Summary Plan Description

IMPORTANT BENEFITS INFORMATION

AT&T East Vision Program

This is the Summary Plan Description (SPD) for the AT&T East Vision Program (Program), a component program under the AT&T Umbrella Benefit Plan No. 3 (Plan). This SPD replaces your existing Vision SPD and all of its summaries of material modifications.

Please keep this SPD for future reference.

NIN: 78-29001

IMPORTANT INFORMATION

In all cases, the official Plan documents govern and are the final authority on Plan terms, if there are any discrepancies between the information in this Summary Plan Description (SPD) and the Plan documents, the Plan documents will control. AT&T reserves the right to terminate or amend any and all of its employee benefits plans or programs. Participation in the plans and programs is neither a contract nor a guarantee of future employment.

What Is This Document?

This SPD is a guide to your Program Benefits. This SPD, together with the SMMs issued for this Program, constitute your SPD for this Program. See the "Eligibility and Participation" section for more information about Program eligibility and other Programs under the Plan.

Este documento contiene un resumen, en inglés. Si usted tiene dificultad en entender este documento, entre en contacto por favor con AT&T Benefits Center, **877-722-0020**.

What Action Do I Need To Take?

Please review this document carefully for detailed information about your Benefits and keep it for future reference.

How Do I Use This Document?

As you read this SPD, pay special attention to the key points at the beginning of most major sections and shaded boxes that contain helpful examples and important notes. While AT&T has provided these tools to help you better understand the Program, it is important that you read the SPD in its entirety, so that you can understand the Program details. Also, throughout this SPD, there are cross-references to other sections in the SPD. Please consult the Table of Contents to help you locate these cross-referenced sections.

Keep your SPDs and SMMs for your future reference. They are your primary resource for your questions about the Program.

Questions?

If you have questions regarding your Program Benefits, eligibility or contributions, contact the applicable administrators. Contact information is provided in the "Contact Information" section.

Si usted tiene alguna dificultad en entender cualquier parte de este documento, entre en contacto por favor con el Recordkeeper en la seccion de "Contact Information."

USING THIS SUMMARY PLAN DESCRIPTION

KEY POINTS

- *The AT&T Umbrella Benefit Plan No. 3 (Plan) is a welfare benefit plan providing coverage for health and welfare benefits through component Programs.*
- *This is a Summary Plan Description (SPD) for the AT&T Umbrella Benefit Plan No. 3 (Plan) with respect to Benefits under the AT&T East Vision Program.*
- *This document is an SPD for the portion of the Program that applies to eligible Bargained Employees of Participating Companies listed in Appendix A.*

This is a Summary Plan Description (SPD) for the AT&T Umbrella Benefit Plan No. 3 (Plan). The Plan was established on Jan. 1, 2001, and incorporates certain welfare plans sponsored by AT&T Inc. Benefits under the Plan are provided through separate component programs. A program is a portion of the Plan that provides benefits to a particular group of Participants or beneficiaries. Each program under the Plans applies to a specified set of benefits and group of Employees.

This SPD is a legal document that provides comprehensive information about the AT&T East Vision Program.

It provides information about eligibility, enrollment, contributions and legal protections for the Program Benefits for Bargained Employees that are associated with the respective Participating Companies listed in *Appendix A*. See the "Eligibility and Participation" section for information on your and your dependent's eligibility to participate in the Program.

Use this SPD to find answers to your questions about your Program Benefits in effect as of January 1, 2014. This SPD replaces all previously issued SPDs and Summary of Material Modifications (SMMs) for the Program covered in this SPD. To learn whether this SPD describes the Program provisions that apply to you, see the "Eligibility and Participation" section and your Participating Company and your Employee group listed in *Appendix A*.

Company Labels and Acronyms Used in This SPD

Most of the information in this SPD applies to all Participants. However, some Program provisions regarding eligibility, contributions, enrollment changes and Benefit levels may differ depending on your employment status, job title, employing Company and service history. When the SPD identifies differences that apply to Participants of an employing Company or an employee group, acronyms are used to refer to the employing Company or the employee group rather than the official name of the employing Company or group. See *Appendix A* for the list of Participating Company names and employee groups and their associated acronyms. If you are not sure what information applies to you, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

Section References

Many of the sections of this SPD relate to other sections of the document. You may not obtain all of the information you need by reading only one section. It is important that you review all sections that apply to a specific topic. Also, see the footnotes and notes embedded in the text. They further clarify content, offer additional information or identify exceptions that apply to certain Covered Persons. These notes are important to fully understand Program Benefits.

Terms Used in This SPD

Certain words and terms are capitalized in this SPD. Some of these words and terms have specific meaning (see the "Definitions" section for their meaning).

Program Responsibilities

Your Ophthalmologist, Optometrist and/or Optician are not responsible for knowing or communicating your Benefits. They have no authority to make decisions about your Benefits under the Program. This Program determines Covered Vision Services and Benefits available. The Plan Administrator has delegated the exclusive right to interpret and administer applicable provisions of the Program to Program fiduciaries. Their decisions, including in the Claims and Appeals process, are conclusive and binding and are not subject to further review under the Program. Neither the Program, its administrators nor its fiduciaries make health care decisions, and they do not determine the type or level of care or Course of Treatment for your personal situation. Only you and your Ophthalmologist, Optometrist or Optician determine the treatment, care and Services appropriate for your situation.

CONTENTS

ELIGIBILITY AND PARTICIPATION

KEY POINTS

- *If you are a full-time or part-time Regular Employee or Term Employee, eligibility for coverage begins on the first day of the month in which you complete a Term of Employment of six months with a Participating Company.*
- *Eligible Employees: Your Eligible Dependents are your Spouse or Legally Recognized Partner (LRP) and your Dependent Children who satisfy the Program's eligibility requirements.*
- *If you enroll in the Program and use a Video Display Terminal (VDT) as part of your job, you are automatically eligible for VDT Vision Care Benefits.*
- *The Program provides various levels of coverage for you or you and your dependents.*
- *You may be eligible for one or more coverage options under the Program.*

Eligibility at a Glance

This section includes information to help you determine if you are eligible for this Program. Review the "What Coverage Options are Available" for the level of coverage (e.g. Individual or Family) available under the Program. To determine if your dependents are eligible for this Program, see the "How to Determine if Your Dependents are Eligible for this Program" section.

In order to determine your eligibility for the Program, you need to know your employment classification and if you are in a bargaining unit or population group of a Participating Company listed in *Appendix A.* Locate the information applicable to you in the "Eligibility Rules" section of the table(s) to determine if you meet the eligibility requirements noted in the table(s) below.

Special eligibility rules apply to Employees who transfer or change positions under circumstances specified in the Benefits Rules for Movement or similar provisions in your collective bargaining agreement. If you move between bargained groups, contact the Eligibility and Enrollment Vendor.

If you do not meet the eligibility requirements for the Program described in this Summary Plan Description (SPD), contact the Eligibility and Enrollment Vendor for assistance in identifying the SPD that might apply to you.

Enrollment is not automatic. You must be enrolled in the Program to receive coverage. See the "Enrollment and Changes to Your Coverage" section for information on how and when you must enroll and effective dates of coverage.

Eligible Employees

If you are an Eligible Employee of a Participating Company, you are eligible for coverage for yourself and your Eligible Dependents as stated in the *Eligibility Rules* table below. Special eligibility rules apply to Rehired Eligible Former Employees. See the "Rehired Eligible Former Employees" section for more information. See the "Participating Companies" section for the identity of the Eligible Employee groups of each Participating Company.

Eligibility Rules	
Eligible Employees	
You are an Eligible Employee if...	You are a Bargained Employee who is classified by your Employer as a full-time or part-time Active Regular Employee or Term Employee in one of the Eligible Employee groups of a Participating Company.
Population Groups	East Region Core CWA
Dual Enrollment	
Dual Enrollment	While you may be eligible under more than one status (for example, as an Employee, Eligible Former Employee or dependent), the Program allows you to be enrolled under only one status. See the "Dual Enrollment" section for more information.
	If your eligible former Spouse/LRP is an Employee, you and your eligible former Spouse/LRP are allowed to • Enroll Eligible Dependents under the Program, that is, each of you may enroll all Eligible Dependents at the same time, or you may split the Eligible Dependents between you. • Enroll Eligible Dependents under another vision program sponsored by the Company, that is, each of you may enroll all Eligible Dependents at the same time, or you may split the Eligible Dependents between you. **IMPORTANT:** Under no circumstance are you and your former Spouse/LRP permitted to provide coverage to each other or to dependents who are not eligible to be covered under the Program. See the "Eligible Dependents" section for further information. The rules discussed above also apply to rehired retirees. In addition, as a rehired retiree, you may not be enrolled at the same time as both an Active and retired Employee in this Program or another vision program sponsored by a member of the AT&T Controlled Group of Companies.

Rehired Eligible Former Employees

Special eligibility rules apply if you terminated employment from a member of the AT&T Controlled Group of Companies with eligibility for Eligible Former Employee vision care coverage as an Eligible Former Employee and you are subsequently rehired by a member of the AT&T Controlled Group of Companies ("Rehired Former Employees"). These special rules establish the conditions under which you and your Eligible Dependents may be eligible for continued coverage under the Program following your reemployment. You will be considered a Rehired Former Employee for purposes of this Program during any period of time following your reemployment that you are eligible under these special rules for continuation of your Program coverage.

These special eligibility rules are contained in the "AT&T Rehired Former Employee Supplement" to the Plan. If you are a Rehired Eligible Former Employee, the rules in the "AT&T Rehired Former Employee Supplement" supersede the eligibility rules in this SPD. If you are being rehired after having qualified for Eligible Former Employee coverage due to your employment by a member of the AT&T Controlled Group of Companies, or are currently a Rehired Eligible Former Employee, contact the Eligibility and Enrollment Vendor and the supplement will be mailed to you at no cost to you. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section.

How to Determine if Your Dependents Are Eligible for This Program

Review this section to determine if your dependents (e.g., your Spouse/Legally Recognized Partner (LRP) and/or Child) are eligible to enroll in the Program. Coverage for your Eligible Dependents is not automatic. **You must enroll your dependents if you want them to be covered under the Program.**

Unless your dependent's eligibility for coverage is due to surviving dependent status or COBRA continuation coverage, your dependent(s) cannot be enrolled in the Program, unless you are also enrolled. You may not cover a Spouse and a Partner as Eligible Dependents under the Program at the same time. In addition, there may be restrictions on whether you can cover another Employee or Eligible Former Employee as a dependent under this Program. See the "Dual Enrollment" section for more information.

The Company reserves the right to verify eligibility of any enrolled dependents. See the "Dependent Eligibility Verification" section for more information. Once a dependent is enrolled, it is your responsibility to contact the Eligibility and Enrollment Vendor to cancel coverage whenever you have a dependent that is no longer eligible, including, for example, when you are divorced. See the "Enrollment and Changes to Your Coverage" section for more information.

If one of your dependents does not meet the eligibility requirements of the Program, the Program will not pay Benefits for any expenses incurred for that dependent. Also, if the Program pays Benefits for a dependent while the dependent is ineligible, you may be required to reimburse the Program for all such payments.

Note: If coverage for your dependent is based upon the terms of a Qualified Medical Child Support Order (QMCSO), see the "Alternate Recipients Under Qualified Medical Child Support Order" section for coverage information.

Eligible Dependents

Eligibility Rules	
Eligible Dependents	
Your dependents who meet the eligibility rule are eligible for Program coverage.	Your Eligible Dependents are: • Your Spouse. • Your LRP. • Your unmarried Children*or your Spouse/LRP's unmarried children who are dependent on you for support (Dependent Child) up to the end of the year in which they reach age 23. • Your unmarried disabled dependent Child(ren)* who is mentally or physically disabled, and was mentally or physically disabled before the age of 23. Contact the Eligibility And Enrollment Vendor well before the Child will reach age 23 to start the disability certification process. * Children include your own child; a child who is placed for adoption in your home; a child you have legally adopted or your stepchild, including the child of your LRP, who resides in your home; and a child for whom either you or your Spouse/LRP is Legal Guardian and who resides in your home.
Important: A physically or mentally disabled dependent adult Child must be certified as an Eligible Dependent for coverage. You can do this by completing the application forms available from the Eligibility and Enrollment Vendor and submitting them for approval to the address on the forms. See the "Certification of Disabled Dependents" section for details of the certification process.	

IMPORTANT: Under limited circumstances, exceptions to the disabled dependent and Legal Guardianship provisions may apply. See the "Eligible Dependent Exceptions" section for more information.

Eligible Dependent Exceptions

The information in this section describes special exceptions to the "Eligible Dependents" rules set forth above.

Grandfathered Disabled Dependent Child(ren)

A disabled dependent Child will be treated for purposes of Program eligibility as an Eligible Dependent if all of the following conditions are met:

- The Child was enrolled as your Eligible Dependent in a health or welfare benefit plan or program sponsored by a Company that has been merged into or acquired by AT&T Inc. or an affiliate of AT&T Inc. (Premerger Plan) immediately before the time you first became eligible for Program coverage.
- The Child has been continuously enrolled as a disabled dependent since the Child was first enrolled in the Program or other Company-sponsored plan.
- The Child remains unmarried and continuously disabled.

For purposes of this provision, "disabled" shall mean incapable of self-support as a result of a mental or physical disability as determined by the Benefits Administrator under the dependent verification process.

Grandfathered Legal Guardianship Provisions

This section applies to your Child who was enrolled in (i) a health or welfare benefit plan or program sponsored by a company that has been merged into or acquired by AT&T Inc. or an affiliate of AT&T Inc. (Premerger Plan) or (ii) a health or life insurance plan sponsored by Southwestern Bell Corporation on Aug. 1, 1994 (SBC Health or Life Plan). Such a Child will be treated as if the Child were a natural-born or biological Child of you or your Spouse/Legally Recognized Partner (LRP) for purposes of Program eligibility, if all of the following conditions are met:

- The Child was enrolled as your Eligible Dependent pursuant to a Legal Guardianship, adoption or similar arrangement either in (1) a Pre-merger Plan or an SBC Health or Life Plan immediately prior to the Employee first becoming eligible for coverage under the Program, or (2) an SBC Health or Life Plan as of July 31, 1994.
- You or your Spouse/Legally Recognized Partner (LRP) has maintained custody of the Child pursuant to the Legal Guardianship, adoption or similar arrangement continuously since the Child was first enrolled in the Program or, if the Child has reached the age of majority as defined by the jurisdiction in which the Child resides, the Custodial Participant continuously maintained custody of the Child from the time the Child was first enrolled in the Program until the Child reached the age of majority.

If applicable, the determination that the arrangement is similar to a Legal Guardianship or adoption is made by the Eligibility and Enrollment Vendor, in its sole discretion.

Certification of Disabled Dependents

To certify an unmarried Eligible Dependent who is disabled, you must contact the Eligibility and Enrollment Vendor to obtain the required forms for certification and follow the instructions on the forms. You and the dependent's physician must complete the application form and submit it for approval to UnitedHealthcare (UHC). UHC will determine eligibility and advise the Eligibility and Enrollment Vendor of the results of the review. The Eligibility and Enrollment Vendor will advise you whether your dependent qualifies for coverage under the terms of the Program. The Eligibility and Enrollment Vendor will enroll your Eligible Dependent for coverage, if appropriate. In addition, the Eligibility and Enrollment Vendor will periodically solicit you for disabled dependent verification.

Vision coverage for a disabled dependent begins when the disabled dependent is certified by UHC and all other eligibility requirements are met. A disabled dependent does not have to be continuously enrolled to be eligible for Program coverage. However, coverage is not retroactive for vision expenses incurred before certification.

IMPORTANT: It is best to contact the Eligibility and Enrollment Vendor three to six months before your Eligible Dependent reaches the age at which he or she is no longer eligible for vision coverage under the Program unless he or she is certified as being disabled. Failure to timely certify your Eligible Dependent prior to the age at which he or she is no longer eligible for vision coverage under the Program will result in a break in Program coverage.

Each of your unmarried disabled Children must provide satisfactory evidence of such disability upon request in order to be eligible for coverage under the Program. In addition, an independent medical Examination of your unmarried disabled Child(ren) may be required at the time of certification or recertification.

Ineligible Dependents

You must notify the Eligibility and Enrollment Vendor when one of your Eligible Dependents becomes ineligible to continue coverage under the Program. In addition, the ineligible dependent should not continue using his or her coverage after the last day of the month in which he or she becomes ineligible, unless the ineligible dependent is eligible for and elects to continue coverage under COBRA. If the Company pays expenses for this ineligible dependent before the ineligibility is identified, you must reimburse the Company for any Benefits paid after the last day of the month in which the Eligible Dependent becomes ineligible.

For more information on eligibility requirements and for the rules for when an Eligible Dependent becomes ineligible, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information. The Company reserves the right to request verification of Eligible Dependent status at any time.

Note: If your dependent does not meet the eligibility requirements of the Program, the Program will not pay any of his or her vision expenses. If the Program has paid vision expenses for an ineligible dependent before the ineligibility is identified, you will be required to reimburse the Program for all such expenses.

It is expected that the Active Employees covered under the Program will use the Benefits provided according to the terms of the Program. If you attempt to obtain Benefits to which you are not entitled under the terms of the Program (for example, by submitting false information on Claims for Benefits), or if you permit others to obtain Benefits by fraudulent means (for example, by allowing a Provider to submit Claims for Benefits for services not provided), you may be subject to prosecution and termination of your participation under the Program. Such behavior is also in violation of AT&T's Code of Business Conduct and, as such, you will be subject to disciplinary action, including, but not limited to, dismissal.

Dual Enrollment

The Program may provide coverage for you and your Eligible Dependent as described below. However, the Program has rules limiting Dual Enrollment, as described below. Dual Enrollment means that you are enrolled for Program coverage and, at the same time, enrolled in another Company-sponsored vision program under a different eligibility status.

The Program does not permit you or a dependent to be enrolled in the Program as an Employee, Eligible Former Employee or Eligible Dependent at the same time.

Some Employees have eligible Spouses/Partners who are eligible to cover themselves and their Eligible Dependents under a Company-sponsored vision program. The following describes the coverage opportunities and/or limitations that apply for these individuals:

If your eligible Spouse/Partner is an Employee, you and your eligible Spouse/Partner are allowed to:

- Enroll separately and enroll each other and other Eligible Dependents under the Program.
- Enroll in separate Programs. Each may enroll all Eligible Dependents at the same time or you may split the Eligible Dependents between two programs. For example, you may enroll in the Program and your Spouse/Partner may enroll in another medical program sponsored by the Company. You each may enroll all Eligible Dependents or you may cover some Eligible Dependents under the Program and some under another medical program sponsored by the Company.
- Enroll jointly, that is, you may enroll your Spouse/Partner as a dependent (or vice versa) and cover all Eligible Dependents under the Program.

If your eligible former Spouse/former Partner is an Employee, you and your eligible former Spouse/former Partner are allowed to:

- Enroll Eligible Dependents under the Program; that is, each of you may enroll all Eligible Dependents at the same time or you may split the Eligible Dependents between you.
- Enroll Eligible Dependents under another vision Program sponsored by the Company; that is, each of you may enroll all Eligible Dependents at the same time or you may split the Eligible Dependents between you.

> **IMPORTANT:** You and your former Spouse/Partner are not allowed to provide coverage to each other or to dependents who are not eligible to be covered under the Program. See the "Eligible Dependents" section for further information.

ENROLLMENT AND CHANGES TO YOUR COVERAGE

KEY POINTS

- *If you are an eligible employee, coverage under the Program is not automatic; you must actively enroll in the Program to receive coverage for yourself and your Eligible Dependents.*
- *As an Eligible Employee, you can enroll in the Program after your date of hire, during Annual Enrollment, after you experience certain change in status events or prospectively, at any time during the year. You may make changes to your existing coverage during the Plan Year as a result of a change in status event.*
- *As an Eligible Former Employee, you may make changes to your existing Program coverage during Annual Enrollment or after you experience certain change in status events.*
- *For more information on enrollment and changes to your coverage, contact the Eligibility and Enrollment Vendor. See the Eligibility and Enrollment Vendor table for contact information.*

WHAT COVERAGE OPTIONS ARE AVAILABLE

The Program offers the following three levels of coverage:

- Individual – You enroll only yourself.
- Individual + 1* – You enroll yourself and one Eligible Dependent (such as an eligible Child).
- Individual + 2 or more* – You enroll yourself and two or more Eligible Dependents (such as two eligible Children).

** These levels of coverage are also known as Family Coverage.*

See the "Eligible Dependents" section for information about who qualifies as your Eligible Dependent.

Enrollment at a Glance

The *Enrollment Rules for You* table below indicates the enrollment opportunities for which you and your dependents are eligible, as well as the time frames for electing coverage and making changes. For more detailed information regarding types of enrollment, see the sections following the *Enrollment Rules for You* table.

Enrollment Rules for You

	Enrollment
Newly Eligible Enrollment	Within 31 days of the later of your hire date or the date appearing on your enrollment materials - for coverage to be effective on your date of hire for Regular and Term Employees or the first day of the month you complete six months of service if you are a Temporary Employee provided you enroll within the 31-day initial enrollment period.
Annual Enrollment	During annual enrollment - for coverage to be effective on the first day of the following Plan Year.
Prospective Enrollment	At any time, changes to current coverage or newly elected coverage resulting from Prospective Enrollment are effective on the first day of the month following the request for enrollment. Prospective Enrollment does not permit you to change Program options. See the "Prospective Enrollment" section for further information about eligibility.
Change-in-Status Enrollment	See the "Change-in-Status Enrollment" section.

Dependent Eligibility Verification

A dependent is not eligible for Program coverage unless he or she satisfies the Program's Eligible Dependent requirements. The Company has the right to require that you provide documentation establishing the eligibility of the dependents you enroll in the Program. The following process outlines the steps necessary to complete the enrollment of a dependent in the Program.

- Determine if your dependent is eligible for Program coverage. Review the "Eligible Dependents" section for the rules that pertain to dependent eligibility.
- Call the Eligibility and Enrollment Vendor or access the Eligibility and Enrollment Vendor Web site to enroll your dependent.

- Your dependents will be conditionally enrolled and provided Program coverage contingent on your providing documents that verify the dependent's eligibility for coverage under the Program.
- Shortly after you enroll a dependent in the Program, a Dependent Eligibility Verification Kit will be mailed to your home address on record with the Company. The Dependent Eligibility Verification Kit will contain instructions for submitting documents that verify your dependent's eligibility for Program coverage, including a list of the documents that would meet this requirement. For example, if you are enrolling a Child, you will be required to provide a copy of a birth certificate or other specified document that establishes the Child's relationship to you. You must provide the required documentation to establish that your dependent is eligible to be enrolled in the Program before the date specified by the Eligibility and Enrollment Vendor in the Dependent Eligibility Verification Kit. If you do not provide the required documentation and, therefore, do not establish your dependent's eligibility before the stated deadline, your dependent will not be eligible for coverage. Coverage for the dependent will be terminated retroactively to the date the dependent's Program coverage began.
- If coverage is terminated retroactively, your dependent will not be eligible for Benefits under the Program for that period. You may be personally liable for the cost of any Claims incurred by your ineligible dependent. In addition, your dependent will not be eligible for COBRA continuation coverage under the Program, and no certificate of creditable coverage for this period of Program coverage will be provided. This means that your dependent will not receive the protections provided under law for individuals who have had group health plan coverage. See the "ERISA Rights of Participants" section for more information on these protections.

> **IMPORTANT:** Your dependent's enrollment in the Program is contingent upon verification of dependent eligibility by the Eligibility and Enrollment Vendor. It is critical that you immediately begin the eligibility verification process as soon as you receive the Dependent Eligibility Verification Kit from the Eligibility and Enrollment Vendor.

Note: Enrollment of an ineligible dependent in the Program constitutes benefits fraud and violates the AT&T Code of Business Conduct. The Company will refer suspected fraudulent enrollments to AT&T Asset Protection for investigation, which may result in legal action and financial consequences. If you are an Active Employee, you may be subject to employment disciplinary action, up to an including dismissal.

Annual Enrollment

Annual Enrollment occurs each fall. During Annual Enrollment, you will be notified of the coverage options available to you for the next Plan Year. Your enrollment materials will also include information on coverage assigned to you if you do not take action.

> **IMPORTANT:** The assigned coverage will be effective for the next Plan Year if you do not make an election.

It is important to review the materials and take action if needed. Your options, including your assigned coverage, may be different than your current coverage. Some options require you to actively enroll. Coverage begins Jan. 1 of the following Plan Year.

IMPORTANT: If you have a Change-in-Status Event on or after Sept. 1 and want to change your coverage, you need to make two separate elections:

1) Change your current coverage in effect through the end of the Plan Year, and

2) Update your Annual Enrollment elections for coverage beginning Jan 1.

You can enroll online via the Eligibility and Enrollment Vendor website or by calling the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

Prospective Enrollment

Prospective Enrollment means the ability to drop or add coverage for yourself or a dependent outside of Annual Enrollment, newly eligible enrollment or Change-in-Status Events. In general, Prospective Enrollment is available to all Covered Persons who are Active Employees and Eligible Former Employees.

The effective date of the change in coverage is noted in the *Enrollment Rules for You* table.

If you contribute toward the cost of your vision coverage, any additional required contributions resulting from your prospective enrollment must be paid on an after-tax basis until the first day of the next Plan Year. Refer to the "Before-Tax and After-Tax Contributions" section for more information.

Note: Once you enroll in the Program, you may not drop coverage or elect a lower level of coverage for the remainder of the following two calendar years unless you experience a change in status.

Special Enrollment Period

You may be eligible for a special enrollment period for Program coverage if:

- You declined vision coverage for yourself or your Eligible Dependents during Annual Enrollment or when you first became eligible to enroll in the Program because you had coverage through another group health plan or other health insurance coverage and that coverage ends (or if the other employer stops contributing toward the other coverage for you or your dependents). If this happens, you may be able to enroll yourself and your Eligible Dependents for vision coverage in the Program provided that you request enrollment within 31 days after the other coverage ends (or after the other employer stops contributing toward the other coverage).

- You declined vision coverage and later gain a new Eligible Dependent through marriage, birth, adoption or placement for adoption. If this happens, you may be able to enroll yourself and your Eligible Dependents for vision coverage in the Program during a special enrollment period, provided that you request enrollment within 31 days after the event.

To request special enrollment or obtain more information, contact the Eligibility and Enrollment Vendor. See the "Contact Information" section for contact information.

Change-in-Status Enrollment

Circumstances often change. You may get married, welcome a Child to the family, lose benefits under another employer's vision plan or you or a family member takes a leave of absence. These important events are called "Change-in-Status Events" and the Program allows you to change your enrollment when you experience certain specific Change-in-Status Events. See the "Change-in-Status Event" section for more information on events that are considered a Change-in-Status.

- You will be eligible to change Program coverage for you and/or your Eligible Dependents during the course of your two-year enrollment period (if you are an Eligible Employee) or the Plan Year (if you are an Eligible Former Employee), provided that:
- The change you make is consistent with the Change-in-Status Event.
- You contact the Eligibility and Enrollment Vendor within the required time period as described in the applicable "Family Status Changes" and "Special Enrollment Period" sections on the following page and the "Change in Employment Classification" section.

See the "Change in Status Events" section for a complete list of change in status events and the changes you are allowed to make if you experience a Change-in-Status Event.

> **IMPORTANT:** To be considered a Change-in-Status Event, the event must result in the gain or loss of eligibility or a change in the cost for coverage under either the Program or the vision plan of your Spouse, LRP or dependent.

Your ability to change your Program enrollment when you experience a Change-in-Status Event during a Plan Year is in addition to Annual or Prospective Enrollment opportunities. See the "Prospective Enrollment" section and the "Annual Enrollment" section for more information.

Notice of a Change-in-Status Event

It's important to consider how a change will impact your benefits. If any Change-in-Status Event occurs and you want to change your enrollment choices, you must inform the Eligibility and Enrollment Vendor within the timeframes noted below.

You can change your coverage category (for example, changing from individual to individual + 1) during the Plan Year if you have a qualified change in your family status (for example, adoption or marriage). If you are an Eligible Former Employee, this is the only time you will be allowed to change your coverage category during the Plan Year.

- Changes to your coverage as a result of a qualified family status change other than a change on account of death must be made within 31 days of the change in status event for the change in coverage to be effective retroactive to the date the event occurred. If you are an Eligible Former Employee and you do not make changes within this amount of time, you must wait until the next Annual Enrollment period or subsequent change in status event to make a change in coverage.
- The Eligibility and Enrollment Vendor will advise you as to which changes are permissible. If you do not provide the notification within the time frames noted above, your coverage change will become effective on the first day of the month following the date you contact the Eligibility and Enrollment Vendor.

- If you lose a dependent as a result of death, you must notify the Fidelity Service Center at **800-416-2363**. If you lose a dependent as a result of loss of eligibility (for example, through divorce or marriage of your Child), you must notify the Eligibility and Enrollment Vendor. Although you are not required to notify the Fidelity Service Center within a specified period of time after your dependent's death, you should contact the Center as soon as possible to initiate the appropriate changes to your Program coverage. Changes resulting from loss of eligibility under the Program will always be made retroactively to the date of loss of eligibility. Generally, the date of loss of eligibility is the last day of the month during which the event that caused the loss of eligibility occurred. There is no retroactive refund to the date of the event for any required contributions, and your ineligible dependent will not have coverage under the Program after the date on which eligibility is lost.

- If any contributions are adjusted as a result of your change in status event, the new contributions are effective the first day of the month following the date you contact the Eligibility and Enrollment Vendor to request the change in your coverage. However, if you are an Active Employee making before-tax contributions for your vision coverage pursuant to your Company FSA plan, the amount of your before-tax contributions will not change, even if the required contributions for your new coverage are more or less, unless your change in status event also is a qualified status change under your Company FSA plan. Refer to the "Before-Tax and After-Tax Contributions" section for more information on before-tax and after-tax contributions. Although generally similar, not all Change-in-Status Events under the Program are considered qualified status changes under your Company FSA plan. See your Company FSA SPD for a description and list of events that are considered qualified status changes.

The Effective Date of Your Change In Status Enrollment

It is very important that you notify the Eligibility and Enrollment Vendor within the time frames stated above when requesting a change to your enrollment. Your eligibility to make a change and the effective date of your request for your change in enrollment depends on when you request that change.

To change your enrollment, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

As noted above, your change in enrollment request is subject to review by the Eligibility and Enrollment Vendor. This review could have an impact on the effective date of your enrollment. For example, if you request enrollment for your newly eligible Child, your enrollment is subject to the same rules that apply to newly Eligible Employees and dependents, including the Dependent Eligibility Verification Process. Therefore, it is especially important to submit the necessary documents that prove eligibility for your dependent in a timely manner. Failure to submit the documents on time may delay his or her effective date of coverage under the Program beyond the effective dates listed below. See the "Dependent Eligibility Verification" section for more information.

If you request your enrollment change within the specified time frame and you provide all documentation requested by the Eligibility and Enrollment Vendor within the time required, your new enrollment will become effective either on:

- The date of the Change-in-Status Event in the case of birth, adoption or placement for adoption.

- On the first of the month after the event for all other Change-in-Status Events.

If you do not provide notification within the time frames noted above, your enrollment will become effective on the first day of the month following the date you notify the Eligibility and Enrollment Vendor.

Your Change in Status May Affect Your Tax Treatment of Your Contributions

A change in enrollment may lead to an adjustment to your required contributions and may also affect the tax treatment of your new contribution amount. For information about how your specific enrollment change may affect the amount of your contributions, contact the Eligibility and Enrollment Vendor.

> **IMPORTANT:** This section does not contain information about your right to change the amount of your before-tax contribution. The section outlines your right to change your Program coverage enrollment only. For more information on how contributions are affected by Change-in-Status Events, please see the "Before-Tax and After-Tax Contributions" section.

Change in Employment Classification

If your employment classification changes, such as going from part-time to full-time status, it may affect your vision coverage. In addition, if the number of hours you are scheduled to work changes, you may be required to contribute to the cost of your coverage or your current contribution may be waived, depending on the increase or decrease in the number of hours you are scheduled to work.

Change-in-Status Events

Permissible Change-in-Status Enrollment Events

Change-in-Status Events permit you to change your Program enrollment. For a detailed description of each of these events, see *Appendix B*. The permitted enrollment changes reflected in *Appendix B* are based on the terms and conditions of the Program and are consistent with federal law. The Plan Administrator has the discretion to determine whether or not a requested enrollment change is consistent with the event. See the "Status Change Codes legend" at the end of the tables in *Appendix B* for an explanation of the codes used in the tables.

There are certain requirements that your change in enrollment request must meet in order to be permitted under the Program.

- The enrollment change must be consistent with the event. The Change-in-Status Event must:
  - Affect eligibility and coverage under the Program and
  - Must be on account of and consistent with the event.

LEAVE OF ABSENCE

KEY POINTS

- *Special rules apply if you are on a leave of absence. You may be required to pay for coverage that continues during your Leave of Absence.*
- *If you do not continue coverage while on a Leave of Absence, you may be required to re-enroll upon your return to work.*

Your eligibility for continued coverage under this Program and whether you are required to pay for this coverage during your leave of absence depends on the type of absence and, in some cases, on the duration of your leave. If you are on an approved leave of absence, you will receive a notice explaining what coverage you are eligible to continue to receive and whether you will be required to pay for this coverage. If you continue coverage, you must make all contributions during the required time frame to avoid interruption of your benefits. If you do not continue coverage under the Program while you are on your leave of absence, you must re-enroll upon your return to work by contacting the Enrollment and Eligibility Vendor and speaking to a representative. All coverage that continued while you were on leave will be continued when you return to work unless your eligibility has changed, for example, a change in your position results in eligibility for a different benefit program.

Special rules apply if you are absent from work by reason of Military Service or on a leave of absence subject to the Family and Medical Leave Act ("FMLA leave"). These rules are covered in the next two sections.

Because your coverage generally will be continued until the end of the month in which your active employment ends, a leave of absence that begins and ends in the same month will not affect your eligibility for coverage, but you may be required to re-enroll for coverage upon your return to work in order to continue your coverage uninterrupted.

Extended Coverage for Employees on Active Military Duty

The Uniformed Services Employment and Re-employment Rights Act of 1994, as amended (USERRA), provides the right to elect continued coverage under this Program for an Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services.

The terms "Uniformed Services" or "Military Service" mean the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the commissioned corps of the United States Public Health Service and any other category of persons designated by the President of the United States in time of war or national emergency.

If you are qualified to continue coverage pursuant to USERRA, you may elect to continue your coverage under this Program by notifying the Eligibility and Enrollment Vendor in advance and providing payment of any required contribution for this coverage. This may include the amount the Company normally pays on your behalf. If your Military Service is for a period of time shorter than 31 days, you will not be required to pay more than the regular contribution amount for your coverage under this Program.

You may continue your coverage under USERRA for up to the shorter of:

- The 24-month period beginning on the date of your absence from work due to Military Service.
- The day after the date on which you fail to apply for, or return to, a position of employment with the Company.

Regardless of whether you continue coverage under this Program while in Military Service, if you return to employment with the Company, your coverage and coverage for your Eligible Dependents will be reinstated under the Program. No exclusions or waiting period will be imposed in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of Military Service.

This is a brief overview of the provisions of USERRA. For information concerning coverage for Employees who are absent from employment by reason of service in the Uniformed Services and their Eligible Dependents, contact the Eligibility and Enrollment Vendor. See to the *Eligibility and Enrollment Vendor* table for contact information.

Extended Coverage While on an FMLA-Protected Absence or on FMLA

During a leave covered by the Family and Medical Leave Act (FMLA leave), the Company will maintain your coverage under the Program for up to 12 weeks of leave on the same terms and conditions as applicable to similarly situated Active Employees who are not on FMLA leave. If you receive pay while on an FMLA Leave, your required contributions will continue to be taken from your pay. If you do not receive pay while on an FMLA Leave, you will be billed and required to pay your required contributions.

Repayment of Cost of Health Care Coverage Paid or Advanced by the Company

If you do not return to work for the Company following FMLA leave for a reason other than the continuation, recurrence or onset of a serious health condition that entitles you to approved FMLA leave or as a result of other circumstances beyond your control (for example, a layoff), you may be required to reimburse the Company for the cost of your Program coverage during your FMLA leave. If you return to work for the Company following FMLA leave, you will be required to reimburse the Company for the Employee contributions that were not paid during your FMLA leave.

Continuation of Coverage Under COBRA

If you don't return to active employment after your FMLA leave ends or you notify the Company that you do not intend to return after the end of your FMLA leave, you will be eligible to continue coverage through COBRA. The period of COBRA continuation coverage will begin on the earlier of:

- The date your FMLA leave ends if you don't return to active employment.
- The date you notify the Company that you do not intend to return after the end of your FMLA leave.

For More Information

FMLA leave information is also available on the HROneStop website at **onestop.web.att.com**. At the OneStop home page, select the *Your Time & Attendance* tab, then the *Family Medical Leave Act* section. The website contains information on FMLA Qualifying Events, eligibility requirements, details on the application process and other helpful resources. If you are not at work, you will be able to find additional information about FMLA leaves at **access.att.com**.

You may also send correspondence to:

AT&T FMLA Operations
105 Auditorium Circle, 12th Floor
San Antonio, TX 78205

Telephone Number
Toll-free: **888-722-1787**

Hours of Operation
Customer Care Specialists are available Monday through Friday, 8 a.m. to 6 p.m. Central time.

WHEN COVERAGE ENDS

KEY POINTS

- *Coverage under the Program generally terminates on the last day of the month in which your employment with the Company ends.*
- *Coverage for an eligible Spouse/Partner or Child will end as of the last day of the month, when the Spouse/Partner or Child no longer meets the requirements to be eligible under the Program.*
- *Under certain circumstances, coverage will be continued for a disabled Former Employee and a Disabled Child(ren).*
- *You and your eligible Spouse/Partner and Child(ren) may be able to continue coverage under COBRA in certain circumstances. In some circumstances, continued coverage may be provided after your death for some period of time.*

For Employees

Coverage under the Program will stop on the earliest of the following:

- The last day of the month in which your employment with the Company ends (including by reason of death or retirement).
- The last day of the month in which you stop being an Eligible Employee.
- Your company is no longer a Participating Company.
- The last day of a period for which contributions for the Cost of Coverage have been made in full, if the contributions for the next period are not made in full when due.
- The day the Program ends.

See the "Extension of Coverage – COBRA" section for information about what rights you may have to continue coverage.

The remainder of this section describes certain other situations where continued coverage may be available for you and/or your covered dependents.

For Covered Spouse/Partner and Child(ren)

Coverage for your Spouse/Partner, and/or your Child(ren), stops when one of the following occurs:

- Your coverage stops.
- The last day of a period for which contributions for the Cost of Coverage have been made in full if the contributions for the next period are not made in full when due.

Coverage for a Spouse/Partner or Child(ren) will stop sooner if one of the following occurs:

- The individual becomes covered as an Employee of the Company under this Program.
- The individual is no longer eligible as defined in the section called "Eligible Dependents."

See the "Extension of Coverage – COBRA" section for information about what rights you or your dependents may have to continue coverage.

A mentally or physically incapacitated Child's benefit coverage under the Program will continue as long as your dependent's coverage under the Program continues and the Child continues to meet the conditions described in the sections entitled "Eligible Dependents" and "Certification of Disabled Dependents."

Rescission of Coverage

A rescission of your coverage occurs if the coverage is cancelled retroactively except when the termination is for nonpayment. Your coverage can be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice or omission that constitutes fraud; or if you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact.

You will be provided with 30 calendar days advance notice before your coverage is rescinded. You have the right to request an internal Appeal of a rescission of your coverage. Once the internal Appeal process is exhausted, you may have the additional right to request an independent external review. If you appeal a rescission in coverage, coverage will be maintained pending a resolution of the Appeal to the extent required by law. See the "External Appeals Process for Certain Eligibility Claims" section for information.

If You Are Laid Off From Active Employment

If you terminate employment due to a force adjustment or layoff, continued Company contributions to your coverage may be available for a limited period (as long as you continue to pay any applicable contribution). You will be notified following your termination of employment if the severance or force adjustment program or agreement under which you terminated employment provides for an extension of vision coverage. You may also contact the Eligibility and Enrollment Vendor for assistance with questions.

If You Are Retiring From the Company

Active Program coverage for you and your enrolled Dependents will continue through the end of the month in which you retire. If you are eligible for Eligible Former Employee vision coverage, your coverage will automatically be converted the first day of the following month. You may have different monthly required contributions when you retire.

The Eligibility and Enrollment Vendor will send you information regarding your Eligible Former Employee vision coverage options and any required monthly contribution, if applicable. Contact the Eligibility and Enrollment Vendor if you do not receive this statement and/or if you would like to make any changes to your coverage. See the Eligibility and Enrollment Vendor table in the "Contact Information" section for contact information.

If you retire from the Company, you and your Eligible Dependents who are enrolled in the Program immediately before your retirement may be eligible to continue coverage under the Program as provided under COBRA. See the "Extension of Coverage - COBRA" section for more information.

If Your Active Employment Ends By Reason of Disability

If you are an Eligible Employee receiving short-term disability benefits from a Company-sponsored short-term disability program (STD Program) and you were eligible to participate in this Program immediately before commencing STD Program benefits, your Program coverage continues as if you were actively at work.

After your STD Program benefits end, you and your Eligible Dependents who are enrolled for vision coverage under the Program immediately before the cessation of your STD Program benefits may be eligible to continue Program coverage under COBRA. See the "Extension of Coverage — COBRA" section for more information on COBRA.

If Your Active Employment Ends By Reason of Your Death

If you die, the coverage under the Program for your surviving Eligible Dependents will end on the last day of the month during which your death occurs. Following your death, your surviving Eligible Dependents who are Qualified Beneficiaries may elect to continue vision coverage under COBRA. If elected, the COBRA continuation coverage will be effective as of the first day of the first month following the month during which you die. See the "Extension of Coverage — COBRA" section for more information. To report a death, call the Fidelity Service Center at **800-416-2363**.

If You Are Rehired

If you are an Eligible Former Employee who is covered under the Program and you are rehired by a member of the AT&T Controlled Group of Companies, coverage for you and your Eligible Dependents under the Program will terminate following your reemployment, if you do not then qualify as a Rehired Eligible Former Employee or if you subsequently cease to qualify as a Rehired Eligible Former Employee. The special rules that apply in determining whether you qualify as a Rehired Eligible Former Employee following your reemployment or when you may cease to qualify as a Rehired Eligible Former Employee are contained in the "AT&T Rehired Eligible Former Employee Supplement". See the "Rehired Eligible Former Employees" section for information regarding the "AT&T Rehired Eligible Former Employee Supplement".

If Your Dependent Becomes Ineligible

Program coverage for your Eligible Dependent ends on the last day of the calendar year or month, as applicable, (in which your Eligible Dependent no longer meets the eligibility requirements. Your Eligible Dependent may continue coverage under COBRA. See the "Extension of Coverage — COBRA" section for more information on COBRA. See the "Eligible Dependents" section for information on when coverage for your Eligible Dependents ends.

If You Are on a Leave of Absence

If you are on an approved leave of absence, you will receive a notice explaining the coverage that you and your Eligible Dependents are eligible to continue and whether you will be required to pay for this coverage. See the "Leave of Absence" section for additional information. If Company-provided coverage is not available during your leave, you may continue coverage under COBRA. See the "Extension of Coverage — COBRA" section.

If You Do Not Make Required Contributions

Program coverage ends if you stop making any required contributions. Coverage will end on the last day of the month for which the required contributions were paid in full.

If you are an Eligible Former Employee, you will not be eligible for COBRA continuation coverage. Under these circumstances, you will not be eligible to re-enroll for coverage under the Program until the next Annual Enrollment unless you experience a change in status event that permits you to enroll sooner.

If You Receive a Promotion

If you are promoted to a management or a nonmanagement nonunion position with the Company, Program coverage ends for you and your Eligible Dependents on the last day of the month in which the promotion occurs. You and your covered Eligible Dependents may, however, be eligible for Company-sponsored vision coverage under the vision program that is applicable to your new employment classification.

If Coverage Is Cancelled

Program coverage ends for you and your Eligible Dependents on the last day of the month during which Program coverage is canceled. If Program coverage is canceled, you may be eligible for COBRA. See the "Extension of Coverage — COBRA" section for more information on COBRA.

If the Program Is Terminated

If the Company terminates the Program, coverage under the Program ends for you and your Eligible Dependents on the last day of the month in which the Program is terminated.

COBRA

You and your covered Eligible Dependents may be eligible to elect COBRA coverage when Program coverage ends. In considering whether to elect COBRA, you should take into account that a failure to continue your group health coverage will affect future rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), such as: (1) the right to obtain medical coverage from either group health plans or individual insurance policies without being subject to preexisting condition exclusions and (2) special enrollment rights. See the "Extension of Coverage — COBRA" section beginning for information regarding your rights to elect COBRA continuation coverage.

Leave of Absence

If you are an Eligible Employee on an approved leave of absence (LOA), your eligibility for coverage under the Program while you are on the LOA and any requirement for you to pay for that coverage will be subject to the terms of your LOA. When your LOA begins, you will receive a notice explaining the coverage that you are eligible to continue and whether you will be required to pay for this coverage during your leave.

All coverage that continued while you were on leave will continue when you return to work, provided that you pay any required contributions by the required due dates. If you do not continue coverage under the Program while you are on your LOA and would like to reenroll upon your return to work, you must contact the Eligibility and Enrollment Vendor to determine whether you are eligible. See the *Eligibility and Enrollment Vendor* table for contact information. Rules governing your right to reenroll upon your return to work from your LOA are set forth in the "Change in Status Events" section.

If you are an Employee currently on active military leave as a result of executive order, certain special provisions may apply. See the "Company-Extended Coverage for Employees on Active Duty with the Uniformed Services" section for information.

If you take an LOA under the Family and Medical Leave Act of 1993 (FMLA), special provisions apply. See the "Extended Coverage While on an FMLA-Protected Absence or on FMLA" section for information.

CONTRIBUTIONS

KEY POINTS

- *Your contribution is the amount you are required to pay monthly for Program coverage.*
- *The number of Eligible Dependents you cover impacts your contribution cost.*

If you are an Active Employee, the amount you contribute toward the Cost of Coverage is affected by a number of factors, including:

- Your employment classification (e.g., full-time or part-time).
- The level of coverage in which you are enrolled.

You will receive information about contributions at Annual Enrollment each year, any time the Eligibility and Enrollment Vendor determines that you have a Change-in-Status Event that allows you to make an enrollment election and anytime you make a change that results in a contribution change. Refer to your enrollment materials for information concerning the contribution amount that applies to you. You also may obtain an electronic or printed personalized contribution statement any time through the Eligibility and Enrollment Vendor. These documents are considered to be a component of your Summary Plan Description. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

Contributions for Eligible Employees

The contribution amounts for each Plan Year are determined annually by the Company, acting as plan sponsor, and will be announced during Annual Enrollment. See your enrollment materials for information concerning the contribution amount that apply to you. You also may obtain an electronic or printed personalized contribution statement at any time through the Eligibility and Enrollment Vendor. These documents are considered to be a component of your Summary Plan Description. See the *Eligibility and Enrollment Vendor* table for contact information.

Before-Tax and After-Tax Contributions

If you are an Active Employee, your Program contributions will automatically be deducted from your pay on a before-tax basis upon enrolling in the Program, if you are eligible under your Company FSA plan (unless you enroll through prospective enrollment or elect after-tax contributions). If you do not want these contributions deducted on a before-tax basis, you must elect after-tax contributions when you enroll. Even if you are eligible to change your Program coverage to an option with lower or higher contributions due to a Change-in-Status Event or Prospective Enrollment, you cannot change the amount of your before-tax contributions unless you experience a Qualified Status Change event as defined in your Company FSA plan. Although generally similar, not all Change-in-Status Events under the Program are considered qualified under your Company FSA plan. See your Company FSA plan SPD for more information on before-tax contributions and for a list of events that are considered Qualified Status Change events. If you are not an Active Employee, you must pay your Program contributions on an after-tax basis.

The Difference Between Before-Tax and After-Tax Contributions

It is important that you understand the difference between before-tax and after-tax contributions, and the rules that apply to before-tax contributions.

Before-Tax Contributions

Your Company FSA Plan allows you to pay applicable Program contributions on a before-tax basis. When your contributions are deducted from your paycheck *before* federal, state and local (if applicable) taxes are taken out, they are known as before-tax contributions. Before-tax contributions reduce taxable income for federal income tax purposes; therefore, you pay less in taxes. In most (but not all) states, before-tax contributions also reduce income subject to state (and local) taxes.

Before-tax contributions are subject to IRS regulations. These regulations require you to make elections for benefits paid through before tax-contributions during your initial or Annual Enrollment period. Before-tax contributions cannot be changed outside of these enrollment periods unless a Qualified Status Change occurs that allows the change.

If you experience a Qualified Status Change event as outlined in the FSA Plan, you may make changes to your benefits and associated changes to your before-tax deductions provided you report the event to the Eligibility and Enrollment Vendor, and make the associated change in your benefits coverage within the time period specified for making the change under the AT&T FSA Plan.

For example, if you drop a dependent or cancel coverage outside an enrollment period without declaring a Qualified Status Change event within the required time frame, your before-tax contribution will not change even if the amount of your contribution would otherwise decrease. If you add a dependent or enroll in new coverage outside an enrollment period without timely declaring a Qualified Status Change event, and the contribution amount for your new dependent or coverage is greater than your before-tax contribution, the additional amount will be deducted from your pay on an after-tax basis. See the *Change-in-Status Events* table for a list of Qualified Status Change events.

> **IMPORTANT:** Active Employee contributions are automatically deducted from your paycheck on a before-tax basis, so if you want these contributions deducted on an after-tax basis, you must make this election during your enrollment period.

After-Tax Contributions

You are not required to pay applicable contributions on a before-tax basis. You may elect to have your contributions deducted from your paycheck on an after-tax basis. After-tax contributions do not reduce your taxable income. This means you pay income taxes on the amount of your contributions.

You must elect after-tax contributions by making an affirmative election.

Contribution Policy

The amount that you must contribute monthly toward coverage is determined before Annual Enrollment each year and is subject to change annually at the sole discretion of the Company, subject to applicable collective bargaining agreements. The following table summarizes the amount you pay toward the Cost of Coverage under the Program.

Employee Classification		Contribution Rules
Regular and Term Employee (at least 6 months Term of Employment)	Full-time	The Company pays the monthly Cost of Coverage
	Part-time (regardless of scheduled hours per week) with an original hire date before Jan. 1, 1981	
	Part-time (25 or more scheduled hours per week) with an original hire date on or after Jan. 1, 1981	
	Part-time (at least 17 scheduled hours but less than 25 scheduled hours per week) with an original hire date on or after Jan. 1, 1981	You pay 50% of the monthly Cost of Coverage rounded to the nearest dollar
	Part-time (less than 17 scheduled hours per week) with an original hire date on or after Jan. 1, 1981	You pay 100% of the monthly Cost of Coverage
Eligible Former Employees	See Former Employee Eligibility and Enrollment table	

Your Participating Company pays for VDT coverage for all eligible Active Employees.

IMPORTANT: Active Employee contributions are automatically deducted from your paycheck on a before-tax basis, so if you want these contributions deducted on an after-tax basis, you must make this election during your enrollment period.

Tax Consequences of Coverage for Legally Recognized Partners and Their Dependents

The Company's level of contribution toward Program coverage for an LRP and an LRP's Child(ren) is the same as the Company's contribution for coverage of a Spouse and a Spouse's Child(ren).

However, when an LRP or the LRP's Child(ren) are covered under the Program, and your relationship is not recognized as a marriage under the applicable state law or federal law, the Company may be required to include the Cost of Coverage as taxable income on your annual tax reporting statement, unless you provide information each year that your covered dependents qualify as tax dependents under the Internal Revenue Code as well as your state and local income tax laws, if applicable.

Employees on Leave of Absence

If you are on an approved leave of absence (LOA), you will receive a notice explaining what Program coverage you are eligible to continue and any contributions that you are required to pay for this coverage. If contributions are required, the Eligibility and Enrollment Vendor will send you a monthly bill. Payment is due on the first of the month for the following month of coverage. For example, the bill you receive on June 15 applies to coverage for the month of July. Payment is due by July 1.

If you have questions concerning billing or payment of your contribution, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table for contact information.

> **IMPORTANT:** You have a 60-day grace period from the day your payment is due to make your payment before coverage is terminated. Failure to pay all required contributions will result in loss of coverage retroactive to the last day of the month for which full payment was received. You may not be eligible to re-enroll until you return from your LOA. If you do not continue coverage under the Program while you are on LOA and you would like to re-enroll upon your return to work, you must contact the Eligibility and Enrollment Vendor to determine if you are eligible. If you are eligible to re-enroll, you will also receive enrollment materials from the Eligibility and Enrollment Vendor upon your return to work.

Individuals Covered Through COBRA

If you or your Eligible Dependents are continuing coverage through COBRA, you or your Eligible Dependents will be required to pay for the coverage through the direct billing process administered by the Eligibility and Enrollment Vendor. See the "Extension of Coverage — COBRA" section for more information about COBRA rights.

Direct billing will be handled through the Eligibility and Enrollment Vendor. If you have questions concerning billing or payment of COBRA continuation coverage, you can contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table for contact information.

If after reading the information in this section you have additional questions or wish to confirm the contribution provisions or contribution amounts that apply to you, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table for contact information.

YOUR PROGRAM BENEFITS

KEY POINTS

- *The Program provides Benefits for covered services or supplies provided by Network Providers and Non-Network Providers.*
- *Each time you need vision care, you decide whether to use a Network Provider or a Non-Network Provider.*
- *Program Benefits differ depending on whether you choose a Network Provider or a Non-Network Provider.*
- *Generally, your out-of-pocket expenses are lower when you use Network Providers.*

This section describes the Benefit provisions of the Program. The Program is designed to keep your vision care costs low while still allowing you the freedom to visit any Provider you choose. This is accomplished by giving you a choice of using Network Providers or Non-Network Providers for your vision care needs. The Network Providers are a group of Providers that comply with the quality standards of the Benefits Administrator and have agreed to limit their charges for most covered services or supplies. Each time you or your covered Eligible Dependents need care, you have the option of using a Network Provider or a Non-Network Provider.

If you use a Network Provider, and provide your insurance information before the services are provided, your out-of-pocket expenses will usually be lower than if you use a Non-Network Provider and you won't have to file any Claims.

If you use a Non-Network Provider, you pay the Non-Network Provider for the vision care services or supplies you receive and then you submit a Claim to be reimbursed for eligible vision care expenses.

Accessing Network Providers

Each time you need vision care services, you decide whether to use a Network Provider or a Non-Network Provider. For example, you can visit a Network Provider for your Examination and purchase your Frames and Lenses from a different Network Provider or a Non-Network Provider. You do not have to use the same Provider each time you need vision care services or supplies.

When you need vision care services, you choose which Provider you want to use. You'll generally pay less out of pocket when you use a Network Provider. To find out which Providers in your area are Network Providers, contact the Benefits Administrator. See the *Benefits Administrator for the Program* table in the "Contact Information" section for contact information.

Before receiving services, provide your coverage information before the services are provided to verify the network status of the Providers for both the Examination and supplies (Lenses and Frames). For example, Providers that share the same facility (such as an Ophthalmologist and an eyeglass/Contact Lenses supplier) might not both be Network Providers.

Note: If you use a Non-Network Provider, you will be responsible for any ineligible expenses under the Non-Network Provider provisions of the Program. It is important for you to verify that your Provider is a Network Provider and is accepting new patients by contacting the Provider or the Benefits Administrator before you seek vision care services.

What You Need to Know About Network Providers

The Benefits Administrator is responsible for establishing and managing the network of Network Providers and for determining vision care Claim payments. Providers (such as Ophthalmologists) do not determine your Benefits under the Program and are not qualified to advise you about what the Program covers. Network Providers are independent practitioners. They are neither Company employees nor employees of the Benefits Administrator. It is your responsibility to select your Provider.

BENEFITS AT A GLANCE

KEY POINTS

- *Program Benefits are summarized in the Benefits at a Glance table(s). More detailed information, including exclusions and limitations are listed in the "What Is Covered" section.*
- *The Benefits at a Glance table(s) provides information on how you and the Program share in the cost of the most commonly used Covered Vision Services.*

The following *Benefits at a Glance* table(s) provides you:

- **A list, not an exhaustive list, of the most commonly used Covered Vision Services.** See the "What Is Covered" section for more detailed information on what is covered. Even if a Service is listed as a Covered Vision Service, certain exclusions or limitations may apply that affect Benefits payable under the Program. Other Services are specifically excluded from coverage regardless of the circumstances. For information on what is not covered, as well as circumstances affecting whether a Service is covered, see the "Exclusions and Limitations" section.
- **A list of limitations specific to the Covered Vision Services in the table.** This information is not exhaustive. See the "What Is Covered" section for more detailed information on limitations to the Covered Vision Services.
- **Cost-sharing information.** You and the Program share in the cost of care as summarized in the table(s) below. The following *Benefits at a Glance* table(s) provides information on how you and the Program share in the cost of the most commonly used Services. However, circumstances specific to your situation may impact your level of cost sharing. To better understand these cost-sharing features and how they impact your Benefits, see the "Cost Sharing" section of this SPD.

When you have an Examination, you are responsible for paying the required applicable Copayment. The Benefits Administrator pays the Network Provider directly for covered charges in excess of that Copayment.

If the Network Provider prescribes eyeglasses or Contact Lenses, you will be required to pay an additional Copayment directly to the Network Provider. The Benefits Administrator pays the Network Provider for eligible covered charges in excess of that Copayment. You are responsible for paying the Network Provider any applicable Copayments and any additional costs resulting from a cosmetic option or non-covered services and supplies you select.

If you have used a Non-Network Provider, you are responsible for paying the Provider in full and submitting a Claim for reimbursement to the Benefits Administrator based on the Non-Network Provider Benefits listed in the *Vision at a Glance* table.

Benefits at a Glance

	Network	Non-Network	Limitations and Exceptions
Cost Sharing			
Annual Limits	Amounts determined by the percentages below are applied to the Allowable Amount.	Dollar amounts below are what the Program pays up to.	Required: You must advise Provider of coverage at time of service to receive Network Benefits. The VDT benefit is covered for Eligible Employees only.

	Network	Non-Network	Limitations and Exceptions
Exams			
Routine vision exams	**First Pair** Program pays 100%, after a $15 Co-payment **VDT Only** Program pays 100%, after a $10 Co-payment The Co-payment amount is based on eye exam performed and services requested.	$40	Once every 12 months, from last date of service.
Standard Lenses			
Single	**First Pair** Program pays 100%, after a $10 Co-payment **VDT Only** Program pays 100%, after a $10 Co-payment	$25	Once every 12 months, from last date of service.
Bifocals		$35	Once every 12 months, from last date of service.
Trifocals		$45	Once every 12 months, from last date of service.
Lenticular		$90	Once every 12 months, from last date of service.
Progressive	Not covered	$0	Discounts may be available, check with the Network Provider.
Standard Lens Options	Not covered Lens options include tints, progressive, polycarbonate (lightweight) lenses, scratch resistant, anti-reflective coating, photogrey/transitions, edge coating, edge polishing, etc.		Discounts may be available, check with the Network Provider.
Frames			
Frames	**First Pair** $10 Co-payment $105 Allowance **VDT Only** $10 Co-payment $105 Allowance	$35	Once every 24 months, from last date of service. Discounts may be available, check with the Network Provider.
Contact Lens Benefits			
Elective Conventional	$10 Co-payment $115 Allowance **VDT Only** Not covered	$80	Once every 12 months, from last date of service. Allowance includes supplies only.
Elective Disposable			

	Network	Non-Network	Limitations and Exceptions
Medically necessary lenses	Program pays 100% after $10 Co-payment	$155	Covered only with prior authorization from Benefits Administrator. If you require an additional exam due to a medical condition, Benefits may be available under your medical program.
Contact Lens Examination Option - Fit and Follow-up	Not covered	Not covered	Discounts may be available, check with the Network Provider.
Other Services			
LASIK Eye surgery	Not covered	Not covered	To obtain the name of a provider who participates in the discount LASIK offering contact 800-988-4221.

VDT VISION CARE FOR ELIGIBLE EMPLOYEES

If you use a Video Display Terminal (VDT) as part of your job, you are automatically covered under the VDT Vision Care portion of the Program as long as you enroll in the Program.

IMPORTANT: Only Active Employees are eligible for this coverage.

Receiving VDT Benefits

To obtain VDT Vision Care Benefits you simply make an appointment with a vision Provider.

If you are receiving care from a Network Provider, the Program will pay him or her directly for covered charges. If you are receiving care from a Non-Network Provider, you will be reimbursed according to the Non-Network Provider level of Benefits in the *Summary of VDT Vision Care Benefits* table.

Covered VDT Services and Appliances

The Program will cover the following VDT Benefits:

- VDT vision Examination — Analysis of the eyes and related structures to identify problems or abnormalities. Examinations are covered once every 12 months, from the last date of service.
- Eyeglass Lenses — Eyeglass Lenses normally prescribed for use, such as single intermediate focal Lenses. Lenses are covered up to one pair per every 12-months, from the last date of service, if needed.
- Eyeglass Frames — Special VDT eyeglass Frames are covered once every 24 months, from the last date of service. If you select a Frame that is more expensive than allowed, you will be responsible for paying the difference in cost.

IMPORTANT: Benefits payable under this part of the Program are in addition to those payable for the other vision services covered by the Program.

Schedule of Benefits for VDT Vision Care

	Network	Non-Network	Limitations and Exceptions
Cost Sharing			
Annual Limits	Amounts determined by the percentages below are applied to the Allowable Amount.	Not covered	Required: You must advise Provider of coverage at time of service to receive Network Benefits.
Exams			
Routine vision exams	Program pays 100%	Not covered	Once every 12 months, from the last date of service.
Standard Lenses			
Single Bifocals Trifocals Lenticular	Program pays 100%	Not covered	Once every 12 months, from the last date of service.
Progressive	Not covered		Discounts may be available, check with the Network Provider.
Standard Lens Options	Not covered Lens options include tints, progressive, polycarbonate (lightweight) lenses, scratch resistant, anti-reflective coating, photogrey/transitions, edge coating, edge polishing, etc.		Discounts may be available, check with the Network Provider.
Frames			
Frames	$50 Allowance	Not covered	Employees ONLY. Once every 24 months, from the last date of service. Discounts may be available, check with the Network Provider.
Other Services			
LASIK Eye surgery	Not covered	Not covered	To obtain the name of a provider who participates in the discount LASIK offering contact 800-988-4221.

If you use a Network Provider, you pay a separate Copayment for each Examination and set of eyeglass Lenses and Frames provided.

If you combine your regular vision Examination and VDT eye Examination into one appointment, you will pay only one Copayment for both of the Examinations. However, you will be required to pay separate Copayments for covered regular vision care supplies and for covered VDT vision care supplies.

If you use a Non-Network Provider, you are required to pay for the full cost of the vision care services at the time of the service, but the Program will reimburse you according to the Non-Network Provider level of Benefits described in the *Summary of VDT Vision Care Benefits* table above.

What Is Covered

The Program pays scheduled Benefits for:

- One routine Examination with dilation, as necessary, or Contact Lenses Examination every 12 months from the last date of service.
- One pair of prescription eyeglass Lenses or prescription Contact Lenses (conventional, disposable or medically necessary), subject to the Contact Lens allowance amount, every 12 months from the last date of service.
- One Frame, if fitted and used with prescription Lenses, every 24 months from the last date of service.

The limits on the Benefits available within a 12- or 24-month period apply separately to you and each of your covered Eligible Dependents. The 12- or 24-month period, as applicable, begins on the last date of service. The limits apply regardless of whether you use a Network Provider or a Non-Network Provider. You can verify the last date of service for you and your dependents by logging into the Benefit Administrator's website or by calling Customer Service.

The Program does not provide Benefits for both eyeglass Lenses/Frames and Contact Lenses during the same 12-month period. If the Program provides Benefits for Contact Lenses, you or your covered Eligible Dependent will not be eligible for the Frame Benefit during the 24-month period that begins on the date that you or your covered Eligible Dependent orders the prescription Contact Lenses.

See the "VDT Vision Care" section for information concerning the scheduled Benefits and limitations under the VDT Vision Care portion of the Program.

Eligible Employees: Exclusions and Limitations

Exclusions and Limitations	
General	Claims for Benefits submitted later than 12 months following the date of the service or the purchase of the supply occurred
	Examinations or supplies provided for any condition, disease, ailment or injury arising from, or in the course of, employment
	Examinations performed or Lenses and Frames ordered/purchased/submitted either (1) For an individual not covered under the Program (2) Before the individual became covered under the Program (3) After termination of the individual's coverage under the Program; or (4) Before the date of service the individual is eligible for that service or supply again.
	Services or supplies available from any government agency or covered by any government plan
	Services or supplies covered by any other health benefit program offered by the Company or by a safety lens program
	Services or supplies for which no obligation to pay exists or for which no charge would be made in the absence of Program Benefits
	Services or supplies not prescribed by a licensed Optometrist or Ophthalmologist or facility
	Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof
Lens/Frames/Supplies	Charges for replacement of lost or broken Lenses (including Contact Lenses) or Frames before a 12- or 24-month period, as applicable, has passed since the date on which the supply was last ordered, from the last date of service
	Follow-up care, care kits, cleaners, solutions and subsequent office visits
	Drugs or any other medication
	Lens options (although Lens options are not covered by the Program, discounts may be available from Network Providers as part of their agreement with the Claims Administrator)
	Plano (nonprescription) Lenses, including sunglasses and Contact Lenses
	Additional charges for Oversized, Photosensitive or anti-reflective photochromatic or tinted, blended, progressive multifocal, cosmetic coated or laminated Lenses, whether or not medically necessary
	Two pairs of glasses in lieu of bifocals

Exclusions and Limitations	
Procedures/Treatments	Charges for services or supplies generally considered experimental, developmental or investigatory treatment
	Examinations or corrective eye wear required by the Company as a condition of employment
	Medical and/or surgical treatment of the eye, eyes or supporting structures
	Special or unusual treatment, including Orthoptic Training, Vision Training and associated supplemental testing, Subnormal Vision Aids, aniseikonic Lenses or Tonography
The Program does not cover certain vision care services, supplies or expenses. These are called exclusions. The list of exclusions presented in this section applies to Network Providers and Non-Network Providers. If you have questions about whether a vision care service or supply is covered under the Program, contact the Benefits Administrator.	

CLAIMS AND APPEALS PROCEDURES

KEY POINTS

- *Two types of Claims may be made and appealed under the Program: Claims for Eligibility and Claims for Benefits.*
- *You must exhaust all Appeals processes offered by the Program before filing a lawsuit.*

You, your covered dependents or duly authorized persons have the right under ERISA and the Plan (including the Program) to file a written Claim for Eligibility or Claim for Benefits under the Program.

The following sections describe the procedures used by the Program to process a Claim for Eligibility or a Claim for Benefits, along with your rights and responsibilities. These procedures were designed to comply with the rules of the United States Department of Labor (DOL) concerning a Claim for Eligibility or Claim for Benefits. It is important that you follow these procedures to make sure you receive the full extent of your Benefits under the Program. You may file suit in federal court if you are denied eligibility or Benefits under the Program. However, you must complete all available Claims and Appeals processes offered under the Program before filing suit.

IMPORTANT: All of the facts and circumstances of your case will be thoroughly reviewed. If you have completed all of the Claims and Appeals procedures explained in the following sections and your Appeal is denied, you have the right to file suit in federal court if you are denied eligibility to participate or if you are denied Benefits under the Program.

CLAIMS FOR ELIGIBILITY

KEY POINTS

- *If your or your dependent's enrollment in the Program is denied, you may file a written Claim for Eligibility with the Eligibility and Enrollment Vendor.*
- *If your Claim for Eligibility is denied, you may appeal the decision within 180 days of receipt of the denial notice.*

When to File a Claim for Eligibility

If you or your dependents attempt to enroll or participate in the Program and are told you or your dependent is not eligible to enroll or participate in the Program, you may call the Eligibility and Enrollment Vendor to attempt to resolve the issue. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section. If the issue is not resolved to your satisfaction, you may file a written Claim for Eligibility.

> **IMPORTANT:** The Eligibility and Enrollment Vendor should only be contacted for denials related to enrollment or participation in the Program. For Benefit-related situations, you will need to contact the Benefits Administrator. Please see the "Claims for Benefits" section for the Claim for Benefits process.

You are responsible for initiating the Claim for Eligibility process. The Claim for Eligibility process does not begin until you have provided a written Claim, as outlined below.

How to File a Claim for Eligibility

To file a Claim for Eligibility, you must submit your written Claim for Eligibility, along with any documentation that supports your Claim for Eligibility, to the Eligibility and Enrollment Vendor at the address listed in the "Contact Information" section. To submit a Claim for Eligibility you must file a completed Claims Initiation Form (CIF) or other written document asserting your Claim, along with any supporting documentation, with the Eligibility and Enrollment Vendor. A CIF is available from the Eligibility and Enrollment Vendor on request.

The Eligibility and Enrollment Vendor will notify you of its decision within 30 days of the date it receives your Claim for Eligibility. The Eligibility and Enrollment Vendor may extend this period once (for up to 15 days) if it determines that special circumstances require more time to decide your Claim for Eligibility. If this happens, you will receive a written notice of the special circumstances requiring the extra time and when to expect a response.

If the Eligibility and Enrollment Vendor requires additional information from you in order to determine your Claim for Eligibility, you will receive Notification and you will have 45 days from the date you receive the Notification to provide the information. The Eligibility and Enrollment Vendor's decision time period will be suspended until you provide the requested information, up to 45 days.

Once the information is received, the Eligibility and Enrollment Vendor will decide your Claim within the time remaining in the initial 30-day or extended 45-day review period, whichever applies.

If you do not respond to the request for information, your Claim for Eligibility will be determined on the available information, but you may appeal this decision.

The following table summarizes the Program's Claim for Eligibility decision time frame:

Activity	Number of Days Allowed	
Eligibility and Enrollment Vendor decides on Claim	30 days	From the date the Eligibility and Enrollment Vendor receives your initial Claim for Eligibility
Time period is extended if Eligibility and Enrollment Vendor determines special circumstances require more time	Up to 15 additional days	After the initial 30-day period
You must provide additional information requested by the Eligibility and Enrollment Vendor	45 days	From the date you receive notice from the Eligibility and Enrollment Vendor stating that additional information is needed

What Happens If Your Claim for Eligibility Is Denied

Your Claim for Eligibility is denied when the Eligibility and Enrollment Vendor sends written notice that denies your Claim for Eligibility in whole or in part or if you do not receive notice of the denial within the time periods described above. A written denial notice will contain:

- Specific reasons for the denial.
- Specific references to the Program provisions upon which the denial is based.
- If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination and that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request.
- If applicable, a description of any additional information needed to make your Claim for Eligibility acceptable and the reason the information is needed.
- A description of the Program's Appeal procedures.
- A statement of your right to file a civil action under ERISA after you have exhausted all opportunities to appeal under the Program.

How to Appeal a Denied Claim for Eligibility

If your Claim for Eligibility is denied and you disagree with the decision, you may appeal the decision by filing a written request for review. To appeal the Claim, you or your authorized representative must file a written Appeal with the Eligibility and Enrollment Vendor within 180 days of receipt of the denial notice. A special form is not required, however, you may contact the Eligibility and Enrollment Vendor and obtain an Appeal form. A service representative also can provide the appropriate address to direct your Appeal.

See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

If you or your authorized representative submit an Appeal of a denied Claim for Eligibility, you or your representative has the right to:

- Send a written statement of the issues and any other comments. Be sure to clearly state any facts and/or reasons you believe should be considered and include any documents, records or other information relating to your Appeal.
- Include any new or additional evidence or materials that support your Appeal. This information must be provided with your written statement when you file your Appeal.
- Request and receive, free of charge, documents relevant to your Claim for Eligibility, such as any internal rule, guideline, protocol or other similar criterion relied on in denying your Claim for Eligibility.
- Reasonable access to and copies of all documents, records and other information relevant to your Claim for Eligibility.

Internal Appeals Process

Eligibility and Enrollment Appeals Committee (EEAC) members, who were not involved in the initial decision to deny your Claim for Eligibility, will review and decide your Appeal. In the review of your Appeal, the EEAC will not afford deference to the denied Claim.

The EEAC will notify you of its decision within 60 days of the date of receipt of your Appeal. The EEAC can extend this period once (for up to 60 days) if special circumstances require more time to decide your Appeal. If this happens, you will receive a written notice of the special circumstances requiring the extra time and when to expect a response.

The EEAC's decision on your Appeal will be in writing and will include the specific reasons and references to Program provisions relied on to make the decision. The EEAC's decision will include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your Claim for Eligibility. The EEAC has been delegated the exclusive right to interpret and administer applicable provisions of the Program, and its decisions are conclusive and binding and are not subject to further review under the Program. If your Appeal is denied, it is final and is not subject to further review. However, you may have further rights under ERISA, as described in the "ERISA Rights of Participants and Beneficiaries" section.

The following table summarizes the Program's Appeal for Eligibility decision time frame:

Activity	Number of Days	
You request a review of a denied Claim for Eligibility	180 days	From receipt of a denial notice
Eligibility and Enrollment Appeals Committee (EEAC) decides on Appeal	60 days	From the date the EEAC receives your Appeal
Time period is extended if EEAC determines special circumstances require more time	Up to 60 days	After the initial 60-day period

External Review Process for Certain Eligibility Claims

If your Appeal of a denied Claim for Eligibility is denied by the EEAC, there is an opportunity for external review but only in situations that involve rescission of Program coverage. Generally, rescission of Program coverage is the cancellation or discontinuance of your coverage that has retroactive effect, except to the extent it is attributable to failure to timely pay required contributions or due to an act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact. For further description of rescission of coverage, see the "When Coverage Ends" section of this SPD. If you feel a rescission of Program coverage is not properly determined under the Program pursuant to the Claims and Appeals process, see the "Claims for Benefits" section for more information on the external Appeal process.

CLAIMS FOR BENEFITS

KEY POINTS

- *A Claim for Benefits is the initial request that is made to the Benefits Administrator by your Provider or by you to receive Benefits under the Program.*
- *You must file your request for payment of Benefits within the time period specified.*
- *Pre-Service and Post-Service Claims are the two different types of Claims for Benefits with different Claims procedures. If all or part of your Claim for Benefits is denied, you can appeal the decision. You must file your Appeal within the time limit.*
- *If your Appeal is denied based on vision judgment and you believe the outcome of your Appeal is unsatisfactory, you can request an external review.*

This section explains how to file a Claim for Benefits and how to file an appeal if your Claim for Benefits is denied.

How to File a Claim for Benefits

You, your covered dependents or an authorized representative have the right under ERISA and the Plan (including the Program) to file a written Claim for Benefits. A Claim for Benefits is the initial request that is made to the Benefits Administrator for Benefits under the Program. In some cases, the initial Claim for Benefits is filed by the service Provider, and, in other instances, you have the responsibility to file the initial Claim for Benefits or make certain that the Provider files it on your behalf.

An enrollment or eligibility request is not considered a Claim for Benefits. This is considered a Claim for Eligibility. Please see the "Claims for Eligibility" section for more information. But, if your Claim for Benefits is denied on the basis that you are not eligible to participate in the Program, it may be a Claim for Benefits.

Generally, when you use Network Providers, you do not need to file Claims the Network Provider will file on your behalf for direct payment to be made to the Network Provider. The Provider will collect any part of the cost of the services and supplies that will not be covered by the Program from you at the time of service or bill you for any amount not paid by the Program. You will receive an explanation of benefits (EOB) showing charges and Benefits paid.

If you choose to go to a Non-Network Provider when you need vision care, you must file a Claim for Benefits for covered services or supplies provided under the Program. The Provider will collect payment from you at the time of service or bill you. Claims for Benefits for expenses incurred by

using a Non-Network Provider must be submitted to the Benefits Administrator using the Benefits Administrator's claim form. The Benefits Administrator will reimburse you for covered services or supplies and will send you an EOB. You can request a claim form by contacting the Benefits Administrator. You can also download a claim form from the Benefits Administrator's Web site. See the *Benefits Administrator for the Program* table in the "Contact Information" section for contact Information.

The following describes the procedures the Program uses to process Claims for Benefits, along with your rights and responsibilities. These Claims for Benefits procedures comply with the rules of the Department of Labor (DOL). It is important that you follow these procedures to make sure that you receive full Program Benefits. This section provides you with information about how and when to file a Claim for Benefits.

Claim Filing Limits

You or your Provider must submit your Claim for Benefits within 12 months from the date of the service If a Non-Network Provider submits a Claim for Benefits on your behalf, you are responsible for the timeliness of the Claim for Benefits and these timing requirements still apply. If you or your Provider do not file a Claim for Benefits within this time period, Benefits will be denied or reduced at the Benefits Administrator's discretion.

In no case will a Claim for Benefits be paid if filed more than 90 days after the end of the Plan Year during which the date of the service or the purchase of the supply occurred.

When you submit a Claim for Benefits, be sure to provide all the information requested on the Claim form and include the Provider's itemized bill. Keep a copy of the Claim form and itemized bill for your records.

The Benefits Administrator may ask for additional information to support your Claim for Benefits. If so, you will receive this request in writing.

You may be eligible for reimbursement through your Health Care FSA for expenses not covered by the Program. For more information, refer to the separate summary plan description for reimbursement accounts.

Payment of Benefits

The Benefits Administrators are responsible for administration of a Claim for Benefits. The Benefits Administrator will make a determination of the Program's applicability to your Claim for Benefits. See the *Benefits Administrator* table in the "Contact Information" section for information about Claim forms and procedures.

The Benefits Administrator will make a Benefit determination as set forth in the "Benefit Determinations" section. Once a Claim for Benefits is approved, Benefits will be paid directly to you unless either:

- The Provider notifies the Benefits Administrator that you authorized payment directly to the Provider.
- You make a written request for payment to be made directly to the Provider when you submit your Claim for Benefits.

The Benefits Administrator will not reimburse third parties who have purchased or been assigned Benefits by Providers.

Time Period for Initial Determinations on Claims for Benefits

Notification of an Adverse Benefit Determination on an initial Claim for Benefits will be made within 30 days of the Benefits Administrator's receipt of the Claim for Benefits. Notification may be in the form of an Explanation of Benefits (EOB).

In the event the Claimant fails to provide sufficient information for the Benefits Administrator to make a decision on the Claim for Benefits:

- The extension notice to the Claimant will describe the specific information that is needed to enable the Benefits Administrator to make a decision on the Claim for Benefits;
- The Claimant will have 45 days after the receipt of the extension notice to provide the Benefits Administrator with the specified information; and
- The 45-day period of time for the Benefits Administrator to make a benefit determination on the Claim for Benefits will be tolled from the date on which notification of the extension is sent to the Claimant until the date the requested information is received by the Benefits Administrator.

What Happens If Your Claim for Benefits Is Denied

If your Claim for Benefits is denied in whole or in part, it is an Adverse Benefit Determination. An Adverse Benefit Determination is any denial, reduction or termination of a Benefit, or a failure to provide or make a payment (in whole or in part) for a Benefit, including any based on your eligibility to participate in the Program, a determination that the service is not a Benefit under the Program, a Network exclusion or other limitation on Benefits under the Program, or not Medically Necessary or appropriate. You have the right to appeal any Adverse Benefit Determination of the Claim under the procedures described below.

If your Claim for Benefits is denied in whole or in part, the Benefits Administrator will provide you with written or electronic Notification of the Adverse Benefit Determination, which may be in the form of an explanation of benefits (EOB). The Notification will include all of the following:

- Information sufficient to identify the Claim (including the date of service, the health care Provider, the Claim amount (if applicable), a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.
- Specific reasons for the denial.
- Specific references to the Program provisions upon which the denial is based.
- If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination and that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request.
- If applicable, an explanation of the scientific or clinical judgment for the determination, applying the Program's terms to your medical circumstances or a statement that this explanation will be provided free of charge upon request.
- If applicable, a description of any additional information needed to make your Claim for Benefits acceptable and the reason the information is needed.

- A description of the Program's Appeal procedures.
- A statement of your right to file a civil action under ERISA after you have exhausted all opportunities to appeal under the Program.

How to Appeal an Adverse Benefit Determination on a Claim for Benefits

You have the right to appeal any Adverse Benefit Determination under the procedures described below. Your Appeal must be submitted to the Benefits Administrator within 180 days following receipt of the notice of the denial of your Claim for Benefits or the date your Claim for Benefits is deemed denied. This is referred to as a First Level Appeal.

You or your authorized representative can Appeal the denied Claim for Benefits within the time limits set forth in this section for the applicable type of Claim. If you wish to appeal a denied Claim, you must contact the Benefits Administrator in writing to appeal.

> **IMPORTANT:** If your Claim for Benefits is denied on the basis of eligibility to enroll or participate in the Program, you should follow these procedures; however, your Appeal must be filed with the Eligibility and Enrollment Vendor. (See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section.)

The Appeal will take into account all comments, documents, records and other information you submit relating to the Claim for Benefits, without regard to whether such information was submitted or considered in the initial Benefit determination. If you wish, you or your authorized representative may review the appropriate Plan documents and submit written information supporting your Claim for Benefits to the Benefits Administrator.

If the Program fails to meet the time requirements for your Claim for Benefits, your Claim for Benefits is deemed denied and you may begin an appeal. If the Program fails to meet the time requirements for your appeal of an Adverse Benefit Determination, your Appeal is deemed denied and you may pursue your Claim for Benefits in a civil action under ERISA.

You have the right to, upon request and free of charge, reasonable access to and copies of all documents, records or other information relevant to your Claim for Benefits. You must make this request in writing. You will be able to review your file and present information as part of the Appeal.

The Benefits Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with your Claim, as well as any new or additional rationale to be used in reaching the decision. You will be given this information in advance of the date the notice of final Appeal decision is made to give you a reasonable opportunity to respond.

How to File an Appeal for Benefits

You can file a written Appeal if your Claim is denied (in whole or in part). To file an Appeal, you must send a written summary to the Benefits Administrator with the following information:

- Your name
- Patient's name and patient's identification number from his or her vision ID card
- Dates of service

- Provider's name
- A summary of the issue, including the reason you believe the Claim for Benefits should be paid
- All relevant documents, such as letters, Explanation of Benefits (EOBs) and statements.

See the *Benefits Administrator* table in the "Contact Information" section for more information.

The Benefits Administrator will decide your Appeal based on whether the Program provides Benefits for the proposed treatment or procedure and the amount of such Benefits. You and your Provider decide the appropriateness and necessity of pending vision services.

If the Adverse Benefit Determination was based on ineligibility to enroll or participate, the first-level appeal will be reviewed by the Eligibility and Enrollment Vendor and the second-level appeal will be reviewed by the Eligibility and Enrollment Appeals Committee (EEAC). See the "How to Appeal a Denied Claim for Eligibility" above.

The Benefits Administrator or Eligibility and Enrollment Vendor, as applicable, will make a decision on the first-level appeal of an Adverse Benefit Determination within 30 days after receipt of the appeal.

If an Adverse Benefit Determination is made by the Benefits Administrator or Eligibility and Enrollment Vendor, as applicable, on the first-level appeal and the Claimant is not satisfied with that decision, the Claimant has the right to request a second-level appeal from the Benefits Administrator or the EEAC, as applicable. The Claimant's request for a second-level appeal:

- Must be made in writing within 180 days after the Claimant receives notification of the Adverse Benefit Determination on the first-level appeal; and
- Must state, as clearly and specifically as possible, all issues that relate to the Claim for Benefits which is the subject of the appeal and all reasons why the Claimant believes the Adverse Benefit Determination on the first-level appeal is incorrect.

The second-level appeal of an Adverse Benefit Determination (excluding an Adverse Benefit Determination based on ineligibility to enroll or participate) should be submitted to the Benefits Administrator at the address stated previously in this section. A second-level appeal of an Adverse Benefit Determination based on ineligibility to enroll or participate should be submitted to the EEAC through the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for the appropriate address.

The Benefits Administrator or EEAC, as applicable, will make a decision on the second-level appeal of an Adverse Benefit Determination within 30 days after receipt of the request for review of the first-level appeal decision.

The Benefits Administrator will review the first-level and second-level appeals of an Adverse Benefit Determination, unless the Adverse Benefit Determination was based on your or your dependent's ineligibility to enroll or participate in the Program.

Decisions on Appeals Involving Claims for Benefits

The decision after each level of the appeal of an Adverse Benefit Determination on a Claim for Benefits will be communicated in writing to the Claimant. In the event that an Adverse Benefit Determination is made on the appeal, the Benefits Administrator, Eligibility and Enrollment Vendor or Eligibility and Enrollment Appeals Committee (EEAC), as applicable, will provide written notification to the Claimant which will include all of the following:

- Information sufficient to identify the Claim (including the date of service, the health care Provider, the Claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning
- Specific reasons for the denial.
- Specific reference to the Program provisions upon which the Adverse Benefit Determination is based.
- If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination, and that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request
- If applicable, an explanation of the scientific or clinical judgment for the determination, applying the Program's terms to your medical circumstances or a statement that this explanation will be provided free of charge upon request
- A statement of your right to file a civil action under ERISA after you have exhausted all opportunities to appeal under the Program.

A qualified individual who was not involved in the decision to deny your initial Claim or to review your first Appeal will be appointed to decide the Appeal. If your Appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field and who was not involved in the initial determination. The vision Benefits Administrator may consult with, or seek the participation of, vision experts as part of the appeal resolution process.

When you file your Claim or Appeal, you consent to this referral and the sharing of pertinent vision Claim information.

Scope of Review — Claims for Benefits

- Except for appeals based on ineligibility to enroll or participate in the Program, an Appeal of an Adverse Benefit Determination: Will take into account all comments, documents, records and other information you submit relating to the Claim for Benefits, without regard to whether such information was submitted or considered in the initial Benefit determination. If you wish, you or your authorized representative may review the appropriate Plan documents and submit written information supporting your Claim for Benefits to the Benefits Administrator or Plan Administrator.
- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Program documents.
- Follow reasonable procedures to ensure that the applicable Program provisions are applied to the Claimant in a manner consistent with how such provisions have been applied to other similarly situated Claimants.

The Benefits Administrator shall serve as the final reviewer under the Program for all Claims for Benefit except those that have been denied based on ineligibility to enroll or participate in the Program. The EEAC shall serve as the final review committee under the Program. In their respective capacities, the Benefits Administrator and the EEAC shall have sole and complete discretionary authority to determine conclusively for all parties and, in accordance with the terms of the documents or instruments governing the Program:

- Any and all questions arising from the administration of the Program and interpretation of all Program provisions.
- All relevant facts.
- The construction of all terms of the Program.

The Benefits Administrator shall also have sole and complete discretionary authority to determine (i) all questions relating to eligibility for Benefits and (ii) the amount and type of Benefits to be provided to any Eligible Employee or covered Eligible Dependent. The EEAC shall also have sole and complete discretionary authority to determine all questions relating to eligibility for enrollment and participation of Employees and their dependents. Respective decisions on appeals of Adverse Benefit Determinations by the Benefits Administrator and the EEAC shall be conclusive and binding on all parties and not subject to further review.

In any case, as an Employee/Eligible Former Employee or Eligible Dependent covered under the Program, you may have further rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA). See the "ERISA Rights of Participants" section.

A Claimant must pursue all the Claims and Appeals rights described above before seeking any other legal recourse regarding Claims for Benefits.

COORDINATION OF BENEFITS

KEY POINTS

- *Coordination of Benefits (COB) applies when you have health coverage under more than one plan.*
- *The COB rules describe how Program Benefits are determined and which Coverage Plan will pay first.*

Receiving Benefits From Other Coverage

You may be eligible to receive Benefits for vision care services and supplies from the Program and another source. This can happen if you or any of your covered Eligible Dependents have coverage under both the Program and another plan that provides benefits for vision care services and supplies. It can also happen if the Program pays Benefits and you later receive a legal settlement that includes all or part of the cost of your vision care. This section explains how Benefits are determined in these circumstances.

When Coordination of Benefits Applies

The Program contains a provision called "Coordination of Benefits" (COB). This feature coordinates benefits from all group plans covering you and your covered Eligible Dependents to prevent duplication of vision care benefit payments. Under COB, the total benefits paid by all plans

combined will not exceed 100 percent of the Allowable Amount of your vision care expenses. See the “How COB Works” section for additional information.

The COB feature applies when you are eligible for vision care benefits (in addition to those provided under your Program) from another source, such as:

- A group-sponsored insurance or prepayment plan.
- A government-sponsored plan.

COB rules apply to all of your covered Eligible Dependents. However, COB doesn’t apply to any personal insurance policy (except no-fault or other state-mandated automobile insurance).

Determining Which Plan or Program Pays First

Under the COB provision, the Claims Administrator follows standardized rules to determine which plan is “primary” and which plan is “secondary.” Under this provision, the primary plan pays benefits first. After the primary plan has processed your claim, you can then submit your claim to the secondary plan, along with the explanation of benefits you received from the primary plan and the Provider’s itemized bill. This is how primary and secondary plans are determined:

- When the other plan doesn’t have a COB provision, that plan is considered primary and the Program is secondary.
- When both plans have COB provisions, one plan must be designated as the primary plan. The determination is generally made in accordance with the following guidelines:
    - A plan that covers the Claimant as an active employee is primary over a plan that covers the Claimant as a former employee.
    - A plan covering the Claimant as an active or Eligible Former Employee is primary over a plan that covers the Claimant as a dependent.

COB for Eligible Dependent Child(ren)

For Eligible Dependent Children, determining primary and secondary coverage follows this sequence:

- The plan covering the parent whose birthday comes first in the year (month and day) is the primary plan for the Children; the plan covering the other parent is secondary for the Children. This is called the birthday rule. The program uses this rule. If both parents have the same birthday, the primary plan is the plan that has covered the parent for the longer period of time.
- In plans that don’t include the birthday rule, the father’s group insurance is the primary plan for the Children; the mother’s group insurance is secondary for the Children. This is called the male-female rule.
- If one parent is covered by the male-female rule and the other by the birthday rule, the male-female role applies to the extent permitted by applicable law.

COB if the Parents Are Divorced or Legally Separated

If the parents of Eligible Dependent children are divorced or legally separated, the Claims Administrator will determine if there is a court decree of Qualified Medical Child Support Order (QMCSO) establishing financial responsibility for vision care:

- If there is such a decree of QMCSO, the plan covering the parent who has that responsibility will be the primary plan.
- If there is no decree of QMCSO, the plan that covers the parent with custody will be the primary plan; the other parent's plan will be secondary.
- If there is no decree or QMCSO and the parent with the custody remarries, that parent's plan remains primary; the stepparent's plan is secondary. The noncustodial parent's plan is third.
- If payment responsibilities are still unresolved, the plan that has covered the patient for the longest time is the primary plan.

Refer to the 'Qualified Medical Child Support Orders' section for more information.

How COB Works

When you are covered by more than one group plan that provides vision care benefits, you should always submit claims to the primary plan first. Then, when you submit your claims to the secondary plan, include the explanation of benefits statement you received from the primary plan along with the itemized bills.

When the Program is the primary plan, it will pay Benefits as specified in the Program. If the Program is the secondary plan, then the Program will coordinate Benefits with the primary plan to ensure that the benefits payable under both plans do not exceed 100% of the Participants Allowance so the total amount reimbursed by both plans will equal the amount payable by the more generous of the two plans. If service frequency maximums apply, the services covered under the primary plan will be counted toward the frequency maximum under the Program.

Example: How COB Works

Here's an example of how COB works when the Program is the secondary coverage plan.

Example of How COB Works	
Primary Coverage Plan	Your Spouse's plan because your Spouse is the patient
Secondary Coverage Plan	The Program
Vision Service	Your Spouse purchases new Contact Lenses from a Network Provider
Network Provider's Charge for the Service	$100
Primary Coverage Plan Benefit	$80 (80% x $100 = $80)
Program Benefit If It Is the Primary Coverage Plan	$80
Vision Benefit After Coordination of Benefits	$20 (Allowance for vision care expense of $100 minus the primary coverage plan payment of $80 = $20)

EXTENSION OF COVERAGE - COBRA

KEY POINTS

- *COBRA continuation coverage is a temporary extension of group coverage that allows Program Participants who have lost coverage due to a Qualifying Event to continue coverage for a period of time.*
- *If you experience a COBRA Qualifying Event, you must notify the Eligibility and Enrollment Vendor no later than 60 days after the date the event occurs.*
- *If you or your Spouse/Partner and dependent Child(ren) do not elect your COBRA continuation coverage within the 65-day election period, you will lose your right to elect continuation coverage.*
- *Generally, you will be required to pay the entire cost of COBRA continuation coverage.*
- *If you fail to pay the COBRA premium by the due date, your COBRA coverage will end and you will not be able to re-enroll.*

COBRA Continuation Coverage

Federal law requires most employers sponsoring group health plans to offer a temporary extension of coverage (called "continuation coverage" or "COBRA" coverage) in certain instances when coverage under the Program would otherwise end. This coverage is available to Employees/Eligible Former Employees and their families who are covered by the Program.

In this section, "you" is defined as the person or persons who lost coverage due to a COBRA or insurance continuation Qualifying Event (the "Qualified Beneficiary").

The Program is a group health plan subject to this law. You do not have to show that you are insurable to elect COBRA continuation coverage during the election period. However, you will have to pay the entire premium for your COBRA continuation coverage. At the end of the maximum coverage period (described below in this section), you may be allowed to enroll in an individual conversion health plan if it is available under the Program. You will be responsible for paying the premiums for this coverage as required by the individual conversion health plan.

This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive this coverage. This section provides only a summary of your COBRA continuation coverage rights. See the "Your ERISA Rights" section for contact information.

The COBRA Administrator is the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a temporary extension of group health coverage. It is available when coverage would otherwise end because of a life event known as a Qualifying Event. Specific Qualifying Events are listed later in this section.

After a Qualifying Event occurs and any required notice is provided to the COBRA Administrator, COBRA continuation coverage must be offered to each person who is a Qualified Beneficiary. A Qualified Beneficiary is someone who will lose coverage under the Program because of a

Qualifying Event. Only Qualified Beneficiaries may elect to continue their group health coverage under COBRA. Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Depending on the type of Qualifying Event, the following may be considered "Qualifying Beneficiaries" if they are covered under the Program on the day before the Qualifying Event occurs:

- Employees/Eligible Former Employees.
- Spouses/Partners of Employees/Eligible Former Employees.
- Dependent Child(ren) of Employees/Eligible Former Employees.
- Certain newborns, newly adopted Child(ren) and alternate recipients under Qualified Medical Child Support Orders ("QMCSOs") may also be Qualified Beneficiaries. This is discussed in more detail in the "Child(ren) Born to or Placed for Adoption With the Covered Employee/Eligible Former Employee During COBRA Period" section and the "Alternate Recipients Under Qualified Medical Child Support Orders" section.

COBRA continuation coverage is the same coverage that the Program gives to Covered Persons or beneficiaries who are currently participating in the Program and not receiving COBRA continuation coverage. Ordinarily, the COBRA continuation coverage will be the same coverage that you had on the day before the Qualifying Event occurred. But if coverage is changed for similarly situated Active Employees or Eligible Former Employees covered by the Program, or their Spouses/Partners or dependent Child(ren), the COBRA continuation coverage generally will be changed in the same way for the Qualified Beneficiaries on COBRA at the same time.

As a COBRA continuation coverage Participant, you will have the same rights under the Program during your COBRA continuation coverage period as other Covered Persons or beneficiaries covered under the Program, including Annual Enrollment and special enrollment rights.

You can find specific information describing the coverage to be continued under the Program elsewhere in this document and in the Plan document. For more information about your rights and obligations under the Program, you can get a copy of the Plan document by requesting it from the Plan Administrator as described in the "Your ERISA Rights" section.

COBRA Qualifying Events: When Is COBRA Continuation Coverage Available?

If you are an Employee of a Participating Company and are covered by the Program, you become a Qualified Beneficiary and have the right to elect COBRA continuation coverage if you lose your coverage under the Program due to one of the following "Qualifying Events":

- Your employment ends for any reason other than your gross misconduct.
- Your hours of employment are reduced.

Spouse or Legally Recognized Partner

If you are the Spouse or Legally Recognized Partner of an Eligible Employee, covered under the Program, you will become a Qualified Beneficiary and have the right to elect COBRA continuation coverage if you lose your coverage under the Program because of any of the following "Qualifying Events":

- Your Spouse or Legally Recognized Partner dies.
- Your Spouse's or Legally Recognized Partner's employment ends for any reason other than his or her gross misconduct, or your Spouse's or Legally Recognized Partner's hours of employment are reduced.
- You become divorced or legally separated from your Spouse or your legally recognized partnership is dissolved.
- Your Spouse or Legally Recognized Partner becomes entitled to Medicare Part A, Part B or both.

> **IMPORTANT:** If you are an Employee/Eligible Former Employee and you eliminate coverage for your Spouse or Legally Recognized Partner in anticipation of a divorce or partnership dissolution, and the divorce or partnership dissolution occurs, then the actual divorce or partnership dissolution will be considered a COBRA Qualifying Event even though the ex-Spouse or ex-Legally Recognized Partner lost coverage earlier. If the ex-Spouse or ex-Legally Recognized Partner notifies the Eligibility and Enrollment Vendor within 60 days after the later of the divorce or partnership dissolution or the date coverage terminates under the Program and can establish that the coverage was eliminated earlier in anticipation of the divorce or partnership dissolution, then COBRA continuation coverage may be available for the period after the divorce or partnership dissolution.

- Your Spouse/Partner becomes entitled to Medicare Part A, Part B or both.

Child(ren)

Your Child who is covered by the Program will become a Qualified Beneficiary and have the right to elect COBRA continuation coverage if he or she loses group health coverage under the Program because of any of the following "Qualifying Events", or he or she is born to or placed with you for adoption during a period of COBRA continuation coverage and is enrolled in the Program:

- The Employee/Eligible Former Employee-parent dies.
- The Employee/Eligible Former Employee-parent's employment ends for reasons other than gross misconduct, or the Employee/Eligible Former Employee-parent's hours of employment with the Company are reduced.
- The parents' divorce or legally separate or the parents' partnership dissolves.
- The Employee/Eligible Former Employee parent becomes entitled to Medicare Part A, Part B or both.
- The Child ceases to be eligible as a Child under the Program.

FMLA (Active Employee Only)

Special COBRA rules apply if you take FMLA leave and do not return to work at the end of the leave. Failure to return to work at the end of an FMLA leave may constitute a COBRA Qualifying Event (i.e., an Employee and the Employee's Spouse/Partner and Child(ren) may elect COBRA continuation coverage). In this case, you and your Spouse/Partner and Child(ren), if any, will be entitled to elect COBRA if both of the following conditions are met:

- They were covered under the Program on the day before the FMLA leave began (or became covered during the FMLA leave).
- They will lose coverage under the Program because you do not return to work at the end of the FMLA leave.

This means that you may be entitled to elect COBRA continuation coverage at the end of an FMLA leave for yourself and your dependents even if coverage under the Program ended during the leave.

If you are on a non-FMLA leave that provides coverage as if you were still an Active Employee, and if your employment is terminated during the leave or your coverage ends at the end of the maximum coverage period specified for your leave, you (and your Spouse/Partner and Child(ren)) may elect COBRA coverage to be effective as of the date your coverage would end if you are both:

- Covered under the Program on the day before beginning the leave of absence (LOA).
- Terminated from employment for any reason except gross misconduct or lost your coverage due to the expiration of the maximum coverage period.

If COBRA continuation coverage is elected, the maximum coverage period will begin with the date your coverage would otherwise have ended. See the "How Long Does COBRA Continuation Coverage Last?" section for more information.

Important Notice Obligations

You will only receive Notification that COBRA continuation coverage is available to you if you notify the COBRA Administrator in a timely manner that a Qualifying Event has occurred.

Your Employer's Notice Obligations

When the Qualifying Event is one of the following, AT&T will notify the Eligibility and Enrollment Vendor within 30 days of the Qualifying Event:

- The end of your employment.
- The reduction of your hours of employment.
- AT&T Inc.'s or your Participating Company's commencement of a Chapter 11 proceeding in bankruptcy.

If your employment ends due to a termination that your Employer determines to have been a result of your gross misconduct, you will receive a notice indicating that you have been determined **not** to be eligible for continuation coverage and why. You may appeal this determination by filing an Appeal with the Benefits Administrator within 60 days after your receipt of this determination. See the "How to File a Claim for Eligibility" section for more information on your right to appeal an adverse eligibility determination under this Program.

Your Notice Obligations

You are responsible for notifying the Eligibility and Enrollment Vendor if your Spouse/Partner or Child loses coverage under the Program as a result of divorce, legal separation, partnership dissolution, or your entitlement for Medicare (Part A or Part B or both), or the Child's loss of eligible status under the Program. Your Spouse/Partner or Child is responsible for notifying the Eligibility and Enrollment Vendor if your Spouse/Partner or Child loses coverage under the Program as a result of your death. You, your Spouse/Partner or Child *must* provide this notice, using the procedures specified in the "COBRA Notice and Election Procedures" section, no later than 60 days after the later of the date the event occurs or the date the Qualified Beneficiary loses or would lose coverage under the terms of the Program. This is generally at the end of the month in which the date on which the COBRA Qualifying Event occurs (see the "When Coverage Ends" section for more details).

If you, your Spouse/Partner or Child fails to provide this notice to the COBRA Administrator during this 60-day notice period (using the procedures specified), any Spouse/Partner or Child who loses coverage will not be offered the option to elect continuation coverage. If you, your Spouse/Partner or Child fails to provide this notice to the Eligibility and Enrollment Vendor and if any Claims are mistakenly paid for expenses incurred after the date coverage should have terminated, then you, your Spouse/Partner and Child will be required to reimburse the Program for any Claims so paid.

If the COBRA Administrator is provided with timely notice of a Qualifying Event that has caused a loss of coverage for a Spouse/Partner or Child, then the COBRA Administrator will send a COBRA Enrollment Notice to the last known address of the individual who has lost coverage. The COBRA Administrator will also notify you (the Employee/Eligible Former Employee), your Spouse/Partner and Child of the right to elect continuation coverage after the administrator receives notice of either of the following events that results in a loss of coverage:

- Employee's termination of employment (other than for gross misconduct)
- Reduction in the Employee's hours
- Eligible Former Employee's death
- Eligible Former Employee becomes entitled to Medicare (Part A, Part B or both)

COBRA Notice and Election Procedures

All COBRA notices must be provided to the Eligibility and Enrollment Vendor within the time frames and methods specified in this section.

Important: COBRA Notice and Election Procedures

You must provide all required notices (or make your COBRA election) no later than the last day of the required notice period (or election period). You can do this by placing a telephone call to the COBRA Administrator at the telephone number in the "Contact Information" section of this SPD or subsequent summaries of material modifications. You must speak to a service associate at the time of the call. Written or electronic communications or calls to other telephone numbers will not meet your obligation to provide this notice. (If you are unable to use a telephone because of deafness, the COBRA Administrator has TTY telephone service available.) See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

When you call to provide notice or elect coverage, you must provide the name and address of the Employee/Eligible Former Employee covered under the Program and the name(s) and address(es) of the Qualified Beneficiary(ies) affected. If your notice concerns a Qualifying Event, you also must include the name of the Qualifying Event or second Qualifying Event, if applicable, as well as the date the event(s) happened. If your notice concerns the disability of a Qualified Beneficiary, you also must include the name of the disabled Qualified Beneficiary, the date when the Qualified Beneficiary became disabled and the date the Social Security Administration made its determination. You may be required to provide documentation to support eligibility.

Electing COBRA Continuation Coverage

Once you inform the Eligibility and Enrollment Vendor that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each Qualified Beneficiary. If you elect COBRA continuation coverage in a timely fashion, COBRA continuation coverage will begin on the date that the Program coverage would otherwise have been lost.

In order to elect COBRA continuation coverage (if you are entitled to do so), you and/or your Spouse/Partner and Child(ren) must complete and return the form within 65 days after the later of:

- The date you and/or your dependents lose coverage; or
- The date you and/or your covered dependents are notified of your right to continue coverage (the date on the COBRA Enrollment Notice).

If you or your Spouse/Partner and Child(ren) do not elect continuation coverage within this 65-day election period using the procedure described in the "COBRA Notice and Election Procedures" section above, you will lose your right to elect continuation coverage.
However, as described in the "Surviving Spouse/Partner and Child(ren)" section, when you or a Child is eligible for extended coverage during a leave of absence or after termination of employment and the extended coverage runs concurrently with COBRA continuation coverage, you will automatically be enrolled in COBRA continuation coverage for the duration of your eligibility for extended coverage. At the end of your extended coverage, you may continue COBRA continuation coverage for the remainder of your eligible period (if any), by paying the required COBRA premiums. See the "Company Extended Coverage" section for more information.

If you reject COBRA continuation coverage during the election period, you may change that decision and enroll anytime until the end of the election period, using the required election procedure.

In most cases, a single COBRA election form and notice will be provided to the Employee/Eligible Former Employee and any eligible Spouse/Partner and Child(ren) or, in the case of an election provided only to the Spouse/Partner and Child(ren), a single election form and notice will be provided to the Spouse/Partner. However, each Qualified Beneficiary has an independent right to elect continuation coverage. For example, both you and your Spouse/Partner may elect continuation coverage, or only one of you may choose to elect continuation coverage. In addition, each eligible Child may elect coverage, even if one or both of you do not. Parents may elect to continue coverage on behalf of their Child(ren).

Even if you have other health coverage or are enrolled in Medicare benefits on or before the date COBRA is elected, you are entitled to elect COBRA continuation coverage. However, as discussed below, a Qualified Beneficiary's eligibility for COBRA continuation coverage will end if, **after** electing COBRA, he or she becomes covered under another employer-sponsored group health plan or program (after any pre-existing condition exclusion in that other plan ends) or becomes enrolled in Medicare. If this occurs, the other Qualified Beneficiaries may still elect COBRA continuation coverage.

When you consider whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, if you have a gap in health coverage of 63 days or more, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans. By continuing your coverage through COBRA, you may avoid that coverage gap. Second, if you do not get COBRA continuation coverage for the maximum time available to you, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's/Partner's employer). Make sure you submit your request within 30 days after your group health coverage ends because of a Qualifying Event. You will also have the same special enrollment right at the end of COBRA continuation coverage if you get continuation coverage for the maximum time available to you. Also, in certain circumstances, the Program provides Company Extended Coverage ("CEC") and may share in the cost of that coverage as described in the "When Coverage Ends" section.

Paying for COBRA Continuation Coverage

Generally, each Qualified Beneficiary may be required to pay the entire cost of COBRA continuation coverage. The amount may not exceed 102 percent of the cost to the group health plan (including both Employee/Eligible Former Employee and Employer contributions) for coverage of a similarly situated Covered Person or beneficiary who is not receiving COBRA continuation coverage (or, in the case of an extension of COBRA continuation coverage due to a disability, 150 percent). Your election notice from the Eligibility and Enrollment Vendor will include the cost of COBRA continuation coverage. In some circumstances, when you or your dependents are receiving Company Extended Coverage, the Company will make contributions toward the applicable COBRA premium. See the "When Coverage Ends" section for more information. The amount of your COBRA premium may change from time to time during your period of COBRA coverage, for example, upon annual changes in the cost of group health plan coverage or if you elect changes in your coverage. You will be notified of any COBRA premium changes.

When you elect COBRA, you will receive an initial bill from the Eligibility and Enrollment Vendor. You must make your first payment for COBRA continuation coverage no later than 60 days after the date of your election. The amount of your required first payment will be stated on your initial bill. It will include the cost of COBRA continuation coverage from the date coverage begins through the end of the month following the month the bill is issued. Claims for payment of Benefits under the Program may not be processed and paid until you have elected COBRA continuation coverage and made the first payment. **Any Benefits paid during this period will be retroactively canceled if you do not elect COBRA or if coverage is canceled because you do not make timely payments.** Bills for subsequent coverage will be issued monthly.

How Long Does COBRA Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. The maximum duration for COBRA continuation coverage is described in this section. COBRA continuation coverage can end before the end of the maximum coverage period for several reasons that are described in the "Termination of COBRA Coverage Before the End of the Maximum Coverage Period" section.

COBRA Events	
Event	**Length of Coverage**
If you leave the Company (for reasons other than gross misconduct)	Coverage for you and your dependents may last for up to 18 months*
If coverage stops because you no longer meet the eligibility requirements	Coverage for you and your dependents may last for up to 18 months*
If coverage stops because you are on a military leave	Coverage for you and your dependents may last for up to 24 months
If you die	Coverage for your dependents may last for up to 36 months
If you and your Spouse divorce or become legally separated or Partner requirements are no longer met	Coverage for your Spouse, Partner and/or Eligible Dependent Child(ren) may last for up to 36 months**
If a Child loses dependent status	Coverage for that dependent Child may last for up to 36 months**
If you are laid off	Coverage for you and your dependents may last for up to 18 months*
If you fail to return to work at the end of your family medical leave	Coverage for you and your dependents may last for up to 18 months*
*An 18-month continuation period may be extended. For more information, see the "18 Months (Extended Under Certain Circumstances)" section below. **If you do not call or provide written notice within 60 days after the event, COBRA or insurance continuation rights will be lost for that event.	

18 Months (Extended Under Certain Circumstances)

When the Qualifying Event is the end of employment or reduction in hours, COBRA continuation coverage for you, your Spouse/Partner or Child, as applicable, can last for up to 18 months from the date of termination of employment or reduction in hours. There are three ways this 18-month period of COBRA continuation coverage can be extended:

- **Disability Extension**. An 11-month extension of coverage may be available if any of the Qualified Beneficiaries in your family become disabled. All of the Qualified Beneficiaries who have elected COBRA continuation coverage will be entitled to the 11-month disability extension if one of them is qualified under this rule. The Social Security Administration (SSA) must formally determine under Title II (Old Age, Survivors and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the Qualified Beneficiary was disabled at some time prior to or during the first 60 days of COBRA continuation coverage. You must notify the Eligibility and Enrollment Vendor of this fact, using the notification procedure identified in the "COBRA Notice and Election Procedures" section. You must provide this notification within 60 days after the later of the SSA's determination or the beginning of COBRA coverage **and before the end of the first 18 months of COBRA continuation coverage**. The disabled individual does not need to enroll for coverage in order for the other Qualified Beneficiary family members to be covered. In the event the disabled party does not continue COBRA, only 102 percent of the premium may be charged for months 19 through 29. If the disabled party does continue COBRA, 150 percent of the premium will be charged for months 19 through 29. **If notice of the disability is not provided within the required period using the required procedure, there will be no disability extension of COBRA continuation coverage for any Qualified Beneficiary**. If the Qualified Beneficiary is determined by the SSA to no longer be disabled, you must notify the COBRA Administrator within 30 days after the SSA's determination. This is accomplished by using the notice procedure identified in the "COBRA Notice and Election Procedures" section. COBRA continuation coverage for all Qualified Beneficiaries will terminate as of the first day of the month that is more than 30 days after the SSA's determination that the Qualified Beneficiary is no longer disabled, provided it is after the initial 18-month period. The Program reserves the right to retroactively cancel COBRA coverage and will require reimbursement of all Benefits paid after the first day of the month that is more than 30 days after the SSA's determination.

- **Second Qualifying Event**. An extension of up to 18 months of COBRA continuation coverage will be available to Spouses/Partners and Child(ren) who elect COBRA continuation coverage if a second Qualifying Event occurs during the 18-month or 29-month coverage period following an Employee's termination of employment or reduction in hours. The maximum amount of continuation coverage available when a second Qualifying Event occurs is 36 months. The second Qualifying Event must be an event that would provide a 36-month continuation coverage period, such as the death of a covered Employee/Eligible Former Employee or a Child ceasing to be eligible for coverage. For the extension period to apply, notice of the second Qualifying Event must be provided to the Eligibility and Enrollment Vendor no later than the 60th day after the later of the date of the second Qualifying Event or the date coverage would otherwise end, using the notification procedure specified in the "COBRA Notice and Election Procedures" section. If the notice procedure is not followed or notice is not given within the required period, **then there will be no extension of COBRA continuation coverage due to a second Qualifying Event**.

- **Medicare extension for Spouse/Partner and Child(ren)**. If a COBRA qualifying event that is a termination of employment or a reduction of hours occurs within 18 months after the Employee becomes entitled to Medicare then the maximum coverage period for the Spouse/Partner and eligible Child(ren) will end three years after the date the Employee became entitled to Medicare (but the covered Employee's maximum coverage period will remain 18 months).

Bankruptcy

When the Qualifying Event is Chapter 11 bankruptcy filing by the Company, the maximum coverage period for you ends on your date of death, and the maximum coverage period for your Qualified Beneficiaries ends on the earlier of (i) the date of the Qualified Beneficiary's death; or (ii) the date that is 36 months after your death.

Special Extension for TAA-Eligible Individuals and PBGC Recipients

Under the American Recovery and Reinvestment Act of 2009 (ARRA), you may be eligible for a temporary extension of the maximum period of your COBRA continuation coverage that would otherwise end on or after Feb. 17, 2009. Such a temporary extension will be available to you if your Qualifying Event is termination of employment or a reduction in hours of employment, and you are a former Employee who either (i) is eligible for a tax credit under the Trade Act of 2002 (TAA-eligible individual); or (ii) has a nonforfeitable right to a benefit any portion of which is to be paid by the Pension Benefit Guaranty Corporation (PBGC recipient) under Title IV of ERISA.

If you are a PBGC recipient at the time of your Qualifying Event, your maximum COBRA coverage period will be extended until (i) the date of your death; or (ii) for your surviving Spouse or Eligible Dependent Children, 24 months after your date of death.

If you are a TAA-eligible individual as of the date COBRA continuation coverage otherwise would end, your maximum COBRA coverage period will be extended until the date you cease to qualify as a TAA-eligible individual.

In any event, ARRA provides that the COBRA continuation coverage periods for TAA-eligible individuals and PBGC recipients will not be temporarily extended beyond Dec. 31, 2010.

Conversion Policy Not Available

No conversion of Program coverage to an individual policy is available to a Qualified Beneficiary at the end of the 18-, 29- or 36-month period of COBRA continuation coverage, or at any earlier time when COBRA continuation coverage for the Qualified Beneficiary ends.

Conversion Policy Not Available

If you are an Eligible Former Employee, no conversion of Program coverage to an individual policy is available to a Qualified Beneficiary at the end of the 18-, 29- or 36-month period of COBRA continuation coverage, or at any earlier time when COBRA continuation coverage for the Qualified Beneficiary ends.

Termination of COBRA Continuation Coverage Before the End of the Maximum Coverage Period

COBRA continuation coverage for the Employee/Eligible Former Employee, Spouse/Partner and/or Child(ren) will automatically terminate when any one of the following six events occurs before the end of the maximum coverage period:

- The premium for the Qualified Beneficiary's COBRA continuation coverage is not paid in full within the allowable grace period.
- After electing COBRA continuation coverage, you (the Employee/Eligible Former Employee, Spouse/Partner or Child) become covered under another group health plan/program (as an Employee or otherwise) that has no exclusion or limitation with respect to any pre-existing condition that you have. If the other plan/program has applicable exclusions or limitations that would make your COBRA continuation coverage continue to be of value to you, then your COBRA continuation coverage will terminate after the exclusion or limitation no longer applies. This rule applies only to the Qualified Beneficiary who becomes covered by another group health plan/program.
- After electing COBRA continuation coverage, you (the Employee/Eligible Former Employee, Spouse/Partner or Child) become enrolled in Medicare. This will apply only to the person who becomes enrolled in Medicare.
- During a disability extension period, the disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, however, continuation coverage will not end until the month that begins more than 30 days after the determination.
- If for any reason, other than a COBRA Qualifying Event, the Program would terminate coverage of a Participant or beneficiary not receiving continuation coverage (such as fraud).
- The Company no longer provides group health coverage to any of its Employees.

Information About Other Individuals Who May Become Eligible for COBRA Continuation Coverage

Children Born to or Placed for Adoption With the Covered Employee/Eligible Former Employee During the COBRA Period

A Child born to, adopted by or placed for adoption with you during a period of COBRA continuation coverage is considered to be a Qualified Beneficiary if you are a Qualified Beneficiary and have elected continuation coverage for yourself. The Child's COBRA continuation coverage begins when the Child is enrolled in the Program, whether through special enrollment, Prospective Enrollment or Annual Enrollment. It lasts for as long as COBRA continuation coverage lasts for your other family members. To be enrolled in the Program, the Child must satisfy the otherwise-applicable eligibility requirements (for example, age).

Annual Enrollment Rights and HIPAA Special Enrollment Rights

If you elect COBRA, you will be given the same opportunity available to similarly situated Active Employees to change your coverage options or to add or eliminate coverage for dependents at Annual Enrollment. In addition, the special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA continuation coverage certain rights to add coverage for Eligible Dependents if that person acquires a new dependent (through marriage, birth, adoption or placement for adoption) or if an Eligible Dependent declines coverage because of other coverage and later loses that coverage as a result of certain qualifying reasons. Except

for certain Child(ren) described in the "Child(ren) Born to or Placed for Adoption With the Covered Employee/Eligible Former Employee During COBRA Period" section above, dependents who are enrolled in a special enrollment or Annual Enrollment do not become Qualified Beneficiaries. Their coverage will end at the same time that coverage ends for the person who elected COBRA and later added them as dependents.

Alternate Recipients Under Qualified Medical Child Support Orders

If you have a Child that is receiving Benefits under the Program pursuant to a Qualified Medical Child Support Order received by the Eligibility and Enrollment Vendor during your (the Employee's/Eligible Former Employee's) period of employment with the Company, he or she is entitled to the same rights under COBRA as an eligible Child of yours, regardless of whether that Child would otherwise be considered eligible (other than on account of age).

You Must Notify Us of Address Changes, Dependent Status Changes and Disability Status Changes

In order to protect your rights under the Program and those of your family members, it is vitally important that you keep the Plan Administrator informed of any changes in your mailing address and those of any covered family members who do not live with you. While you are an Active Employee, your address in the system of the Eligibility and Enrollment Vendor will be used to send important Program information to you and your covered dependents, including COBRA notices, should your coverage end because of a Qualifying Event such as termination of employment or reduction of hours. See the *Active Employee Address and Telephone Number Changes* table in the "Information Changes and Other Common Resources" section for information on how to keep your address current while you are an Active Employee. For former Employees, if your mailing address or contact information changes, you must promptly report your address change by calling the Pension Service Center. See the *Pension Service Center* table in the "Information Changes and Other Common Resources" section for information on whom to contact to report your address change. If you are not eligible to receive an AT&T company sponsored pension plan benefit, or have already received your entire AT&T company sponsored pension plan benefit in a lump sum and are not eligible for an Eligible Former Employee death benefit from your pension plan, contact the Eligibility and Enrollment Vendor to update your home address. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

Also, for all Participants, if your marital status changes or if a covered Child ceases to be eligible for coverage under the Program terms, you, your Spouse, or Legally Recognized Partner or Child must promptly notify the Eligibility and Enrollment Vendor to remove that person from your coverage. You also must provide the appropriate mailing address for mailing your Spouse's/Partner's or Child's COBRA notice. Such notification is necessary to protect COBRA rights for your Spouse, Legally Recognized Partner and Child(ren). In addition, you must notify us if a disabled Employee or family member is determined to **no longer be disabled**. Once your dependent is enrolled in COBRA, he or she must promptly report any **address changes**. See the *Pension Service Center* table in the "Contact Information" section for more details. If you are an Eligible Former Employee and are not eligible to receive a pension plan benefit, or have already received your entire pension plan benefit in a lump sum and are not eligible for an Eligible Former Employee death benefit from your pension plan, contact the Eligibility and Enrollment Vendor to update your home address. See the Eligibility and Enrollment Vendor table for contact information.

For More Information

Contact the Eligibility and Enrollment Vendor if you, your Spouse, Legally Recognized Partner or Child(ren) have any questions about this section or COBRA. You also may contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and telephone numbers of regional and district EBSA offices are available online at **dol.gov/ebsa** (EBSA's website).

Contact Information

For contact information for the COBRA Administrator, see the *Eligibility and Enrollment Vendor* table in the "Contact Information" section. For contact information for the Plan Administrator, see the *Other Plan Information* table in the "Plan Information" section.

PLAN ADMINISTRATION

KEY POINTS

- *The Plan is administered by the Plan Administrator, who has full authority and discretion to administer, interpret and enforce the terms of the Plan, and who may delegate that authority and discretion to other entities or individuals. The Plan Sponsor has the right to amend or terminate the Plan at any time.*
- *You must exhaust your Claims and Appeals rights under the Program before bringing a court action for Benefits.*
- *There are time limits for filing an action for Benefits under the Program.*
- *It is very important that you keep the Plan informed of any changes in your mailing address, contact information and family status changes.*

Plan Administrator

The Plan Administrator is the named fiduciary of the Plan, including all component Programs, and has the power and duty to do all things necessary to carry out the terms of the Plan. The Plan Administrator has the sole and absolute discretion to interpret the provisions of the Plan, to resolve any ambiguity in the terms of the Plan, to make findings of fact, to determine the rights and status of you and others under the Plan, to decide and resolve disputes under the Plan and to delegate all or a part of this discretion to third parties. To the extent permitted by law, such interpretations, findings, determinations and decisions are final, conclusive and binding on all persons for all purposes of the Plan.

If the Plan Administrator fails to strictly enforce any provision of the Plan in a given instance, it will not be construed as a waiver of that provision in any later case. The Plan Administrator reserves the right to strictly enforce each and every Plan provision at any time without regard to its prior actions and decisions, the similarity of the circumstances or the number of occurrences.

The Plan Administrator has the authority and discretion to settle or compromise any Claim against the Plan based on the likelihood of a successful outcome as compared with the cost of contesting such Claim. The Plan Administrator also has the authority and discretion to pursue, relinquish or settle any Claim of the Plan against any person. No person may rely on the actions of the Plan Administrator regarding Claims by or against the Plan in connection with any subsequent matter.

Coverage under the Program will be determined solely according to the terms of the Program and the applicable facts. Only the duly authorized acts of the Plan Administrator are valid under the Program. You may not rely on any oral statement of any person regarding the Program and may not rely on any written statement of any person unless that person is authorized to provide the statement by the Plan Administrator and **one** of the following applies:

- The statement is an official decision of the Plan Administrator to an individual whose eligibility for enrollment, participation or payment of Benefits under the Program is in dispute.
- The statement constitutes a duly authorized interpretation of an ambiguous or doubtful term of the Program.
- The statement constitutes the issuance of a rule, regulation or policy under the Program and applies to all Participants.
- The statement communicates an amendment to the Program and applies to all Participants.

Administration

The Plan Administrator has contracted with third parties for certain functions, including, but not limited to, the processing of Benefits and Claims related thereto. In carrying out these functions, these third-party administrators have been delegated responsibility and discretion for interpreting the provisions of the Program, making findings of fact, determining the rights and status of you and others under the Program and deciding disputes under the Program. The *Plan Information* table indicates the functions performed by a third-party contractor, as well as the name, address and telephone number of each contractor.

Nondiscrimination in Benefits

The federal tax and other laws prohibit discrimination in favor of highly compensated Participants or key Employees with regard to some of the Benefits offered under the Program. The Plan Administrator may restrict the amount of nontaxable Benefits provided to key Employees or highly compensated Participants and their covered dependents so that these nondiscrimination requirements are satisfied.

Benefits provided under the Program will not discriminate in any of the following ways:

- On the basis of any health factor, including evidence of insurability.
- As to eligibility for Benefits on the basis of a health factor.
- On the basis of Premiums or contributions for similarly situated individuals.

Amendment or Termination of the Plan or Program

AT&T Inc. intends to continue the Program described within this SPD, but reserves the right to amend or terminate the Program and eliminate Benefits under the Program at any time.

In addition, your Participating Company (or the Participating Company from which you terminated employment) reserves the right to terminate its participation in the Program. In any such event, you and other Program Participants may not be eligible to receive Benefits as described in this SPD and you may lose Benefits coverage. However, no amendment or termination of the Program will diminish or eliminate any Claim for any Benefits to which you may have become entitled prior to the termination or amendment, unless the termination or amendment is necessary for the Program to comply with the law.

Although no Program amendment or termination will affect your right to any Benefits to which you are already entitled, this does not mean that you or any other Active or Eligible Former Employee will acquire a lifetime right to any Benefits under the Program, or to eligibility for coverage under the Program or to the continuation of the Program merely by reason of the fact that the Program was in effect during your employment or at the time you received Benefits under the Program or at any time thereafter.

Limitation of Rights

Participation in the Program does not give you a right to remain employed with your Participating Company or any other AT&T-affiliated Company.

Legal Action Against the Plan

If you wish to bring any legal action concerning your right to participate in the Plan or your right to receive any Benefits under the Plan, you must first go through the Claims and Appeals process described in this SPD. You may not bring any legal action against the Plan for any denied Claim until you have completed the Claims and Appeals process, except as provided in the "Claims and Appeals" section of this SPD. Legal action involving a denied Claim for Benefits under the Plan must be filed directly against the Plan. The Plan Administrator is the Plan's agent for receipt of legal process in legal actions for Benefits under the Plan, as provided in the *Plan Information* table below. In order to bring an action against the Plan for Benefits, you must bring the action no later than five years following the date on which your Claim was denied.

Plan Information

This section provides you with important information about the Plan. The following *Other Plan Information* table provides you important administrative details including:

- **Plan Administrative Information.** The Plan can be identified by a specific name and identification number, which is on file with the U.S. Department of Labor. The *Other Plan Information* table provides this official Plan name, the name of the Program addressed in this SPD, the Plan identification number, Plan Year and certain details on Plan records.

- **Important Entities and Addresses.** Situations may occur that require you to contact (in writing or by phone) a specific administrative entity related to the Plan. Details throughout this SPD explain instances when the entities identified in the Other Plan Information table are important to a process related to the Plan.

- **Plan Funding.** In most instances, the Plan shares in the Cost of Coverage under the Program. The *Other Plan Information* table provides details on how the Plan funds the Cost of Coverage.

- **External Review Procedures.** The External Review Process available for review of certain Adverse Benefit Determinations and Rescissions of Coverage. This process utilizes Independent Review Organization (IRO). Information regarding the availability of the External Review process and arrangements with IROs is provided in this table.

- **Collective Bargaining Procedures (if applicable).** Certain Programs contain provisions maintained pursuant to a collective bargaining agreement. The *Other Plan Information* table provides information on how to obtain copies of the collective bargaining agreement.

The text immediately after the table provides information regarding the arrangements by the Plan Administrator with various third parties to provide services to the Plan, including Benefits Administration and eligibility and enrollment functions. Please see the applicable *Benefits Administrator* table in the "Contact Information" section for contact information for these third parties.

Other Plan Information	
Plan Name	AT&T Umbrella Benefit Plan No. 3
Program Name	AT&T East Vision Program
Plan Number	603
Plan Sponsor/Employer Identification Number (EIN)	AT&T Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333** EIN 43-1301883
Plan Administrator	AT&T Services Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333**
Name and Address of Employer	Affiliates of AT&T Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333**
Type of Administration	Plan administration is retained by the Plan Administrator. However, the Plan Administrator has contracted with third parties for certain functions associated with the Program as follows The Plan Administrator administers Claims and Appeals for Benefits under the Program on a contract basis with the Benefits Administrator, see the "Contact Information" section for more information. The Benefits Administrator has full discretionary authority to interpret Plan provisions as they apply to entitlement for benefit. The Plan Administrator administers enrollment, eligibility, monthly contribution and COBRA under the Program provisions, including the determination of initial Claims for eligibility, on a contract basis with the Eligibility and Enrollment Vendor, see the "Contact Information" section for more information. The AT&T Eligibility and Enrollment Appeals Committee (EEAC) determines final Appeals from the denial of eligibility. The EEAC has full discretionary authority to interpret Plan provisions as they apply to eligibility for benefits. See the "Contact Information" section for the address to write to.

Other Plan Information	
Agent for Service of Legal Process	Process in legal actions in which the Plan is a party should be served on the Plan at the following Address CT Corporation 350 N. St. Paul St. Dallas, TX 75201 Service of legal process also may be made upon a Plan Trustee.
Type of Plan	The Plan is an employee welfare benefit plan.
Plan Year	Jan. 1 through Dec. 31
Trustee	AT&T Voluntary Employee Beneficiary Association Trust Frost National Bank 100 W. Houston St. P.O. Box 2950 San Antonio, TX 78299
Plan Funding and Contributions	Certain Participating Company Employees and former Employees share in the cost of the Program. Certain costs associated with providing Benefits under the Program may be paid through the AT&T Voluntary Employee Beneficiary Association Trust, a trust set up under Code Section 501(c)(9). The Program is self-insured Program Benefits are not paid by insurance.
Plan Records	All Plan records are kept on a calendar year basis beginning Jan. 1 and ending Dec. 31.
Collectively Bargained Plan	With respect to certain Eligible Employees, the Program is maintained pursuant to one or more collective bargaining agreements. A copy of the collective bargaining agreement may be obtained by Participants and beneficiaries whose rights are governed by such collective bargaining agreement upon written request to the Plan Administrator and also is available for examination by Participants and beneficiaries as specified under Department of Labor Regulations Section 2520.104b-30.

Type of Administration and Payment of Benefits

Plan administration is retained by the Plan Administrator. However, the Plan Administrator has contracted with third parties for certain functions associated with this Program, as described below. Benefits under vision are paid by AT&T Participating Companies directly or through funds made available for this purpose through the trusts identified in the "Plan Funding" row in the *Other Plan Information* table above. The Benefits Administrators below do not insure Benefits provided under the Program.

Vision Benefits Administrator

The Plan Administrator administers Claims and Appeals for vision Benefits on a contract basis with EyeMed Vision Care. The Plan Administrator has discretionary authority to interpret the provisions of the vision Benefit and to determine entitlement to vision Benefits.

Eligibility and Enrollment Vendor

The Plan Administrator administers enrollment, eligibility, monthly contributions and COBRA under the Program provisions, including the determination of initial Claims for Eligibility, on a contract basis with Aon Hewitt (AT&T Benefits Center). The AT&T Eligibility and Enrollment Appeals Committee (EEAC) determines final Appeals from the denial of a Claim for Eligibility. The EEAC has full discretionary authority to interpret the provisions of the Program and to determine eligibility for Program Benefits and monthly contribution amounts.

Note: Contact information for the above Benefits Administrators and the Eligibility and Enrollment Vendor is located in the "Contact information" section.

RIGHT OF RECOVERY AND SUBROGATION

KEY POINTS

- *In this section, the term "you" includes your covered family members or dependents and also includes any trust or special needs trust established to receive monies recovered on account of your Injury.*
- *The Program will pay Benefits for you, but will have the right to recover those Benefit payments from the party who caused the Injury or from an insurance policy.*
- *You have an obligation to cooperate with the Program's exercise of its rights under this section.*
- *If the Program pays Benefits that should have been paid by another or pays excessive Benefits, the Program will have a right to recover the excess payment.*

This section applies if you or your covered family members are injured, suffer an Illness or are disabled as a result of the negligent or wrongful act or omission of another.

Summary of the Program's Right of Recovery

If you recover any amount for your Injury, Illness, or disability by way of a settlement or a judgment in or out of a court of law, the Program must be reimbursed out of the recovery for the amounts paid by the Program, up to the full amount you have recovered, without any reduction for legal fees or costs and without regard to whether you have been made whole by the recovery. The Program's right of reimbursement shall have the status of an equitable lien against your recovery.

It is the intent of this Program that you should recover only one payment for any cost that is covered under the Program. If you suffer an Injury, Illness, or disability for which another may be responsible or may have a financial or insurance obligation, the Program will be reimbursed from any recovery you may obtain, to the extent of the Benefits paid by the Program. For example, if you are injured by another person and obtain a recovery from the other person's insurance or from your own uninsured or underinsured motorist coverage, then you must reimburse the Program for the expenses the Program paid for that Injury.

Under this section, the term "recovery" means any and all sums of money and/or any promise to pay money in the future, received by you from the person who caused the Injury or Illness, or from any other source (such as your or their other insurance coverage, uninsured, underinsured, homeowners or umbrella insurance policies). "Recovery" includes payments no matter how characterized, including but not limited to sums paid or promised as compensation for actual

vision expenses, pain and suffering, aggravation, wrongful death, loss of consortium, punitive or exemplary damages, attorneys' fees, costs, expenses or any other compensatory damages. "Recovery" may be obtained by way of judgment, settlement, arbitration, mediation, or otherwise. The Program shall have an equitable lien on any recovery, and the Program's right to recovery shall not be reduced, even if you receive less in recovery than the full amount of damages claimed or suffered by you, unless the Program agrees to a reduction. The amount of money to be recovered by the Program shall not be reduced by any legal fees or costs that you incur in connection with obtaining a recovery unless the Program agrees to such reduction.

If you decline to pursue a recovery, the Program is "subrogated" to your rights and shall succeed to all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan pays on your behalf relating to any Illness, Injury, or disability caused by any third party. This means the Program can step into your shoes and possess your right to pursue a recovery to the extent of the Benefits paid (and to be paid) for the Injury. The Program has the option to bring suit against or otherwise make a Claim to collect directly from the person or entity that may be responsible for the Injury or Illness, with or without your consent. If the Program exercises this option, you must cooperate in pursuing such recovery, including assisting the Program's attorneys in preparing or pursuing the case, including attendance at hearings, depositions and trial. In the event the Program obtains any recovery, the Program will apply the monies received first to the Program as reimbursement for Benefits, second to the Program or its attorneys for costs, expenses and attorneys' fees incurred in connection with the recovery, and third, any remaining balances to you. The Plan Administrator, however, may, in its sole discretion, apportion the recovery in some other manner if it chooses to do so.

You are required to cooperate fully with the Program, the Benefits Administrator or their agents in the exercise of these rights of subrogation and recovery, including:

- You must sign all necessary forms requested by the Program or the Benefits Administrator, including, without limitation, an acknowledgement of the Program's rights to reimbursement or subrogation and an assignment of your Claims or causes of action against the other party.
- You must provide the Program or the Benefits Administrator with all reasonably necessary information as requested.
- You may not take any action after your Illness, Injury, or disability that could prejudice the Program's rights as described in this section, or the Program's ability to obtain reimbursement or subrogation.
- You must promptly notify the Program of any recovery obtained from the responsible person or entity, or their or your insurer, whether by judgment, settlement, arbitration or otherwise.

Right of Recovery of Overpayments

The Program or the Benefits Administrator may pay Benefits that should have been paid by another plan or program, organization or person, or may pay Benefits in excess of what should have been paid under this Program. In such event, the Program may recover the excess amount from the other plan, organization or person, or from you, including by reducing future Benefits otherwise payable under this Program, if necessary.

ERISA RIGHTS OF PARTICIPANTS AND BENEFICIARIES

KEY POINTS

- *ERISA is a federal law that provides certain rights and protections to all Participants.*
- *The persons who are responsible for the operation of the Plan have a duty to act prudently and in the interest of the Plan and their beneficiaries.*
- *No one may fire or discriminate against you for exercising your rights under ERISA.*

Your ERISA Rights

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income and Security Act of 1974 (**ERISA**). ERISA provides that all Participants are entitled to:

- Receive information about your Plan and Benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including collective bargaining agreements, insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the EBSA.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies. Your written request must be directed to:

  AT&T Services, Inc.
  Attn: Plan Documents
  P.O. Box 132160
  Dallas, TX 75313-2160.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report (SAR).
- Continue group health plan coverage (including vision coverage under this Program) in certain situations.
- You may have the right to continue health care coverage for yourself or Eligible Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event (see the “Extension of Coverage — COBRA” section). You or your Eligible Dependents may have to pay for such coverage. Review this SPD and the other documents governing the Plan for the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of any exclusionary periods of coverage for preexisting conditions under this Plan.

- If you have creditable coverage from another group health plan or health insurance issuer before you became a Participant in this Plan, you should be provided with a certificate of creditable coverage, free of charge, from the other plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage or when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage under this Plan.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including the Company, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining any Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your Claim for Benefits under the Plan is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator. If you have a Claim for Benefits that is denied or ignored, in whole or in part, and you have exhausted all applicable administrative remedies under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous.

Assistance With Your Questions

If you have questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

OTHER PROGRAM INFORMATION

KEY POINTS

- *This section describes various laws that may impact your right to Program Benefits.*
- *Some laws provide specific Program eligibility rights.*
- *Certain laws protect the privacy and security of your protected health information.*

This section describes some additional information about the Program and various laws that may impact your right to Benefits under the Program.

Qualified Medical Child Support Orders

Generally, your Benefits under the Program may not be assigned or alienated. However, an exception applies in the case of a Qualified Medical Child Support Order (QMCSO). Basically, a QMCSO is an administrative agency or court-ordered judgment, decree, order or settlement agreement in connection with a state domestic relations law (including a community property law) that either:

- Creates or extends the rights of an "alternate recipient" to participate in a program that provides group health benefits.
- Enforces certain laws relating to medical child support.

An alternate recipient is any Child of a Participant who is recognized by a medical child support order as having a right to enrollment under a Participant's program for group health benefits.

A medical child support order has to satisfy certain specific conditions to be qualified. The Eligibility and Enrollment Vendor will notify you if the Company receives a medical child support order that applies to you and will provide you with a copy of the Program's procedures used for determining whether the medical child support order is qualified. A medical child support order will generally not be considered to be qualified if it requires the Program to provide certain benefits or options that are not otherwise provided by the Program. Participants and beneficiaries can obtain, free of charge, a copy of such procedures from the Eligibility and Enrollment Vendor.

If the Eligibility and Enrollment Vendor determines the order to be qualified, your Child named in the order will be eligible for coverage as required by the order. You must then enroll the Child in the Program and pay any applicable contributions for coverage of the Child. Also, if a QMCSO is issued for your Child and you are eligible but not participating in the Program at that time, you and your Child will be enrolled in the Program and pay any applicable contributions.

Federal guidelines for medical child support orders as required under ERISA are continually evolving; however, the Program and its Eligibility and Enrollment Vendor are making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to a QMCSO, please see the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

IMPORTANT NOTICES ABOUT YOUR BENEFITS

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage under the Program, but are unable to afford the premiums, some states have premium-assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

- If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state that participates in CHIP, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.
- If you or your dependents are **not** currently enrolled in Medicaid or CHIP and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial **877-KIDS NOW (877-543-7669)** or **insurekidsnow.gov** to find out how to apply.
- If you qualify, you can ask the state if it has a Medicaid or CHIP program that might help you pay the premiums for health coverage under the Program.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, the Program is required to permit you and your dependents to enroll in the Program — as long as you and your dependents are eligible, but not already enrolled in the Program. This is called a "special enrollment" opportunity in the Program, but you must request coverage within 60 days of being determined eligible for premium assistance.

Alternatively, if you and your dependents are eligible, but not enrolled in the Program, and you lose your eligibility for premium assistance under Medicaid or CHIP, you are entitled to a "special enrollment" opportunity in the Program, but you must request coverage within 60 days of losing eligibility for premium assistance.

Federal guidelines related to premium assistance are constantly evolving, however, the Program is making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to premium assistance, please see the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

For information on which states have a premium assistance program or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor Employee Benefits Security Administration **dol.gov/ebsa** **866-444-EBSA (866-444-3272)**	U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services **cms.hhs.gov** **877-267-2323, ext. 61565**

Notice of HIPAA Privacy Rights

The privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) went into effect April 14, 2003, and require that we send you updated notices regarding the privacy of your health information. You have received a summary of those rights from the Plan. If you are an Active Employee, you may also view or print a copy of this notice through the Benefits section of **OneStop** (from work). If you are a former Employee or an Active Employee, you may view or print a copy of this notice through the AT&T secure Internet site at **access.att.com** (from home). See the "Information Changes and Other Common Resources" section for information.

Protecting the Privacy of Your Protected Health Information – Notice of HIPAA Privacy Rights

HIPAA provides you with certain rights in connection with the privacy of your health information. The Program will not use or disclose your protected health information (PHI) for purposes other than treatment, payment or Program administrative functions without your written authorization as required by federal law. The Program routinely discloses PHI to insurance companies, Benefits Administrators and other contracted health operations services such as those who verify Benefits or conduct audits. All PHI used, requested or disclosed is limited to the minimum amount necessary to accomplish the intended purpose of the Program and its administration.

You have the right to inspect and copy, request amendment or correction, restrict the use or disclosure and request an accounting of the uses and disclosures of your PHI. The Plan maintains a Notice of Privacy Practices that provides information to individuals whose PHI will be used or maintained by the Plan.

You may request a free copy of this information at any time upon request by contacting the Benefits Administrator as identified in the "Contact Information" section.

You may also view or print a copy of this Notice through the Benefits section of **OneStop** (from work) or the AT&T secure Internet site at **access.att.com** (from home).

HIPAA Certificate of Creditable Coverage

HIPAA places limits on pre-existing condition exclusion periods and requires that your Employer provide you with a written confirmation of your health care coverage under a plan, if applicable. A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six months before your "enrollment date." Your enrollment date is your first day of coverage under the Program, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to Pregnancy and cannot apply to a Child who is covered under any creditable coverage within 30 days after birth, adoption or placement for adoption and does not subsequently have a break in coverage, as explained below.

In order to reduce the pre-existing condition limitation period, you must provide proof of your prior creditable coverage. Creditable coverage includes coverage under a self-insured or insured employer group health plan, an individual or group health insurance indemnity or health maintenance organization (HMO) plan, a state or federal continuation Coverage Plan, individual or group health conversion plans, Part A or B of Medicare, Medicaid (except for coverage of pediatric vaccines), the Indian Health Service, the Peace Corps Act, a state health benefits risk pool, a

public health plan, health coverage for current or former members of the armed forces and any dependents, medical savings accounts, and health insurance for federal employees and any dependents.

Federal law no longer permits the Program to impose pre-existing condition exclusions for health care coverage of Participants or dependents under the age of 23. However, the Program may impose pre-existing conditions exclusion periods for Participants over the age of 23, including coverage for your adult dependent Child.

Proof of creditable coverage is generally demonstrated through a certificate generated by your prior plan, which shows evidence of your prior health coverage. However, if you cannot obtain a certificate, you may demonstrate creditable coverage if you satisfy all of the following:

- Attest to the period of creditable coverage.
- Present corroborating evidence of some creditable coverage for the period (such as pay stubs that reflect a deduction of health insurance, Explanation of Benefits (EOB) or health statements, or verification by a doctor or former health care benefits Provider that the individual had prior health coverage).
- Cooperate in verifying the information provided.

You also may demonstrate proof of dependent creditable coverage without a certificate if you satisfy the following:

- Attest to such dependency and the period of such status as a dependent.
- Cooperate with the verification of dependent status.

If you lose coverage under a plan that provides health care benefits that is offered by the Company, you are entitled to a certificate that shows evidence of your prior health coverage. If you leave the Company and are hired by another employer that has a pre-existing condition limit in its health plan, you must provide a prior certificate of coverage to offset the limit.

A certificate will be automatically issued when you lose your health care coverage under this Program. You may also request a certificate of creditable coverage by contacting the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

The certificate of creditable coverage is used to determine pre-existing condition exclusion periods, because under HIPAA, your period of creditable coverage under another health care plan will offset the exclusion period of a new health care plan as long you have not had a break in coverage for more than 63 days. Any waiting period before your effective date of coverage under a health plan does not count toward the number of days considered as a break in coverage.

Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any pre-existing condition exclusion if you enroll in another plan.

If you lose coverage, you will automatically receive a written certificate of creditable coverage that identifies all of the following:

- The names of the individuals covered under the Program.
- The period of coverage under the Program.
- Any waiting periods under the Program.

A certificate of creditable coverage is provided when any of the following occurs:

- You terminate employment with the Company.
- You or your covered dependent loses coverage under the Program.
- Your or your dependent's COBRA continuation coverage under the Program ends.
- You request a copy of your certificate of creditable coverage within 24 months of your termination of participation in the Program.
- You or your covered dependent becomes eligible for coverage under another plan.

If your employment with the Company ends and you obtain health care coverage under another health care plan, check with your new plan's administrator to determine if your new plan has a pre-existing condition exclusion and if you need to provide a certificate or other information regarding your prior health care coverage or benefits.

Effective Jan. 1, 2015, this requirement becomes null and void based on regulations issued under the Patient Protection and Affordable Care Act and shall automatically be stricken from this document as of such date.

CONTACT INFORMATION

Contact Information	
Benefits Administrator	
Name	AT&T Benefits Center
Type	Eligibility and Enrollment Vendor
Services Provided	For FSA, medical, dental, life insurance, Medicare Part B premium reimbursement and vision
Benefits Administrator Contact Numbers	
Contact Numbers Information	To access the AT&T Benefits Center by phone, you will need to provide the last four digits of your Social Security number, your date of birth and your AT&T Benefits Center password.
Domestic Telephone Number	**877-722-0020**
International Telephone Number	**847-883-0866** (international)

Contact Information	
Benefits Administrator Hours of Operation	
Hours of Operation	**Service Center:** Monday through Friday from 7 a.m. to 7 p.m. Central time. **IVR System:** An interactive voice response system is available 24 hours a day (except Sunday from 1 a.m. to noon Central time and periodically during the week for one hour between midnight and 5 a.m. for maintenance and updates).
Benefits Administrator Website	
Website Access Information	Access the AT&T Benefits Center website 24 hours a day at **resources.hewitt.com/att.** To access the website, you will need your AT&T Benefits Center user ID and password. On the website, you can • View your current vision coverage and contribution amounts. • View your dependent coverage. • Find information on where to go to change your personal data and address information. • Learn which changes you can make if you experience a change-in-status event, such as a birth or adoption, marriage or divorce, gain or loss of LRP. You can also learn when those changes would be effective. • Access Plan and Program documents. • Preview how your Benefits may change if you get married, retire or go on a leave of absence.
Website	**resources.hewitt.com/att**
Benefits Administrator Mailing Address	
General Mailing Address	
Domestic	AT&T Benefits Center 4 Overlook Point P.O. Box 1474 Lincolnshire, IL 60069-1474
Claims	
Claims Regular	AT&T Benefits Center Benefits Determination Review Team P.O. Box 1407 Lincolnshire, IL 60069-1407
Claims Overnight	Urgent Care claims regarding eligibility that require expedited action may be initiated by calling **877-722-0020.**

Contact Information	
Claims International	Urgent Care claims regarding eligibility that require expedited action may be initiated by calling **847-883-0866.**
Appeals	
Appeals Regular	**First-Level Request for Review** If your Claim for Benefits is denied on the basis of your eligibility or enrollment under the Program, you may submit a first-level request for review to AT&T Benefits Center Benefits Determination Review Team P.O. Box 1407 Lincolnshire, IL 60069-1407 **Second-Level Request for Review** If your first-level request for review is denied, you may submit a second-level request for review to AT&T Benefits Center Eligibility and Enrollment Appeals Committee P.O. Box 1407 Lincolnshire, IL 60069-1407 Procedures for submitting and processing appeals of Claims for Benefits denied on the basis of eligibility or enrollment can be found in the "Claims for Benefits" section of this SPD.
Benefits Administrator Fax Number	
Domestic	**847-883-8217**
Benefits Administrator Special Instructions	
Instructions	Call the AT&T Benefits Center to enroll in the Program or to inquire about • Eligibility. • Cost of Coverage. • Enrollment administration. • Network Providers. • General Benefits information. • Billing. • COBRA. • Change-in-status events.

Contact Information	
Vendor	
Name	EyeMed Vision Care
Type	Benefits Administrator
Services Provided	Vision
Vendor Contact Numbers	
Domestic Telephone Number	**800-638-4288**
Hearing Impaired Telephone Number	**866-308-5375** (hearing impaired)
Vendor Hours of Operation	
Hours of Operation	**Service Center:** Customer service representatives are available Monday through Saturday 6:30 a.m. to 10 p.m. Central time and Sunday 10 a.m. to 7 p.m. Central time. Assistance for the hearing-impaired is available Monday through Friday from 7:00 a.m. to 7:00 p.m. Central time. **IVR System:** An interactive voice response system is available 24 hours a day, seven days a week (except during days that require scheduled maintenance).
Vendor Website	
Website Access Information	Access the EyeMed website for information about the Program. When you access the website for the first time, you will be asked to register. After you have completed the registration, you will have immediate access to the site. Through **eyemed.com,** you can • Locate a Provider. • Check eligibility. • Find Benefits information. • Download a Non-Network Benefits Claim form.
Website	**eyemed.com**
Vendor Mailing Address	
General Mailing Address	
Mailing Address Information	EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040
Claims	
Claims Regular	First American Administrators, Inc. P.O. Box 8504 Mason, OH 45040-7111 Attn: Claims Department

Contact Information	
Appeals	
Appeals Regular	EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040 Attn: Quality Assurance Department
Vendor Special Instructions	
Instructions	If you use Non-Network Providers, you will have to file a Claim for Benefits. Refer to the "Claims for Benefits" section for information concerning the Program's procedures for submitting and processing Claims and appeals. • Claim forms are available through **eyemed.com** (the EyeMed website - registration is required); or • The EyeMed Customer Service Center at the telephone number provided in this table. To use a Claim form, you must • Complete the Claim transmittal form; and • Mail the form and the vision care bills to the address on the form. **IMPORTANT:** Claims for Benefits must be submitted no later than 12 months after the date of the service or the purchase of the supply. Claims for Benefits submitted after the filing deadline will not be considered for reimbursement. Remember to keep a copy of your Claim for Benefits for your records.

Active Employee Address and Telephone Number Changes	
It's important to keep your work and home addresses current because the majority of your Benefits, payroll or similar information is sent to them. Please include any room, cubicle or suite number that will help make mail routing more efficient. For Employees with access to the Employee intranet, go to **myintranet.att.com** to review and/or update your:	
***eLink* Users**	**Home address:** • Go to **HROneStop** at **hronestop.att.com** and select **eLink (eCorp)** in the left navigation bar. • Enter your ATTUID and AT&T Global Logon password. (If you do not know your password, please follow the instructions on the screen.) • Once logged on, click **OK.** • On the eCORP home page, click on the **Employee Services** tab. (Note: Please be sure the far right-hand scroll bar is all the way to the top.) • Select **Personal Information.** • Select **Maintain Addresses and Phone Numbers.**

	• To update your address, select **Edit.** • Make any necessary changes, and click **Save.** **Work address:** • Go to **myintranet.att.com** on the Employee intranet. • Review your work address information by looking up your name in the Webphone Directory section on the home page. • If you have changes, contact your supervisor or eLink assistant. Remember to include any room, cubicle or suite number that will help make mail routing more efficient. For Employees without access to the Employee intranet, contact your supervisor or eLink assistant.

DEFINITIONS

The definitions in this section apply to the terms used in this SPD. These terms are capitalized when they appear in the text.

Active Employee. An Employee who is on a Participating Company's active payroll, regardless of whether such Employee is currently receiving pay**.**

Adverse Benefit Determination. A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a Program Benefit, including any such denial, reduction, termination of, or failure to provide or make a payment that is based on a determination of a Participant's eligibility to participate in the Program.

Allowances. The portion of a Provider's charge that is eligible for reimbursement either in full or in part.

Annual Enrollment. The period specified by the Company during which Eligible Employees, Eligible Former Employees and COBRA participants may make changes to their coverage (including coverage options and enrolled dependents) under the Program. See the "Annual Enrollment" section for additional information.

Appeal. A written request for the review of an Adverse Benefit Determination or a denial of a Claim for Eligibility under the formal process outlined in the Program for a Claim for Eligibility or Claim for Benefits, as applicable. See the "Claims Procedure" section for more information.

AT&T Controlled Group. AT&T Controlled Group includes any of the following:

- Corporation that is a member of a controlled group of corporations within the meaning of section 414(b) of the Code of which the Company is a member;
- Trade or business (whether or not incorporated) with which the Company is under common control (as defined in section 414(c) of the Code;

- Organization (whether or not incorporated) that is a member of an affiliated service group (as defined by section 414(m) of the Code) that includes the Company; and
- Other entity required to be aggregated with the Company and treated as a single employer under section 414(o) of the Code.

AT&T Controlled Group Member. Each entity in the AT&T Controlled Group.

Bargained Employee. Either: (1) an Employee whose job title and classification is included in a collective bargaining agreement between a Participating Company and a union, or (2) an Employee whose job title and classification have been excluded from a collective bargaining agreement represented by the union, but for whom the Company provides the same Benefits provided to Employees included in a collective bargaining agreement between the union and the Participating Company.

Benefits. Payments for covered services or supplies that are available under the Program. The availability of Benefits is subject to the terms, conditions, limitations and exclusions of the Program.

Benefits Administrator. Any third party, insurance company or other organization or individual to which the Company or the Plan Administrator has delegated the duty to process and/or review Claims for Benefits under the Program.

Benefits at a Glance. A list of covered services and supplies and the maximum dollar amount the Program will pay in Benefits for each.

Bifocal Lenses. Lenses containing two foci (points of convergence of rays of light), usually arranged with the focus for distance above and a smaller segment for near focus below.

Blended Lenses. Bifocal lenses having two distinct powers; one on the top for distance and one on the bottom for near. The blended bifocal is where the line is blended, appearing invisible.

Child(ren). See the "Eligible Dependents" section for the definition of Child(ren).

Claim. A Claim for Benefits or a Claim for Eligibility.

Claim for Benefits. A request for Benefits from the Plan, provided that a request concerning enrollment or eligibility shall not be considered a Claim for Benefits unless the Claimant's eligibility is a basis for the denial of a request for the payment of Benefits under the Program.

Claim for Eligibility. A written request for eligibility or enrollment sent to the address specified by the Eligibility and Enrollment Vendor following a denial of enrollment that has not been resolved informally.

Claimant. A Participant or the Participant's authorized representative who has submitted a Claim for Benefits under the Program.

Claims Administrator. See the definition of Benefits Administrator.

COBRA. The Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272) as enacted April 7, 1986, and as subsequently amended from time to time. Any reference to COBRA shall be deemed to include any applicable regulations and rulings. See the "Extension of Coverage – COBRA" section for information.

Code. The Internal Revenue Code of 1986, as it may be amended from time to time. Any reference to any section of the Code shall be deemed to include any applicable regulations and rulings.

Company. AT&T Inc. and its subsidiaries and affiliates that are Participating Companies, former Participating Companies, or any successor or successors thereof.

Contact Lenses. The prescription lenses that fit directly on the eyeball under the eyelids.

Coordination of Benefits. The method of determining which health plan pays a plan Participant's Claims first (primary), which pays second (secondary and, in some cases, which pays third (tertiary), when the Participant has coverage under more than one health plan. See the "Coordination of Benefits" section for more information.

Copayment. The fixed amount you are required to pay generally at the time care is received for the eye exam and/or supplies.

Cost of Coverage. The total cost of the Program on which your specific contributions are based, if applicable.

Disability Pensioner or Disability Service Pensioner. A former Employee who terminated employment from the AT&T Controlled Group of Companies (or its predecessor) and was granted a disability pension or disability service pension under a Company management pension plan.

Domestic Partner. Your partner of the same gender:

- Who resides in the same household as you;
- Who is at least 18 years old, mentally competent to enter into a valid contract, unrelated to you and not legally married to anyone;
- With whom you have a close and committed personal relationship and there is no other such relationship with any other person;
- With whom you share responsibility for each other's welfare and financial obligations; and
- Who was enrolled as your dependent in the Program on the day before you became eligible for coverage under the Program.

Domestic Partner's Child(ren). The Child(ren) of your Domestic Partner. See the "Eligible Dependents" section for information and enrollment requirements.

East Region Companies. The AT&T affiliates operating in Connecticut, Massachusetts or Rhode Island.

Eligibility and Enrollment Vendor. The Eligibility and Enrollment Vendor, referred to as the AT&T Benefits Center, is the third-party vendor that the Plan Administrator has delegated responsibility under the Program for initial eligibility determinations, enrollment administration, Cost of Coverage information, billing, COBRA administration and Change-in-Status Event administration.

Eligible Dependent. An individual who is eligible to participate in the Program as described in the "Eligible Dependents" section.

Eligible Employee. An Employee of a Participating Company who satisfies the conditions for eligibility to participate in the Program set forth in the "Eligibility and Participation" section.

Eligible Former Employee. A former Employee of a Participating Company who satisfies the conditions for eligibility to participate in the Program set forth in the "Eligibility and Participation" section.

Employee. Any individual, other than a leased employee or Nonresident Alien Employed Outside the United States, who is carried on the payroll records of a Participating Company as a common law employee and who receives a regular and stated compensation, other than a pension or retainer, from that Participating Company, in exchange for services rendered to that AT&T Participating Company.

- For purposes of the preceding sentence, the term "leased employee" refers to any individual who is a leased employee within the meaning of Section 414(n)(2) of the Code; and
- The term "Employee" does not include any individual:
  - Who is rendering services to an AT&T Participating Company pursuant to a contract, arrangement or understanding either purportedly (i) as an independent contractor, or (ii) as an employee of an agency, leasing organization or any other such company that is outside of the AT&T Controlled Group and is providing services to an AT&T Participating Company, or
  - Who is treated by an agency, leasing organization or any other such company that is outside of the AT&T Controlled Group as an employee of such agency, leasing organization or other such company while rendering services to an AT&T Participating Company, even if such individual is later determined (by judicial action or otherwise) to have been a common-law employee of an AT&T Participating Company rather than an independent contractor or an employee of such agency, leasing organization or other such company.
- For purposes of this definition, "Nonresident Alien Employed Outside the United States" is any individual who receives no earned income (within the meaning of Section 11(d)(2) of the Code) from any AT&T Participating Company that constitutes income from sources within the United States (within the meaning of Section 861(a)(3) of the Code). Notwithstanding the preceding sentence, any individual who is classified by an AT&T Participating Company as a global manager will not be considered a Nonresident Alien Employed outside the United States.

Employer. The AT&T Controlled Group Member that issues your paycheck/that pays you.

ERISA. The Employee Retirement Income Security Act of 1974, as amended from time to time. Any reference to any section of ERISA shall be deemed to include any applicable regulations and rulings.

Examination. Examination means, but is not limited to, these component services when performed by an Ophthalmologist or Optometrist, including: (1) case history; (2) external examination of the eye and adnexa; (3) determination of refractive status; (4) ophthalmoscopy; (5) application of pharmaceutical agents for diagnostic purposes when indicated and allowed by state law; (6) tonometry test when indicated; (7) binocular measure; (8) summary findings and recommendations; and (9) prescribing corrective Lenses, if needed.

Expatriate Employee. An Employee (including a Global Manager) who is assigned by a Participating Company to work outside the United States of America for a period originally intended to be six or more consecutive months**.**

FMLA. The Family and Medical Leave Act, as amended from time to time.

Frames. Standard eyeglass frames adequate to hold two prescription Lenses.

Full-Time Student. A student is considered full-time if he or she is unmarried and taking 12 or more credit hours per semester (or the equivalent) at an accredited institution. If your Child is no longer a Full-Time Student, you must notify the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table for additional information on this process.

Global Manager. An Employee who has been so designated by his Participating Company Employer for the purpose of transferring him from country to country in order to allow maximum use of his or her business skills, cultural background and language, who does not have exclusive United States citizenship and who has not been assigned to an employment position within the United States.

HIPAA. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended from time to time including any applicable regulations and rulings.

Legal Guardian or Legal Guardianship. The tables in this definition provide the applicable definition under the Program for the following groups:

- Management Employees, see **Table 1**
- Nonmanagement Nonunion Employees of AT&T Corp. hired on or after Aug. 9, 2009, AT&T Mobility Services LLC, AT&T Mobility Puerto Rico Inc. or SBC Global Services, Inc., see **Table 1**
- Bargained Employees of AT&T Mobility Services LLC – IBEW Local 1547 hired, rehired or transferred on or after Jan. 1, 2012, SBC Global Services, Inc. – CWA District 9 (*Appendix D* of the AT&T West Core Contract), or AT&T Services, Inc. – National Internet Contract – Tier 1 or Tier 2, see **Table 1**
- Bargained Employees and Nonmanagement Nonunion Employees of AT&T Southwest Core Contract – CWA District 6, see **Table 1**
- All other Bargained Employees or Nonmanagement Nonunion Employees, see **Table 2**

Legal Guardian or Legal Guardianship - Table 1
A legally declared guardian relationship (or its equivalent) under applicable state law between you and/or your Spouse/Partner and a Child, only if both I and II below are demonstrated: I. A court of competent jurisdiction has issued an order assigning to you and/or your Spouse/Partner sole and exclusive care, custody and control of the Child, as well as exclusive financial and legal responsibility for the Child, and: II. Either A or B below are established: A. All prior parental rights with regard to the Child have been completely and permanently terminated either: 1. As a result of the death of both of the Child's parents or any and all other persons having legally established parental rights, responsibilities and duties with regard to the Child; or 2. By a court with jurisdiction over the Child. B. Circumstances exist under which both parents or any and all other persons having legally established parental rights, responsibilities and duties with regard to the Child are unable to perform substantially all parental duties and responsibilities as a result of one or more of the following conditions: 1. Physical, mental and/or medical disability, as determined by a physician or a court with jurisdiction over that person(s); 2. Imprisonment and/or 3. Disappearance and the inability to locate that person(s) by any reasonable means, but only for as long as the conditions in 1, 2, or 3 continue. See the "Eligible Dependent Exceptions" section for grandfathered exceptions to the Legal Guardian/Legal Guardianship definition.
Legal Guardian or Legal Guardianship - Table 2
A legally declared guardian under applicable state law between you and/or your Spouse/Partner and a Child, if a court of competent jurisdiction has issued a guardianship order assigning to you and/or your Spouse/Partner sole and exclusive care, custody and control of the Child, as well as exclusive financial and legal responsibility for the Child.

Legally Recognized Partner (LRP). Any individual:

- Who is a Registered Domestic Partner (RDP), or
- With whom an Eligible Employee or Eligible Former Employee has entered into a same-gender relationship pursuant to and in accordance with state or local law, such as civil union or another legally recognized arrangement that provides similar legal benefits, protections and responsibilities under state law to those afforded to a Spouse

Lens or Lenses. An ophthalmic corrective lens, either glass or plastic, ground or molded, as prescribed by an Ophthalmologist or Optometrist, to be fitted into a Frame.

Lenticular Lens. A high-power plastic lens in which the prescribed prescription is provided only over the central region of the Lens; used primarily for post-cataract Lens.

Medicaid. The program providing health care benefits under Title XIX of the Social Security Act of 1965, as amended.

Medicare. The insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq., and as later amended.

Modified Rule of 75. See the "Eligibility and Participation" section for an explanation of the Modified Rule of 75.

Network Provider. Any doctor of optometry or ophthalmology licensed to render vision care services and practicing within the scope of that license who acts as an independent contractor for the Benefits Administrator, and has agreed to limit his or her charges to Participants for most covered services and supplies.

Nonmanagement Nonunion Employee (NMNU Employee). An Employee who is not covered by a collective bargaining agreement and who is not classified as management

Non-Network Provider. Any doctor of optometry or ophthalmology licensed to render vision care services and practicing within the scope of that license but who is neither a member nor a participant in the Benefits Administrator's Vision Network.

Notification. A written or oral notice provided by you, your Provider or your representative to the applicable Benefits Administrator using the procedure specified by the Benefits Administrator.

Ophthalmologist. A licensed doctor of medicine or osteopathy legally qualified to practice medicine and who, within the scope of his or her license, performs vision Examinations and prescribes Lenses to improve visual acuity.

Optician. A person qualified in the state in which the service is rendered to supply eyeglasses according to prescriptions written by an Ophthalmologist or Optometrist, to grind or mold Lenses or have them ground or molded according to prescription, to fit them into a Frame and to adjust the Frame to fit the face.

Optometrist. Any doctor of optometry who is legally qualified to practice optometry in the state in which vision care services are rendered, perform Examinations and prescribe Lenses to improve visual acuity.

Orthoptic Training. A series of scientifically planned exercises for developing or restoring coordinate ocular movements.

Oversized Lenses. Generally means glass Lens Blanks with a diameter exceeding 66 millimeters or a plastic Lens Blanks with a diameter exceeding 68 millimeters.

Participant. Either the Eligible Employee or an Eligible Dependent of an Eligible Employee who is enrolled in the Program. The term also includes a Qualified Beneficiary who has elected coverage under the terms of COBRA and whose coverage has not ceased.

Participating Company. Any AT&T Company that has elected to participate in the Program subject to approval by the Plan Sponsor.

Payroll. The system used by an entity to pay those individuals it considers Employees and to withhold employment taxes from the compensation it pays those Employees. "Payroll" does not include any system that an entity uses to pay individuals whom it does not consider its Employees and for whom it does not actually withhold employment taxes (including individuals whom it regards as independent contractors).

Photosensitive Lenses. Lenses that tint in the presence of light. In bright illumination, the Lenses darken; in dim illumination, the Lenses lighten. The Lenses may be worn continuously and do not require a change from one environment illumination to another. Photochromic Lenses are a type of Photosensitive Lenses.

Plan. The AT&T Umbrella Benefit Plan No. 3

Plan Administrator. AT&T Services, Inc.

Plan Year. The calendar year beginning Jan. 1 and ending Dec. 31.

Provider. Any doctor of optometry or ophthalmology licensed to render vision care services and practicing within the scope of that license.

Qualified Beneficiary. A Covered Person losing coverage under the Program who is eligible to elect COBRA continuation coverage. See the "Extension of Coverage — COBRA" section for more information.

Qualified Medical Child Support Order (QMCSO). See the "Qualified Medical Child Support Orders" section for a definition and requirements.

Qualifying Event. An event, such as loss of your job, reduction of your hours, death of a covered Employee or former Employee, divorce, or loss of eligibility as a Dependent, that results in the loss of coverage under the Program and gives rise to a right to elect COBRA continuation coverage. See the "Extension of Coverage – COBRA" section for more information.

Registered Domestic Partner (RDP). Any individual with whom an Employee or Eligible Former Employee has entered into a domestic partnership that has been registered with a governmental body pursuant to state or local law authorizing such registration and such relationship has not terminated. You may be asked to provide a copy of the domestic partner registration and other evidence that you continue to meet the requirements of the applicable registry and that the registered domestic partnership has not ended. See the "Dependent Eligibility Verification" section for information for dependent enrollment and verification of dependent eligibility.

Regular Employee. An individual who is classified as a Regular Employee by a Participating Company.

Rehired Eligible Former Employee. See the "Eligibility and Participation" section for an explanation regarding who is a "rehired Eligible Former Employee".

Represented Employee. An Employee:

- Whose job title and classification are included in a collective bargaining agreement between a Participating Company and a union; or
- Whose job title and classification have been excluded from a collective bargaining agreement represented by the union, but for whom the Company provides the same Benefits provided to Employees included in a collective bargaining agreement between the union and the Participating Company.

Service Pensioner. A former Employee who satisfies the conditions for a "Service Pensioner" described in the "Eligibility and Participation" section.

SNET Disabled Rule. The eligibility rule described in the "Eligibility and Participation" section that is applicable to a qualifying disabled management former Employee who terminated employment from an East Region Company.

SNET Rule of 75. The eligibility rule described in the "Eligibility and Participation" section that is applicable to a qualifying management former Employee who was either hired or rehired by an East Region Company**.**

Spouse. The person to whom you are legally married including through Common Law Marriage.

Standard Progressive Lenses. Bifocal Lenses or Trifocal Lenses that are line-free. The power gradually changes from distance vision to intermediate vision to near vision moving invisibly from the top to the bottom of the Lens.

Subnormal Vision Aids. Aids relating to a set of procedures involving patients who are partially sighted, partially blind or legally blind. Subnormal Vision Aids are special Lens forms, such as ocular microscopes, ocular telescopes, hand-held magnifiers and other ophthalmic devices that include very high ocular prescriptions. Patients with low-vision aids are given special instructions in order to accommodate their special visual needs. Subnormal Vision Aids are sometimes called low-vision aids.

Temporary Employee. An individual who is classified as a "Temporary Employee" by a Participating Company.

Term Employee. An individual who is classified as a "Term Employee" by a Participating Company**.**

Term of Employment. A period of employment of an Employee in the service of one or more members of the AT&T Controlled Group, as determined in accordance with the pension benefit plan the Employee participates in as of termination of employment.

Trifocal Lenses. Lenses containing three foci, usually arranged with the focus for distance above, for intermediate distance in the middle and for near vision below.

Vision Training. A set of procedures involving visual reeducation, visual posturing and visual exercises used to alleviate problems related to the efficient coordination of both eyes. These problems may include convergence, insufficiency, amblyopia and visual skills.

APPENDIX A: PARTICIPATING COMPANIES AND FORMER PARTICIPATING COMPANIES

This appendix lists the Companies that participate in the Program and provides general information about groups of Employees and Eligible Former Employees that may be eligible to participate.

This section also provides general information regarding which groups of Eligible Employees and Eligible Former Employees within a Participating Company are eligible to participate in the Program.

This appendix is intended to provide information regarding Participating Companies and the Employee groups eligible to participate in the Program, not an individual's eligibility. Do not use this appendix to determine if you personally are eligible to participate in the Program. See the "Eligibility and Participation" section for specific information on eligibility.

Note: In addition, with prior approval of the AT&T Inc. board of directors (or its delegate) or the successor to such board, other Companies may hereafter become Participating Companies in the Program. A complete updated list of all the Participating Companies for the Program may be obtained from the Plan Administrator. The list also may be examined at the Plan Administrator's office or at other Participating Company locations in your area.

	Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
SBCSI - CWA District 1	AT&T Services, Inc. SBCSI	Bargained	AT&T East Core Contract - CWA District 1
SNET - CWA District 1	The Southern New England Telephone Company SNET	Bargained	AT&T East Core Contract - CWA District 1
TCORP - CWA District 1 (SNEDG)	AT&T Corp. TCORP	Bargained	AT&T East Core Contract - CWA District 1 (SNEDG)

APPENDIX B: CHANGE-IN-STATUS EVENTS

Change-in-Status Events

The following provides further clarification on the Change-in-Status Events and actions you are able to take during those Change-in-Status Events.

Change in Legal Marital or Partnership Status

You may change your enrollment if you experience a marriage, partnership, divorce, death of Spouse/Partner, termination of partnership, legal separation or legal annulment. Marriage will generally trigger a HIPAA special enrollment right in addition to your right to a change in enrollment.

For specific information about dependent eligibility, see the "Eligible Dependent" information detailed in the "Eligibility and Participation" section.

CHANGE IN LEGAL MARITAL OR PARTNERSHIP STATUS	CHANGES PERMITTED	NOTES
Marriage or Partnership	AD, AS, C, DD, E, W	E, AD, AS: For newly eligible Spouse/Partner Spouse/Partner and any dependent Child(ren) of Employee or new Spouse/Partner. DD, W: Only if coverage is effective under new Spouse/Partner's vision plan.
Death of Spouse/Partner*	AD, C, DD, DS, E	E, AD: Only if you lose coverage under your Spouse/Partner's vision plan. DD: Only if other dependent loses coverage under your Spouse/Partner's vision plan.
Divorce, Legal Separation, Legal Annulment or Dissolution of Partnership	AD, C, DD, DS, E	E, AD: Only if you or your dependent loses coverage under your Spouse/Partner's vision plan. DD: Only if dependent loses coverage under your Spouse/Partner's vision plan.

Change in Number of Dependents or Dependent Eligibility

You may change your enrollment if your dependent experiences a gain or loss of dependent status including birth, adoption, placement for adoption and death. Gaining a dependent will also trigger HIPAA special enrollment rights in addition to a change in enrollment.

CHANGE IN NUMBER OF CHILD DEPENDENT(S)	CHANGES PERMITTED	NOTES
Birth, Adoption or Placement for Adoption	AD, AS, C, E, W, DD, DS	W: Only if vision coverage is effective under your Spouse/Partner's vision plan.
Death of Child Dependent*	DD	You may only drop the deceased dependent.

**If a Dependent Dies*

If your dependent dies, you must notify the Fidelity Service Center at 800-416-2363. Although you are not required to notify the Fidelity Service Center within a specified period of time after the

death of your dependent, please contact the Center as soon as possible to initiate the appropriate changes to your Program coverage.

Dependent Satisfies or Ceases to Satisfy Dependent Eligibility Requirements

In addition to birth and adoption, there are other Change-in-Status Events that may affect your dependent's eligibility under the Program and permit you to enroll the dependent. This applies to both your Spouse and Child dependents. There are many events which affect a dependent's eligibility under the Program including circumstances where a dependent:

- Reaches the maximum age for adult dependent Child coverage under the Program.
- Loses eligibility as a Spouse or dependent Child under the terms of the Program.
- Becomes your legal dependent.
- Becomes your certified disabled dependent Child.

CHANGE IN DEPENDENT STATUS	CHANGES PERMITTED	NOTES
Gain of Dependent Status	AD, AS, C, E, W	E, AD, AS: For the dependent only. W: Only if there is a gain of coverage under another health plan.
Loss of Dependent Status	DD, DS	May only drop coverage for the newly ineligible dependent.

Change in Employee's Employment Status

You may change your enrollment if you experience a change in employment that affects your eligibility under the Program including: termination of employment, commencement of employment, strike or lockout, commencement of an unpaid LOA, termination of an unpaid LOA, change in worksite that constitutes a change in employment status.

IMPORTANT:

(1) A change in employment status generally does not apply unless benefit eligibility under the Program is affected as a result of the event.

(2) A change in financial circumstance (for example, a pay reduction) is not considered a change in employment status unless it affects eligibility under the Program.

CHANGE IN EMPLOYEE EMPLOYMENT STATUS	CHANGES PERMITTED	NOTES
Gain of Eligibility Due to a Change in Employee's Work Schedule or Employment Status	AD, AS, E	Only if eligibility for vision coverage option is gained.
Loss of Eligibility Due to a Change in Employee's Work Schedule or Employment Status	DD, DS, W	

CHANGE IN EMPLOYEE EMPLOYMENT STATUS	CHANGES PERMITTED	NOTES
Employee Commences Strike or Lockout Resulting in a Change in Benefit Eligibility	W	Participants must lose eligibility and coverage.
Employee Returns From Strike or Lockout Resulting in a Change in Benefit Eligibility	AD, AS, E, W	
Employee Rehires Within 30 Days of Termination	Reinstate prior enrollment	No change permitted unless there is another permissible status change within that 30 day period.
Employee Rehires After 30 Days Following Termination	AD, AS, E	You may enroll and make new enrollment choices.

Change in Spouse's or Dependent's Employment Status

You may change your enrollment if your Spouse/Partner or dependent experiences a gain or loss of eligibility for vision coverage under another employer's plan as a result of a change in their employment status. Your change in enrollment for that individual under the Program must correspond with their specific Change-in-Status Event.

For example, if your dependent loses eligibility under his employer's vision plan due to a reduction of hours, you could change your enrollment to add him to your Program coverage. However, you could not change your election to drop all coverage under the Program.

CHANGE IN SPOUSE/PARTNER OR DEPENDENT'S EMPLOYMENT STATUS	CHANGES PERMITTED	NOTES
Gain of Employment	DD, DS, W	Enrollment changes under the Program are only permitted for you, your Spouse/Partner or dependent who gain coverage under another employer's vision plan.
Loss of Employment Spouse	AD, AS, C, E	AD, AS, E: Only with respect to you, your Spouse/Partner or dependent who lose coverage under another employer's vision plan.
Change in Work Schedule that Triggers a Loss of Eligibility Under their Employer's Vision Plan	AD, AS, C, E	AD, AS, E: Only with respect to the individual who lost coverage under another employer's plan.
Change in Work Schedule that Triggers a Gain of Eligibility under their Employer's Vision Plan	DD, DS, W, C	Only with respect to the individual who gains coverage under another employer's plan.

CHANGE IN SPOUSE/PARTNER OR DEPENDENT'S EMPLOYMENT STATUS	CHANGES PERMITTED	NOTES
Spouse/Partner or Dependent Commences a Strike or Lockout	AD, AS, C*, E	*Only if there is a loss in coverage consistent with the event.
Spouse/Partner or Dependent Returns from a Strike or Lockout	C*, DD, DS, W	*Only if there is a loss in coverage consistent with the event.

Change in Residence

If you experience a change of residence that affects eligibility under the Program, you are permitted to make an enrollment change. For example, you may change your option enrollment if, as a result of a move, you are no longer eligible for the vision benefit option under the Program.

CHANGE IN RESIDENCE	CHANGES PERMITTED	NOTES
Relocation Triggers Gain in Eligibility	AD, AS, E	
Relocation Triggers Gain in Vision Benefit Option Availability	AD, AS, E, C, E	Only if eligibility for coverage option is gained.
Relocation Triggers Loss in Eligibility	C, W, DD, DS	
Relocation Triggers a Loss of Vision Benefit Option Availability	C, W, DD, DS	Only if eligibility for coverage option is lost.

Change in Benefit Coverage Under Another Employer's Plan

You may change your enrollment to add or drop vision coverage for you, your Spouse/Partner or dependent if any of you gain or lose coverage under another employer's vision plan.

CHANGE IN BENEFIT COVERAGE	CHANGES PERMITTED	NOTES
Gain of Vision Coverage under Another Employer's Plan	DD, DS, C, W	
Loss of Vision Coverage under Another Employer's Vision Plan	AD, AS, C, E	AD, AS: Only with respect to the Spouse/Partner or dependent who lost coverage under another employer's vision plan.
Spouse/Partner or Dependent's Annual Enrollment Does Not Correspond with the Program's Annual Enrollment Period	AD, AS, C*, DD, DS, E, W **Only if there is a loss of coverage*	AD, AS, DD, DS, E, W: Changes are permitted that reflect corresponding changes in non-AT&T Spouse/Partner or dependent's vision plan.

CHANGE IN BENEFIT COVERAGE	CHANGES PERMITTED	NOTES
You Gain Eligibility Under Another Employer's Vision Benefit Plan(s)	DD, DS, W	If Employee, Spouse/Partner and/or dependent coverage under other employer's vision plan is effective.
You Lose Eligibility Under Another Employer's Vision Benefit Plan(s)	AD, AS, C, E	

Loss of Coverage Under a Government or Educational Institution

You may change your enrollment if you experience a loss of group health coverage sponsored by an educational or governmental institution (for example: student health coverage provided by a university, coverage due to military service or certain Indian tribal programs, etc.).

> **IMPORTANT:** There is no change in enrollment permitted for a gain of coverage from a government or educational institution. However, there are special rules for a gain or loss of Medicaid or state sponsored Children's Health Insurance Program (CHIP) coverage. See the "Change in Medicaid and CHIP Coverage" section below.

LOSS OF EDUCATIONAL OR GOVERNMENTAL INSTITUTIONAL COVERAGE	CHANGES PERMITTED	NOTES
Your Loss of Other Government or Educational Institution Coverage (for example state risk pool coverage, student coverage under a university health plan, tribal coverage, etc.)	AD, AS, C, E	Note: Loss of coverage under state Medicaid or CHIP programs will permit you a 60 day enrollment period.
Spouse/Partner or Dependent's Loss of Other Government or Educational Institution Coverage (for example state risk pool coverage, student coverage under a university health plan, tribal coverage, etc.)	AD, AS, C, E	Note: Loss of coverage under state Medicaid or CHIP programs will permit you a 60 day enrollment period.

Change in Cost

You may change your enrollment if you experience a significant increase or decrease in your portion of the cost of your vision option under the Program during a period of coverage.

You may also change your enrollment if your Spouse/Partner or dependent experiences a significant increase or decrease in the cost of another employer's vision plan.

Enrollment changes may include revoking existing coverage and enrollment in a similar alternative coverage or waiving coverage altogether.

If the cost of a vision option significantly decreases, eligible individuals who have not enrolled in the Program may enroll. Those already enrolled in the Program may change their current vision option to the option with the lower cost.

The Eligibility and Enrollment Vendor generally will notify you of increases or decreases in the cost of vision coverage.

If there is an insignificant increase or decrease in the cost of your current vision option, the Eligibility and Enrollment Vendor may automatically adjust your enrollment contributions to reflect the minor change in cost and you will not be permitted to change your vision coverage.

CHANGE IN COST	CHANGES PERMITTED	NOTES
Significant Increase in Cost of Your Vision Benefit Option	AS, AD, C*, DD, DS, E, W **Only if Company contributions cease*	May change enrollment to match cost increase OR W and AD, AS, E: Another vision benefit option providing similar coverage OR W, DD, DS: If no other vision benefit option provides similar coverage
Significant Decrease in Cost of Your Vision Benefit Option	AS, AD, DD, DS, E, W	May change enrollment to match the cost decrease OR W, DD, DS: Current option and AD, AS, E: Drop other vision benefit option and add the vision benefit option with decreased cost
Increase in Cost Under Spouse/Partner or Dependent's Employer's Benefit Plan	AD, AS, C*, E	**Only if Company contributions cease*
Decrease in Cost Under Spouse/Partner or Dependent's Employer's Benefit Plan	DD, DS, W	
You, your Spouse/Partner or Dependent Experience a Complete Loss of Vision Plan Subsidy from Another Employer	C, E, AD, AS	

Change in Coverage Under Another Employer's Plan

You may make an enrollment change if you experience a change under another employer's plan (including a plan of your Spouse's or Dependent's employer) if the enrollment change is on account of and corresponds with the change and the other plan permits its participants to make an enrollment change.

CHANGE IN ENROLLMENT UNDER ANOTHER EMPLOYER'S PLAN	CHANGES PERMITTED	NOTES
Increase in Coverage Under Spouse/Partner or Dependent's Employer's Benefit Plan	DD, DS, W	If coverage under other employer's plan is effective.
Decrease in Coverage Under Spouse/Partner or Dependent's Employer's Benefit Plan	AD, AS, C*, E	AD, AS, E: If coverage under another employer's plan is decreased or dropped. **Only if Company contributions cease*

Addition or Significant Improvement of Benefit Plan Option

You may change your enrollment if the Program adds a new vision benefit option or significantly improves an existing vision benefit option; the Plan Administrator may permit you to enroll in the new or improved vision benefit option.

If a vision option is added or significantly improves, eligible individuals who have not enrolled in the Program may enroll.

If an addition or significant improvement is made under your Spouse/Partner or dependent's vision plan, you may change your enrollment under the Program consistent with those changes.

ADDITION OR SIGNIFICANT IMPROVEMENT OF BENEFIT PLAN OPTION	CHANGES PERMITTED	NOTES
Addition or Significant Improvement of a Program Vision Benefit Option	AD, AS, DD, DS, E, W	DD, DS, W then AD, AS, E: May drop current vision benefit option and elect the new or significantly improved vision benefit option. AD, AS: If previously enrolled in a vision benefit option, you may elect the new or significantly improved vision benefit option.
Addition or Significant Improvement of Vision Benefit Option to Spouse/Partner or Dependent's Employer's Benefit Plan	DD, DS, W	Only if coverage under another employer's plan is effective.

Significant Curtailment of Coverage (With or Without Loss of Coverage)

You may change your enrollment if you experience a significant curtailment of coverage under the Program during a period of coverage. In this case, you may change your enrollment for an existing vision benefit option even if there is no loss of coverage. An enrollment may be changed to a different vision benefit option or, in some cases, drop coverage if no similar coverage option is available under the Program.

Coverage is "significantly curtailed" only if there is an overall reduction in coverage provided under the Program that reduces coverage generally.

SIGNIFICANT CURTAILMENT OF COVERAGE	CHANGES PERMITTED	NOTES
Significant Curtailment or Termination of Coverage With or Without a Loss of Coverage	C, DD, DS, W	
Significant Curtailment or Termination of Spouse/Partner or Dependent Coverage under Another Employer's Vision Benefit Plan	AD, AS, C, E	You may only change your election if there is a loss of coverage and no similar coverage is available under another employer's plan.

Medicare or Medicaid

If you, your Spouse/Partner, or dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Program. Similarly, if you, your Spouse/Partner or your dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to enroll or increase that person's coverage under the Program.

CHANGE DUE TO MEDICARE OR MEDICAID	CHANGES PERMITTED	NOTES
You Gain Medicare or Medicaid Coverage	C, W	
You Lose Medicare or Medicaid Coverage	AD, AS, C, E	
Spouse/Partner Gains Medicare or Medicaid Coverage	DD, DS	If Spouse/Partner or dependent enrolls in Medicare or Medicaid coverage.
Spouse/Partner Loses Medicare or Medicaid Coverage	C, E, AD, AS	AD, AS, E: If Spouse/Partner or dependent loses Medicare or Medicaid coverage.

Leave of Absence (LOA)

You may change your enrollment if you, your Spouse/Partner or dependent begin or return from an LOA.

Common LOAs that trigger the right to a change in enrollment are: federal Family and Vision Leave Act (FMLA), state family and vision leave, federal military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA), unpaid personal leave, etc.

CHANGE DUE TO LOA	CHANGES PERMITTED	NOTES
You Begin an LOA	DD, DS, W	Whether paid or unpaid whether FMLA or non-FMLA.
You return from an LOA	AD, AS, E	Whether paid or unpaid whether FMLA or non-FMLA.

CHANGE DUE TO LOA	CHANGES PERMITTED	NOTES
Spouse/Partner or Dependent Begin an Unpaid LOA (including a FMLA leave) Resulting in a Loss of Eligibility under Another Employer's Vision benefit plan	AD, AS, C, E	AD, AS, E: Only with respect to Employee, Spouse/Partner who lost coverage under another employer's plan.
Spouse/Partner or Dependent Returns from an Unpaid LOA (including a FMLA leave) Resulting in a Gain of Eligibility Under Another Employer's Vision Benefit Plan	DD, DS, W	Only with respect to you, your Spouse/Partner who gains coverage under another employer's plan.
Spouse/Partner or Dependent Starts an Unpaid LOA (Non-FMLA) Without a Change in Eligibility under Another Employer's Plan	AD, AS, E	Only with respect to you, your Spouse/Partner who loses coverage under another employer's plan.
Spouse/Partner or Dependent Returns from an Unpaid LOA (Non-FMLA) Without Change in Eligibility Under Another Employer's Plan	DD, DS, W	Only with respect to you, your Spouse/Partner who gain you, your Spouse/Partner's coverage under another employer's plan.

Judgments, Orders and Decrees

If a judgment, court order or judicial decree resulting from a divorce, legal separation, annulment or change in legal custody requires vision coverage for your Spouse/Partner or dependent, you (or in some cases, the Program) may make a change to your enrollment to meet the legal obligation. While the judgment order or decree will cause you to be able to make the change in enrollment, it will not cause a Spouse or dependent to be eligible for coverage.

In addition, coverage may be dropped for the dependent if another person (e.g. your former Spouse) is required to cover the dependent.

Note: This enrollment change does not apply to voluntary changes in responsibility for vision coverage of a dependent between ex-Spouses.

CHANGE IN COVERAGE UNDER A JUDGMENT, ORDER OR DECREE	CHANGES PERMITTED	NOTES
QMCSO or Court Order Requiring You to Cover a Dependent	AD, C	
QMCSO or Court Order Requiring Another Individual to Cover Your Dependent	DD	
Expiration or Termination of a QMCSO or Court Order	W, DD, C	

Change in COBRA Continuation Coverage

CHANGE IN COBRA CONTINUATION COVERAGE	CHANGES PERMITTED	NOTES
Mid-Year Expiration of Maximum Coverage Period of COBRA Continuation Coverage Under Another Employer's Group Health Plan	AD, AS, C, E	You must exhaust the maximum COBRA coverage period available to you in order to make this change in enrollment. In general, you will not be permitted to make this change if your COBRA continuation coverage is terminated by you or your COBRA continuation coverage Provider before the maximum period of coverage.

Status Change Codes:

E	Enroll yourself and/or your Eligible Dependent under the Program
AS	Add your Spouse/Partner to vision coverage under the Program
DS	Drop vision coverage for your Spouse/Partner under the Program
AD	Add your Eligible Dependent(s) to vision coverage under the Program
DD	Drop vision coverage for your dependent under the Program
W	Waive or terminate your vision coverage enrollment under the Program
C	Change vision coverage options under the Program

APPENDIX C: ELIGIBLE FORMER EMPLOYEES

You are an Eligible Former Employee if: (1) you are a former Employee of a Participating Company; (2) you are a member of one of the Covered Bargaining Units or the Population Groups listed in the table below; (3) you meet the Employment Termination and Hire/Rehire Date requirements under the Program for your Eligible Employee Group; and (4) you meet the Age and Service Based Eligibility requirements or the Pension Based Eligibility requirements.

You may also qualify as an Eligible Former Employee if: you are an Eligible Former Disabled Employee, or you meet grandfathered or other special retirement provisions listed below.

Eligible Former Employees

Age and Service Based Eligibility

You are eligible for Program coverage as an Eligible Former Employee if you are a former Employee of an Eligible Employee Group and you meet both the age and corresponding Term of Employment requirements of the Modified Rule of 75, as shown in the table below, at the time you terminate employment.

Modified Rule of 75		
Minimum Age		**Corresponding Term of Employment**
Any age	And	At least 30 years
Age 50	And	At least 25 years
Age 55	And	At least 20 years
Age 65	And	At least 10 years
Age and service are based on completed whole years.		

Pension Based Eligibility

You are eligible to participate in the Program as an Eligible Former Employee if you are a former Employee of an Eligible Employee Group, you were granted at Termination of Employment a service pension, disability, or disability service pension under an applicable Company-sponsored pension benefit plan

Eligible Employee Groups

The following table lists each Covered Bargaining Unit or Population Group, their Employment Termination and Hire/Rehire Date requirements. See *Appendix A* for a list of Participating Companies and information that explains your Bargaining Unit or Population Group. See the "Enrollment and Changes to Your Coverage" section for information on enrollment and effective dates of coverage.

Covered Bargaining Unit and Population Groups	Employment Termination and Hire/Rehire Date	Eligible Former Employee Eligibility
Management Employees	Any Date	Age and Service Based Eligibility
AIS – NMNU	Any Date	Age and Service Based Eligibility
CINW – NMNU	Any Date	Age and Service Based Eligibility
AT&T Corp. Company (except AT&T of Puerto Rico, Inc.) – NMNU	Hire/Rehire Date on or After Aug. 9, 2009	Age and Service Based Eligibility
AT&T Corp. Company (except AT&T of Puerto Rico, Inc.) – NMNU	Hire/Rehire Date Before Aug. 9, 2009	Pension Based Eligibility
AIS – CWA District 9	Hire/Rehire Date Before Jan. 1, 2011	Age and Service Based Eligibility
SBCSI Tier 1 – CWA	Any Date	Age and Service Based Eligibility
SBCSI Tier 2 – CWA	Hire/Rehire Date Before Jan. 1, 2011	Age and Service Based Eligibility
AT&T East, AT&T Southwest, AT&T Midwest or AT&T West Surplus Special Appendix Employee	Hire/Rehire Date Before Aug. 9, 2009	Pension Based Eligibility
AT&T East, AT&T Southwest, AT&T Midwest or AT&T West Surplus Special Appendix Employee	Hire/Rehire Date on or After Aug. 9, 2009	Age and Service Based Eligibility
Bargained Employees of AT&T Mobility	Any Date	Age and Service Based Eligibility
Bargained Employees of AT&T East	Hire/Rehire Date Before Aug. 9, 2009	Pension Based Eligibility
Bargained Employees of AT&T East	Hire/Rehire Date on or After Aug. 9, 2009	Age and Service Based Eligibility
Bargained Employees and Nonmanagement Nonunion Employees of AT&T Midwest (except AIS COS – CWA District 4 and AIS – IBEW Local 494)	Hire/Rehire Date Before Aug. 9, 2009	Pension Based Eligibility
Bargained Employees and Nonmanagement Nonunion Employees of AT&T Midwest (except AIS COS – CWA District 4 and AIS – IBEW Local 494)	Hire/Rehire Date on or After Aug. 9, 2009	Age and Service Based Eligibility
AIS COS – CWA District 4	Any Date	Age and Service Based Eligibility

Covered Bargaining Unit and Population Groups	Employment Termination and Hire/Rehire Date	Eligible Former Employee Eligibility
Legacy AT&T Corp. Company (except AT&T Corp. – NMNU hired or rehired on or after Aug. 9, 2009)	Hire/Rehire Date Before Aug. 9, 2009	Pension Based Eligibility
Legacy AT&T Corp. Company (except AT&T Corp. – NMNU hired or rehired on or after Aug. 9, 2009)	Hire/Rehire Date on or After Aug. 9, 2009	Age and Service Based Eligibility
Bargained Employees of AT&T Southeast (except Bargained Employees who were formerly Nonmanagement Nonunion Employees of SBC Internet Services, LLC (in AT&T Southeast) with a Termination of Employment on or after April 1, 2013)	Hire/Rehire Date Before Aug. 9, 2009	Pension Based Eligibility
Bargained Employees of AT&T Southeast (except Bargained Employees who were formerly Nonmanagement Nonunion Employees of SBC Internet Services, LLC (in AT&T Southeast) with a Termination of Employment on or after April 1, 2013)	Hire/Rehire Date on or After Aug. 9, 2009	Age and Service Based Eligibility
Bargained Employees of AT&T Southeast who were formerly Nonmanagement Nonunion Employees of SBC Internet Services, LLC (in AT&T Southeast) with a Termination of Employment on or after April 1, 2013	Any Date	Age and Service Based Eligibility
Bargained Employees and Nonmanagement Nonunion Employees of AT&T Southwest Core Contract – CWA District 6	Hire/Rehire Date Before Aug. 9, 2009	Pension Based Eligibility
Bargained Employees and Nonmanagement Nonunion Employees of AT&T Southwest Core Contract – CWA District 6	Hire/Rehire Date on or After Aug. 9, 2009	Age and Service Based Eligibility
Bargained Employees and Nonmanagement Employees of AT&T West Core Contract – CWA District 9, PB – IBEW Local 1269, and PB – TIU Local 103	Hire/Rehire Date Before Aug. 9, 2009	Pension Based Eligibility
Bargained Employee and Nonmanagement Employees of AT&T West Core Contract - CWA District 9, PB - IBEW Local 1269, and PB – TIU Local 103	Hire/Rehire Date on or After Aug. 9, 2009	Age and Service Based Eligibility

Covered Bargaining Unit and Population Groups	Employment Termination and Hire/Rehire Date	Eligible Former Employee Eligibility
Legacy AT&T Corp. Company (except AT&T Corp. – NMNU hired or rehired on or after Aug. 9, 2009)	Hire/Rehire Date Before Aug. 9, 2009	Pension Based Eligibility
Legacy AT&T Corp. Company (except AT&T Corp. – NMNU hired or rehired on or after Aug. 9, 2009)	Hire/Rehire Date on or After Aug. 9, 2009	Age and Service Based Eligibility

Eligible Former Disabled Employees

The benefit provisions for you are the same as those which apply to Eligible Former Employees who have met the applicable age and service or pension based eligibility requirements above, except as otherwise noted in this SPD.

Bargained Employees (and Nonmanagement Nonunion Employees who receive the same Benefits) of AT&T East or AT&T Midwest

You are an Eligible Former Employee if:

- You terminated employment from a Participating Company after exhausting disability benefits under a Company-sponsored disability benefit program; and
- At the time you exhausted such disability benefits, your Term of Employment was 15 or more years with one or more Participating Companies

Note: If you are a former AIS – IBEW Local 494 Employee, you are not eligible for Program coverage regardless of whether you are eligible for a service or disability pension. However, you will be eligible for Program coverage if you are an Eligible Former Disabled Employee who was approved for long-term disability (LTD) benefits under a program sponsored by a Participating Company (LTD Program) and you or your enrolled Eligible Dependents continue to be eligible for LTD benefits.

Bargained Employees (and Nonmanagement Nonunion Employees who receive the same Benefits) of a Legacy AT&T Corp. Company

You are an Eligible Former Employee if your Term of Employment is 15 or more years at the time you are approved to receive LTD. Coverage will cease if you are no longer eligible for LTD benefits due to reasons other than attaining the maximum age under an LTD Program, unless you are also eligible for Program either due to age and service or pension. Additionally, if you continue to be disabled at the time you attain the maximum age under an LTD Program, you will continue to be eligible for Program coverage as an Eligible Former Employee

Grandfathered or Other Special Retirement Provisions

In addition to the previously listed eligibility provisions, you may be an Eligible Former Employee if you meet grandfathered or other special retirement provisions listed below.

Employees Who Elect the Transitional Program Under the AT&T Inc. Severance Pay Plan

If upon Termination of Employment you elect the Transitional Program under the AT&T Inc. Severance Pay Plan as revised from time to time, and pursuant to the terms of the Transitional Program, you are eligible for Benefits as an Eligible Former Employee.

AT&T West Early Retirement Benefit

Eligible Former Employee includes a Bargained Employee of AT&T West Core Contract – CWA District 9 who, at Termination of Employment, was granted a service pension under the West Program of the AT&T Pension Benefit Plan through the application of the Early Retirement Benefit provisions.

Surplus Special Appendix Employees

If you are a Surplus Special Appendix Employee, you may be eligible to receive Benefits as an Eligible Former Employee upon your Termination of Employment from a Special Appendix Employee job title.

To be eligible for Benefits as an Eligible Former Employee, you must have remained in the same Special Appendix Employee job title to which you were transferred for a continuous and uninterrupted period before your Termination of Employment. In addition, you must meet the Pension Based Eligibility or Age and Service Based Eligibility applicable to the job title you held before the declaration of the surplus or layoff, to be eligible for Benefits as an Eligible Former Employee as are currently and in the future provided to Bargained Employees in your previous job title.

> **IMPORTANT**: Unless you meet the criteria stated above, if you terminate your employment from a Special Appendix Employee job title, you are not eligible for Benefits as an Eligible Former Employee.

Transition Group 1 Employee – Cingular Wireless

As a Rehired Retiree on active payroll as of Jan. 1, 2008, refer to the "Rehired Eligible Former Employees" section to determine if you are an Eligible Former Employee.

Transition Group 2 Employee – Cingular Wireless

You are an Eligible Former Employee if, as of Dec. 31, 2001, you were classified as a Transition Group 2 Employee because you either (i) were within five years of meeting the BellSouth or SBC age and service requirements for post-employment coverage (without regard to the Cingular Wireless Accelerated Bridging and One-Time Prior Service Recognition Program); or (ii) had at least 15 years of service (without regard to the Cingular Wireless Accelerated Bridging and One-Time Prior Service Recognition Program).

Transition Group 3 Employee – Cingular Wireless

You are an Eligible Former Employee if, as of Dec. 31, 2001, you were classified as a Transition Group 3 Employee because you had at least five years of service with BellSouth or SBC but not 15 years of service, and is at least age 55 with at least 10 years Term of Employment by Dec. 31, 2008, and terminates employment on or after Jan. 1, 2009.

Transition Group 4 Employee – Cingular Wireless

You are an Eligible Former Employee if you are classified as a Transition Group 4 Employee because you are at least age 55 with at least 10 years Term of Employment by Dec. 31, 2008, and terminates employment on or after Jan. 1, 2009.

Note: For purposes of determining Transition Group eligibility, any service credited under the Cingular Wireless Accelerated Bridging and one-time prior service recognition programs is not counted.

IMPORTANT: The only former Employees covered by Transition Group 1, 2 or 3 are those who, on or before Dec. 31, 2001, were contributed directly to Cingular Wireless, LLC from BellSouth Corporation or SBC Communications Inc. (except employees of CCPR Services, Inc., USVI Cellular Telephone Corporation, Houston Cellular or BellSouth Wireless Data – Cingular Interactive) as part of the formation of Cingular Wireless, LLC and who met the applicable age and service requirements. The Group 1, 2 and 3 transition benefits were contingent upon continuous active employment with Cingular Wireless, LLC. Upon any break in service for any duration, an Employee will no longer have the Group 1, 2 or 3 transition status. Upon rehire with Cingular, an Employee will be treated as a newly hired Employee for Program coverage.

Note: If you are a Transition Group Employee and you transferred from a Management Employee to a Bargained Employee classification on or after Jan. 1, 2005, while employed at a Cingular Wireless Company, you keep your Transition Group Employee status (1-4) and your eligibility as an Eligible Former Employee is determined under the Transition Group rules described above. If you were not identified as a Transition Group Employee as of Dec. 31, 2001, or you did not maintain continuous Term of Employment after that date, then you are eligible for Program coverage only upon satisfying the following Age and Service Based Eligibility.

APPENDIX D: SPECIAL PROVISION APPLICABLE TO EMPLOYEES WHO WERE OUTSOURCED TO AMDOCS, INC.

Certain former Employees who were outsourced to Amdocs, Inc. and are considered "Transitioned Employees" (see note in the box below) may be eligible for Eligible Former Employee benefits under the AT&T benefit plans. The table below describes the eligibility requirements as well as the benefits available to you if you meet the eligibility requirements. In addition, if you meet the eligibility requirements below, you may apply for these benefits as soon as you become eligible, but no later than July 31, 2008. To apply for the benefits, see the "Applying for AT&T Eligible Former Employee Health and Life Benefits" section on the following page.

Transitioned Employees — Your AT&T Eligible Former Employee Benefits Opportunity	
If You ...	**Then ...**
• As of Feb. 28, 2003, were within five years of satisfying Eligible Former Employee health and life benefit eligibility in the SBC Communications Inc. (SBC) plans in which you were participating as of your SBC termination date • Are considered a "Transitioned Employee" (see note below) • Satisfy the requirements provided on the following page*	Your service with Amdocs will count toward your eligibility for the following Eligible Former Employee health and life benefits: **Health Benefits** • Medical (includes Prescription Drug, Mental Health/Chemical Dependency and Medicare Part B premium reimbursement benefits) • Dental • CarePlus • Vision **Long-Term Care**** **Life Insurance (basic life insurance only)** *Note: The compensation used in calculating your basic life insurance coverage at the time you attain retirement eligibility will be your annual basic pay as determined by AT&T as of your SBC termination date to the extent such annual basic pay remains eligible under AT&T's then-current basic life insurance plan. Basic life insurance coverage will be subject to any applicable Eligible Former Employee age-related reductions.*

**In order to qualify for the AT&T Eligible Former Employee health and life benefits listed on the previous page, you must remain continuously employed by Amdocs until you attain the age and service requirements for these benefits as they exist on the date you would have qualified for them if you had remained employed by AT&T. You will not be eligible for these benefits if you terminate employment from Amdocs before attaining such eligibility. If you satisfy these eligibility rules, AT&T Eligible Former Employee health and basic life insurance benefits will be provided under the applicable AT&T plans as they may be amended or terminated from time to time. Your service with Amdocs will not be counted for any other purpose, even if you are re-employed by AT&T in the future. AT&T reserves the right at any time, in its discretion, to amend or terminate its life insurance and health benefits plans, including, but not limited to, the right to amend eligibility provisions, Eligible Former Employee contribution rates, copayments and annual deductibles.*

***Important: If your service with Amdocs is recognized for purposes of qualifying for AT&T Eligible Former Employee health and life insurance benefits, whether or not you previously maintained long-term care insurance, you will be eligible to apply for coverage in an AT&T long-term care insurance plan (if available) under plan terms that then pertain to an AT&T Eligible Former Employee who is not enrolled at the time of his or her retirement (e.g., premiums may be based on your subsequent enrollment age. You may have to meet any evidence of insurability requirements, etc.).*

Note: The term "Transitioned Employee" refers to Employees of SBC Communications Inc. (SBC) who were outsourced to Amdocs by SBC between March 1, 2003, and Aug. 31, 2004, accepted Amdocs' offer of employment and received a letter from SBC concerning "Your SBC Benefits Opportunity."

Applying for AT&T Eligible Former Employee Health and Life Benefits

You will be eligible to apply for AT&T Eligible Former Employee health and life benefits beginning the date you meet the age and service requirements for these benefits as they exist on the date you would have qualified for them if you had remained employed by AT&T. If you do not apply by this date, you may apply later, **but no later than July 31, 2008.** To apply, you must contact AT&T's Eligibility and Enrollment Vendor and provide any required documentation, including a notarized statement by the Vice President of Human Resources of Amdocs indicating:

- Your name
- Your Social Security Number
- Your original Amdocs hire date
- Your Amdocs termination date (if applicable)
- That you were continuously employed at Amdocs through the date you meet the age and service requirements for these benefits. *Note: This statement must identify the periods of continuous employment by Amdocs*.

To apply, contact the AT&T Eligibility and Enrollment Vendor at **877-722-0020** and identify yourself as a transitioned Amdocs employee who would like to be considered for AT&T's Eligible Former Employee health and life benefits. The service associate will connect you with a specialist who will verify that you have applied for Eligible Former Employee benefits within the required time period and ask you to provide a copy of your notarized statement from the Vice President of Human Resources of Amdocs.

Note: Please keep the original notarized statement for your records.

Once all required information has been received, the Eligibility and Enrollment Vendor will determine whether you are eligible to enroll in AT&T's Eligible Former Employee health and life benefits based upon the eligibility requirements at that time.

If eligible, you'll have the following enrollment opportunities:

Medical, Dental and CarePlus

Provided you meet the eligibility criteria applicable as of the date you apply for AT&T Eligible Former Employee health and life benefits, you may enroll immediately in one or all of these benefits, or you may postpone enrollment until a later date. For those benefits in which you enroll immediately, your coverage will be effective on the first of the following month. If you postpone enrollment, coverage will be effective according to the terms of the particular benefit plan applicable to similarly situated AT&T Eligible Former Employee at that time. Under current rules, coverage will be effective the first of the following month.

Vision

Provided you meet the eligibility criteria applicable as of the date you apply for AT&T Eligible Former Employee health and life benefits, you may enroll in vision benefits during the next available Annual Enrollment period. If you do not enroll during that first available Annual Enrollment, you will need to wait until a subsequent Annual Enrollment.

Life Insurance (Basic Only)

As of Sept. 1, 2004, no contributions are required for basic life insurance. Provided there continue to be no contributions for basic life insurance and you meet the eligibility criteria in existence as of the date you apply for AT&T Eligible Former Employee health and life benefits, your coverage will automatically become effective the first of the month following the month in which you are determined to be eligible.

Long-Term Care (LTC)

If you do not have LTC coverage through an AT&T LTC plan or you cancel your LTC coverage, you may apply for LTC coverage at any time, provided you meet the eligibility criteria as of the date you apply. You will be required to complete an application, which will include a Statement of Health. Coverage will be effective the first of the month after the date your application is reviewed, processed and approved.

If you continued your LTC coverage through an SBC LTC plan when you transitioned to Amdocs, coverage will continue, provided you continue to pay any required premium payments directly to the long-term care Benefits Administrator.

Note: If you apply and qualify for AT&T's Eligible Former Employee health and life benefits, you will automatically begin receiving AT&T Eligible Former Employee communications.

IMPORTANT: If you do not contact the Eligibility and Enrollment Vendor to apply for eligibility to enroll in these benefits by **July 31, 2008, you will forfeit your opportunity to apply.**

Address Changes

Make sure you keep your address current. Former Employees may do so by notifying the Fidelity Service Center at **800-416-2363.**

APPENDIX E: LASER VISION CORRECTION CARE

Access to laser vision correction care (i.e., Laser Assisted In-Situ Keratomileusis [LASIK]) through a network of Providers is available at a reduced cost to you and your covered Eligible Dependents. You can receive treatments at a lower cost than you would otherwise pay without the negotiated discounts. The telephone number to obtain information regarding Providers who participate in the discount LASIK offering is **800-988-4221**.

> **IMPORTANT:** The discounts for laser vision correction care are arranged by the Network Administrator and are not part of the Program. The Program does not pay any Benefits toward the cost of laser vision correction care; you pay the full cost of such services.