Exchanges, the Office of Personnel Management, which administers the Federal Employees Health Benefit Program, will contract with private insurers to offer at least two multi-state plans in each Exchange, including at least one offered by a non-profit entity. In addition, funds will be made available to establish non-profit, member-run health insurance CO-OPs in each state.

Plans in the Exchanges will be required to offer benefits that meet a minimum set of standards. Insurers will offer four levels of coverage that vary based on premiums, out-of-pocket costs, and benefits beyond the minimum required plus a catastrophic coverage plan.

The four levels of coverage will be:

- o Bronze – minimum level of coverage, provides essential health benefits. Cover 60% of benefit costs of plans, with an out of pocket limit equal to the HSA current limit ($5,950 for individual and $11,900 for family).
- o Silver plan - provides the essential health benefits, covers 70% of the benefit costs of plan, with the HSA out-of-pocket limits.
- o Gold plan – provides the essential health benefits, covers 80% of the benefit costs of plan, with the HSA out-of-pocket limits.
- o Platinum plan – provides the essential health benefits, covers 90% of the benefit costs of plan, with the HSA out-of-pocket limits.

Premium subsidies will be provided to families with incomes between 100-400% of the poverty level (or $22,050 to $88,200 for a family of four in 2009) to help them purchase insurance through the Exchanges. These subsidies will be offered on a sliding scale basis and will limit the cost of the premium to between 2% of income for those between 100-133% of the poverty level to 9.8% of income for those between 300- 400% of the poverty level.

Cost-sharing subsidies will also be available to people with incomes between 100-200% of the poverty level to limit out-of-pocket spending.

Broker Role – HHS Secretary is required to “establish procedures under which a State may allow agents and brokers to enroll individuals” in Exchanges.

An Advisory Board must be set up by HHS and must include “individuals with experience in facilitating the enrollment in qualified health plans.”

A “Navigators” Program must be set up by Exchanges to engage in education, marketing, and enrollment activities. Insurance agents and brokers are expressly included in the list of potential “Navigators” but they may not serve as a “Navigator” if they are paid in any way “directly or indirectly” in connection with enrollment in an Exchange-provided plan. Regulations will be forthcoming from HHS on this issue. Importantly, any Navigator must be “qualified, and licensed if appropriate.”

Employer Requirements

There is no employer mandate but employers with more than 50 employees will be assessed a fee of $2000 per full-time employee (excluding the first 30 employees from the assessment) if they do not offer coverage and if they have at least one employee who receives a premium credit through an Exchange. Employers that do offer coverage but have at least one employee who receives a premium credit through an Exchange are required to pay the lesser of $3,000 for each employee who receives a premium credit or $750 for each full-time employee.

Employers that offer coverage will be required to provide a free choice voucher to employees with incomes below 400% of the poverty level if their share of the premium cost is between 8-9.8% of income and who choose to enroll in a plan in an Exchange. Employers that offer a free choice voucher will not be subject to the above penalty.

Large employers (more than 200 employees) that offer coverage will be required to automatically enroll employees into the employer's lowest cost premium plan if the employee does not sign up for employer coverage or does not opt out of coverage.
No employer may impose a waiting period that exceeds 90 days.

Private Insurance Mandates

New insurance market regulations will prevent health insurers from denying coverage to people for any reason, including their health status, and from charging people more based on their health status and gender. These new rules will also require that all new health plans provide comprehensive coverage that includes at least a minimum set of services, caps annual out-of-pocket spending, does not impose cost-sharing for preventive services, and does not impose annual or lifetime limits on coverage (existing individual and employer-sponsored plans do not have to meet the new benefit standards).

Health plan premiums will be allowed to vary based on age (by a 3 to 1 ratio), geographic area, tobacco use (by a 1.5 to 1 ratio), and the number of family members.
Health insurers will be prohibited from imposing lifetime limits on coverage and will be prohibited from rescinding coverage, except in cases of fraud.

Increases in health plan premiums will be subject to review before they can be implemented.

Young adults will be allowed to remain on their parent's health insurance up to age 26.
States will be allowed to form health care choice compacts that enable insurers to sell policies in any state that participates in the compact under a single set of rules.

Merging of Individual and Small Group Markets

Beginning in 2014, the legislation allows states the option of merging the individual and small group markets within the Exchanges.

Expansion of Public Programs

Medicaid will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009). This expansion will create a uniform minimum Medicaid eligibility threshold across states and will eliminate a current limitation of the program that prohibits most adults without dependent children from enrolling in the program today. Eligibility for Medicaid and the Children's Health Insurance Program (CHIP) for children will continue at their current eligibility levels until 2019. People with incomes above 133% of the poverty level will obtain coverage through the newly created state health insurance Exchanges.

The federal government will provide 100% federal funding for the costs of those who become newly eligible for Medicaid for three years (2014-2016). In 2017 and 2018, states will receive an increase in the federal medical assistance percentage (FMAP) based on current state eligibility levels for adults, and then beginning in 2019, all states will receive the same FMAP increase. Different funding rules apply for Nebraska and certain states that are not eligible for the increased FMAP because they have already expanded Medicaid eligibility.

New Taxes and Fees

"Cadillac Tax"-- Imposes a 40% excise tax on insurers of employer sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage (these threshold values will be indexed to the consumer price index for urban consumers (CPI-U). This tax would apply to self-insured plans and sold in the group market, but not plans sold in the individual market.

Non-Wage Medicare Tax- starting in 2013, households with incomes above $200,000 ($250,000 for married couples) will have a new, 3.8 percent tax applied to their income from interest, dividends, capital gains, and some profits from investments in partnerships and S corporations.

0.9% Medicare Tax Increase- starting in 2013, households with incomes above $200,000 ($250,000 for married couples) will have a 0.9% increase to their Medicare taxes on their wages.

Third party administrators and health insurers must pay a three-year aggregate industry fee to fund a reinsurance program that will total $12 billion in 2014, $8 billion in 2015, and $5 billion in 2016.

There is a fee on health insurers and self-insured plans of $2 per covered beneficiary to fund comparative research initiatives.

Health insurers must pay a new annual fee based on their market share. The fee will be assessed based on their net premiums written starting in 2014. The fee will total (across all health insurers) $8 billion in 2014, $11.3 billion in 2015, $11.3 billion in 2016, $13.9 billion in 2017, and $14.3 billion in 2018. After 2018 the fee will be indexed to growth based on premium growth for the preceding year.

The pharmaceutical manufacturing sector must pay a new annual fee ($2.5 billion in 2011).

The deduction for the subsidy for employers who maintain prescription drug plans for the Medicare part D eligible retirees is eliminated started in 2013.

HSA and FSA Changes

Only prescribed drugs would be permitted to be reimbursable through a health savings account.

The tax on distributions from a health savings account that are not used for qualified medical expenses would be increase to 20% (from the current 10%) of the disbursed amount.

The amount of contributions to FSA's for medical expenses would be limited to $2,500 per year, adjusted for inflation.

Medical Loss Ratio (MLR)

Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. Requirement to report medical loss ratio effective plan year 2010, requirement to provide rebates effective January 1, 2011.

Small Business Tax Credit

Provides a two year tax credit to small businesses (less than 25 employees) with aver annual wages of less than $40,000 that purchase health insurance with the tax credit.

For tax years 2010 to 2013, the tax credit would be up to 35% of the employer's contribution toward the employee's health insurance premium if the employer contributes at least 50% of the total premium cost.

For tax years 2014 and later, for eligible businesses that purchase through the Exchanges, the tax credit would be up to 50% of the employer's contribution toward the employee's premium if the employer contributes at least 50% of the employee's total premium cost.

The full credit will be available to employers with 10 or few employees and average annual wages of $25,000 and less, the credit phases out as firm size and wages increase.

Prevention/Wellness Programs

Establish the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness, and public health activities. Develop a national strategy to improve the nation's health. (Strategy due one year following enactment)
Create a Prevention and Public Health Fund to expand and sustain funding for prevention and public health programs. (Initial appropriation in fiscal year 2010)

Create task forces on Preventive Services and Community Preventive Services to develop, update, and disseminate evidenced-based recommendations on the use of clinical and community prevention services. (Effective upon enactment)

Establish a grant program to support the delivery of evidence-based and community based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates, and addressing health disparities, especially in rural and frontier areas.

Provide grants for up to five years to small employers that establish wellness programs. (Funds appropriated for five years beginning in fiscal year 2011)

Provide technical assistance and other resources to evaluate employer-based wellness programs. Conduct a national worksite health policies and programs survey to assess employer-based health policies and programs. (Conduct study within two years following enactment)

Permit employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Employers must offer an alternative standard for individuals for whom it is unreasonably difficult or inadvisable to meet the standard. The reward limit may be increased to 50% of the cost of coverage if deemed appropriate.

CLASS Act

Establishes a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program). Following a five-year vesting period, the program will provide individuals with functional limitations a cash benefit of not less than an average of $50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. (Effective January 1, 2011)

AT&T ANNOUNCES $1 BILLION FIRST QUARTER, 2010 CHARGE DUE TO ELIMINATION OF THE MEDICARE PART D TAX SUBSIDY AND DEDUCTION

So the effects of this Health Care bill begin to hit. Disaster! But wait! There's more! Michael Calabrese (the lawyer who processes our Shareholder Proposal) sent Carole an analysis of this action, which Carole has shared with the AASBCR® Board and Committee members.

As I understand it (and I'm not sure I do), before the 2003 Medicare D bill became law, If I had $1,000 of prescription costs over and above my various deductibles, AT&T paid $1,000. After that bill, AT&T paid $1,000 and the Federal Government GAVE them (tax-free) $280 (28%). They got to deduct the full $1,000 from their taxes. This is so AT&T won't shove its retirees into the Medicare D arena.

The change that AT&T (and other companies) is reacting to is that after implementation, AT&T will still pay the $1,000, and the Federal Government will still GIVE (tax-free) the $280 (28%). But now AT&T will only be able to deduct the $720 IT ACTUALLY COST THEM!

But wait, there's even more! We aren't even talking about real money here! This is an "Accounting Procedure" (and I'm in way over my head). It seems that there is a ten-year Forward Looking account for this kind of stuff, so the $1 Billion is a projection of what it might cost through 2019. In actual money, the experts cited in Carole's e-mail project an annual cost of $40 - $50 Million per year for ALL retirees – less than 8 times the retirement benefits Ed Whitacre gets while double dipping at General Motors.

And AT&T might use this to "justify" dropping our (promised!) Prescription benefits.

Art Comings
AASBCR® Newsletter Editor

The opinions expressed above are NOT the position of the AASBCR® or the Board of Directors, and may not even be the position of the Editor by the time you are reading this.

The AASBCR® accepts a limited amount of advertisements from its members and friends. These advertisements are of wide interest to our membership. The revenue from these ads is used to offset the publication of our Quarterly Newsletter. AASBCR® offers these ads with no warranties expressed or implied.

I don't know how I got over the hill without getting to the top.

Ah, being young is beautiful, but being old is comfortable.

You know you are getting old when everything either dries up or leaks.

QUARTERLY CORRESPONDENCE:

During the past quarter we have sent the following correspondence via e-mail.
(E-mail recipients please click on the following links to the AASBCR® web site.)

- 03/26/2010 NEWS REGISTER - AASBCR® Shareholder Proposal for AT&T April 2010 Annual Meeting
- 03/17/2010 NEWS REGISTER - I have seen an increase in taxes on my "At Home" telephone bill. What is this all about?
- 03/17/2010 LEGISLATIVE LEDGER - NRLN Annual Board & Leadership Conference
- AASBCR® BLUE BULLETIN VOL.5 NO.2 Health care Insurance Problem Resolution Details method to achieve resolution of the problems dealing with CVS/Caremark. - 3/10/2010
- 01/14/2010 NEWS REGISTER - AT&T is looking for temporary staff
- AASBCR® BLUE BULLETIN VOL.5 NO.1 AT&T 2010 Healthcare Update - 1/12/2010
- 01/04/2010 NEWS REGISTER - Qwest (Formerly US West) Eliminates Retiree Death Benefit

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Ramblings of a Retired Mind

I was thinking about how a status symbol of today is those cell phones that everyone has clipped onto their belt or purse. I can't afford one. So, I'm wearing my garage door opener. I also made a cover for my hearing aid and now I have what they call blue teeth, I think.

You know, I spent a fortune on deodorant before I realized that people didn't like me anyway.

I was thinking that women should put pictures of missing husbands on beer cans!

I was thinking about old age and decided that old age is 'when you still have something on the ball, but you are just too tired to bounce it.'

I thought about making a fitness movie for folks my age, and call it 'Pumping Rust'.

I've gotten that dreaded furniture disease. That's when your chest is falling into your drawers!

When people see a cat's litter box, they always say, 'Oh, have you got a cat?' Just once I want to say, 'No, it's for company!'

Employment application blanks always ask who is to be notified in case of an emergency. I think you should write, 'A Good Doctor'!

I was thinking about how people seem to read the Bible a whole lot more as they get older. Then, it dawned on me. They were cramming for their finals.

As for me, I'm just hoping God grades on the curve.

Enjoy Your Days & Love Your Life, Because Life is a Journey to be Savored.