Summary Plan Description

IMPORTANT BENEFITS INFORMATION

AT&T East Dental Program (Program) under the AT&T Umbrella Benefit Plan No. 3 (Plan)

This Summary Plan Description (SPD) is a guide for using the AT&T East Dental Program, a component program under the AT&T Umbrella Benefit Plan No. 3.

Please keep this SPD for future reference.

NIN: 78-30495

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 any summaries of material modifications (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) and the AT&T East Dental Program.*
- *This document is an SPD for the portion of the Program that applies to certain eligible active Bargained Employees, Management Employees, and Nonmanagement Nonunion Employees of Participating Companies.*

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 Plan 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 Dental Program.

It provides information about eligibility, enrollment, contributions, and legal protections for the Program Benefits for certain active Bargained, Management and Nonmanagement Nonunion Employees of Participating Companies.

Use this SPD to find answers to your questions about your Program Benefits in effect as of Jan. 1, 2014. This SPD replaces all previously issued SPDs and Summary of Material Modifications (SMMs) for the portion of 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 or Former 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 Providers 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 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 Provider determine the treatment, care and services appropriate for your situation.

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ELIGIBILITY AND PARTICIPATION

KEY POINTS

- *You and your dependents are eligible for coverage under this Program if you meet the eligibility requirements described in this section.*
- *Your eligibility rules are based on your current or former employing Company and employment classification, Termination Date, service history and disability status.*
- *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 next section “What Coverage Options are Available” for the level of coverage (e.g. individual or family) available under the Program and the “Program Options” subsection to determine what Program options are 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 or former 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.

If you do not meet the eligibility requirements for the Program described in this 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.

Rehired Eligible Former Employees

You are considered a “rehired retiree” also known as a “rehired Eligible Former Employee” and special eligibility rules apply if:

- You previously terminated employment from a member of the AT&T Controlled Group and at that time were eligible for coverage under the Program as an Eligible Former Employee.
- Your eligibility for Post-Employment Benefits was not a result of disability.
- You are subsequently rehired by a member of the AT&T Controlled Group.

These special rules establish the conditions under which you may be eligible for continued Program coverage following your re-employment. You will be considered a rehired retiree for purposes of this Program during any period of time following your re-employment for which you are eligible under the special rules for continuation of your Program coverage.

If you are being rehired after having qualified for coverage as an Eligible Former Employee due to your employment by a member of the AT&T Controlled Group or are currently a rehired retiree,

contact the Eligibility and Enrollment Vendor if you have questions. See the *Eligibility and Enrollment Vendor* table in the “Contact Information” section for contact information.

Eligible Employees

Eligibility Rules	
Eligible Employees	
You are an Eligible Employee if…	You are an Employee of a Participating Company listed in *Appendix A* and you are classified by your Participating Company as a regular full-time or part-time active bargaining unit Employee, you are eligible to participate on the first day of the month in which you attain six months Term of Employment (formerly Net Credited Service).
Population Groups: Employee Classifications	See *Appendix A,* Participating Companies for information on Employee groups eligible to participate in this Program.
Options	• Preferred Provider Organization Option
Dual Enrollment	While you may be eligible under more than one status (for example, as an Employee, Eligible Former Employee or dependent), the Program only allows you to be enrolled under a single status. See the "Dual Enrollment" section for more information.

How to Determine If Your Dependents Are Eligible for This Program

Review this section to determine if your dependents 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 continuation of coverage under COBRA, your dependent(s) cannot be enrolled in the Program, unless you are also enrolled. In addition, if more than one coverage option is available under the Program, you and your Eligible Dependents must be enrolled in the same coverage option. 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 Orders” section for coverage information.

Eligible Dependents

Eligibility Rules	
Eligible Dependents	
Your dependents who meet the eligibility rule are eligible for Program coverage.	• Your Spouse. • Your LRP. • Your unmarried Child(ren)*or your Spouse/LRP's unmarried Child(ren) who are dependent on you for support (dependent Child) up to the end of the year in which they reach the age of 23. • For active and retired Bargained Employees: 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 the age of 23 to start the disability certification process. * Child(ren) 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: *Physically or mentally Disabled Children over the age of 23 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 more information on the certification process.*	

Dual Enrollment

The Program is designed to provide coverage for you and your Eligible Dependents. 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 medical program under a different eligibility status.

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

Program Option

The Program provides coverage under a PPO. The following option is available under this Program:

- Preferred Provider Organization (PPO) Option, which includes Network and Non-Network Providers. Your Benefits are based on the Provider you chose at the point of service.

The Preferred Provider Organization (PPO) Option

The PPO Option provides you flexibility and freedom of choice. With this option, you may receive care from any licensed Dentist or specialist and no referrals are required. The PPO Option offers you access to a Network of Dentists and specialists who have agreed to provide services at lower

rates negotiated with the Benefits Administrator. These reduced fees are called Allowable Charges. You are not required to use Network Providers, but when you do, the Provider generally files your claims for you and you are not responsible for charges in excess of the Allowable Charges. When you receive Non-Network Services, you must pay any amount above the Allowable Charge and this amount will not count toward your Annual Deductible or Annual Maximum. Keep in mind that even if you use a Dentist who is not in the Network, you can still reduce your costs and maximize your Benefits by using a Network Provider when you need a specialist such as an orthodontist or oral surgeon. To find a Network Provider, visit the Benefits Administrator's website. See the "Contact Information" section for Benefits Administrator contact information. See the "What You Need to Know About Providers" section for more information about Network Providers and the "Definitions" section for details about Allowable Charges.

The PPO Option covers services such as routine cleanings, oral exams, Fluoride treatments and X-rays, as well as many basic and restorative services. This option pays Benefits based on Coinsurance levels for different types of services and whether Covered services are obtained from a Network or Non-Network Provider. An Annual Deductible applies to Covered services, except certain Preventive Care received from a Network Provider. See the *Benefits at a Glance* table, "What Is Covered" and "Limitations and Exclusions" sections for more information on the Dental PPO Benefit. Whether care is received in or outside the Network, Benefits under the PPO Option will be paid up to the Annual Maximum Benefit.

You can find details about PPO Option coverage, Benefits and cost sharing in this SPD. If you have any questions about the terms of a PPO Option, please contact the Benefits Administrator. If you have questions about eligibility, enrollment or contributions for a PPO Option under the Program, contact the Eligibility and Enrollment Vendor. See the "Contact Information" section for contact information.

ENROLLMENT AND CHANGES TO YOUR COVERAGE

KEY POINTS

- *You must enroll to receive Program coverage.*
- *For your dependents to receive Program coverage, you and your dependents must be enrolled.*
- *You must act within the required time frames for enrolling and making changes to your Program coverage. If you miss the window of opportunity to enroll or make changes to your elections, you may have a gap in coverage or may not be able to make changes you desire to your coverage.*
- *You have certain responsibilities. You must notify the Eligibility and Enrollment Vendor if:*
    - *Your address changes.*
    - *You have a change in enrollment.*
    - *You receive a Qualified Medical Child Support Order (QMCSO).*

- *You or a covered dependent enrolls in Medicare.*
- *An enrolled dependent loses eligibility for any reason, such as divorce and reaching a certain age.*

What Coverage Levels Are Available

The Program offers the following levels of coverage:

- Individual – You only
- Individual + 1 – You and one Eligible Dependent*
- Individual + 2 or more – You and two or more Eligible Dependents*

** 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	Coverage is not automatic. If you do not enroll, you will not have coverage. To have coverage under the Dental Program, you must enroll through the Eligibility and Enrollment Vendor. You will receive personalized enrollment materials from the Eligibility and Enrollment Vendor shortly after you are hired. Follow the instructions in your enrollment materials and enroll within the 31 day period described in your enrollment materials - for coverage to be effective on the first day of the month in which you complete six months of TOE. Contributions will be on a before-tax basis unless you elect to have your payroll deductions made on an after-tax basis. Your enrollment election can be made • Between your Hire Date and the first day of the month in which you complete six months Term of Employment/TOE (previously Net Credited Service) - for coverage to be effective on the first day of the month in which you attain seven months of TOE. Contributions will be on an after-tax basis.
Annual Enrollment	During Annual Enrollment - for coverage to be effective on the first day of the following Plan Year.

Enrollment	
Prospective Enrollment	At any time during the year - for coverage to be effective on the first day of the month following your enrollment. Prospective Enrollment does not permit you to change Program options. See the "Prospective Enrollment" section for further information about eligibility and how to prospectively enroll. Prospective Enrollment is not available to Employees or former Employees on Company Extended Coverage, or COBRA participants.
Change-in-Status Enrollment	See the "Change-in-Status Enrollment" section.

Newly Hired Employee Enrollment

If you are classified by the Company as an Eligible Employee, you may enroll yourself and your Eligible Dependents in Dental Program coverage. You will receive enrollment materials from the Eligibility and Enrollment Vendor shortly after you are hired. You need to follow the instructions provided on how to enroll and you must enroll within the 31 day window period described in your enrollment materials for your coverage to be effective on the first day of the month in which you attain six months Term of Employment if you are a Bargained Employee . Your enrollment is subject to the before-tax premium option provided under the AT&T Flexible Spending Account (FSA) Plan, any contributions made through payroll deduction will be deducted on a before-tax basis unless you elect otherwise. If you do not elect to enroll you will default to “no coverage.”

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.

How Prospective and Flexible Enrollment Affect Changes to Your Coverage

For Active Employees Who Are Eligible for Prospective Enrollment	
Changes That You Can Make at Any Time	**Coverage Effective Date**
• Enroll in dental coverage • Drop dental coverage • Add or drop dependents	The first day of the month following the month in which the request is made. For example, if you make your enrollment request in March, your change will be effective April 1.
• Switch from the PPO to the DHMO or vice versa	The first day of the month following the month in which the request is made, provided you make the request between the first and the 10th of the month. For example, if you make your change request by March 10, your change will be effective April 1. If you make your change request on March 15, your change will be effective May 1.
** If you previously had coverage as a Primary Subscriber in the current calendar year and you are an Employee of the following groups, you are not eligible to enroll in dental coverage outside of Annual Enrollment or a Change–in-Status Event:* • *Management Employees* • *Bargained Employees of AIS-CA/NV, AIS-COS, ASI-SBC Telecom OutRegion, SBCIS, SBLD-CWA and SWBAG* *Note: Bargained Employees of SBVS-SWBT are not eligible for Prospective Enrollment.*	

For Eligible Former Management and Bargained Employees Who Are Eligible for Flexible Enrollment and Prospective Enrollment	
Changes That You Can Make at Any Time	**Coverage Effective Date**
• Enroll in dental coverage • Drop dental coverage	The first day of the second month following the month in which the request is made. For example, if you make your enrollment request in March, your change will be effective May 1.
• Add or drop dependents	The first day of the month following the month in which the request is made. For example, if you make your enrollment request in March, your change will be effective April 1.

<table>
<tr><th colspan="2">For Eligible Former Management and Bargained Employees Who
Are Eligible for Flexible Enrollment and Prospective Enrollment</th></tr>
<tr><th>Changes That You Can Make at Any Time</th><th>Coverage Effective Date</th></tr>
<tr><td>• Switch from the PPO to the DHMO or vice versa</td><td>The first day of the month following the month in which the request is made, provided you make the request between the first and the 10th of the month. For example, if you make your change request by March 10, your change will be effective April 1. If you make your change request on March 15, your change will be effective May 1.</td></tr>
<tr><td colspan="2">* If you previously had coverage as a Primary Subscriber in the current calendar year and you are an Eligible Former Employee of the following groups, you are not eligible to enroll in dental coverage outside of Annual Enrollment or a Change-in-Status Event:
• Southeast Eligible Former Employees
• Mobility CSNET Eligible Former Employees
• Legacy T Eligible Former Employees</td></tr>
</table>

<table>
<tr><th colspan="2">For Eligible Former Management and Bargained Employees Who Are Not Eligible for Flexible Enrollment</th></tr>
<tr><th>Changes That You Can Make at Any Time</th><th>Coverage Effective Date</th></tr>
<tr><td>• Enroll in dental coverage
• Drop dental coverage
• Add or drop dependents</td><td>The first day of the month following the month in which the request is made. For example, if you make your enrollment request in March, your change will be effective April 1.</td></tr>
<tr><td>• Switch from the PPO to the DHMO or vice versa</td><td>The first day of the month following the month in which the request is made, provided you make the request between the first and the 10th of the month. For example, if you make your change request by March 10, your change will be effective April 1. If you make your change request on March 15, your change will be effective May 1.</td></tr>
<tr><td colspan="2">* If you previously had coverage as a Primary Subscriber in the current calendar year and you are an Eligible Former Employee of the following groups, you are not eligible to enroll in dental coverage outside of Annual Enrollment or a Change-in-Status Event if you have a retirement date of:
• East Region – On or after Jan. 1, 1992
• Midwest Region – On or after Jan. 1, 1986
• Southwest Region, Southeast Region, Mobility CSNET, Legacy T – Any date
• West Region – On or after Jan. 1, 1987
• Retired Bargained Employees of AIS-CA/NV, AIS-COS, ASI-SBC Telecom OutRegion, SBCIS, SBCTI-OutRegion, SBLD-CWA, and SWBAG – Any date</td></tr>
</table>

For Eligible Former Management and Bargained Employees Who Are Not Eligible for Flexible or Prospective Enrollment	
Changes That You Can Make at Any Time	**Coverage Effective Date**
• Drop dental coverage • Drop Dependents	The first day of the month following the month in which the request is made. For example, if you make your enrollment request in March, your change will be effective April 1.
• Switch from the PPO to the DHMO or vice versa	The first day of the month following the month in which the request is made, provided you make the request between the first and the 10th of the month. For example, if you make your change request by March 10, your change will be effective April 1. If you make your change request on March 15, your change will be effective May 1.

Change-in-Status Enrollment

Circumstances often change. We may get married, welcome a Child to the family, lose benefits under another employer's 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.

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.

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 *31 days* after the event.

There is an exception to this rule:

- **If you or a covered dependent dies**, inform the Fidelity Service Center *as soon as possible* at 800-416-2363 to initiate the appropriate changes to Program enrollment.

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.

Enrollment Rules for Your Dependents

Program coverage is not automatic for you or your Eligible Dependents. You must enroll through the Eligibility and Enrollment Vendor to have coverage. To enroll a dependent, you must be enrolled in coverage. See the *Eligibility and Enrollment Vendor* table for contact information.

> **IMPORTANT:** Special enrollment provisions apply if you do not enroll when you are first eligible. See the "Enrollment Rules for You" section.

Your enrollment elections can be made:

- During Annual Enrollment – for coverage beginning the first day of the following Plan Year.
- Within 31 days of the later of your Hire Date or the date on your enrollment materials – for coverage beginning on your date of hire or as provided under your collective bargaining agreement. See the section on "Eligible Employees" for the date your coverage begins.

You may defer when coverage begins for you and your Eligible Dependents until you are eligible for the Company contribution toward your dental coverage. See the "Eligibility and Participation" and "Contribution" sections for information.

- After a Change-in-Status Event. See the "Change-in-Status Events" section for additional information, including a list of Change-in-Status Events and the changes in coverage you are allowed to make. A Change-in-Status Event includes the date you are first eligible for the Company contribution toward your dental coverage.

- At any time during the year with coverage beginning at a later date if you are eligible for Prospective Enrollment. See the section on “Prospective Enrollment” for more information.

See the *Eligibility and Enrollment Vendor* table for contact information. For information about contributions required to maintain your Program coverage, see the “Contributions” section.

> IMPORTANT: If you are denied enrollment in the Program, you have the right to file a Claim for Eligibility. See the “How to File a Claim for Eligibility” section for information.

Dependent Eligibility Verification

Your dependent may participate in the Program if he or she is eligible under the terms of the Program and enrolled.

In order to enroll your dependent, you must call the Eligibility and Enrollment Vendor.

The Eligibility and Enrollment Vendor will mail a dependent eligibility verification package to your address. If you do not receive the package in 7-10 days, it is your responsibility to call the Eligibility and Enrollment Vendor again. See the *Eligibility and Enrollment Vendor* table in the “Contact Information” section for contact information.

The dependent eligibility verification package will contain instructions for submitting documents that verify your dependents’ eligibility for coverage, including a list of 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 and/or other specified document that establishes the Child’s relationship to you.

> IMPORTANT: You must provide documentation proving the eligibility of your dependent prior to the date specified by the Eligibility and Enrollment Vendor and before your dependent’s coverage can become effective under the Program.

If you provide the required documentation within the required time frame and the Eligibility and Enrollment Vendor has reviewed your documents and approved the eligibility of your dependent, coverage under the Program will become effective as of the first of the month following the date you requested enrollment (if Prospective Enrollment is permitted under the Program) or earlier if pursuant to Annual Enrollment or a Change-in-Status Event as described under the Program.

If the Eligibility and Enrollment Vendor denies your application to add your dependent for coverage under the Program, you may file a Claim on this decision to the Eligibility and Enrollment Vendor. If the Eligibility and Enrollment Vendor denies your initial Claim, you may appeal that decision to the Eligibility and Enrollment Appeals Committee (EEAC). See the “How to File a Claim for Eligibility” section.

If you do not provide the required documentation prior to the deadline stated, your dependents will not be enrolled for coverage under the Program retroactively.

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.

Certification of Disabled Dependents

It is necessary to certify that your Child(ren) is disabled in order to obtain extended eligibility under the Program. Your disabled dependent will not receive Benefits under the Program if you fail to certify his or her disabled status. Review this section carefully to understand the steps necessary for certification (and recertification).

To certify an unmarried Child (including the Child of a Partner) 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 Child's physician must complete the application form and submit it for approval as directed in the form. The Eligibility and Enrollment Vendor will advise you whether the Child qualifies for coverage under the terms of the Program. The Eligibility and Enrollment Vendor will enroll your Child for coverage, if your Child is eligible under the terms of the Program. In addition, the Eligibility and Enrollment Vendor will periodically solicit you for disabled dependent verification.

Dental coverage for your Disabled Child(ren) begins when your Child(ren) is certified. Coverage is not retroactive for expenses incurred before certification.

A disabled dependent may have to be continuously enrolled to be eligible for Program coverage. See the "Eligibility and Participation" section of the SPD to determine if this requirement applies.

> **IMPORTANT:** It is best to contact the Eligibility and Enrollment Vendor three to six months before the Child reaches the age of 23. Failure to timely certify your dependent prior to that age will result in a break in Program coverage.

You must recertify your Disabled Child(ren) by providing satisfactory evidence of his or her disability at the discretion of the Plan Administrator, in order to continue eligibility for Program coverage. In addition, an independent medical examination of your unmarried Disabled Child(ren) may be required at the time of certification or recertification.

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.
- **Request your enrollment before the deadline:** Your request for a change in your enrollment must occur within *31 days* of the Change-in-Status Event.

- **Document your event:** While not always required, the Program has the right to request documentation that supports your Change-in-Status Event. For example:
    - Adding a newborn dependent Child will require a copy of the Child's birth certificate.
    - Adding a new Spouse will require a copy of a marriage certificate.
    - Waiving coverage under the Program in favor of coverage under another employer's dental plan may require proof of enrollment in the other dental plan.

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 Employee on Active Military Duty

The Uniformed Services Employment and Reemployment 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 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 your 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 day 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 the *Eligibility and Enrollment Vendor* table in the “Contact Information” section 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. The Company will automatically advance any required Employee contributions for your Program coverage on your behalf while you are on an FMLA leave.

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

If you do not return to work for the Company following an 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 an 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 do not 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 coverage will begin on the earlier of:

- The date your FMLA leave ends if you do not 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 available on the OneStop 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 also may 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.

WHAT HAPPENS WHEN YOU LEAVE THE COMPANY

Active Program Coverage

Active Program coverage for you and your covered dependents continues through the end of the month in which your employment terminates. If eligible for Post-Employment Benefits, your Post-Employment Benefits will be subject to provisions that apply to Eligible Former Employees unless you elect COBRA continuation coverage under your active Program coverage. Information concerning your options as a former Employee will be provided by the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the “Contact Information” section for contact information.

Post-Employment Benefits Coverage

The Eligibility and Enrollment Vendor will send you information regarding Post-Employment Benefits and required monthly contributions. Contact the Eligibility and Enrollment Vendor if you do not receive this statement within two weeks of your employment Termination Date 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 more information.

If you are eligible for Post-Employment Benefits, your coverage will begin on the first day of the month following your employment Termination Date, subject to the payment of any required contributions. For example, if you terminate employment on June 15, the effective date for Post-Employment Benefits is July 1. See the “When Coverage Ends” section for more information.

There is a separate SPD for your post-employment coverage Program Benefits. You will receive a copy of your post-employment SPD either electronically or by mail. You can also access a copy of your SPD at the Eligibility and Enrollment Vendor’s website.

Steps You Must Take to Ensure Coverage Continuation	
Within two weeks of your termination of employment date	Look for information from the Eligibility and Enrollment Vendor
Within 31 days of receipt of information from the Eligibility and Enrollment Vendor	Enroll for Post-Employment Benefits available to Eligible Former Employees, if applicable

Steps You Must Take to Ensure Coverage Continuation	
Within 31 days of enrollment for Post-Employment Benefits available to Eligible Former Employees	Submit payment for any required contributions
Within 65 days of your active Program coverage end date or receipt of COBRA Enrollment Notice, whichever is later	Elect COBRA coverage, if applicable
Within 45 days of receipt of a bill for COBRA coverage from Eligibility and Enrollment Vendor	Submit payment for COBRA coverage
Ongoing	• Submit payments to the Eligibility and Enrollment Vendor by the payment due date. • Promptly report your address change by calling the Pension Service Center. If you 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 a retiree death benefit from your pension plan, report your address change to the Eligibility and Enrollment Vendor. • Promptly report any Change-in-Status Events to the Eligibility and Enrollment Vendor. • See the "Contact Information" section for contact information.

Dependent Coverage

If you are eligible for Post-Employment Benefits, you may cover your Eligible Dependents that were enrolled in active Program coverage at the time you terminate employment, subject to dependent eligibility requirements and payment of any required contributions. If you acquire a new dependent after you terminate employment, contact the Eligibility and Enrollment Vendor to find out if your new dependent is eligible for coverage. The Eligibility and Enrollment Vendor will advise you of the steps you must take to enroll your new dependent, if eligible, and any additional cost you must pay for coverage of your new Eligible Dependent.

Annual Deductible Credit

If the dental option you were covered under as an Active Employee does not change when you terminate employment and begin your Post-Employment Benefits, you will receive credit for any amounts applied to your Annual Deductible as an Active Employee for the remainder of the calendar year in which you retire. Your Annual Deductible will begin anew on Jan. 1 of the following year.

If the post-employment dental option you are covered under is different than the dental option you were covered under as an Active Employee, you will not receive any Annual Deductible credit. You will be subject to the full Annual Deductible amount that applies to your Post-Employment Benefits.

COBRA Coverage in Lieu of Post-Employment Benefits

Upon your termination of employment from the Company, you will receive a COBRA enrollment notice from the Eligibility and Enrollment Vendor. As an alternative to Post-Employment Benefits for Eligible Former Employees, you may choose to continue your active Program coverage by electing COBRA coverage, as provided by federal law. Eligibility for COBRA coverage does not

affect your eligibility for Post-Employment Benefits for Eligible Former Employees. However, if you elect COBRA coverage, you may not commence your Post-Employment Benefits for Eligible Former Employees until such time as COBRA coverage ends. Once COBRA coverage ends, you may enroll in Post-Employment Benefits for Eligible Former Employees. See the “Extension of Coverage – COBRA” section for more 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.*

The amount you contribute toward the Cost of Coverage is affected by a number of factors, including:

- Your employment status (for example, Actively at Work or on a leave of absence).
- The number of hours that you are scheduled to work if you are an Active Employee.
- Whether or not you cover Eligible Dependents.
- Whether your coverage is continued through Company Extended Coverage (CEC) or COBRA Continuation Coverage.
- Your employment Termination Date.
- The date you commence Long-Term Disability (LTD) Benefits if you are an LTD beneficiary.

The contribution amounts for each Plan Year are determined annually by the Company acting in its capacity as Plan Sponsor. 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.

How Contributions Are Made

Contributions are deducted from your paycheck. If your contributions are not deducted from your paycheck, for example, you are on a leave of absence, you will be billed and direct payments will be required, generally through check or money order. If the Eligibility and Enrollment Vendor makes this service available, you may choose to have your contributions automatically withdrawn from your checking or savings account. If you are direct billed, the Eligibility and Enrollment Vendor may permit you to pay your contributions up to one year in advance. Contact the Eligibility and Enrollment Vendor to determine what options are available to you. See the *Eligibility and Enrollment Vendor* table in the “Contact Information” section 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 for both you and any covered dependents will result in loss of coverage retroactive to the last day of the month for which full payment was received. Coverage will be canceled and you may not be eligible to re-enroll until the next Annual Enrollment, or you may be limited to Prospective Enrollment only, unless you experience a Change-in-Status Event that permits you to enroll sooner. In addition, if you are making contributions toward coverage under any other Company health and life insurance plans, coverage under those health and life plans will be canceled as well, and you may not be able to re-enroll in those plans, if at all, until the next Annual Enrollment unless you experience a Change-in-Status Event that permits you to enroll sooner. You should contact the Eligibility and Enrollment Vendor for more information. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section 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 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 dental 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 the AT&T Flexible Spending Account (FSA) Plan. Although generally similar, not all Change-in-Status Events under the Program are considered qualified under the AT&T FSA Plan. Refer to the AT&T 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.

	Employee Classification	**Contribution Rules**
Regular and Term Employee (at least six months Term of Employment)	Full-time	No contribution required
	Part-time Hired before 1981	
	Part-time (Average work week more than or equal to 25 hours*) Hired on or after Jan. 1, 1981 *Determined as of the end of the calendar quarter	
	Part-time (Average work week more than or equal to 17 hours but less than 25 hours*) Hired on or after Jan. 1, 1981 *Determined as of the end of the calendar quarter	You pay 50% of the monthly Cost of Coverage.
	Part-time (Average work week less than 17 hours*) Hired on or after Jan. 1, 1981 *Determined as of the end of the calendar quarter	You pay 100% of the monthly Cost of Coverage.

Surviving Dependent Contributions

Company contributions toward the Cost of Coverage are available to your surviving dependents receiving Company Extended Coverage (CEC) for up to 12 full months following your death, subject to the payment of any required participant contributions. Your surviving dependent(s) who continue coverage under CEC after the 6 month period will pay 100 percent of the Cost of Coverage with no Company contribution.

As described in the "Surviving Dependent Coverage" section, CEC is integrated with COBRA continuation coverage. As a result, while you are eligible for CEC, COBRA premiums will be reduced by the amount of Company contributions available under CEC. Once Company contributions under CEC end, your surviving dependent(s) will pay 100 percent of the applicable Cost of Coverage for continued COBRA coverage for up to 24 months (total of 36 months).

Rehired Eligible Former Employee Contributions

You are considered a "Rehired Retiree" also known as a "Rehired Eligible Former Employee" and special contribution rules apply if:

- You previously terminated employment from a member of the AT&T Controlled Group and at that time were eligible for dental coverage as an Eligible Former Employee.
- You are eligible for dental coverage as an Eligible Former Employee as described in the "Eligibility and Enrollment" section; and
- You are subsequently rehired by a member of the AT&T Controlled Group.

If you are a Rehired Eligible Former Employee, the rules in the *AT&T Rehired Eligible Former Employee Supplement* supersede the contribution rules in this SPD. Contact the Eligibility and Enrollment Vendor to obtain the *AT&T Rehired Eligible Former Employee Supplement*. It will be mailed to you at no cost. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

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 in the "Contact Information" section for contact information.

> **IMPORTANT:** You have a 60-day grace period from the day your payment is due to make 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. Additional information on paying for COBRA coverage is provided in the "Paying for COBRA Continuation Coverage" subsection. See the "How Contributions Are Made" section for details on the direct billing process. 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 in the "Contact Information" section for contact information.

Conditions for Program Benefits

Program Benefits are available if you meet all of the following:

- You are a Covered Person, which means you meet all eligibility requirements for Program coverage and are properly enrolled for coverage.
- You continue to meet all of the eligibility requirements and all required contributions for your coverage are paid timely.
- You receive covered services while your Program coverage is in effect – after you meet eligibility requirements and before coverage ends, as described in the "When Coverage Ends" section.
- You or your Provider file a timely Claim for Benefits, as described in the "How to File a Claim for Benefits" section and provide any required information in support of your Claim.

BENEFITS AT A GLANCE

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

- **A summary, not an exhaustive list, of the most commonly used covered services.** See the “What Is Covered” section for more detailed information on what is covered. Even if a service is listed as a covered dental 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 summary of limitations specific to the covered services in the table.** This information is not exhaustive. See the “What Is Covered” section for more detailed information on limitations to the covered 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.

- **For the DHMO Option only, information on when Notification or Preauthorization (predetermination of benefits) is required.** The Program requires Notification or Preauthorization for certain specialty Dentist services. If you do not provide Notification or Preauthorization when it is required, your Benefits may be reduced or denied. The “Predetermination of Benefits” section provides more detailed information.

This section does not include Benefits provided under the DHMO Option available under the Program. See the “DHMO Option” section for information.

> **IMPORTANT:** No coverage will be provided for services that the Benefits Administrator does not determine are Medically Necessary. Just because a Provider prescribes, orders, recommends, approves or views a service as Medically Necessary does not mean the Program will pay the cost of that service. See the “Limitations on Benefit Payments” section for a description of Medically Necessary.

For a complete understanding of Benefits coverage, read this SPD in its entirety. If you have any questions about your dental Benefits, contact your Benefits Administrator.

	Network	Non-Network
Predetermination of Benefits		
Pretreatment Estimate/Predetermination of benefits	Recommended for expenses over $200	Recommended for expenses over $200

	Network	Non-Network
Cost Sharing		
Deductible	$50 Deductible per individual per calendar year Network/Non-Network combined (unless otherwise noted, the Annual Deductible applies)	$50 Deductible per individual per calendar year Network/Non-Network combined (unless otherwise noted, the Annual Deductible applies)
Annual Maximum Benefit	Individual: $1,400 Network/Non-Network combined	Individual: $1,400 Network/Non-Network combined
Coinsurance	Percent of Eligible Expenses you pay after Annual Deductible. See the Cost Sharing section.	Percent of Eligible Expenses you pay after Annual Deductible. See the Cost Sharing section.
Preventive/Diagnostic Care	Annual Deductible waived	Not applicable
Preventive Care Services		
Covered Services	Type A Services: preventive and diagnostic	Type A Services: preventive and diagnostic
Preventive Care	0% of Allowable Charge	0% of Reasonable and Customary charge Member owes difference between Provider's fee and Reasonable and Customary charge
Preventive Care Annual Service Limits	Exams, cleanings and x-rays: 2 per calendar year Topical Fluoride: 2 per calendar year	Exams, cleanings and x-rays: 2 per calendar year Topical Fluoride: 2 per calendar year
Oral Exams	0% of Allowable Charge 2 per calendar year	0% of Reasonable and Customary charge 2 per calendar year Member owes difference between Provider's fees and Plan Payment

	Network	Non-Network
Space maintainer	0% Allowable Charge For Children under the age of 19, including • Installation of fixed or removable Appliances designed to maintain existing space by preventing adjacent or opposing teeth from moving (limited to when these Appliances replace prematurely lost or extracted teeth). • Subsequent adjustment of these Appliances when required because of a relative change in the condition of the mouth.	0% Reasonable and Customary charge Member owes difference between Provider's fees and Plan payment For Children under the age of 19, including • Installation of fixed or removable Appliances designed to maintain existing space by preventing adjacent or opposing teeth from moving (limited to when these Appliances replace prematurely lost or extracted teeth). • Subsequent adjustment of these Appliances when required because of a relative change in the condition of the mouth.
Teeth cleaning and polishing	0% of Allowable Charge 2 per calendar year	0% of Reasonable and Customary charge Member owes difference between Provider's fees and Plan payment 2 per calendar year
Topical application of fluoride	0% of Allowable Charge 2 per calendar year	0% of Reasonable and Customary charge Member owes difference between Provider's fees and Plan payment 2 per calendar year
Sealants	Up to Scheduled Amount of $15 for permanent molars for Children under the age of 15 2 per lifetime	Up to Scheduled Amount of $15 for permanent molars for Children under the age of 15 2 per lifetime
X-rays - Bitewing	0% of Allowable Charge 2 per calendar year	0% of Reasonable and Customary charge Member owes difference between Provider's fees and Plan payment 2 per calendar year
X-rays - Full mouth/panoramic	0% of Allowable Charge 1 every 3 calendar years	0% of Reasonable and Customary charge Member owes difference between Provider's fees and Plan payment 1 every 3 calendar years

	Network	Non-Network
X-ray for Diagnosis	20% of Allowable Charge If x-ray required for a specific condition, except x-ray in conjunction with Orthodontics	0% of Reasonable and Customary charge if required for a specific condition, except x-ray in conjunction with Orthodontics Member owes difference between Provider's fees and Plan payment
Basic Services		
Fillings	20% of Allowable Charge	30% Reasonable and Customary charge Member owes difference between Provider's fee and Reasonable and Customary charge
Routine extractions	20% of Allowable Charge	30% Reasonable and Customary charge Member owes difference between Provider's fee and Reasonable and Customary charge
Endodontics (root canal therapy)	20% of Allowable Charge	30% Reasonable and Customary charge Member owes difference between Provider's fee and Reasonable and Customary charge
Periodontics	20% of Allowable Charge	30% Reasonable and Customary charge Member owes difference between Provider's fee and Reasonable and Customary charge
Emergency treatment	0% Allowable Charge	0% of Reasonable and Customary charge Member owes difference between Provider's fee and Reasonable and Customary charge
Basic Care Annual Service Limits	Not applicable	Not applicable
Major Services		
Inlays/Onlays	40% Coinsurance of Allowable Charge	50% of Reasonable and Customary charge Member owes difference between Provider's fee and Reasonable and Customary charge

	Network	Non-Network
Crowns	40% Coinsurance of Allowable Charge	50% of Reasonable and Customary charge Member owes difference between Provider's fee and Reasonable and Customary charge
Dentures	40% Coinsurance of Allowable Charge	50% of Reasonable and Customary charge Member owes difference between Provider's fee and Reasonable and Customary charge
Bridges	40% Coinsurance	50% of Reasonable and Customary charge Member owes difference between Provider's fee and Reasonable and Customary charge
Dental implants	Not covered	Not covered
Oral surgery	20% Coinsurance	30% of Reasonable and Customary charge Member owes difference between Provider's fee and Reasonable and Customary charge
Anesthesia for dental care	20% Coinsurance	30% of Reasonable and Customary charge Member owes difference between Provider's fee and Reasonable and Customary charge
TMJ		
TMJ Services	Nonsurgical treatment for Appliance only, Benefits for covered expenses are applied against the lifetime maximum for orthodontia Benefits	Nonsurgical treatment for Appliance only, Benefits for covered expenses are applied against the lifetime maximum for orthodontia Benefits
TMJ Annual or Lifetime Service Limits	Maximum reimbursement: $1,500 per individual per lifetime Network/Non-Network combined Combined with orthodontia	Maximum reimbursement: $1,500 per individual per lifetime Network/Non-Network combined Combined with orthodontia
Orthodontia		
Orthodontia Participant Coverage	Coverage available for Child and adult	Coverage available for Child and adult
Orthodontia covered services	Initial banding Active treatment after initial banding Retention visit and removable Appliance therapy	Initial banding Active treatment after initial banding Retention visit and removable Appliance therapy

	Network	Non-Network
Plan coverage	0% Coinsurance	0% Coinsurance of Reasonable and Customary charge
Orthodontia Maximum Service Limits	Maximum reimbursement: $1,500 per individual per lifetime Network/Non-Network combined Combined with orthodontia	Maximum reimbursement: $1,500 per individual per lifetime Network/Non-Network combined Combined with orthodontia

Your Program Coverage Overview

The Program offers Benefits to help you pay the cost of dental services for you and your Eligible Dependents.

This section of the SPD includes further details about your Program Benefits. It is important you read these sections of this SPD to receive the maximum Benefits from the Program. As you read the details of the Program, it is important to keep the following in mind:

- The *Benefits at a Glance* table only provides a high-level summary of your Benefits. To best understand the full extent of covered services and any limitations or exclusions applicable to your Benefits, see the “What Is Covered” and “Limitations and Exclusions” sections.
- You and the Program share the cost of most covered services. See the “Cost Sharing” section for information on how you and the Program share in this responsibility. The following are exceptions to the general cost-sharing provisions contained in this section of the SPD:
- Generally, services are not considered a covered dental service unless they are determined to be Medically Necessary and the care is provided by a licensed Dentist. See the “Limitations on Benefit Payments” section for more information.

> **IMPORTANT:** The Benefits Administrator determines whether a service is covered and what Benefits the Program will pay, based on the terms of the Program. No other person has the authority to make any statement, decision or representation regarding coverage under this Program. See the “Plan Administration” section for information.

COST SHARING

KEY POINTS

- ➢ *You and the Company share in the cost of Benefits provided under the Program.*
- ➢ *Cost sharing may be in the form of an Annual Deductible, Coinsurance, an Annual Maximum, a Lifetime Maximum, Allowable Charge or other provisions.*

Cost Sharing

You and the Program share in the cost of your care. You should be aware of how the cost share provisions affect your Benefits.

This section describes cost-sharing features that are built into the Program. See the *Benefits at a Glance* table for specific amounts.

Annual Deductible

The Annual Deductible is the amount that you (and your covered family members) pay each year for Allowable Charges before the Program begins to pay Benefits for Type B covered services.

See the *Benefits at a Glance* table for Annual Deductible amounts and information on what services are subject to the Annual Deductible.

Coinsurance

Coinsurance is the percentage of Allowable Charges you pay for covered services. If a covered dental service is subject to the Annual Deductible, you will be responsible for paying 100 percent of the cost of the service until after you meet your Annual Deductible.

The Coinsurance percentage varies depending on the covered dental service. For covered services that are subject to a Network requirement, the Coinsurance percentage also varies, depending on whether or not you use a Network Provider.

If you use a Provider who charges more than the Allowable Charge for a covered dental service, you also will be responsible for any charges in excess of the Allowable Charge. See the *Benefits at a Glance* table for specific Coinsurance amounts that apply to you.

Annual Maximum

The Annual Maximum limits the amount the Program pays for covered services each year. Once your payments for covered services reach the Annual Maximum, the Program will no longer pay Benefits for the remainder of that calendar year. See the "Impact of a Midyear Change in Coverage on the Annual Deductible and Annual Maximum" section for more information.

Annual Maximum Benefits are shown in the *Benefits at a Glance* table.

Allowable Charges for Eligible Expenses

The Program Benefits payable for an Eligible Expense are limited to the Allowable Charge determined by the Benefits Administrator. Benefits are not paid for amounts billed for a covered dental service that are above the Allowable Charge.

The Benefits Administrator determines Allowable Charges for Eligible Expenses based on the type of Provider (Network or Non-Network).

The following table indicates the basis used by the Benefits Administrator to determine the Allowable Charge for Eligible Expenses. For example, if the Eligible Expense is for a covered dental service provided by a Network Provider, the Allowable Charge will be the Negotiated Rate determined by the Benefits Administrator.

If this Program Is Primary	
Network Providers	**Non-Network Providers**
Allowable Charge or Negotiated Rate	The Maximum Non-Network Reimbursement Program (MNRP) amount, which is the fee negotiated with the Provider, if applicable. Otherwise, the MNRP is based on Reasonable and Customary charges or a fee schedule that the Benefits Administrator develops.
If Another Coverage is Primary	
See the "Coordination of Benefits" section for more information.	

Benefit Maximums

A Benefit Maximum is a limit on how much the Program will pay for a covered dental service over a specified period. For example, the Program may include an Annual Maximum or lifetime Benefit Maximum on specific covered services.

Benefit maximums are shown in your *Benefits at a Glance* table.

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 your 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 stops.
- The last day of the month in which you stop being an Eligible Employee.
- The date you die.
- 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.” Coverage stops on the last day of the month in which the individual is no longer eligible. Coverage ends for your Child(ren) at the end of the month in which they turn the age of 23.

See the “Extension of Coverage – COBRA” and “Surviving Dependent Coverage” sections for information about what rights you or your dependents may have to continue coverage.

A mentally or physically incapacitated Child’s dental Benefit coverage under the Program will not stop due to age. It 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 canceled 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 Review 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) in accordance with the layoff provisions of your Company’s collective bargaining agreement. You should refer to your collective bargaining agreement to determine the layoff benefits and what options are available for extended coverage. You may also contact the Eligibility and Enrollment Vendor for assistance with questions.

If You Are Retiring from the Company

If you are retiring from the Company, you may be eligible for Post-Employment Benefits under this Program or a program for Eligible Former Employees for your job classification. The eligibility requirements for Post-Employment Benefits are set forth in the Summary Plan Description (SPD) of the program or programs available to your job classification. Contact the Eligibility and Enrollment Vendor to request a copy of the applicable SPD. See the "Contact Information" section for contact information. You also may be eligible to elect continuation coverage under COBRA in lieu of the benefits available for Eligible Former Employees.

If Your Active Employment Ends By Reason of Disability

If you are disabled, you may be eligible to continue your (and your Eligible Dependents') coverage under this Program or a program for Eligible Former Employees. See the section entitled "Eligible Former Disabled Employees" for a description of the eligibility requirements applicable to totally disabled former Employees.

If Your Active Employment Ends By Reason of Your Death

If you have a surviving Spouse/Partner and/or Child(ren) covered by the Program as of the date of your death, they will be eligible to elect continuation coverage under COBRA. See the "Extension of Coverage – COBRA" and "Surviving Dependent Coverage" sections for information about what rights you or your dependents may have to continue coverage.

In addition, your surviving dependents may be able to obtain continued coverage under the Program for a limited period on the same basis as during your active employment or may be able to continue coverage at their own expense for a period longer than the maximum COBRA coverage period. See the "Surviving Dependent Coverage" section for more information about these rights to Company Extended Coverage.

Extension of Benefits When Coverage Ends

Even after your coverage ends, the Program will pay the Scheduled Amounts for the following items:

- Prosthetic devices such as Dentures or Fixed Bridgework, if the Dentist took the Impressions and prepared the Abutment teeth while the patient was covered, and installs the device within three calendar months after coverage ends.
- A Crown, if the Dentist prepared the tooth while the patient was covered and installs the Crown within three calendar months after coverage ends.
- Root Canal Therapy, if the Dentist opened the tooth while the patient was covered and completes the treatment within three calendar months after coverage ends.

See "How the Plan Works" for additional information on what the Program reimburses for Covered Expenses.

Surviving Dependent Coverage

If you are enrolled in the Program as of your date of death, dental coverage for your enrolled dependents will continue through the end of the month and continued coverage under Company Extended Coverage (CEC) will be available after that, under the same terms that would have applied if you remained alive, subject to their continued eligibility and payment of required contributions. Company contributions toward the Cost of Coverage will be available for up to six months for your surviving Spouse/Partner and other dependents who are enrolled under CEC. See

the “Surviving Dependents” subsection in the “Contribution” section for more information on surviving dependent contributions.

At the end of the Company-subsidized CEC period described above, a surviving Spouse/Partner may continue Program coverage for his or herself and any enrolled dependents, subject to payment of required contributions and continued dependent eligibility. Surviving dependent coverage under CEC will terminate for all covered survivors at the end of the month in which the surviving Spouse/Partner:

- Fails to make the required contributions.
- Drops the coverage.
- Dies.
- Marries or forms a legally recognized partnership.

If surviving dependent CEC coverage terminates for any of these reasons, continuation of coverage under these provisions, including the Company subsidy toward the Cost of Coverage, cannot be reinstated.

The following additional conditions apply to this extended coverage:

- Surviving dependent CEC is not available if you die while receiving long-term disability benefits.
- Surviving Spouses, Partners or Child(ren) cannot add new dependents during this CEC period.

In the event of your death, COBRA continuation coverage may be available for your surviving enrolled dependents, whether or not they are eligible to continue coverage under CEC. See the “COBRA Continuation Coverage” section for more information on COBRA continuation coverage. If COBRA coverage is available, CEC runs concurrently with COBRA coverage. Your Eligible Dependents will be enrolled in CEC and COBRA to avoid loss in coverage. COBRA and/or CEC coverage can be dropped at any time; however, once coverage is dropped, eligibility will not be reinstated. Any Company contributions that are available under CEC will reduce the cost of COBRA coverage for the first 12 months of the COBRA continuation period. After the Company contributions under CEC end, contributions for your Spouse/Partner and other Dependents for the remainder of the applicable COBRA period will be 100 percent of the Cost of Coverage. See the “Surviving Dependents” subsection of the “Contributions” section for more information on surviving dependent contributions.

During the period that CEC and COBRA are running concurrently, CEC and COBRA rules will be integrated and the more generous rule regarding coverage will apply. As a result, COBRA rules permitting the addition of certain dependents will apply and COBRA rules providing for the termination of eligibility when an Eligible Dependent enrolls in alternative coverage, will not apply during this period.

IMPORTANT: To report a death, call the Eligibility and Enrollment Vendor listed in the “Contact Information” section. Please have information regarding the deceased available when you call, such as name and Social Security number.

WHAT HAPPENS WHEN YOU RETIRE

Active Program coverage for you and your enrolled Dependents will continue through the end of the month in which your employment terminates. If you are eligible for Post-Employment Benefits as an Eligible Former Employee, 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 dental 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.

As an alternative to Post-Employment Benefits, you may elect to continue your dental coverage under COBRA, as provided by federal law. When you retire, the Eligibility and Enrollment vendor will send you a COBRA enrollment notice. Eligibility for COBRA does not change your (and/or your enrolled Dependent's) eligibility for Post-Employment Benefits. However, if you elect to continue dental coverage under COBRA, any Eligible Former Employee dental coverage will be canceled. Upon termination of COBRA coverage, you will be allowed to enroll in Post-Employment Benefits, if eligible. See the "Extension of Coverage – COBRA" section for additional information on COBRA.

DENTAL BENEFITS

KEY POINTS

- *The overview provides you with key concepts to understand your dental Benefits.*
- *The Benefits at a Glance table gives you a broad overview of your dental coverage.*

Overview

- *This section describes dental Benefits. Topics in this section include what is covered and excluded, cost-sharing provisions, Provider Networks and predetermination of benefits requirements. To take advantage of the Benefits noted in this section, you must be enrolled in the Program at the time you receive covered services. Also, you (or your Provider) must file a timely Claim for Benefits. See the "Claim Filing Limits" section for deadline information. Here is an overview of this section:*
- ***Network vs. Outside Network Area Coverage.*** *If your home ZIP code falls in the Network Area, you generally are assigned Network coverage. If your home ZIP code does not fall in the Network Area, you are assigned Outside Network Area (ONA) coverage, although you may elect Network coverage.*
- ***Network vs. Non-Network Providers.*** *Even when you are enrolled in Network coverage, you are not required to use Network Providers. However, you generally pay more if you use Non-Network Providers, except for emergency services. Note: Emergency services are paid at the same level regardless of the Provider's Network status.*

- ➢ ***Allowable Charge.*** *Network Providers accept the amount that they agree on with the Benefits Administrator (referred to as the Allowable Charge) as payment for services. Non-Network Providers may charge more. Amounts above the Allowable Charge are not eligible Program expenses (referred to as Eligible Expenses) and do not count toward the Annual Deductible or Annual Maximum. See the "Cost Sharing" section for more information.*

- ➢ ***Annual Deductible.*** *You must meet an Annual Deductible before the Program begins to pay Benefits. Note: Deductibles start over each year.*

- ➢ ***Coinsurance.*** *After you meet the Annual Deductible, you and the Company share the cost of covered services in the form of Coinsurance.*

- ➢ ***Predetermination of Benefits.*** *For services costing more than $200 the Benefits Administrator recommends that you request a Predetermination of Benefits (or pretreatment estimate) before receiving care. Also, Fully-Insured Managed Care Options generally require you to preauthorize care and obtain a Predetermination of Benefits if you need care from a specialist Dentist. See the "Predetermination of Benefits" section for more information.*

> **IMPORTANT:** If you are enrolled in the Dental Health Maintenance Organization (DHMO) Option, you are not eligible for Benefits under the Program as described in this section. See the "DHMO Option" section of this SPD for more information.

How the Plan Works

The Program provides coverage for dental care services for you and your Eligible Dependents through a dental Preferred Provider Organization (PPO) Option with Network and Non-Network Providers. You also may choose the Dental Health Maintenance Organization (DHMO) Option (if available based on your home ZIP code) and use DHMO Providers.

You and your Eligible Dependents must all be enrolled under the same option.

Benefits under the Program are subject to certain provisions and limitations, Annual and Lifetime Maximum Benefits, frequency limitations and examples of Coinsurance amounts for covered expenses under the PPO Option. A complete List of Dental Services and a List of Orthodontic Procedures may be obtained from the Benefits Administrator upon request.

If You Elect the Preferred Provider Organization Option

With the PPO Option, you have access to a Network of Providers who have agreed to provide services at reduced fees. Under this option, you may also seek care from any Non-Network Provider of your choice, but your Benefits will be paid at Non-Network levels.

Network Providers

When you receive services from a Network Provider, the PPO Option pays:

- 100 percent of the PPO contracted fee for certain preventive and Diagnostic Services (Type A Services) without requiring payment of the Annual Deductible.

- Coinsurance for basic and major restorative services (Type B Services) provided the Annual Deductible has been satisfied.

Benefits under the PPO Option for each Covered Person are capped annually by the Annual Maximum Benefits. The Program will not pay Benefits in excess of this amount for services provided to a Covered Person in a Plan Year.

What You Need to Know About Providers

The Benefits Administrators or their affiliates arrange for Providers to participate in a Network.

The Benefits Administrator negotiates rates with Providers who have agreed to join the Network administered by the Benefits Administrator. Each Provider who joins the Network goes through a process to confirm information about his or her licenses and other credentials. This process confirms that Network Providers meet certain standards established by the Program or the Benefits Administrator. However, this credentialing process does not assure the quality of the services provided.

A list of Network Providers is available online at the applicable Benefits Administrator's website. You must verify your Provider's Network status before you receive care, even when you are referred by another Network Provider. At any time, a Provider's status may change as Providers may drop out of or join the Network throughout the year. Network Providers also may not be accepting new patients. If a Provider leaves the Network or is not available to you, you must choose another Network Provider to receive Network level of Benefits. You can verify the Provider's status by contacting your Benefits Administrator. See the "Contact Information" section for Benefits Administrator contact information.

Do not assume that a Network Provider's agreement includes all covered services at Negotiated Rates. Some Network Providers contract to provide only certain covered services. Contact your Benefits Administrator for information about the type of covered services offered by a Network Provider.

Providers do not determine your Program Benefits and are not qualified or authorized to advise you about Eligible Expenses. Network Providers are independent Dentists. They are not Employees of the Company or the Benefits Administrator.

How Network Areas Are Determined

Whether you live in a Network Area can be a significant factor in determining your Benefits payable under the Program. Network Areas are determined based on ZIP code. Your home ZIP code listed on Company records is used to determine your level of coverage.

You are considered to be in a Network Area and assigned Network coverage if:

- You live in a PPO service area.
- Your home ZIP code is within 30 miles of a Network Provider.

If your home ZIP code is not in a Network Area, you are assigned an Outside Network Area (ONA) level of coverage. If you are assigned ONA coverage, you may elect Network coverage. See the "Outside Network Area (ONA) Option" section for more information.

Network Benefits

Each time you need care, you choose which Provider to use. Generally, the choice you make affects the level of Benefits you receive and any Benefit limitations that may apply.

You are eligible for the Network level of Benefits under the Program when you receive covered services from Providers who have contracted with the Benefits Administrator to provide services in the Network.

Generally, when you receive covered services from a Network Provider, you pay less than you would if you receive the same care from a Non-Network Provider.

In addition, when you use a Network Provider, the Network Provider will generally file your Claims.

Non-Network Providers

If specific covered services are not available from a Network Provider, you may be eligible for the Network level of Benefits when those Services are received from a Non-Network Provider. In this situation, you or your Network Provider must notify your Benefits Administrator, who will work with you and your Network Provider to coordinate care through a Non-Network Provider. However, the PPO Option pays Benefits only up to the Reasonable and Customary (R&C) charge. This means that if the Non-Network Provider charges more than what the Benefits Administrator determines to be R&C, you are responsible for paying the difference between the R&C charge and the Non-Network Provider's billed charge.

Non-Network Coverage

When you are enrolled in Network coverage and you receive care from a Non-Network Provider, you will generally pay more out of pocket than if you received care from a Network Provider. This is because the Program only shares the cost for covered services up to the Reasonable and Customary charge determined by the Benefits Administrator. When you use a Network Provider, you are not responsible for charges in excess of the Allowable Charge. However, when you receive Non-Network Services, you must pay any amount above the Reasonable and Customary charge. This amount will not count toward your Annual Deductible. You may want to ask your Non-Network Provider how much will be billed charges for a service before you receive care.

For certain types of care, different provisions may apply. See the *Benefits at a Glance* table for more information.

If you must receive care outside of the Network, exceptions to Non-Network cost sharing apply. For more information, contact your Benefits Administrator.

Covered Expenses Under the PPO Option

Examples of Coinsurances and Scheduled Amounts for covered expenses under the PPO Option are described in the *Benefits at a Glance* table.

If you are currently enrolled in the PPO Option, see the *Benefits at a Glance* table for information regarding the most common covered expenses provided under the PPO Option. A copy of the complete Patient Charge Schedule (PCS) may be obtained from the Benefits Administrator, upon request, and free of charge. See the "Contact Information" section for the Benefits Administrator's contact information.

Choosing Your Providers

If you are enrolled in a Network level of coverage, you choose whether or not to use a Network Provider each time you need Program Benefits. When you use a Network Provider, you receive the Network level of Benefits and generally pay less out-of-pocket. When you use Non-Network Providers, you receive the Non-Network level of Benefits that may result in more out-of-pocket expenses for you.

If you are enrolled in an ONA level of coverage, you receive the same level of Benefits no matter which Provider you use. However, when you use Network Providers, you generally pay less out-of-pocket because charges are based on the Allowable Charge.

See the "How Your Choice of Providers Affects Your Benefits" section for more information.

How Your Choice of Providers Affects Your Benefits

The amount you pay may be affected by whether you use a Network or Non-Network Provider.

- **Network Providers** — Your Benefits Administrator has identified a group of Providers who are "in Network" and have agreed to provide covered services at a Negotiated Rate (or discounted rate). Generally, these Negotiated Rates are lower than what Non-Network Providers would charge. This means you pay less. The Network Provider will generally bill and be reimbursed by the Benefits Administrator.

- **Non-Network Providers** — When you receive covered services from a Non-Network Provider, the Provider's fees are not subject to Negotiated Rates. The Program only pays up to the amount that the Benefits Administrator determines is the Allowable Charge for a given service in your area. This means that if your doctor charges above this determined Allowable Charge, you may have to pay the remainder. In most cases, you also will have to file a Claim for Benefits with the Benefits Administrator.

Note: In some circumstances, a Negotiated Rate arrangement will apply even when you use a Non-Network Provider. If a Negotiated Rate arrangement between a Provider and the Benefits Administrator or one of its vendors, affiliates or subcontractors applies, the Negotiated Rate will be the Allowable Charge and you will not be responsible for any difference between the amount the Provider bills and the Allowable Charge for Eligible Expenses. This can occur with Non-Network Providers, for example, if the Provider participates in a Network administered by the Benefits Administrator other than the Network utilized by the Program or the Benefits Administrator is able to negotiate an agreed fee for your service.

> **IMPORTANT:** The Benefits Administrator will provide you an Explanation of Benefits (EOB) that identifies the amounts the Benefits Administrator paid on your behalf and amounts that you must pay. Some administrators may refer to this statement by another name, such as personal health statement.

Showing Your ID Card

You will receive an identification (ID) card from your Benefits Administrator after you enroll. Be sure to carry your ID card with you at all times and show it to your Provider when you receive services. Your ID card includes important information about your Program Benefits and lets your Provider know that you are enrolled in the Program and that Negotiated Rates may apply.

Predetermination of Benefits

PPO/ONA Option Process

A review by the Benefits Administrator of a Provider's planned treatment and expected charges, including those for diagnostic x-rays, is available upon request. This review, referred to as a predetermination of benefits or pretreatment estimate, should be made whenever dental work of at least $200 is proposed. The information should be sent to the Benefits Administrator before services begin. If there is a major change in the treatment plan, a revised plan should be sent to the Benefits Administrator.

The expenses that will be considered covered expenses will be determined by the Benefits Administrator and are subject to the "Alternate Procedures" section below. When there has not been a predetermination of Benefits, the Benefits Administrator will determine the expenses that will be considered covered expenses at the time the Claim for Benefits is received.

Predetermination of Benefits does not guarantee payment. The estimate of Benefits payable may change based on the Benefits, if any, for which a person qualifies at the time services are completed and the work actually performed. The estimate of Benefits also does not take into consideration the existence of a primary Plan.

See the *Benefits Administrator* table in the "Contact Information" section for information about obtaining dental Claim forms for submitting a predetermination of Benefits request or a Claim for Benefits.

DHMO Option Process

A request for a Network specialist requires Preauthorization. The NGD will give the patient a referral to a specialist Dentist and have any necessary x-rays taken. You must make an appointment with the specialist Dentist and give him or her the referral form and the x-rays. The specialist will complete a Claim form (treatment plan) and send the referral, x-rays, and treatment plan to the Benefits Administrator. The Benefits Administrator will authorize services based on Program specifics and return the authorization to the specialist. The specialist will complete the services and return the Claim form and Preauthorization to the Benefits Administrator, indicating the date the services were completed, for payment.

IMPORTANT:

- Predetermination of benefits does not mean Benefits are payable. The service for which you are seeking Benefits must be a covered dental service, and you must meet the Program's eligibility requirements and any other Program requirements related to the covered dental service, at the time the covered dental service is provided.
- If another plan is your primary coverage (i.e., the other plan pays benefits before this Program), you do not need to request a Predetermination of Benefits for any Services covered by the other plan, as long as you follow any required Predetermination of Benefits requirements for the other plan.

It is your responsibility to determine whether you or your Provider will complete this process. If you receive services from a Network Provider, in most cases, the Provider will complete the Predetermination of Benefits process for you. If your Provider does not provide this service, or if you are using a Non-Network Provider, you will need to complete the process yourself. Refer to your ID card for the appropriate number to call. Contact information is also located in the "Contact Information" section of this SPD.

LIMITATIONS ON BENEFIT PAYMENTS

Your Program covers Medically Necessary covered services as determined by the Benefits Administrator based on the terms of the Program. Care must be provided by a licensed Dentist. Although decisions regarding the course of treatment you receive are entirely between you and your Provider, whether or not a service is "Medically Necessary" determines payment as a covered dental service under the Program.

A specific dental service is Medically Necessary if, in the reasonable medical judgment of the Benefits Administrator, the service meets the requirements described in the definition of Medically Necessary below.

Definition of Medically Necessary

Medically Necessary means the treatment, service or supply must be reasonable and appropriate for preventive care or the diagnosis and treatment of a dental condition and provided based on generally accepted dental practice. To be considered as Medically Necessary, the treatment, service or supply must be reasonable and appropriate and meet the following requirements:

- Be consistent with the symptoms, diagnosis or treatment of the condition present.
- Conform to the commonly accepted standards throughout the medical/dental field.
- Not be used primarily for the convenience of the participant or the Provider of care.
- Not exceed the scope, duration or intensity of that level of care needed to provide safe and appropriate treatment.

Benefit requests that do not meet the criteria listed above will be denied.

See the "Predetermination of Benefits" and "Claims Procedures" sections of this SPD for more information.

> **IMPORTANT:** Keep in mind that a Medically Necessary determination does not guarantee that Benefits are available. Benefits are only payable for services that are a covered dental service and not subject to any exclusion or limitation. The Medically Necessary determination does not override the Program's Benefit provision or the final determination on that Claim for Benefits.

In considering the amount of dental Program Benefits you can receive, the Benefits Administrator will consider the most economical way to treat a particular dental problem.

The dental Program will pay for replacing an existing Crown, Partial Denture, full removable Denture or Fixed Bridgework only if the existing Appliance is at least five years old and cannot be made serviceable. Other limitations may apply and could differ based on the option you elect, such as frequency of services, age restrictions for certain services, etc. See the *Benefits at a Glance* table for specific information on limitations.

You may also contact the Benefits Administrator to answer specific questions regarding your Benefits. See the "Contact Information" section for contact information.

ALTERNATE PROCEDURES

Often there is more than one way to treat a particular dental problem. For example, either a Crown or a filling could be used to restore a tooth. Also, choices can be made in materials to be used, for example, precious metal or plastic.

The Benefits payable under the Program will be based on the most economical treatment appropriate for the particular dental problem. This determination is made by the Benefits Administrator in its discretion. Obtaining a predetermination of benefits informs you and your Provider what the Benefits Administrator considers the most economical way to treat a particular dental problem and how it will be covered under the Program. If the Benefits Administrator recommends an alternate procedure, the Program will only reimburse you for the cost of the less expensive dental procedure. If you and your Provider decide upon a more costly treatment, you are responsible for the additional charges beyond those approved by the Benefits Administrator.

Contact the Benefits Administrator for additional information or to answer specific questions regarding your Benefits. Refer to the “Contact Information” section for contact information.

WHAT IS COVERED

KEY POINTS

➢ *See this section to determine what dental services are covered by the Program. You may be required to take additional action to receive certain Benefits.*

This section provides detailed information about the kinds of Benefits the Program provides. The term “Program,” when used in this section, does not include the DHMO Option that is available under the Program. See the “DHMO Option” section for information. For specific information about what you pay for these covered services, see the *Benefits at a Glance* table. To better understand how to use this section and better understand what is covered, here is some important information:

- Covered services are grouped by category and follow the order of the *Benefits at a Glance* table.
- In general, the Program only covers Medically Necessary care.
- Even though a service is included as a covered dental service, certain circumstances can cause the Benefits to be reduced or denied.
- Certain circumstances may result in the Program not providing Benefits for what would generally be a covered dental service. For example, if the Claim for Benefits is filed after the time period for filing Claims has passed. See the “Exclusions and Limitations” section for information.
- The Benefits Administrator may provide an opportunity for Covered Persons to lower their out-of-pocket costs through a specialized Network of health care Providers.

Covered Services

The following listed services are covered under the Dental Program. For Coinsurance information see the *Benefits at a Glance* table for cost sharing information related to each of these covered services.

Preventive Services

Preventive Services, including exams and treatments, sometimes called Type A Services that are covered under the Program, subject to the limits specified in the *Benefits at a Glance* table include:

- Oral exams.
- Teeth cleanings and polishing.
- Topical Fluoride application.
- Space Maintainers and their adjustment.
- Sealants (permanent molars only).
- X-rays.

- Bitewing.
- Full mouth/panoramic.
- For diagnosis (excluding orthodontia).

Restorative Services

Restorative services, sometimes called Basic Services or Major Services depending on the option, covered under the Program include:

- Permanent and primary Amalgam (one, two or three surfaces).
- Composite resin anterior (one, two or three surfaces).
- Metallic Inlays (two or three surfaces).
- Pulp cap, direct.
- Crowns (limited to one Crown per tooth every five years), including porcelain, porcelain fused to semiprecious metal, gold full cast, gold ¾ cast, and stainless steel.
- Bridge Pontics, including cast gold, porcelain fused to semiprecious metal, and plastic processed to semiprecious metal.
- Oral Surgery for the surgical extraction of a) an erupted tooth, b) a tooth with partial bony impaction, and c) a tooth with complete bony impaction.
- Orthodontics, comprehensive full-banded treatment which includes a) preliminary study including x-rays and treatment plan, b) the first month of treatment including Appliances and c) active treatment per month.
- Root Canal Therapy, including one canal for anterior, two canals for Bicuspid, and three canals for molars.
- Periodontics, including gingivectomy – active treatment per Quadrant and osseous surgery (flap entry and closure per Quadrant).
- Prosthodontics – complete Dentures, including care for six months following delivery of a complete upper Denture, a complete lower Denture, an immediate upper Denture or an immediate lower Denture.
- Partial Dentures, including care for six months following delivery of an upper Partial Denture either resin base or metal base with resin saddles (including any conventional clasps, rests and teeth) or lower Partial Dentures either resin base or metal base with resin saddles (including any conventional clasps, rest and teeth).

Covered Expenses

- Examples of Coinsurances and Scheduled Amounts for covered expenses are described in the *Benefits at a Glance* table.
- See the *Benefits at a Glance* table for information regarding the most common covered expenses provided under the Program. A copy of the complete PCS may be obtained from the Benefits Administrator, upon request, and free of charge. See the "Contact Information" section for the Benefits Administrator's contact information.

EXCLUSIONS AND LIMITATIONS

KEY POINTS

- *Certain services are never covered by the Program.*
- *Other services are covered only if they are Medically Necessary.*
- *Some services are covered but only in certain circumstances or to a limited extent.*

The Program does not cover certain dental services or expenses. These are called exclusions. All care must be Medically Necessary to be covered. No Benefits will be provided for services that are not Medically Necessary in the judgment of the Benefits Administrator.

This section provides a list of services and expenses that are not covered. "Services" includes all services, treatments and supplies for which Claims are submitted.

Even if not included in the following list, a service would not be covered if it is not a covered expense as described in the "What Is Covered" section. The Program reserves the right to limit or exclude other services and supplies and related charges that are determined to be inappropriate in the sound discretion of the Benefits Administrator under the scope and intent, as well as the terms and conditions, of the Program. If you have questions about whether a service or expense is covered under the Program, contact the Benefits Administrator.

In addition, the Program will not pay for Benefits for any of the services or expenses described in this section, even if either of the following is true:

- It is recommended or prescribed by a Dentist or Provider.
- It is the only available treatment for your condition.

Exclusions

Exclusions and Limitations	
General	Charges for broken or canceled appointments
	Charges for completion of Claim forms or filing of Claims
	Work that is payable under workers' compensation or similar laws
	Charges for Type A services above the Reasonable and Customary charge when services are provided by a Non-Network Dentist. Charges for Type B services that are in excess of Reasonable and Customary charges.
	Replacement of teeth removed before coverage is effective with the following two exceptions (1) The replacement of existing Partial Dentures, full removable Dentures, and Fixed Bridgework is a covered expense if the existing Denture or Bridgework cannot be made serviceable and was installed at least five years before its replacement (2) The replacement of a Denture or Bridgework because of additional extractions while the individual is covered by the Dental Program
	Services performed free of charge to patients

Exclusions and Limitations	
	Services, supplies and treatment that do not meet the dental practice standards accepted by the American Dental Association or that are not necessary for proper dental care
	Services covered by any other Company health plan in which you participate
	Work done while the individual is not covered under the Dental Program
Appliances/Devices/Supplies	Appliances, Restoration and procedures to alter vertical dimension (that is, the vertical height of the face with the teeth in occlusion or acting as stops)
	Extra sets of Dentures or other Appliances
	Drugs or their administration
	Replacement of lost or stolen Prosthetic Appliances
Procedures/Treatment	Experimental procedures, as determined by the Benefits Administrator in its sole discretion
	Charges for equipment and services used by your Dentist for infectious disease control
	Educational training programs, dietary instructions or plaque control programs
	Periodontal Splinting
	Services performed for cosmetic reasons
	Implants
	Services rendered by a Dentist or other dental Provider to himself or herself or for services rendered to his or her immediate family, including parents, Spouse and Children
	Prosthetic services for third molars (wisdom teeth)
	Retreatment of Root Canal Therapy

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 Appeal 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 Appeal 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 based 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

Activity	Number of Days	
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 dental 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 Claims 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.

If you are enrolled in the DHMO Option, you must use the DHMO Option's procedures for filing Claims for Benefits and Appeals. For information concerning these procedures, contact the DHMO Option administrator or refer to your Evidence of Coverage (EOC).

Generally, when you use Network Providers, you do not need to file Claims for a follow-up visit resulting from a routine examination as described in the "What Is Covered" section. 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 use a PPO/ONA Non-Network Provider when you need dental 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 from 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 website. 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 90 days after the end of the calendar year in which you receive the services. 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 Flexible Spending Account (FSA) and/or Health Savings Account (HSA) for expenses not covered by the Program. For more information, refer to the separate SPD 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 or Retail Pharmacy 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 dental 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 (EOB) 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 dental 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 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.
- 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 dental Claims Administrator may consult with, or seek the participation of, dental 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 dental 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 for all Claims for Benefit that have been denied based on ineligibility to enroll or participate in 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 Claims Administrator and the EEAC shall be conclusive and binding on all parties and not subject to further review.

In any case, as an 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 dental coverage under more than one plan.*
- *The COB rules describe how Program Benefits are determined and which Coverage Plan will pay first.*

Determining Which Plan or Program Pays First

When two or more Coverage Plans pay Benefits, there are rules that determine which plan pays first. The rules for determining the order of payment are as follows:

- A Coverage Plan may consider the Benefits paid or provided by another Coverage Plan in determining its Benefits only when it is secondary to the other Coverage Plan. The primary Coverage Plan pays Benefits as if the secondary Coverage Plan(s) does not exist.
- The primary Coverage Plan pays first without regard to what another Coverage Plan may cover. A secondary Coverage Plan pays after the primary Coverage Plan and as a result, may reduce the Benefits it pays.
- A Coverage Plan that does not contain a Coordination of Benefits (COB) provision pays first unless the Coverage Plan is group coverage provided to an organization's members that supplements a basic Benefits package and provides coverage in addition to that basic Benefits package.
- Automobile or any type of motor vehicle insurance policies, including "no fault" policies, are always primary for payment of medical expenses related to an accident to the extent covered under those policies.
- If you are enrolled in coverage under the DHMO Option, Benefits are coordinated with other Coverage Plans (other than the Program) based on the COB rules of the DHMO Option and not the rules described in this section. If the other Coverage Plan is offered under the Program, the rules described in this section will apply.
- The following rules describe which Coverage Plan pays Benefits before another Coverage Plan — the first applicable rule is the rule that is used:
  - **Non-dependent or dependent**. The Coverage Plan that covers you as a non-dependent (for example, as an Employee, member, subscriber or Eligible Former Employee) is primary, and the Coverage Plan that covers you as a dependent is secondary. However, if you are Medicare Eligible and Medicare is your primary Coverage Plan, then the Coverage Plan covering you as a member, subscriber, retiree or Eligible Former Employee is secondary and the Coverage Plan that covers you as a dependent is third. If Medicare is your secondary Coverage Plan, then Medicare is secondary and the Coverage Plan that covers you as a dependent is third, unless Medicare is also secondary to that Coverage Plan.
  - **Active or inactive Employee.** The Coverage Plan that covers you as an Active Employee (not laid off or retired) is primary. This also applies if you are covered under separate plans as a dependent of an Eligible Former Employee and an Employee. If the other Coverage Plan does not have this rule and the Coverage Plans do not agree on the order of Benefits, this rule does not apply. If you are covered under separate plans as an Eligible Former Employee or retiree and as a dependent of an actively employed Spouse, the "non-dependent or dependent" rule described above applies.
  - **Continuation coverage.** If you are covered under any federal or state provided right of continuation coverage and also covered under another Coverage Plan, the Coverage Plan covering you as an Employee, member, subscriber, retiree or Eligible Former Employee (or as that person's dependent) is primary and the continuation coverage is secondary. If the other Coverage Plan does not have this rule and the Coverage Plans do not agree on the order of Benefits, this rule does not apply.

- **Longer or shorter length of coverage.** The Coverage Plan that covers you as an Employee, member, subscriber or Eligible Former Employee longest is primary.
- If the preceding rules do not determine the primary Coverage Plan, the Coverage Plans (as defined in this section) share the Allowable Charges equally. The sum of all Benefits payable from this Program and the primary Coverage Plan will not exceed actual Allowable Charges incurred.

COB for Eligible Dependent Child(ren)

When more than one Coverage Plan covers a Child, the order of Benefits determination is:

- The Coverage Plan of the parent whose birthday is earlier in the year ("birthday rule") is primary if:
  - The parents are married;
  - The parents are not separated (whether or not they ever have been married); or
  - A court decree awards joint custody without specifying who has responsibility to provide health care coverage.
- The Coverage Plan that covers either of the parents longer is primary if both parents have the same birthday.
- The Coverage Plan of the parent who is responsible for a Child's health care expenses or coverage, as specified by the terms of a court decree, is primary if the parent has knowledge of the terms. This rule applies to Claim determination periods or Plan Years beginning after the Coverage Plan receives notice of the court decree.

How COB Works

When this Program is secondary, it may pay reduced Benefits. When processing a Claim, this Program will:

- Determine the Benefits the Program would pay if it were primary, however, if a negotiated rate applies to the service, special rules apply to determine the Allowable Charge for the service under the Program. Contact the Benefits Administrator if you have questions.
- Determine if total Benefits payable (before applying COB rules) under this Program and other Coverage Plans is more than 100 percent of actual Allowable Charges. If so, this Program reduces its Benefits so that the sum of all Benefits payable from this Program and the primary Coverage Plan do not exceed Allowable Charges incurred.
- COB rules do not apply if you enroll in two or more closed panel Coverage Plans and Benefits are not payable by a closed panel Coverage Plan. For example, COB does not apply if the closed panel Coverage Plan does not pay Benefits because you went to a non-panel Provider.
- Payment made under another Coverage Plan may include an amount this Program should have paid. If this occurs, this Program may pay that amount to the organization that made the payment. This Program treats this amount as if it were a Benefit paid, and this Program will not have to pay that amount again. The term "payment made" includes providing services, in which case "payment made" means reasonable cash value of the services provided.

- If the amount of the payments the Program made is more than it should have paid under this COB provision, the Program may recover the excess. The Program may recover this amount from one or more of the persons paid, from one or more of the persons for whom the Program paid or any other person or organization that may be responsible for the Benefits or services provided. The amount of payments made includes the reasonable cash value of any Benefits provided in the form of services.
- If service frequency maximums apply, the services covered under the primary program or plan will be counted toward the frequency maximum under the Program.

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?

Eligible Employee

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 Partner

If you are the Spouse/Partner of an Employee/Eligible Former 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/Partner dies.
- Your Spouse's/Partner's employment ends for any reason other than his or her gross misconduct or your Spouse's/Partner's hours of employment are reduced.
- You become divorced or legally separated from your Spouse, or your legally recognized partnership is dissolved.

> **IMPORTANT:** If you are an Employee/Eligible Former Employee and you eliminate coverage for your Spouse/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/Partner lost coverage earlier. If the ex-Spouse/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 legal separation 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 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 continuation 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, your entitlement to 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 Program's terms. 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 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

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.

If you or a Child are eligible for Company Extended Coverage (CEC) during a leave of absence or after termination of employment, you will automatically be enrolled in COBRA continuation coverage for the duration of your eligibility for CEC. At the end of your CEC, you may continue COBRA continuation coverage for the remainder of your eligible period (if any), by paying the required COBRA premiums.

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 in which 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 becomes 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(ren) 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 on which 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).

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

Child(ren) Born to or Placed for Adoption With the Covered Employee/Eligible Former Employee During 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 provided 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).

When You Must Notify Us of Changes Affecting Your Coverage

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the **addresses of family members**. While you are an Active Employee, your address in the system of the Eligibility and Enrollment Vendor will be used to send COBRA notices. 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 address changes, you must promptly report your address change. 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 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 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/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/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.

For More Information

Contact the Eligibility and Enrollment Vendor if you, your Spouse/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 related Benefits and Claims. 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, 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.

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.

Also, for all participants, if your marital status changes, you must promptly report the change to the Eligibility and Enrollment Vendor. If you have any changes in your dependents, such as the birth or death of a Child or if a covered Child ceases to be eligible under the Program terms because of reaching the maximum age limit under the Program or if a Child is placed with you for adoption, you must report these changes to the Program's Eligibility and Enrollment Vendor.

Where eligibility of a dependent is lost through divorce or other loss of eligibility, you, your Spouse/Partner or dependent must promptly notify the Eligibility and Enrollment Vendor to remove that dependent from your coverage and provide the appropriate mailing address for mailing the affected dependent's COBRA notice. Such notification is necessary to protect COBRA rights for your Spouse/Partner or dependent Child who is affected by the loss of coverage. Failure to keep the Eligibility and Enrollment Vendor advised of changes in your marital status, dependents, mailing address and contact information may result in the permanent loss of significant Benefits rights.

EXAMPLE: Joseph Employee lives at 123 Main Street, Our Town, USA, and is covered under the Program. Employee moves to 456 Broadway, Our Town, USA, but does not notify the Plan of his new address. Three months later, Employee quits to seek other employment. The Program's COBRA Administrator sends Employee's COBRA notice and election materials to his last known address at 123 Main Street, Our Town, USA. Employee does not receive the COBRA materials and does not elect COBRA continuation coverage. Six months later, Employee has a serious health condition and incurs substantial medical expenses. Employee inquires with the Plan Administrator about COBRA continuation coverage. Employee has no COBRA rights because the COBRA Administrator of the Plan sent his COBRA notice and election form to the last known address in its files, and Employee did not elect COBRA continuation coverage within 60 days. Employee's COBRA rights have extinguished, and he cannot obtain health coverage through the Program.

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 that 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 telephone) 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 Process.** The external review process is available for review of certain Adverse Benefit Determinations and Rescissions of Coverage. This process utilizes an 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

Other Plan Information	
Plan Name	AT&T Umbrella Benefit Plan No. 3
Program Name	AT&T East Dental 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.
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.

Other Plan Information	
Type of Plan	The Plan is an employee health and 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	With certain limited exceptions, the Company pays the costs associated with providing Benefits under the Program 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 Program records are kept on a calendar year basis beginning on 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.
Insurance	As an alternative to Program Benefits, participants in certain geographic areas may be permitted to enroll in and receive Benefits through a Fully-Insured Option (such as a DHMO). All questions regarding Benefits, including but not limited to, benefit levels, coverage, policies, benefit summaries, Claims determination and Claims Appeals will be provided to you by the Fully-Insured Option administrator.

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 the PPO Option 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.

Benefits Administrator

The Plan Administrator administers Claims and Appeals for dental Benefits under the PPO Option on a contract basis with Cigna. The Plan Administrator has discretionary authority to interpret the provisions of the PPO Option and to determine entitlement to dental 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 dental 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, 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 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 in certain situations.

  You may have the right to continue health care coverage for yourself, Spouse/Partner or 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, your Spouse/Partner or your covered dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan.

  If you had creditable coverage from another group health plan or health insurance issuer before you became a participant in this Plan, you should be provided 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 Plan 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 a welfare 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 because of 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 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 your 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 Avenue N.W., Washington, D.C. 20210. You may also 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

The Program extends Benefits to an Employee's noncustodial Child, as required by a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court or agency order that does both of the following:

- Meets all applicable legal requirements for qualification.
- Creates, recognizes or assigns to a Child of an Employee (alternative recipient) the right to receive health benefit coverage under the Program.

An alternative 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 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. If a QMCSO is issued for your Child and you are eligible but not participating in the Program at that time, you must enroll yourself and your Child 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.

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 contribution 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 (choose option 4), ext. 61565**

Protecting the Privacy of Your Protected Health Information – 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.

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 that 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 lose 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 become 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.

CONTACT INFORMATION

Contact Information	
Benefits Administrator	
Name	Cigna
Type	Dental
Services Provided	Dental Benefits Administration
Benefits Administrator Contact Numbers	
Domestic Telephone Number	**888-722-5505**
Hearing Impaired Telephone Number	**800-735-2258** (All except CA) **800-735-2929** (CA residents only)
Benefits Administrator Hours of Operation	
Hours of Operation	Monday through Friday from 7 a.m. to 7 p.m. Central time.
Benefits Administrator Website	
Website Access Information	You must register on the Cigna website, setting up a user name and password.
Website	**mycigna.com**
Benefits Administrator Mailing Address	
General Mailing Address	
Domestic	AT&T Dental Service Center P.O. Box 188040 Chattanooga, TN 37422

Contact Information	
Claims	
Claims Regular	AT&T Dental Service Center P.O. Box 188040 Chattanooga, TN 37422
Appeals	
Appeals Regular	AT&T Dental Service Center P.O. Box 188040 Chattanooga, TN 37422

Contact Information	
Vendor	
Name	AT&T Benefits Center
Type	Eligibility and Enrollment Vendor
Services Provided	Eligibility, enrollment, contributions, billing and COBRA processing
Vendor Contact Numbers	
Contact Numbers Information	To access the AT&T Benefits Center by telephone, 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**
Vendor 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 (IVR) 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).
Vendor Website	
Website Access Information	To access the website, you will need your AT&T Benefits Center user ID and password. To access the AT&T Benefits Center via the telephone, 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.
Website	**resources.hewitt.com/att**

Contact Information	
Vendor Mailing Address	
General Mailing Address	
Mailing Address Information	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
Appeals	
Appeals Regular	AT&T Benefits Center Eligibility and Enrollment Appeals Committee P.O. Box 1407 Lincolnshire, IL 60069-1407
Vendor Fax Number	
Domestic	**847-883-8217** for general information **847-554-1397** for Claims and Appeals only

<table>
<tr><th colspan="2">Active Employee Address and Telephone Number Changes</th></tr>
<tr><td colspan="2">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:</td></tr>
<tr><td>eLinkUsers</td><td>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 eLinkassistant. 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 eLinkassistant.</td></tr>
</table>

DEFINITIONS

Abutment. A terminal tooth or root that retains or supports a bridge or a fixed or removable Prosthesis.

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 Covered Person's eligibility to participate in the Program.

Allowable Charge. Any necessary, Reasonable and Customary charge for services, treatment or supplies at least a portion of which is covered in whole or in part under the Dental Program, but not for any services, treatment or supplies listed under the "Expenses Not Covered" section.

Amalgam. A filling made of alloy of copper, tin, silver and mercury.

Anesthesia. Anesthesia includes:

- *Local Anesthesia.* Local Anesthesia means the condition produced by the administration of specific agents to achieve the loss of conscious pain response in a specific location or area of the body.
- *General Anesthesia.* General Anesthesia means the condition produced by the administration of specific agents to render the patient completely unconscious and completely without conscious pain response.

Anesthetic. A drug that produces a loss of feeling or sensation either generally or locally.

Annual Deductible. The amount of money you must first pay out of pocket each calendar year for non-preventive covered services before the Program begins to pay Benefits.

Annual Enrollment. The period specified by the Company during which Eligible Employees or Eligible Former Employees may make changes to their coverage under the Program.

Annual Maximum. The maximum amount that the Program will reimburse in a calendar year for certain nonessential health benefits.

Appeal. A written request for the Program to review an Adverse Benefit Determination under the formal process outlined in the Program for a Claim for Eligibility or Claim for Benefit. See the “Claims Procedure” section for more information.

Appliance. A device used to provide function or therapeutic (healing) effect and includes:

- *Fixed.* A Fixed Appliance means one that is cemented to the teeth or attached by adhesive materials.
- *Prosthetic.* A Prosthetic Appliance means one that is used to provide replacement for a missing tooth or teeth.

Applicable Premium Rate. The premium charged by a Fully-Insured Managed Care Option for a specified coverage category such as “Individual + 1” or “Individual + 2 or more.”

AT&T Inc. AT&T Inc. or its successor. Sometimes referred to as “Company”.

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; provided, however, that for purposes of the annual limitation on benefits set forth in Section 11.1, AT&T Controlled Group Member will not include a member of an affiliated service group as defined in section 414(m) of the Code and will be determined by application of a more than fifty percent (50%) control standard in lieu of an eighty percent (80%) control standard.

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, by agreement between a union and a Participating Company, have been excluded from a collective bargaining agreement represented by the union, but for whom the Company has elected to provide the same Benefits provided to Employees included in a collective bargaining agreement between the union and the Participating Company.

Benefit Maximum. See the" Benefits At A Glance" and "What Is Covered" sections for Benefit information, including any Benefit Maximums and other Benefit limitations.

Benefits. Payments for covered services 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.

Bicuspid. The two teeth in each Quadrant behind each canine or eye tooth.

Bitewing. A dental x-ray showing approximately the coronal (Crown) halves of the upper and lower jaw.

Bridgework. Bridgework includes:

- *Fixed*. Fixed Bridgework means a Partial Denture retained with Crowns or Inlays cemented to the teeth, which are used as Abutments.
- *Fixed-removable*. Fixed-removable Bridgework means one that the Dentist can remove but the patient cannot.
- *Removable*. Removable Bridgework means a Partial Denture retained by attachments that permit removal of the Denture (normally held by clasps).

Calculation Year. The calendar year immediately preceding the Plan Year for which the dental Premium Equivalent Rate will be in effect.

Change-in-Status Event. Certain circumstances in our lives such as marriage, birth of a Child, loss of benefits under another employer's dental plan, or you or a family member a leave of absence that allows you to change your enrollment under the Program. See the "Enrollment and Changes to Your Coverage" section for information.

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 that is made by the claimant in accordance with the Plan's established procedures for filing a Claim for Benefits, and includes both Pre-Service and Post-Service Claims.

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.

Claims Administrator. See the Benefits Administrator definition.

COBRA. The Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272) as enacted April 7, 1986, and as subsequently amended from time to time. See the ”Extension of Coverage – COBRA” section for information.

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

Coinsurance. The percentage of the Allowable Charge that you pay for covered services. Other cost sharing requirements may apply. See the “Cost Sharing” section for more information.

Company. AT&T Inc. and its subsidiaries and affiliates (including Participating Companies), or any successor or successors thereof.

Company Extended Coverage or CEC. Continued coverage under the Program that may be available to you or your dependents in limited circumstances. For more information, see the “When Coverage Ends” section.

Company Self-Funded Option. A coverage option under the Program the Benefits under which are funded through the Company and not through a third-party insurer.

Congenital Anomaly. A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Coordination of Benefits (COB). 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, to avoid the insured's total benefits exceeding 100 percent of the medical expenses. See the “Coordination of Benefits” section for more information.

Co-pay (Co-payment). The specific fixed dollar amount (for example $15) you pay for certain dental services under the Program. See the “Benefits At A Glance” subsection of the “What Is Covered” section for further information”.

Copayment Basis Schedule (CBS). A list of the “National Average” for each covered dental procedure.

Cost of Coverage. The total cost to the Plan to provide benefits under the Program. With respect to the Fully Insured Managed Care Option, the Cost of Coverage is the Applicable Premium Rate. With respect to the Company Self-Funded Options, the term means the Company Self-Funded Premium Equivalent Rate. See the specific definitions for more information.

Coverage Plan. See the “Coordination of Benefits” section.

Covered Person. Either the Employee, Eligible Former Employee, or a dependent if, and only if, the individual is enrolled under the Program. References to "you" and "your" throughout this SPD are references to a Covered Person. See the “Eligibility and Participation” section for eligibility provisions.

Crown. The portion of a tooth covered by enamel.

Custodial Parent. See the “Coordination of Benefits” section for a definition of the term.

Dental Health Maintenance Organization (DHMO). An option that provides benefits under an insured arrangement and not through a Company Self-Funded arrangement.

Dental Hygienist. A person trained in an accredited school and who is licensed by the state to practice the art of dental Prophylaxis and practice under the direction and supervision of a Dentist.

Dentist. A person licensed to practice dentistry by the governmental authorities having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered. As used in this Dental Program, the term Dentist also includes a licensed physician authorized by his/her license to perform the particular dental service he/she has rendered.

Denture. A device replacing missing teeth.

Diagnostic Services. Professional services rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or Injury.

Disabled Child(ren). Your Child who is over the limiting age and meets the requirements to be eligible for Program coverage due to disability. See the “Eligible Dependents” section for more information.

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.

Eligibility and Enrollment Appeals Committee (EEAC). The committee appointed by the Company to make the final determination on eligibility and enrollment Appeals.

Eligibility and Enrollment Vendor. The Eligibility and Enrollment Vendor, known as the AT&T Benefits Center, is the third-party vendor to which the Plan Administrator has delegated responsibility under the Program for 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 an AT&T Participating Company who satisfies the conditions for eligibility to participate in the Program set forth in the “Eligibility and Participation” section.

Eligible Expenses. The maximum amount on which payment is based for covered services. This may be called “Allowable Charge“, “allowed amount,” “payment allowance" or "negotiated rate." The Program will not pay Benefits toward any amount above the Eligible Expense for a covered dental service.

Eligible Former Disabled Employee. An Employee who has terminated employment with a Participating Company or former Participating Company and who meets the eligibility requirements for Program coverage described in the “Eligible Former Disabled Employees” section.

Eligible Former Employee. An Employee who has terminated employment with a Participating Company or former Participating Company and who meets the eligibility requirements for Program coverage described in the "Eligible Former Employees" 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, the term "Nonresident Alien Employed Outside the United States" means any individual who receives no earned income (within the meaning of Section 11(d)(2) of the Code) from any AT&T Participating Company which 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. AT&T Inc.

Endodontics. Procedures used for prevention and treatment of diseases of the dental pulp such as pulp capping and root canal work.

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.

Expense Incurred. The actual billed cost for a service or procedure; except when the Provider has contracted directly or indirectly or negotiated with the Benefits Administrator for a different amount

Explanation of Benefits (EOB). A statement you receive after a Benefits Administrator has processed your Claim. The EOB shows the expenses submitted for payment, the Allowable Charge for Eligible Expenses, the amount of Benefits payable, and any amounts you must pay.

Family Coverage. Coverage for a Covered Person and more than one dependent as described in the “Levels of Coverage” section.

FDA. The U.S. Food and Drug Administration (FDA). A federal regulatory agency that collects and analyzes data about medications to determine if they are safe for manufacture and sale to consumers.

Fill. The dispensing of a prescription medication.

Fixed Bridge. A cemented Prosthesis that replaces one or several teeth. It consists of Pontics held in place by retainers on the Abutment teeth.

Flexible Enrollment. See the “Flexible Enrollment” section for the definition of Flexible Enrollment.

Fluoride. A solution that is applied topically to the teeth for the purpose of preventing dental decay.

FMLA. The Family Medical Leave Act of 1993, as amended from time to time.

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

Illness. A disorder of the body or mind, and pregnancy. Pregnancy shall include normal delivery, cesarean section, miscarriage, abortion, or any complications resulting from Pregnancy.

Impression. A negative reproduction of a given area. For example, in Bridgework, an Impression of a tooth (Abutment) that has been prepared for an Inlay or Crown.

Injury. Bodily damage from trauma other than Sickness, including all related conditions and recurrent symptoms.

Inlay. A Restoration made to fit a prepared tooth cavity and then cemented into place.

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, or
- With whom an Eligible Employee, Eligible Former Employee or participant, as applicable, has entered into a same-gender relationship pursuant to and in accordance with state or local law, such as civil union or other legally recognized arrangement that provides similar legal benefits, protections and responsibilities under state law to those afforded to a Spouse.

Limited Term Employee. See Term Employee.

List of Dental Services. The list of certain dental services and the scheduled limit, if any, for each service set forth in the "Covered Services" section. See the *Benefits at a Glance* table for Scheduled Amounts for the most commonly used covered services. A complete List of Dental Services may be obtained from the Benefits Administrator, free of charge, upon request.

List of Orthodontic Procedures. The list of certain Orthodontic Procedures and the scheduled limit, if any, for each service set forth in the Covered Services section. See the *Benefits at a Glance* table for Scheduled Amounts for covered services. A complete List of Orthodontic Procedures may be obtained from the Benefits Administrator, free of charge, upon request.

Malocclusion. An abnormal relation of the opposing teeth when brought into habitual opposition.

Management Employee. An Employee who is classified as management.

Medically Necessary or Medical Necessity. See "Definition of Medically Necessary" in the "Limitations on Benefit Payments" section for details regarding how the Benefits Administrator determines Medically Necessary Services, including examples of what is Medically Necessary and what is not considered Medically Necessary.

Net Credited Service (NCS). See Term of Employment definition.

Network. The group of Providers of health care services that have an agreement in effect with the applicable Benefits Administrator or an affiliate (directly or through one or more other organizations) which the Benefits Administrator makes available for use by the Program.

Network Area. The area covered by a Provider Network. See the "How Network Areas Are Determined" section for more information.

Network Benefits. Benefits for covered services that are provided by a Network Provider. See the "Network Benefits" subsection in the "Network Coverage" section for dental information.

Network General Dentist (NGD). A Dentist who is practicing general dentistry (not a specialist) and is listed as a Network Provider by the Benefits Administrator.

Network Provider. A Provider who has contracted to participate in the applicable Benefits Administrator's Network available under the Program. Also referred to as In-Network Provider or Preferred Provider. A complete List of Network Providers may be obtained from the Benefits Administrator, free of charge, upon request.

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

Non-Network Provider. A Provider who has not contracted to participate in the applicable Benefits Administrator's Network available under the Program.

Non-Network Benefits. Benefits for covered services that are provided by a Non-Network Provider. See the "Non-Network Coverage" section for a description of Non-Network Benefits provided under the Program.

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. See the "Predetermination of Benefits" section for information and a list of covered services that require Notification.

Occlusal. Occlusal is the chewing or biting surface of a tooth.

Onlay. An Occlusal rest or Restoration that is extended to cover the entire surface of the tooth. It often is used to restore lost tooth structure and increase the height of the tooth.

Oral Surgery. A surgical procedure for removal of teeth.

Orthodontics. The branch of dentistry primarily concerned with the detection, prevention and correction of abnormalities in the positioning of the teeth in their relationship to the jaws, commonly referred to as straightening teeth.

Partial Denture. An Appliance that replaces one or more, but less than all, of the natural teeth and associated structures. It is supported by the teeth and/or the gums; and may be removable or fixed, one side or two sides.

Participating Company. Any AT&T Company which has elected to participate in the Program subject to approval provided in accordance with the AT&T Schedule of Authorizations.

Partner. Your Legally Recognized Partner or Domestic Partner. See the definition of Legally Recognized Partner or Domestic Partner for information.

Patient Charge Schedule (PCS). See the List of Dental Services definition. A Patient Charge Schedule may be obtained from the Benefits Administrator, free of charge, upon request.

Periapical. Enclosing or surrounding the tissues and bony sockets of the teeth.

Periodontal. The tissue immediately around the teeth.

Periodontics. Nonsurgical and surgical procedures for treatment of the supporting area around the teeth such as scaling and root planning.

Periodontal Splinting. A device used to support, protect, or immobilize oral structures that have been loosened due to Periodontal disease.

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.

Pontic. The part of a Fixed Bridge that is suspended between the Abutments and that replaces a missing tooth or teeth.

Post-Employment Benefits. Program coverage (excluding COBRA) made available to a former Employee who meets eligibility requirements for continued Program coverage after the Employee terminates employment. See the "What Happens When You Leave The Company" section for information.

Preauthorization. Written or oral approval of a covered dental service received from the applicable Benefits Administrator before the covered dental service is delivered. See the "Predetermination of Benefits" section for information and a list of covered services requiring Preauthorization.

Preferred Provider Organization (PPO). The group of Providers of health care services that have an agreement in effect with the Benefits Administrator or an affiliate (directory or through one or more other organizations) who have agreed to participate in the PPO Network which the Benefits Administrator makes available for use by the Program.

Premium Equivalent Rate. The projected average cost of a Company Self-Funded Option for a specified tier, such as "Individual" or "Individual + 1."

Premium Rate. See the definition of Applicable Premium Rate.

Primary Subscriber. An Active Employee, Eligible Former Employee, or surviving Spouse/Partner/dependent who is eligible and enrolled for coverage. A Primary Subscriber is not an Active Employee, Eligible Former Employee, or surviving Spouse/Partner/dependent who is covered as a dependent on another Active Employee's, Eligible Former Employee's, or surviving Spouse/Partner/dependent's coverage.

Program. See the "Terms Used in this SPD" section for a definition.

Prophylaxis. The removal of tartar and stains from the teeth by a Dentist or Dental Hygienist.

Prospective Enrollment. The ability to drop or add coverage outside of Annual Enrollment or a Change-in-Status Event. See the "Prospective Enrollment" section for information.

Prosthesis. An artificial replacement of one or more natural teeth and/or associated structures.

Prosthodontics. Services to replace one or more teeth (except wisdom teeth) extracted while covered under the Program including:

- Initial installation of Fixed Bridgework including Inlays and Crowns to form supports;
- Initial installation of Partial or Full Removable Dentures including adjustments during the six month period after installation;
- Addition of teeth to an existing Partial Removable Denture or to Bridgework;
- Initial installation of a Permanent Full Denture that replaces within 12 months a temporary Denture; and
- Replacing an existing Partial Denture, Full Removable Denture or Fixed Bridgework.

Provider. Any Dentist or specialist Dentist licensed to render dental services, and practicing within the scope of that license.

Quadrant. A quarter of the mouth such as the upper right jaw, lower right jaw, etc.

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 Order" 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.

Reasonable and Customary. The fees charged by your Dentist or the Provider to the majority of patients for a similar service that falls within the range of usual fees charged by Dentists or Providers with similar training and experience for the same or similar service within the same geographical area. The Reasonable and Customary determination made by the Claims Administrator may limit your Benefit.

Registered Domestic Partner. 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.

Restoration. A broad term applied to any Inlay, Crown, Bridge, Partial Denture or Complete Denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape, form and function of part or all of a tooth or teeth.

Root Canal Therapy/Endodontic Therapy. The treatment of a tooth having a damaged pulp usually performed by removing the pulp, sterilizing the pulp chamber and root canals and filling these spaces with sealing material.

Scale. The removal of calculus (tartar) and stains from teeth with special instruments.

Space Maintainers. A Fixed or Removable Appliance (installed to replace prematurely lost or extracted teeth) designed to maintain existing space by preventing adjacent or opposing teeth from moving.

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

Summary Plan Description (SPD). Each of the Program descriptions that are required by Section 102 of ERISA that provide a summary of the dental benefits under the Program.

Temporomandibular Joint (TMJ) Syndrome. A disorder, disease or dysfunction of the temporomandibular joint.

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.

Termination Date. The day immediately following an Employee's last day on active payroll.

Term of Employment (TOE). A period of employment of an Employee in the service of one or more members of the AT&T Controlled Group of Companies, as determined in accordance with the applicable pension benefit program under the AT&T Pension Benefit Plan or the AT&T Puerto Rico Pension Benefit Plan of a Participating Company.

Topical. Painting the surface of teeth as in Fluoride treatment or application of a cream-like Anesthetic formula to the surface of the gum.

Type A Services. Any dental services for certain diagnostic and preventive care included in the List of Dental Services. See the List of Dental Services definition above for additional information.

Type B Services. Any dental services for certain restorative, Oral Surgery, Periodontic, Endodontic, and Prosthodontic care included in the List of Dental Services. In addition, Type B Services include certain Orthodontic procedures included in the List of Orthodontic Procedures. See the *List of Dental Services* and *List of Orthodontic Procedures* definitions above for additional information.

APPENDIX A: PARTICIPATING COMPANIES AND FORMER PARTICIPATING COMPANIES

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. Within this table, you will see various combinations of Company name, Employee groups and bargaining units, if applicable. If you are a Management or Nonmanagement Nonunion Employee, an “N/A” will be in the bargaining unit column. In addition, the Company acronym for this combination of Company name, Employee group and bargaining unit is listed in the first column.

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.

	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
SNEAM - CWA District 1	SNET America, Inc. SNEAM	Bargained No Employees as of Jan. 1, 2010.	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, DD, E, W	E, AD, AS: For newly eligible 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 dental plan.
Death of Spouse/Partner*	AD, DD, DS, E	E, AD: Only if you lose coverage under your Spouse/Partner's dental plan. DD: Only if other dependent loses coverage under your Spouse/Partner's dental plan.
Divorce, Legal Separation, Legal Annulment or Dissolution of Partnership	AD, DD, DS, E	E, AD: Only if you or your dependent lose coverage under your Spouse/Partner's dental plan. DD: Only if dependent loses coverage under your Spouse/Partner's dental 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, E, W	W: Only if dental coverage is effective under your Spouse/Partner's dental 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, 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	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 leave of absence (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 dental coverage option is gained.

CHANGE IN EMPLOYEE EMPLOYMENT STATUS	CHANGES PERMITTED	NOTES
Loss of Eligibility Due to a Change in Employee's Work Schedule or Employment Status	DD, DS, W	
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	
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 or Dependent's Employment Status

You may change your enrollment if your Spouse/Partner or dependent experiences a gain or loss of eligibility for dental 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 dental 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 dental plan.
Loss of Employment Spouse	AD, AS, E	AD, AS, E: Only with respect to you, your Spouse/Partner or dependent who lose coverage under another employer's dental plan.
Change in Work Schedule that Triggers a Loss of Eligibility Under their Employer's Dental Plan	AD, AS, 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 Dental Plan	DD, DS, W	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, E	AD, AS, E: Only with respect to the individual who lost coverage under another employer's plan.
Spouse/Partner or Dependent Returns from a Strike or Lockout	DD, DS, W	Only with respect to the individual who gains coverage under another employer's plan.

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 dental benefit option you are enrolled in.

CHANGE IN RESIDENCE	CHANGES PERMITTED	NOTES
Relocation Triggers Gain in Eligibility	AD, AS, E	
Relocation Triggers Gain in Dental Benefit Option Availability	AD, AS, E	Only if eligibility for coverage option is gained.
Relocation Triggers Loss in Eligibility	W	
Relocation Triggers a Loss of Dental Benefit Option Availability	W	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 dental coverage for you, your Spouse/Partner or dependent, if any of you gain or lose coverage under another employer's dental plan.

CHANGE IN BENEFIT COVERAGE	CHANGES PERMITTED	NOTES
Gain of Dental Coverage under Another Employer's Plan	DD, DS, W	
Loss of Dental Coverage under Another Employer's Dental Plan	AD, AS, E	AD, AS: Only with respect to the Spouse/Partner or dependent who lost coverage under another employer's dental plan.

CHANGE IN BENEFIT COVERAGE	CHANGES PERMITTED	NOTES
Spouse/Partner or Dependent's Annual Enrollment Does Not Correspond with the Program's Annual Enrollment Period	AD, AS, DD, DS, E, W	AD, AS, DD, DS, E, W: Changes are permitted that reflect corresponding changes in non-AT&T Spouse/Partner or dependent's dental plan.
You Gain Eligibility Under Another Employer's Dental Benefit Plan(s)	DD, DS, W	If Employee, Spouse/Partner and/or dependent coverage under other employer's dental plan is effective.
You Lose Eligibility Under Another Employer's Dental Benefit Plan(s)	AD, AS, 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. Refer to 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, 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, E	Note: Loss of coverage under state Medicaid or CHIP programs will permit you a 60 day enrollment period.

Gain or Loss of Medicaid Coverage and CHIP Premium Assistance

You may change your enrollment if you experience a gain or loss of Medicaid coverage or premium assistance provided under a state sponsored CHIP program.

*Note: This Change-in-Status Event permits an extended enrollment period of **60 days** from the date of the event.*

Gain or Loss of Medicaid Coverage and CHIP Premium Assistance	CHANGES PERMITTED	NOTES
Your Gain of Medicaid Coverage or CHIP Premium Assistance	W, C	
Your Spouse/Partner or Dependent's Gain of Medicaid Coverage or CHIP Premium Assistance	DD, DS	
Your Loss of Medicaid Coverage or CHIP Premium Assistance	AD, AS, C, E	
Your Spouse/Partner or Dependent's Loss of Medicaid Coverage or CHIP Premium Assistance	AD, AS, E	

Change in Cost

You may change your enrollment if you experience a significant increase or decrease in your portion of the cost of your dental 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 dental plan.

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

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

If there is an insignificant increase or decrease in the cost of your current dental 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 dental coverage.

CHANGE IN COST	CHANGES PERMITTED	NOTES
Significant Increase in Cost of Your Dental Benefit Option	AS, AD, DD, DS, E, W	May change enrollment to match cost increase OR W and AD, AS, E: Another dental benefit option providing similar coverage OR W, DD, DS: If no other dental benefit option provides similar coverage.
Significant Decrease in Cost of Your Dental 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 dental benefit option and add the dental benefit option with decreased cost.
Increase in Cost Under Spouse/Partner or Dependent's Employer's Benefit Plan	AD, AS, E	
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 Dental Plan Subsidy from Another Employer	AD, AS, E	

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, E	AD, AS, E: If coverage under another employer's plan is decreased or dropped.

Addition or Significant Improvement of Benefit Plan Option

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

If a dental 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 dental 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 Dental Benefit Option	AD, AS, DD, DS, E, W	DD, DS, W then AD, AS, E: May drop current dental benefit option and elect the new or significantly improved dental benefit option. AD, AS: If previously enrolled in a dental benefit option, you may elect the new or significantly improved dental benefit option.
Addition or Significant Improvement of Dental 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 dental benefit option even if there is no loss of coverage. An enrollment may be changed to a different dental 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	DD, DS, W	

SIGNIFICANT CURTAILMENT OF COVERAGE	CHANGES PERMITTED	NOTES
Significant Curtailment or Termination of Spouse/Partner or Dependent Coverage under Another Employer's Dental Benefit Plan	AD, AS, 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.

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 Medical Leave Act (FMLA), state family and medical leave, federal military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA), unpaid personal leave, etc.

CHANGE DUE TO LEAVE OF ABSENCE	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.
Spouse/Partner or Dependent Begin an Unpaid LOA (including a FMLA leave) Resulting in a Loss of Eligibility under Another Employer's Dental benefit plan	AD, AS, 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 Dental 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 dental 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 dental 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	
QMCSO or Court Order Requiring Another Individual to Cover Your Dependent	DD	
Expiration or Termination of a QMCSO or Court Order	W, DD	

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, 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 dental coverage under the Program
DS	Drop dental coverage for your Spouse/Partner under the Program
AD	Add your Eligible Dependent(s) to dental coverage under the Program
DD	Drop dental coverage for your dependent under the Program
W	Waive or terminate your dental coverage enrollment under the Program
C	Change dental coverage options under the Program