2010 Benefits Preview

September 2009
NIN: 78-18014

at&t

IMPORTANT

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

At AT&T, we're proud to provide you with a comprehensive, competitive and personalized benefits package, one that gives you the flexibility and choices you need when making decisions about your health, finances and home life.

Inside this communication, you'll find an overview of those plans and programs you may be eligible to participate in next year. Take the time to read this information carefully, so that your choices meet your and your family's needs.

No action is required at this time. You'll receive more information about enrolling in your 2010 benefits in the coming weeks.

What's Inside

PLEASE KEEP THIS BOOKLET FOR FUTURE REFERENCE.

This booklet, as it pertains to medical and prescription drug benefits, serves as a summary of material modifications (SMM) to the Cingular Wireless Medical Plan for Bargained Employees summary plan description (SPD) dated Jan. 1, 2007. For all other changes to benefits included in this booklet, further information will be provided in a future SPD or SMM.

2010 Benefits Overview

In 2010, you'll still have the opportunity to participate in your current benefits under the Cingular Wireless Health and Welfare Benefits Plan for Bargained Employees. However, as a result of your new bargaining contract, there are changes to your medical, mental health/substance abuse (MH/SA) and prescription drug benefits that affect the way your plan works.

Inside, you'll find information about those changes and some tips to help you get the most out of your medical and prescription drug programs.

An explanation of how your medical plan will work in 2010 begins on the next page. Information about changes to your prescription drug benefits begins on page 10.

For employees of Puerto Rico: The Triple S plan still will be offered as an option in 2010. The changes in monthly contributions described on page 3 and the six-month wait for company subsidy will apply to the plan as well.

There are no changes to your other benefits, which include:

- > Flexible spending accounts
- > MedPlus
- > Dental
- > Vision
- > Short- and long-term disability
- > Pension
- > Voluntary benefits
- > Long-term care
- > Employee assistance plan
- > Life insurance
- > Leave of absence
- > Adoption
- > Savings

To learn more about these offerings, visit the Your Benefits section of HROneStop.

If you participated in the BlueAdvantage EPO in 2009, be aware that it will not be available as a medical plan option in 2010.

In 2010, mental health/substance abuse services (also referred to as behavioral health services) and EAP will be administered by United Behavioral Health instead of Magellan. Information about transitioning care will be provided later in the year.

How Your Medical Plan Works

Here's a high-level look at how your medical plan, the Cingular Wireless Medical Plan for Bargained Employees, will work in 2010 when you use network providers.

1. For preventive medical services (see next section for an explanation), your medical plan pays 100 percent of covered services as long as you use network providers. The plan even picks up the cost of the office visit.
2. For nonpreventive medical services, including prescription drugs, you pay all costs until you meet your applicable annual deductible.
3. Once you meet your annual network deductible, you pay for 10 percent* of your eligible network expenses. You'll pay a copay for your prescription drug expenses when you use a network pharmacy.
4. You continue paying 10 percent* of your eligible expenses and a portion of your prescription drug costs until you reach your annual network out-of-pocket maximum. After that, benefits are payable at 100 percent of your eligible network expenses for the rest of the year; however, all other plan terms and conditions continue to apply.

*You are responsible for paying 20 percent of your eligible expenses if you have met your non-network deductible and use a non-network provider.

NO-COST SERVICES CAN HAVE A BIG PAYOFF

It's been said that without your health you have nothing. Some plan participants delay or don't seek out the health care services that are available to them at no cost. Our thoughts on the topic? Don't wait! Preventive care services (described in more detail on the next page) can help detect small problems before they become big ones. Schedule some time early in the year with your network provider to determine which services make the most sense for you. Remember, no-cost preventive services are not available from non-network providers.

Preventive and Nonpreventive Medical Services

What's the difference? In short, you don't pay for services from network providers that are considered preventive, but you generally do pay for those considered nonpreventive. Preventive care services are generally linked to routine wellness exams, while nonpreventive services are considered treatment or diagnosis for an existing illness, injury or condition.

Eligible preventive care services are covered at 100 percent as long as you receive care from network providers.

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

Your claims administrator's guidelines determine what services are considered preventive care and may change over time.

Examples of preventive care:

- Annual routine physicals
- Pap smears
- Bone density tests
- Pelvic exams
- Cholesterol screenings
- PSA exams
- Immunizations
- Well-adult visits
- Mammograms
- Well-baby and well-child care

This isn't a comprehensive list. For more information on what services qualify as preventive care, contact UnitedHealthcare (see page 14).

Participation Costs

Now let's take a look at the financial aspects — contributions, annual deductibles and out-of-pocket maximums.

Contributions

In the Cingular Wireless Medical Plan for Bargained Employees, you pay a monthly contribution to participate in the plan. The amount of that contribution depends on the date you were hired.

2010 MONTHLY CONTRIBUTIONS FOR FULL-TIME EMPLOYEES		
Hired Before Jan. 1, 2009	Individual Coverage	$30
	Individual + 1 Dependent	$56
	Individual + 2 or More Dependents	$83
Hired on or After Jan. 1, 2009	Individual Coverage	$55
	Individual + 1 Dependent	$105
	Individual + 2 or More Dependents	$154

2010 MONTHLY CONTRIBUTIONS FOR PART-TIME EMPLOYEES	
Greater than or equal to 20 hours per week	50% of full premium cost
Less than 20 hours per week	100% of full premium cost

The method of calculating monthly contributions for long-term disability recipients and for survivors of active employees is not changing.

QUICK QUIZ: PREVENTIVE OR NOT?

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

SITUATION 1

A woman visits her network doctor for her annual mammogram.

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

SITUATION 2

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

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

QUICK QUIZ: PREVENTIVE OR NOT?

SITUATION 3

A man who takes medicine for high cholesterol has an annual wellness exam and receives a blood test to measure his cholesterol level.

Answer: Although the man is taking cholesterol medicine, the office visit and the blood test are considered preventive care because they are part of his overall wellness exam.

SITUATION 4

A man makes quarterly visits to the doctor for blood tests to check his cholesterol level and to confirm the dosage level is appropriate.

Answer: The quarterly blood tests are considered nonpreventive because they are considered treatment for an existing condition.

IMPORTANT CHANGE

If you are enrolled in Individual + 1 Dependent or Individual + 2 or More Dependents coverage, you must pay 100 percent of the cost for nonpreventive services, until the full Individual + 1 or Individual + 2 annual deductible is satisfied. However, the applicable annual deductible may be satisfied by eligible expenses attributable to a single individual or any combination of family members.

Annual Deductible

Simply put, your annual deductible is the amount of money you must first pay out of pocket before a medical plan starts paying a portion of your nonpreventive costs. You must pay 100 percent of the cost of nonpreventive services — those considered treatment or diagnosis for an existing illness, injury or condition — until you meet your annual deductible.

The annual deductible is considered a combined deductible — meaning all eligible expenses related to nonpreventive care, medical/surgical services, prescription drugs and mental health/substance abuse services that you incur apply to your annual deductible. Any monthly contributions you may make to participate in the plan do not count toward your deductible.

Your annual deductible is based on a percentage of your base wages.

NETWORK/ONA — ANNUAL DEDUCTIBLES

	Percentage of Base Wages	Maximum Amount
Individual Coverage	0.5%	$500
Individual + 1 Dependent	1.0%	$1,000
Individual + 2 or More Dependents	1.5%	$1,500

NON-NETWORK — ANNUAL DEDUCTIBLES

	Percentage of Base Wages	Maximum Amount
Individual Coverage	1.5%	$1,500
Individual + 1 Dependent	3.0%	$3,000
Individual + 2 or More Dependents	4.5%	$4,500

There are different deductibles and out-of-pocket maximum amounts. One set applies when you seek care from network providers or are designated as outside network area (ONA). A separate set applies if you are assigned (or opt into) network status and you use non-network providers. If your eligibility designation is “network” and you use non-network providers, a separate set of deductibles and out-of-pocket amounts apply. After you meet your network/ONA deductible, 90 percent of eligible network expenses are covered. You pay the remaining 10 percent (coinsurance) until you reach your out-of-pocket maximum for medical and MH/SA services.

After you meet your non-network deductible, the plan pays for 80 percent of your eligible non-network expenses. You pay the remaining 20 percent (coinsurance) until you reach your out-of-pocket maximum for medical and MH/SA services. A $35 copayment also will apply if you are admitted to a non-network hospital, except for emergency care.

Please note that your network/ONA charges will apply only to your network/ONA deductible, and your non-network charges will apply only to your non-network deductible.

After you meet your deductible, the plan also pays for a portion of your eligible prescription drug expenses. You will be responsible for making a copayment — see page 11 for copayment information.

Out-of-Pocket Maximum

Your out-of-pocket maximum is the most money you can pay before the plan begins paying for 100 percent of your eligible expenses. There are separate annual out-of-pocket maximums for network/ONA and non-network services.

Your annual network/ONA deductible, coinsurance amounts and prescription drug copayments all count toward your network/ONA annual out-of-pocket maximum. Any monthly contributions you make to participate in the plan do not count toward your out-of-pocket maximum. The applicable out-of-pocket maximum is reached when eligible expenses incurred for a single individual or any combination of family members reach the out-of-pocket maximum amount.

Your out-of-pocket maximum is based on a percentage of your base wages.

NETWORK/ONA — OUT-OF-POCKET MAXIMUM

Annual Base Wages		Percentage of Base Wages	Maximum Amount
$50,000 or Less	**Individual Coverage**	1.5%	$2,000
	Individual + 1 Dependent	2.25%	$3,000
	Individual + 2 or More Dependents	3.0%	$4,000
More Than $50,000	**Individual Coverage**	1.5%	$2,500
	Individual + 1 Dependent	2.25%	$4,000
	Individual + 2 or More Dependents	3.0%	$5,300

NON-NETWORK — OUT-OF-POCKET MAXIMUM

Annual Base Wages		Percentage of Base Wages	Maximum Amount
$50,000 or Less	**Individual Coverage**	4.5%	$6,000
	Individual + 1 Dependent	6.75%	$9,000
	Individual + 2 or More Dependents	9.0%	$12,000
More Than $50,000	**Individual Coverage**	4.5%	$7,500
	Individual + 1 Dependent	6.75%	$12,000
	Individual + 2 or More Dependents	9.0%	$15,900

FREQUENTLY ASKED QUESTION

Do I have to use network providers?

No. You can use any provider you choose. Bear in mind, though, the annual deductibles and out-of-pocket maximums are significantly more expensive when you seek care through non-network providers. Also, the amount the plan pays after you meet the non-network deductible is less, and the preventive care services offered through the plan are covered only when you use network providers.

Understanding Network and Outside-Network-Area Status

Depending on your home ZIP code, you'll be assigned either network or outside-network-area (ONA) status. Though nearly 95 percent of participants are assigned network status, you can check the AT&T Benefits Center Web site (see page 14) during annual enrollment to confirm which status you've been assigned for 2010.

What happens if you're assigned ONA status?

If you're assigned ONA status and choose to remain enrolled in this option, you can use any provider — doctors, hospitals, etc. — you wish and receive the same level of benefits as someone in the network. If you are assigned ONA status, you'll have the option of switching to network coverage. Some participants choose to do this because the prices of some network services are less expensive. Before you make this decision, you should:

> Check out the list of network providers.

> Find out where they are located.

> Understand that you might need to travel farther to receive care.

If you switch to network coverage, you must use network providers or risk paying higher costs.

Note: If you enroll in ONA coverage, you can switch to network coverage at any time; however, you cannot change back to ONA coverage except during your annual enrollment period unless you experience certain change-in-status events.

Network/non-network providers may change during the year

It's possible that your network providers may become non-network providers midyear or vice versa. So check that your provider is in the network before you receive service.

Determining whether your provider is in the network

1. Go to www.myuhc.com.
2. Click on the Find Physician or Facility link under the Links and Tools header.
3. Choose Search for a Physician and click Continue.
4. On the Find Physician page, the site will automatically default to Search for a Physician by Name, Location and/or Specialty. Under Select Plan, choose UnitedHealthcare Choice Plus. Fill in the remaining fields, and click Continue.
5. On the Select a Physician Specialty page, select up to five specialties. Click Continue, and view the results.

NETWORK OR ONA: WHICH SHOULD YOU CHOOSE?

If you live in an area where there are fewer network providers, you may be assigned ONA instead of network status. This may meet your needs because it allows you to receive medical services from any provider and receive the network level of benefits. You may, however, opt to enroll in network coverage instead. The reason some participants elect to enroll in network coverage instead of remaining enrolled in ONA coverage is that network providers charge discounted fees for certain services. Providers outside of the network may charge more for the same services, costing you more out of pocket.

If you are assigned ONA status and enroll in that option, providers within the UnitedHealthcare Options PPO network offer the greatest negotiated discounts on services.

Note: To see if a particular hospital is in the network, select Search for a Hospital or Other Facility in Step 3 on the previous page, and continue as directed. You may also contact UnitedHealthcare (see page 14).

The Participant Experience — Receiving Care

Follow these simple steps to receive care:

1. Present your UnitedHealthcare ID card — which you'll typically receive in late December — to your medical provider before receiving service, and ask your provider to file your claim.
2. After you receive service, your provider will file a claim with UnitedHealthcare. This activity will be reflected online at www.myuhc.com and available for you to view in the form of health statements or explanation of benefits (EOB) notices. These reflect the amount covered by the plan, the negotiated network rate, the amount applied to your applicable deductible and any amount that you may owe.
3. UnitedHealthcare will notify your provider how much of the claim it will pay. Your provider will then send you a bill for the amount you owe, if any.

Things you should know about paying for service

> Generally, you shouldn't pay anything at the time you receive service.

> The medical coding your provider uses generally determines whether services are preventive or nonpreventive. To be safe, ask your provider for clarification before you receive service.

> The money you've paid toward your annual deductible for nonpreventive services and prescription drugs will also be tracked by UnitedHealthcare as claims are processed. You can go online to www.myuhc.com to view this information.

Your Medical Plan in Action

Now let's take a look at a couple of examples. Clearly, these examples are not comprehensive nor are they meant to cover every situation, but they will give you a good sense of how your medical plan works and how costs are paid.

The dollar amounts used in these examples are estimates based on industry averages.

Example: Richard is a 50-year-old man with no dependents who has been working for the company for 10 years and has a base wage of $40,000. He uses network providers for his care. In January, he has his annual physical and cholesterol screening, and his doctor recommends he have a colonoscopy. In April, Richard cuts his hand, which requires stitches. In October, he has strep throat, which his doctor treats with antibiotics. Here's a snapshot of Richard's total medical expenses for the year and how they are paid.

RICHARD'S COSTS

	Plan Pays	Richard Pays
Annual Contributions		Richard pays $30 each month for individual coverage. $360
Preventive Care		Network preventive care is covered at 100%.
> Annual physical ($140)		
> Cholesterol screening ($25)		
> Colonoscopy ($1,315)		
Preventive Care Total: $1,480	$1,480	$0
Nonpreventive Care		
> Cut to hand, including urgent care visit and minor outpatient procedure ($700)		Richard meets his annual deductible; begins copays & coinsurance.
> Follow-up doctor's appointment with a specialist ($150)		
> Doctor visit and test for strep throat ($120)		
Nonpreventive Care Total: $970		
How Richard's nonpreventive costs are paid:		
Annual Deductible: Richard's first charge of the year was for the cut to his hand. He pays the first $200 of this charge, meeting his annual deductible ($40,000 x .5% = $200).		$200
Nonpreventive Services: Richard pays for 10 percent of the remaining nonpreventive costs ($770), and the plan pays 90 percent.	$693	$77
Prescription Drugs		
> Three 30-day generic drug prescriptions ($30 each)		
Richard pays an $8 copay for each prescription because he has met his deductible but not his out-of-pocket maximum.	$66	$24
Total Costs	**$2,239**	**$661**

MANAGE COSTS WITH NETWORK PROVIDERS

One of the easiest ways to control your out-of-pocket health care expenses is to use network providers every time you receive health care services. Staying inside the network helps you meet your annual deductible sooner. And the sooner you meet your deductible, the sooner the plan begins picking up a portion of your eligible costs.

Example: Amanda is 32, has been with the company for three years and has a base wage of $30,000. She and her husband, Daniel, have a 3-year-old daughter and are expecting a son in mid-January. They use network providers for all their care. After their baby is born, the family takes advantage of the well-baby visits and immunizations offered by the plan. Amanda and Daniel take advantage of annual physicals and preventive-care services. In addition, Daniel receives care for a fractured wrist, and their daughter has a handful of doctor visits during the year for a variety of illnesses. Here's a snapshot of the family's total medical expenses for the year and how the expenses are paid.

AMANDA'S FAMILY COSTS

	Plan Pays	Amanda Pays
Annual Contributions		Amanda pays $83 each month to cover her dependents. $996
Preventive Care		
> Annual physical for Amanda ($140)		Network preventive care is covered at 100%.
> Annual physical for Daniel ($140)		
> Multiple well-baby and well-child visits and immunizations ($1,280)		
Preventive Care Total: $1,560	$1,560	$0
Nonpreventive Care		
> Amanda's labor, delivery and hospital charges ($8,500)		
> Daniel's fractured wrist, including urgent care visit ($120), outpatient X-rays ($430), minor outpatient procedure ($1,500) and one follow-up visit with a medical specialist ($150)		
> Four doctor visits for daughter's illnesses ($400)		
Nonpreventive Care Total: $11,100		Amanda meets her annual deductible; begins copays & coinsurance.
How Amanda's family's nonpreventive costs are paid:		
Annual Deductible: Amanda's first charge of the year was for the birth of her son. She pays this in full until the family deductible is met ($30,000 x 1.5% = $450).		$450
Nonpreventive Services: Amanda pays 10 percent of her remaining nonpreventive costs ($10,650) until the family out-of-pocket maximum is met ($30,000 x 3.0% = $900).	$10,200	$450

Example continues on next page.

AMANDA'S FAMILY COSTS (continued)	Plan Pays	Amanda Pays
Prescription Drugs		
> Six 30-day generic drug prescriptions ($30 each)		
> Three 30-day preferred drug prescriptions ($115 each)		
Prescription Drug Total: $525		
Prescription Drugs: Because Amanda met her deductible and out-of-pocket maximum with the birth of her child, she does not pay any charges for prescription drugs.	$525	$0
Total Costs	**$12,285**	**$1,896**

The Prescription Drug Program

In the Cingular Wireless Medical Plan for Bargained Employees, the prescription drug program is administered by CVS Caremark. Your out-of-pocket costs will be largely influenced by two factors: the types of drugs you purchase and where you buy them.

In this section, we'll take a closer look at the program and discuss the special situations that apply to maintenance drugs, specialty prescription drugs and personal choice drugs.

How the Prescription Drug Program Works

CVS Caremark handles claims administration for the program.

The plan features three primary types of drugs:

> **Generic —** the least expensive

> **Preferred —** brand name drugs, more expensive than generic

> **Nonpreferred —** brand name, most expensive

You are responsible for paying the full price of your prescription drugs until you meet your applicable annual deductible. After you meet your deductible, you are responsible for making a copay for each prescription.

You can contact CVS Caremark to obtain the network retail price of the prescription or to get an estimate of the reimbursement amount (see page 14).

The Three Primary Types of Prescription Drugs

Generic Drugs

These have the same active ingredient as brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs. Generic drugs have the least expensive copayment.

Preferred (Formulary) Drugs

These are brand-name prescription drugs. These drugs appear on your prescription drug claims administrator's preferred list.

Nonpreferred (Nonformulary) Drugs

These are brand-name prescription drugs that do not appear on the preferred list. The copayment for nonpreferred drugs is higher than that of generic or preferred drugs.

To see which category your prescription drug belongs to, visit the Caremark Web site (see page 14).

MORE INFO IS JUST A CLICK AWAY

CVS Caremark is the claims administrator of your prescription drug program benefits. To see which category your prescription drug belongs to, visit the Caremark Web site at www.caremark.com.

Paying for Prescription Drugs

You must pay full price for all prescriptions until you meet your annual deductible. The annual deductible for prescription drugs is combined with the medical/surgical and mental health/substance abuse deductible. Once you meet your annual deductible, you pay the copayments listed in the following chart when you have a prescription filled.

PRESCRIPTION DRUG COPAYMENTS

	Network Pharmacy *(up to a 30-day supply)*	Mail Order *(up to a 90-day supply)*
Generic	$8	$17
Preferred	$17	$35
Nonpreferred	$35	$70

If the cost of a drug is less than the copayment, you pay only for the cost of the drug.

IF YOU PURCHASE A HIGHER-PRICED OPTION WHEN A GENERIC DRUG IS AVAILABLE

If a generic drug is available and you opt for the higher-priced preferred or nonpreferred equivalent, you will pay the generic drug copayment plus the difference in cost between the generic drug and the option you choose.

Where to Purchase Prescription Drugs

Participating Network Pharmacy

Use a network pharmacy when you need up to a 30-day supply of medications for short-term conditions. Visit the Caremark Web site or contact a service representative to locate a network pharmacy (see page 14 for details).

Nonparticipating Non-Network Pharmacy

If you use a non-network pharmacy, or if you do not present your prescription drug ID card at a network pharmacy, you will be required to pay full price for the prescription and submit a claim form in order to be reimbursed. Reimbursements will be 50 percent of the network retail price of the drug. Claim forms must be submitted for reimbursement to the prescription drug program claims administrator.

Any prescriptions purchased through a non-network pharmacy will be applied to your non-network deductible.

Mail Order Program

The CVS Caremark mail order program allows you to have up to a 90-day supply of your maintenance drugs shipped directly to your home.

You need a prescription from your doctor that is written for up to a 90-day supply, and you have to complete a mail-service order form, which you can find on the Caremark Web site.

Once you submit the form, your prescription(s) and the appropriate payment, you'll receive your prescription(s) in about two weeks. Once you've purchased a drug through the mail order program, you can easily order refills through the Internet, the mail or by telephone.

Other Important Information

Specialty Pharmacy Services

Specialty prescription drugs are used in the management of chronic diseases that require complex pharmacy management. The specialty pharmacy services program offers delivery of specialty medications, personalized service and educational support.

For a specialty drug, you must purchase the drug through CVS Caremark's specialty pharmacy in order to receive any plan benefit.

Personal-Choice Drugs

Personal-choice drugs include contraceptive devices and injectibles, erectile-dysfunction agents, fertility drugs, hair-loss drugs, influenza drugs, nail-fungal drugs, nutritional and diet supplements, ostomy supplies (retail only), respiratory therapy and other prescription devices, smoking-cessation drugs, toxoids/vaccines, wrinkle-treatment drugs, depigmenting agents and hair-removal drugs. They are not covered under the prescription drug program.

Purchasing personal-choice drugs does not count toward your annual deductible or out-of-pocket maximum.

A Great Way to Save: Flexible Spending Accounts

These days, we're all doing what we can to make our take-home dollars stretch further. One of the easiest ways to do that is by participating in a tax-advantaged flexible spending account (FSA). FSAs can help you pay for eligible health and dependent-care expenses with funds set aside through payroll deduction. You don't pay taxes on the funds you contribute, so more money is available in your paycheck as disposable income. The money you put in an FSA must be used during the calendar year you set it aside, or you'll lose the funds.

Note: Puerto Rico employees can participate only on a pre-FICA tax basis.

Health Care FSA

In 2010, you'll be able to set aside up to $5,000 in a health care FSA. Your annual contribution will be deducted evenly from your paychecks throughout the year, but you'll have access to the full amount of your annual contribution on Jan. 1 for eligible health care expenses incurred in 2010.

Across our company, people use their health care FSAs to pay for such eligible medical expenses for themselves and their dependents as doctor's office visits, prescription drugs and over-the-counter medications, contact lenses, orthodontia and much more.

See your FSA summary plan description to learn more about what expenses are eligible for reimbursement.

Dependent-Care FSA

Dependent-care FSAs are similar to health care FSAs except they are used to pay for day care expenses such as child care or elder care. Unlike a health care FSA, you can be reimbursed only up to the amount in your account at the time of your claim. The maximum amount you can set aside in 2010 is $5,000.

Where to Go for More Info

Your 2010 claims administrators.

WHO	WHY	HOW TO CONTACT
UnitedHealthcare Medical/surgical claims administrator	> Speak with a service representative > Questions about your coverage > Questions about a claim > Locate network providers > Review your personal information > Review health statements (Web only) > Compare hospitals > Estimate cost of treatment	**1-877-506-7221** Monday through Friday from 7 a.m. to 7 p.m. Central time **www.myuhc.com**
United Behavioral Health Mental health/substance abuse claims administrator	> Speak with a service representative > Questions about your coverage > Questions about a claim > Choose and find a clinician > View eligibility and coverage	**1-877-506-7221** **www.liveandworkwell.com**
CVS Caremark Prescription drug claims administrator	> Speak with a service representative > Find medication price > Request/download forms > Find a network pharmacy > Order prescription refills > View list of preferred drugs	**1-800-378-8851** **www.caremark.com**

In addition to our plan claims administrators, our company has several resources that you can turn to for news and information about your benefits.

WHAT	WHY	HOW TO CONTACT
HROneStop	> Access the latest benefits news and info > Review coverage amounts > Review plan details > Review your summary plan descriptions If this is your first visit, you'll need to: > Choose your status. > Choose your appropriate subsidiary. > Save your selections for future visits.	**From work:** hronestop.att.com > Your Benefits **From home:** access.att.com > HROneStop > Your Benefits
AT&T Benefits Center	> Questions about eligibility > Review the cost of coverage > If you have a change-in-status event > View medical plan summary comparison charts, which provide details about your plan > General benefits information	**1-877-722-0020** 7 a.m. to 7 p.m. Central time **resources.hewitt.com/att** 24 hours a day, 7 days a week

Glossary

Annual Deductible. The total amount of costs, other than monthly contributions, you must pay for all applicable covered medical, surgical, mental health/substance abuse services (other than preventive care) and prescription drugs each calendar year before the plan begins to pay benefits. There are separate deductibles for network/ONA services and non-network services.

Base Wages. Used to establish your annual deductible and out-of-pocket maximum, this amount includes the total of your annual base pay rate and annual commission amount in effect:

> Immediately preceding annual enrollment for the next year (for current plan participants).

> As of your date of hire (for newly hired employees).

> On your last day on Active payroll (for Retirees, LTD Recipients and former Employees. The Annual Rate of Pay for a rehired Retiree who is receiving Retiree medical benefits will not be affected by their rehire).

Claims Administrator. As used in this communication, a claims administrator is an organization outside of AT&T with whom the company has contracted to provide the administration of certain aspects of the company's health and welfare plans.

Coinsurance. The percentage of the cost of covered services you pay after meeting your applicable annual deductible. The plan covers the remaining percentage of the allowable charge.

> After you meet your annual network/ONA deductible, you are responsible for paying 10 percent of the cost of eligible network services.

> After you meet your applicable non-network annual deductible, you are responsible for paying for 20 percent of the cost of eligible services.

Copayment. A copayment is the fixed charge you are required to pay for certain covered health services, after you meet the applicable annual deductible.

Dependent-Care Flexible Spending Account. A tax-advantaged account that can be used to set aside money to pay for certain expenses related to day care for dependents who live with you. Although this most commonly means child care, it can also be used for adult dependents who live with you, such as parents. Funds set aside in a dependent-care FSA must be used the year they are set aside and cannot be rolled over from one year to the next.

Eligible Expenses. Those health care expenses that are covered by the Cingular Wireless Medical Plan for Bargained Employees are covered in detail in the summary plan description (SPD).

Health Care Flexible Spending Account (FSA). A tax-advantaged medical account that can be used to set aside money to pay for qualified health care expenses, such as copayments for prescription drugs, eyeglasses, orthodontia and many over-the-counter medications. The funds in an FSA must be used the year they are set aside and cannot be rolled over from one year to the next.

Network. Health care providers, hospitals and pharmacies that contract with the claims administrator to provide services at negotiated rates.

Network Service Area. The area determined by ZIP code and designated by the claims administrator as an area where sufficient network primary providers, specialists, hospitals and other health care providers are available.

Non-Network Provider. A physician, facility or pharmacy that is not a member of the plan's network of providers.

Nonpreventive Care Services. Generally, these are the services that are provided to treat an existing illness, injury or condition.

Out-of-Pocket Maximum. The maximum amount of costs (coinsurance, copayments and annual deductibles) for covered medical and mental health/substance abuse services and prescription drugs that you could pay out of your pocket each year. Any contributions that you pay to participate in the plan do not count toward your out-of-pocket maximum. There are separate out-of-pocket maximums for network/ONA expenses and non-network expenses.

Outside Network Area (ONA). The geographic area outside of a network service area as defined by the claims administrator.

Preventive Care Services. Generally, these are the services and procedures that are administered for routine, precautionary purposes rather than treatment or services for an existing illness, injury or condition.

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