# Summary Plan Description

**Important Benefits Information**

# AT&T Flexible Spending Account Plan

This summary plan description (SPD) is a guide for using the AT&T Flexible Spending Account Plan (Plan).

Please keep this SPD for future reference.

DISTRIBUTION

Distributed to active Employees of AT&T Companies listed in the "Participating Companies" section on Page 55 of the SPD who may be eligible to participate as described in the "Eligibility and Participation" section on Page 10.

NIN 78-21766

## IMPORTANT INFORMATION

In all cases, the official documents for the Plan govern and are the final authority on the terms of the Plan. AT&T reserves the right to terminate or amend any and all of its employee benefit plans or programs. Participation in the plans and programs is neither a contract nor a guarantee of future employment.

### What is this document?

This summary plan description (SPD) is a guide to using the AT&T Flexible Spending Account Plan (Plan) and constitutes the Plan document.

### Why did I receive this document?

You are eligible to participate in the AT&T Flexible Spending Account Plan as described in this SPD.

### What action do I need to take?

Please review this document carefully for detailed information about the Plan provisions and keep it for future reference.

### How do I use this document?

It is important that you read this SPD to get a complete picture of the Plan provisions that may apply to you, including:

- Before-Tax Premium Option
- Health Savings Account Payroll Contributions
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account

### Questions?

If you have questions regarding information in this SPD, contact the applicable administrators. Contact information is provided in the "Contact Information" section on Page 64.

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Appendix A: Employee Group Terms Used in This SPD

Appendix B: Eligibility, Enrollment, Eligibility Waiting Period, and Contribution Limits Matrix

Appendix C: Qualified Status Changes Matrix

# USING THIS SUMMARY PLAN DESCRIPTION

This summary plan description (SPD) is a guide to using the AT&T Flexible Spending Account Plan (Plan) and constitutes the Plan document. The Plan was established Jan. 1, 1990.

This SPD provides information regarding eligibility and benefits under the Plan for Active Employees of Participating Companies listed in the "Participating Companies" section on Page 55. See the "Eligibility and Participation" section on Page 10 for information on your eligibility to participate in the Plan.

This SPD provides information about the following benefits for Eligible Employees:

- Before-Tax Premium Option
- Health Savings Account Payroll Contributions
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account

This SPD does not provide information about Health Reimbursement Accounts (HRAs), which are Company-funded accounts that can be used by Eligible Employees to reimburse themselves for eligible medical expenses. HRAs are available to certain bargained employees and retirees.

Understanding what the Plan offers will help you take advantage of the benefits it provides and make the most of your total compensation package.

Many sections of this SPD are related to other sections of the document. You may not have all of the information you need by reading just one section. Therefore, it is important that you review all sections that apply to a specific topic. In addition, footnotes and notes imbedded in the text are used throughout this SPD where needed to provide clarification or additional information or to identify an exception or other distinction. These notes provide information that is important to fully understand the Plan and the benefits it provides.

Please review this SPD. This SPD replaces information in the following documents related to the Plan provisions described in this SPD to the extent those documents describe provisions of the Plan:

- Prior version of the AT&T Flexible Spending Account Plan SPD dated March 2006 and any later SMMs to that SPD.
- Prior version of the Health and Insurance Plans for Represented Employees SPD dated April 1, 2006 and any later SMMs to that SPD as they apply to BLS Represented Employees.
- Prior version of the Health and Insurance Plans for Special Represented Employees SPD dated April 1, 2006 and any later SMMs to that SPD as they apply to BLS Special Represented Employees.
- Prior version of the following Cingular Wireless SPDs as they apply to Cingular Wireless Bargained Employees:
  - Cingular Wireless Flexible Benefits Plan for Bargained Employees SPD dated Jan. 2007, and any later SMMs to that SPD.

- Plan information in the Eligibility, Enrollment and Other Administrative Provisions SPD dated Jan. 2007, and any later SMMs to that SPD.
- Plan information in the Cingular Wireless LLC Other Important Information For Nonbargained and Bargained Employees SPD dated Jan. 2007, and any later SMMs to that SPD.

### Terms Used in This SPD

Certain terms used in this SPD have specific meanings when applied to your participation. Terms that use initial capital letters, such as Participant and Eligible Dependent, are defined in the "Definitions" section beginning on Page 62. Understanding the defined terms will help you to better understand the information provided in this SPD.

"Plan" refers to the AT&T Flexible Spending Account Plan described in this SPD.

### Company Labels and Employee Group Acronyms Used in This SPD

Not all information in this SPD is applicable to every Eligible Employee. Some Plan provisions regarding eligibility and provisions of the Health Savings Account Payroll Contributions, Health Care Flexible Spending Account and Dependent Care Flexible Spending Account benefits differ depending on your bargained classification, the Company you work for and other factors. These differences are noted in this SPD. In the interest of brevity, any time there is an exception pertaining to a particular Company or Employee group covered by a bargained contract, the Company or Employee group is referred to by an acronym rather than an official Company or Employee group name.

A complete list of Participating Company names is located in the "Participating Companies" section on Page 55. In addition, a complete list of the Employee groups referred to in this SPD and their associated terms (acronyms) is presented in *Appendix A*.

## OVERVIEW

The Plan permits Eligible Employees to choose from a menu of different benefits to suit their individual needs, and to pay for those benefits on a before-tax basis. This type of plan is commonly referred to as a 'cafeteria plan,' because you can pick and choose among several different benefits.

There are four separate components of the Plan: the Before-Tax Premium Option, the Health Savings Account Payroll Contributions, the Health Care Flexible Spending Account and the Dependent Care Flexible Spending Account. Not all Employees are eligible for all components. See the applicable sections for information on eligibility and other important provisions.

The Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended (Code) and the regulations issued thereunder and shall be interpreted to accomplish that objective.

### Before-Tax Premium Option

The Before-Tax Premium Option (BTPO) enables Eligible Employees to pay contributions for Company-sponsored health care plans (including any option available under your Company-sponsored health care plan) and certain welfare plans on a before-tax basis (Eligible Contributions). For this purpose, 'Company-sponsored health care plans' include your medical

(including CarePlus, MedPlus and HMOs), dental, and vision benefit plans. In addition, the BTPO also applies to contributions for supplemental accidental loss insurance and dependent accidental loss insurance programs sponsored by AT&T for Eligible Employees who are eligible to purchase such coverage. If you are an Eligible Employee and you participate in any of the Company-sponsored health care plans, or you purchase supplemental accidental loss insurance and dependent accidental loss insurance sponsored by AT&T, your contributions are automatically deducted on a before-tax basis unless you elect otherwise.

## Health Savings Account Payroll Contributions

Health Savings Account (HSA) Payroll Contributions permit an Eligible Employee the opportunity to make before-tax contributions to an HSA established and maintained with the HSA trustee/custodian. Contributions to an HSA can be used to help pay for certain out-of-pocket health care expenses that a health plan does not cover. If you elect to participate in the HSA Payroll Contributions portion of the Plan, you authorize the Company to reduce your salary by the amount of your election.

In order to participate in an HSA, you must satisfy certain conditions, including that you must be enrolled in a medical plan that meets the Code requirements for a high-deductible health plan. The AT&T Medical Option (also referred to as the consumer-driven health plan) is designed to meet these requirements for nonbargained Employees and some bargained Employees. The Company may limit the HSA trustee/custodians to whom before-tax Payroll deductions can be contributed.

## Health Care Flexible Spending Account

The Health Care Flexible Spending Account (Health Care FSA) is a separate component of the Plan that offers Eligible Employees the option to pay, on a before-tax basis, for certain anticipated out-of-pocket health care expenses that a health care plan does not cover. If you elect to participate in the Health Care FSA portion of the Plan, you authorize the Company to reduce your salary by the amount of your election.

## Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account (Dependent Care FSA) is a separate component of the Plan that offers an Eligible Employee the option to pay, on a before-tax basis, for certain anticipated dependent care expenses that you incur so that you and your spouse, if applicable, can work outside the home. If you elect to participate in the Dependent Care FSA portion of the Plan, you authorize the Company to reduce your salary by the amount of your election.

## How the HSA, Health Care FSA, and Dependent Care FSA Work

When you enroll in an HSA, Health Care FSA or Dependent Care FSA, or any combination of them, you determine the amount of money you want contributed to these reimbursement accounts. Deposits are made on a before-tax basis through Payroll deduction and, when you incur eligible expenses, you receive tax-free reimbursements from the account throughout the year. Since you do not pay taxes on your contributions, you actually reduce your taxable pay and increase your take-home pay.

If you have not incurred enough eligible expenses by Dec. 31 to claim reimbursement of all of the contributions to your Health Care FSA and/or Dependent Care FSA contribution account(s) for that year, the law requires that you forfeit the money remaining in your account(s). You will **not** forfeit the unused balance in your HSA. Also, contributions to the Health Care FSA and HSA

cannot be used to cover expenses eligible for reimbursement under the Dependent Care FSA, and vice versa. You should, therefore, carefully plan your contributions.

## ELIGIBILITY AND PARTICIPATION

### KEY POINTS

A. *You must be an Eligible Employee to participate in the Plan. An Eligible Employee is an individual who is on the United States Payroll of a Participating Company and satisfies all other eligibility requirements.*

B. *If you are an Employee whose job title and classification are included in a collective bargaining agreement between a Participating Company and a union or you are a nonmanagement nonunion Employee who is extended bargained Employee benefits, you are an Eligible Employee only if the collective bargaining agreement provides coverage.*

C. *You will not be eligible to enroll until you have completed your Eligibility Waiting Period. See* Appendix B *for the Eligibility Waiting Period that applies to you.*

This section summarizes the eligibility provisions of the Plan for Eligible Employees. If, after reading this information, you have additional questions or wish to confirm eligibility, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section on Page 64 for contact information.

### Eligible Employees

You must be an Eligible Employee to participate in the Plan. An Eligible Employee is an individual who is on the United States Payroll of a Participating Company and satisfies all other eligibility requirements. See the "Participating Companies" section on Page 55 for a list of Participating Companies. In addition, if you are an Employee whose job title and classification are included in a collective bargaining agreement between a Participating Company and a union or you are a nonmanagement nonunion Employee who is extended bargained Employee benefits, you are an Eligible Employee only if the collective bargaining agreement provides coverage. However, an Eligible Employee does not include any common-law employee who is a leased employee or who is classified by the Participating Company as a contract worker or independent contractor.

If you are a management Employee, your coverage effective date is your date of hire, provided you timely enroll. If you are a bargained or nonmanagement nonunion Employee, your coverage effective date is determined by your Eligibility Waiting Period as explained in Appendix B, provided you timely enroll. If applicable, the Eligibility Waiting Period is the period after an Eligible Employee becomes employed by a Participating Company before he or she is eligible to enroll in the Plan.

See *Appendix A* for an explanation of the special groups referred to in this SPD and their associated terms (acronyms).See *Appendix B* for a summary of the eligibility, enrollment, Eligibility Waiting Period, and contribution limits that apply to you.

***Retirees and Former Employees***

The law does not allow former employees or retirees to participate in the Plan, except for COBRA coverage with respect to the Health Care Flexible Spending Account (see the "COBRA Continuation Coverage" section on Page 38 for information on COBRA coverage).

## ENROLLMENT AND CHANGES TO YOUR COVERAGE

### KEY POINTS

*A. Your Before-tax Premium Option, Health Care FSA and/or Dependent Care FSA elections will begin on the first day of the month following your enrollment, provided you are eligible and have completed your Eligibility Waiting Period. See* Appendix B *for the Eligibility Waiting Period that applies to you.*

*B. If you are a current Eligible Employee, your Before-tax Premium Option contributions are automatically deducted from your pay on a before-tax basis. If you do not want these contributions deducted on a before-tax basis, then you must elect to have them deducted on an after-tax basis during the annual enrollment process each year. You may enroll in the Health Care FSA and/or Dependent Care FSA during the annual enrollment process each year. You may not change your BTPO, Health Care FSA and/or Dependent Care FSA election* ***unless*** *you experience a Qualified Status Change.*

*C. If you are a new Eligible Employee, your Before-tax Premium Option contributions are automatically deducted from your pay on a before-tax basis. If you do not want these contributions deducted on a before-tax basis or if you want to make Health Care FSA and/or Dependent Care contributions, you must contact the Eligibility and Enrollment Vendor within 31 days of your date of hire or the date you receive your enrollment kit, whichever is later.*

*D. If you are eligible for an HSA, you may make an election for before-tax HSA Payroll Contributions at any time after you have opened your HSA with a trustee/custodian with whom the Company has made arrangements.*

*E. Your BTPO, Health Care FSA and Dependent Care FSA elections cannot be changed during the calendar year unless you experience a Qualified Status Change and the election change you wish to make is timely and consistent with that Qualified Status Change event.*

You may make Plan elections during an annual enrollment period or within 31 days following a Qualified Status Change. You will be notified in advance of the timing and duration of the annual enrollment period so that you can make timely elections regarding Plan benefits.

The following chart describes how to enroll and the effective date of your participation:

| **Enrollment and Effective Dates for Eligible Employees** | |
|---|---|
| **If you are …** | **Then …** |
| **Currently employed** | **Before-tax Premium Option (BTPO)**. Under the BTPO, your Eligible Contributions are automatically deducted from your pay on a before-tax basis. If you do not want these contributions deducted on a before-tax basis, then you must elect to have them deducted on an after-tax basis during the annual enrollment process each year. Your election would be effective on the Jan. 1 immediately after it is made during annual enrollment.<br>You may not change your BTPO election **unless** you experience a Qualified Status Change (see the "Qualified Status Changes" section on Page 14 and *Appendix C* for more information). If you experience a Qualified Status Change and want to change your BTPO election, you must contact the Eligibility and Enrollment Vendor within 31 days of your Qualified Status Change; provided if the Qualified Status Change event is the death of your covered dependent, the 31-day notice period does not apply. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section on Page 64 for contact information. A change to your BTPO election as a result of a Qualified Status Change is effective as soon as administratively possible after you timely notify the Eligibility and Enrollment Vendor. |
| **Currently employed** | **Health Care FSA and/or Dependent Care FSA.** To enroll in either the Health Care FSA and/or Dependent Care FSA, you may do so during the annual enrollment process each year. Participation in an FSA begins on the Jan. 1 immediately after you enroll during annual enrollment.<br>You may not change your Health Care FSA and/or Dependent Care FSA election **unless** you experience a Qualified Status Change (see the "Qualified Status Changes" section on Page 14 and *Appendix C* for more information). If you experience a Qualified Status Change and want to enroll in or change your Health Care FSA and/or Dependent Care FSA election, you must contact the Eligibility and Enrollment Vendor within 31 days of your Qualified Status Change; provided if the Qualified Status Change event is the death of your covered dependent, the 31-day notice period does not apply. See the See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section on Page 64 for contact information. FSA changes or enrollment as a result of a Qualified Status Change is effective as soon as administratively possible after you timely notify the Eligibility and Enrollment Vendor. |
| **Currently employed** | **Health Savings Account (HSA) Payroll Contributions.** To make before-tax HSA Payroll Contributions, you must satisfy certain legal requirements, including that you must be enrolled in a consumer-driven medical plan like the AT&T Medical Option under the AT&T Medical Plan, which is designed to meet the Code requirements for a high-deductible health plan with respect to nonbargained Employees and some bargained Employees. You may make an election for before-tax HSA Payroll Contributions during annual enrollment, but you must open your HSA with a trustee/custodian to whom the Company has agreed to make before-tax contributions on your behalf. If elected during annual enrollment, participation in an HSA begins as soon as administratively possible after you open your HSA, but no sooner than Jan. 1.<br>You may change your before-tax HSA Payroll Contributions at any time. Your election to change your before-tax HSA Payroll Contributions is effective as soon as administratively possible after you timely notify the Eligibility and Enrollment Vendor. |
| | ***Table continued on next page*** |

| Enrollment and Effective Dates for Eligible Employees | |
|---|---|
| **If you are ...** | **Then ...** |
| **A new Eligible Employee who wants to make HSA Payroll Contributions, enroll in the Health Care FSA and/or Dependent Care FSA or elect after-tax treatment under the BTPO** | **Health Care FSA, Dependent Care FSA and/or BTPO.** You must contact the Eligibility and Enrollment Vendor within 31 days of your date of hire or the date you receive your enrollment kit, whichever is later. Your BTPO, Health Care FSA and/or Dependent Care FSA elections will begin as soon as administratively possible following your enrollment; provided you are eligible and have completed your Eligibility Waiting Period. See *Appendix B* for a summary of the eligibility, enrollment, Eligibility Waiting Period, and contribution limits that apply to you.<br><br>If you do not enroll in the Health Care FSA and/or Dependent Care FSA within 31 days of your date of hire or the date you receive your enrollment kit, you cannot enroll until the next annual enrollment period, unless you have a Qualified Status Change. If you do not elect after-tax treatment under the BTPO within 31 days of your date of hire, your Eligible Contributions will be deducted from your paycheck on a before-tax basis; and you cannot elect after-tax treatment until the next annual enrollment period unless you have a Qualified Status Change.<br><br>**Health Savings Account (HSA) Payroll Contributions.** To make before-tax HSA Payroll Contributions, you must satisfy certain legal requirements, including that you must be enrolled in a consumer-driven medical plan like the AT&T Medical Option under the AT&T Medical Plan, which is designed to meet the Code requirements for a high-deductible health plan with regard to nonbargained Employees and some bargained Employees. You may make an election for before-tax HSA Payroll Contributions at any time after you have opened your HSA with a trustee/custodian to whom the Company has agreed to make before-tax contributions on your behalf. You must contact the Eligibility and Enrollment Vendor to initiate your before-tax HSA Payroll Contributions. Once your HSA account has been established with the HSA vendor, your election to make before-tax HSA Payroll Contributions is effective as soon as administratively possible after the Eligibility and Enrollment Vendor receives notification that the account is established. |

## Special Enrollment for Employees and their Dependents who lose Eligibility for Medicaid or CHIP Coverage or Gain Eligibility for State Subsidies to Participate in the Plan

An Eligible Employee who is not currently enrolled for coverage under the Plan may enroll in the Plan if either of the following conditions is met:

- The Eligible Employee requests coverage under the Plan within 60 days after the termination of either the Employee's or their dependents' coverage under Medicaid or Children's Health Insurance Program (CHIP) because they are no longer eligible for the coverage, or
- The Eligible Employee or their dependents become eligible for Medicaid or CHIP premium assistance subsidies and the Employee requests coverage within 60 days after the eligibility is determined.

## Changing Your HSA Payroll Contribution Election

You may change your before-tax HSA Payroll Contribution election at any time. To make a change to your HSA Payroll Contribution election, you must contact the Eligibility and Enrollment Vendor. Your election to change your before-tax HSA Payroll Contribution is effective as soon as administratively possible after you timely notify the Eligibility and Enrollment Vendor.

## Changing Your BTPO, Health Care FSA and/or Dependent Care FSA Elections

Generally, you may not enroll, change, or drop your BTPO, Health Care FSA or Dependent Care FSA election(s) during a calendar year. However, election changes during the calendar year are permitted if you experience a Qualified Status Change and the election change is on account of and consistent with the Qualified Status Change event. The Plan Administrator has the discretion to determine whether an election change is on account of and consistent with the Qualified Status Change event.

## Qualified Status Changes

The following events are examples of Qualified Status Changes that **may** allow you to enroll, change or drop your BTPO, Health Care FSA and/or Dependent Care FSA election(s):

- Marriage, divorce or legal separation of a Participant
- Birth or adoption of a child
- Death of a spouse, child or other dependent
- Gain or loss of a dependent
- Commencement or termination of employment of the Participant or spouse
- Switching from part-time to full-time employment status or vice versa by the Participant or spouse
- Taking or returning from an unpaid leave of absence of 30 days or more by the Participant or spouse

For more information regarding specific Qualified Status Changes, see *Appendix C.*

You must contact the Eligibility and Enrollment Vendor within 31 days of any Qualified Status Change if you want to change your BTPO, Health Care FSA or Dependent Care FSA election(s); provided if the Qualified Status Change event is the death of your covered dependent, the 31-day notice period does not apply. You will not be allowed to change these election(s) if you notify the Eligibility and Enrollment Vendor after this time period. The change in these election(s) will be effective as soon as administratively possible after you timely notify the Eligibility and Enrollment Vendor of your Qualified Status Change. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section on Page 64 for contact information.

## Rehire and Return to Work Situations

If your employment terminates or you go on a leave of absence and you subsequently return to work within the same calendar year, you may make new elections, provided that you return to the Payroll more than 30 days after you terminated employment or went on a leave of absence. If

you return to the Payroll within 30 days during the same calendar year, your prior elections will be reinstated.

### *Leave of Absence*

If you go on a paid leave of absence, your participation in the Plan will continue as if you remained actively employed. If you go on an unpaid leave of absence, your before-tax contributions will cease, and you will be given the opportunity to continue making contributions through the end of the calendar year to your Health Care FSA on an after-tax basis through a direct bill process.

If you elect to make after-tax contributions to your Health Care FSA through the direct bill process, current guidelines provide that billing notices are sent on the 15th of each month for the following month. Your full payment is due by the first day of each month, with a 60-day grace period. If full payment is not received before the end of your grace period, your right to make after-tax contributions while on a leave of absence shall terminate.

## Disability

If you are receiving short-term disability benefits under a Company-sponsored disability benefit plan, your Health Care FSA and Dependent Care FSA deductions will continue to be deducted from your benefits check. Since your disability does not affect your eligibility to participate in the Plan, your disability *is not* a Qualified Status Change for purposes of the Health Care FSA, and you may not elect to change your Health Care FSA contributions upon your disability. However, your disability *is* a Qualified Status Change for purposes of the Dependent Care FSA, and you may elect to change your Dependent Care FSA contributions upon your disability.

## Modifications Required by the Plan Administrator

The Plan Administrator may modify your election(s) downward during the Plan Year if you are a key Employee or highly compensated individual (as defined by the Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of federal income tax law. Additionally, if a mistake is made (i) as to your eligibility or participation, (ii) the allocations made to your account(s), or (iii) the amount of benefits to be paid to you or another person, then the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under the Code and other applicable law, allocate, withhold, accelerate or otherwise adjust such amounts as will, in its judgment, accord the credits to the account or distributions to which you are or such other person is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due from your compensation.

# HOW THE HSA AND FSA WORK

## KEY POINTS

A. *Your HSA, Health Care FSA and/or Dependent Care FSA, as applicable, are each a tax-effective way to pay for certain types of eligible expenses.*

B. *Federal tax law places some restrictions on the use of HSA's, Health Care FSAs and Dependent Care FSAs because of their tax-free nature.*

C. *The tax benefits of participation in the Plan do NOT extend to coverage for a Domestic Partner (DP) or Legally Recognized Partner (LRP) and the DP or LRP's children unless the DP, LRP, or their children are dependents within the meaning of the Code.*

You may use your HSA, Health Care FSA and/or Dependent Care FSA, as applicable, as a tax-effective way to pay for certain types of eligible expenses. When you elect to make before-tax HSA Payroll Contributions or enroll in a Health Care FSA or Dependent Care FSA, you agree for your salary to be reduced on a before-tax basis instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. The amount by which you elect to reduce your salary and contribute to your HSA, Health Care FSA and/or Dependent Care FSA is taken from each of your paychecks on a before-tax basis on a pro-rata basis throughout the calendar year.

When you have eligible expenses, you first pay the bills as you normally do, then you submit them for reimbursement. You then use the money in your HSA, Health Care FSA and/or Dependent Care FSA, like cash, to reimburse yourself for eligible expenses. You do not pay taxes on the money set aside in your HSA, Health Care FSA and Dependent Care FSA. The tax advantage of the account is that you pay less federal, state (in most states), and local income tax (if applicable) and Social Security taxes, which increases the amount of your take home pay.

For example, assume you earn $30,000 per year, you elect to contribute $3,000 to your Health Care FSA or Dependent Care FSA and you have $3,000 in expenses eligible for reimbursement. Here's how participation in your FSA reimbursement accounts can reduce the amount of taxes you pay.

| | **With FSA (Before-Tax)** | **Without FSA (After-Tax)** |
|---|---|---|
| Annual Base Salary | $30,000 | $30,000 |
| Health Care FSA and/or Dependent Care FSA contributions | - 3,000 | - 0 |
| Taxable salary | $27,000 | $30,000 |
| Federal income tax (estimated*) | - 4,050 | - 4,500 |
| Social Security (FICA) tax (7.65%) | - 2,066 | - 2,295 |
| After-tax expenses | - 0 | - 3,000 |
| Take-home salary | $20,884 | $20,205 |
| **Tax Savings** | **$679** | |
| *In this example, by contributing on a before-tax basis to a Health Care FSA and/or Dependent Care FSA, you would increase your take home pay by $679.* <br> **Based on 15% tax rate.* | | |

## Limitations on Health Care FSA and Dependent Care FSA

Federal law places some restrictions on the use of Health Care FSAs and Dependent Care FSAs because of their tax-free nature. **Unless otherwise noted, these limitations DO NOT apply to an HSA.** Before you decide to have money deposited in a Health Care FSA or a Dependent Care FSA, you should understand the rules that govern their use.

- Contributions made to an HSA or a Health Care FSA cannot be used to cover expenses eligible for reimbursement under the Dependent Care FSA and vice versa.
- To be eligible for reimbursement from a Health Care FSA or a Dependent Care FSA, the eligible services need to be provided, or the eligible expense for products needs to be incurred, between Jan. 1 and Dec. 31 of the year during which you contributed to the Health Care FSA and/or Dependent Care FSA, and while you were an active Participant in the Health Care FSA and/or Dependent Care FSA.
- You have a three-month grace period after the year in which you contributed to the Health Care FSA and/or Dependent Care FSA to submit all requests for reimbursement of expenses incurred during that year. This means you must file all Claims by March 31 after the year during which you contributed to your Health Care FSA and/or Dependent Care FSA. If you do not timely file a Claim for reimbursement, you will forfeit any amounts remaining in your Health Care FSA or your Dependent Care FSA.
- Important: Federal law requires that you forfeit any funds remaining in your Health Care FSA and/or Dependent Care FSA after all eligible expenses for the year have been reimbursed. Therefore, you will want to carefully choose how much you elect to contribute to your Health Care FSA and/or Dependent Care FSA for the year.
- The amount available for reimbursement from your Health Care FSA at any time during the calendar year is the total amount you elected to have contributed for that year, less any reimbursements you already received for that year.

- The amount available for reimbursement from your Dependent Care FSA at any time during the calendar year is limited to the total amount actually contributed to your Dependent Care FSA at the time of your reimbursement request, less any reimbursements you already received for that year.
- You do not receive interest on amounts you contribute to your Health Care FSA and/or Dependent Care FSA.
- The tax benefits of participation in the Plan do NOT extend to coverage for a Domestic Partner (DP) or Legally Recognized Partner (LRP) and the DP or LRP's children unless your DP or LRP also qualifies as your dependent within the meaning of federal tax laws. For example, unless your DP or LRP qualifies as your dependent for federal tax purposes, you cannot:
    - Pay for Company-sponsored medical plan coverage for your DP or LRP and the DP or LRP's children on a before-tax basis.
    - Receive reimbursement from a Health Care FSA for otherwise eligible expenses incurred on behalf of your DP/LRP or your DP's/LRP's children.
    - Receive reimbursement from your Dependent Care FSA for otherwise eligible expenses incurred on behalf of your DP/LRP or your DP's/LRP's children.

## CONTRIBUTIONS

If you decide to make before-tax HSA Payroll Contributions or to establish a Health Care FSA and/or Dependent Care FSA under the Plan, contributions are deducted from your paycheck each pay period before taxes are taken out. Also, Eligible Contributions such as your Company-sponsored health care plan contributions and/or contributions for supplemental accidental loss insurance and dependent accidental loss insurance programs sponsored by AT&T, if any, will be deducted on a before-tax basis under the BTPO unless you elect otherwise.

If you are paying contributions for your Company-sponsored health care plan, including any option available under your Company-sponsored health care plan, on a before-tax basis and you elect to change your participation to another Company-sponsored health care plan that has a different monthly contribution, the amount deducted from your paycheck **will not change** for the remainder of the calendar year unless you experience a Qualified Status Change as described in the "Qualified Status Changes" section on Page 14 and in *Appendix C*. If you switch to another Company-sponsored health care plan within 31 days of a Qualified Status Change, then the amount of your contribution can change accordingly.

For example, if you elect to participate in an HMO under the Company-sponsored medical plan, you are required to pay contributions for that HMO coverage, and, if during the calendar year, you elect a different option (other than the HMO) with a higher or lower required employee contribution, but you do not experience a Qualified Status Change, the same amount as your original contributions will continue to be deducted from your pay on a before-tax basis. If the contribution for the newly elected Company-sponsored health care plan is more, the excess will be taken from your paycheck on an after-tax basis; if it is less, the higher amount will continue to be taken from your paycheck on a before-tax basis.

Your before-tax HSA Payroll Contributions and your Health Care FSA and/or Dependent Care FSA contributions are not subject to federal income taxes, state income taxes (in most states) or Social Security taxes. Because you reduce your income for Social Security tax purposes, your

contributions to Social Security will be reduced. However, since your final Social Security benefits are based on your entire earnings history, a reduction in your earnings for before-tax contributions under this Plan should have little effect on your final Social Security benefit. Participation in the Plan will not reduce your compensation for purposes of determining any other Company-sponsored benefits. Other Company-sponsored benefits (e.g., life insurance, pension and 401(k) savings) will continue to be based on your salary before your before-tax HSA Payroll Contributions or your contributions to your Dependent Care FSA and/or Health Care FSA are deducted from your paycheck. Before-tax HSA Payroll Contributions and Dependent Care FSA and Health Care FSA contributions will not be taken from special payments such as Team Award payments.

## BEFORE-TAX HEALTH SAVINGS ACCOUNT (HSA) PAYROLL CONTRIBUTIONS

### KEY POINTS

A. *If you elect to make before-tax Payroll contributions to an HSA, your HSA custodian(s) or trustee(s) is limited to one with whom the Company has entered into an arrangement to accept before-tax Payroll contributions.*

B. *To participate in the HSA, you must meet certain requirements: you cannot be enrolled in Medicare; you cannot be covered by another medical plan other than a high-deductible health plan, and you cannot be claimed as a dependent on someone else's tax return (for this purpose, a spouse is not considered a dependent).*

C. *You will not be allowed to make before-tax Payroll contributions to your HSA if you participate in a Full Health Care FSA – one that reimburses all of your eligible medical expenses. You may, however, be eligible to make before-tax HSA Payroll Contributions and participate in a Limited Health Care FSA – one that reimburses only your eligible dental, vision, and preventive care expenses.*

Before-tax HSA Payroll Contributions under this Plan are permitted to be made only to the HSA custodian(s) or trustee(s) with whom the Company has entered into an arrangement to accept before-tax Payroll contributions.

Neither the HSA nor the ability to make before-tax HSA Payroll Contributions is a Company-sponsored employee benefit plan – the HSA is an individual trust or custodial account that you open with an HSA trustee or custodian to be used primarily for reimbursement of eligible medical expenses. Consequently, the HSA trustee or custodian will establish and maintain your HSA. The Company has no authority or control over the funds deposited in your HSA. The Company's role is limited to allowing you to make before-tax Payroll contributions to an HSA and forwarding those funds to the HSA custodian or trustee that is authorized to accept before-tax HSA Payroll Contributions.

## HSA Eligibility

In order to participate in an HSA, you must satisfy certain conditions, as follows:

- You must be enrolled in a consumer-driven medical plan like the AT&T Medical Option under the AT&T Medical Plan, which is designed to meet the Code requirements for a high-deductible health plan with regard to nonbargained Employees and some bargained Employees.
- You cannot be enrolled in any part of Medicare.
- You cannot be covered by another medical plan that does not qualify as a high-deductible health plan, including coverage under a Full Health Care FSA.
- You cannot be claimed as a dependent on someone else's tax return (for this purpose, a spouse is not considered a dependent).

## Your HSA

Before you decide to have money deposited in an HSA, you should understand the rules that govern their use.

- You may increase, decrease or stop your before-tax HSA Payroll Contributions at any time for any reason.
- Your maximum monthly HSA contribution is limited to the amount authorized under the Code.
- Under the Plan, catch-up before-tax HSA Payroll Contributions are not permissible until the first of the month following your 55th birthday and are limited to a monthly amount equal to 1/12 of the maximum annual catch-up amount. However, you may make catch-up contributions to your HSA beginning in the calendar year that you turn 55 by making a deposit directly with your HSA provider.
- You may make an HSA contribution (or HSA catch-up contribution for any calendar year in which you turn 55 or older) by making a deposit directly with your HSA provider, up to the maximum lawful amount. In this case, the monthly maximum limitation does not apply if you are eligible to make an HSA contribution on Dec. 1, but you must remain HSA eligible through Dec. 31 of the following calendar year to avoid adverse tax consequences.
- You can receive reimbursement of eligible medical care expenses from your HSA at any time in accordance with the rules established by your HSA custodian or trustee.
- Eligible expenses must be incurred after your HSA is created in order to be reimbursed from your HSA.
- The maximum reimbursement from your HSA at any point in time is limited to the amount that is in your HSA at the time that you seek reimbursement.
- You do not forfeit amounts contributed to an HSA that are not reimbursed by the end of the year.
- Your HSA belongs to you, and the funds in your HSA are available to you even after your employment with the Company ends.

## Limitations Applicable to Health Care FSAs and HSA Participants

You will not be allowed to make tax-favored contributions to your HSA if you or your spouse participates in a Full Health Care FSA – one that reimburses all of your eligible medical expenses. You may, however, be eligible to make tax-favored contributions to an HSA and participate in a Limited Health Care FSA – one that reimburses only your eligible dental, vision and preventive care expenses.

If you elect to make before-tax HSA Payroll Contributions, you will not be permitted to contribute to a Full Health Care FSA, but you will be permitted to contribute to a Limited Health Care FSA. In addition, if you do not elect to make before-tax HSA Payroll Contributions, but you plan to do so later during the year, or you have set up or plan to set up an HSA outside of the before-tax HSA Payroll Contributions, you must contact the Eligibility and Enrollment Vendor at the time you make your Health Care FSA election and designate your Health Care FSA as “limited.”

In either case, this means that your Health Care FSA participation will be limited to reimbursement of qualified expenses for dental, vision and preventive care from a non-network provider. For example, out-of-pocket expenses for contact lenses, eyeglasses and orthodontia would be considered qualified expenses. Your eligible medical expenses could be reimbursed through your HSA. This would include, for example, all medical expenses up to your deductible, coinsurance for office visits and copayments for prescription drugs.

If you elect to make before-tax HSA Payroll Contributions and you elect to contribute to a Health Care FSA, and you later drop the HSA, your withdrawals from the Health Care FSA will continue to be limited to reimbursements for dental, vision and preventive care expenses for the remainder of the year.

Some employers’ health care FSA plans allow participants to receive reimbursement of eligible expenses for services provided during the calendar year or within the first two and one-half months of the following calendar year. If you contributed to one of these health care FSA plans, you will not be permitted to make before-tax HSA Payroll Contributions until April 1 after the lapse of the two and one-half month period, even if your health care FSA plan has no remaining funds. The AT&T Flexible Spending Account Plan does not allow health care FSA reimbursements for services received and paid after the end of the calendar year.

# HEALTH CARE FSA

## KEY POINTS

A. *Before-tax contributions to a Health Care FSA can be used to reimburse eligible out-of-pocket expenses incurred on your behalf or on behalf of your "Eligible Dependents."*

B. *If you make before-tax HSA Payroll Contributions under this Plan, the types of eligible expenses that can be reimbursed from your Health Care FSA generally will be limited to dental, vision, and preventive care expenses.*

C. *If you don't make before-tax HSA Payroll Contributions under this Plan, expenses incurred for "medical care" within the meaning of Section 213(d) of the Internal Revenue Code may be reimbursed.*

D. *The minimum and maximum Health Care FSA contributions vary by Eligible Employee group.*

You may use your Health Care FSA to reimburse yourself for eligible health care expenses incurred on your or your Eligible Dependent's behalf that are not reimbursed by any other health care plan.

The Plan offers the opportunity to make before-tax contributions to a Health Care FSA, and these contributions are used to reimburse eligible out-of-pocket expenses. The types of eligible expenses that can be reimbursed from your Health Care FSA will be limited to dental, vision and preventive care expenses if you make before-tax HSA Payroll Contributions under this Plan, or if you designate your Health Care FSA as "limited" by calling the Eligibility and Enrollment Vendor when you elect your Health Care FSA. If you do not make before-tax HSA Payroll Contributions, all otherwise eligible expenses can be reimbursed from your Health Care FSA.

| If you are ... | Then ... |
|---|---|
| **A bargained Eligible Employee or nonmanagement nonunion Employee**<br><br>(except AIS-CA/NV, AIS-NMNU, ATTVS-SBVS District 6 CWA, BLS Represented, BLS Special Represented, DGA-NMNU, L. M. Berry NMNU, PBD-IBEW Local 2139, SBCIS-NIC, SBCIS-NICP, SGI Local 121C and Local 540M, Southeast Region NMNU, SWBAG and Tier 1 DSL Customer Assistant) | You may elect to contribute to a Health Care FSA, and there are no limitations on the types of eligible expenses that are reimbursable from your Health Care FSA. |
| **A BLS Represented, BLS Special Represented, and L. M. Berry NMNU Eligible Employee** | You are not eligible to contribute to a Health Care FSA. |
| | ***Table continued on next page*** |

<table>
<tr><th>If you are …</th><th>and …</th><th>Then …</th></tr>
<tr><td rowspan="3">A management Eligible Employee; or<br>A bargained Eligible Employee or nonmanagement nonunion Eligible Employee of one of the following Employee groups:<br>AIS-CA/NV<br>AIS-NMNU<br>ATTVS-SBVS District 6 CWA<br>DGA-NMNU<br>PBD-IBEW Local 2139<br>SBCIS-NIC<br>SBCIS-NICP<br>SGI Local 121C and Local 540M<br>Southeast Region NMNU<br>SWBAG<br>Tier 1 DSL Customer Assistant</td><td>• You are making before-tax HSA Payroll Contributions; or<br>• You are making contributions to an HSA (or intend to make contributions to an HSA) and you designated your Health Care FSA as “limited” by calling the Eligibility and Enrollment Vendor at the time you elect your Health Care FSA.</td><td>You may contribute to a Health Care FSA, but your reimbursements will be limited to eligible dental, vision and/or preventive care expenses ONLY, i.e., your Health Care FSA will be designed as a Limited Health Care FSA.</td></tr>
<tr><td>You are not contributing to an HSA.</td><td>You may contribute to a Health Care FSA, and there will be no limitations on the types of eligible expenses that are reimbursable from your Health Care FSA, i.e., your Health Care FSA will be designated as a Full Health Care FSA.</td></tr>
<tr><td>You contribute to an HSA but are not making before-tax HSA Payroll Contributions, and you did not call the Eligibility and Enrollment Vendor to designate your HSA as “limited.”</td><td>You may contribute to a Health Care FSA, and there will be no limitations on the types of eligible expenses that are reimbursable from your Health Care FSA, however, you may not be eligible to make tax-favored contributions to your HSA.</td></tr>
</table>

If you elect to make contributions to a Health Care FSA during annual enrollment or when you are first eligible to participate in the Plan, and it is a Full Health Care FSA because you did not also elect to make before-tax Payroll contributions to an HSA, you will not be allowed to make before-tax HSA Payroll Contributions. However, you may change the character of your Health Care FSA from “Full” to “Limited” at any time during the calendar year (without experiencing a Qualified Status Change event), and the change will be effective on the first day of the month following a reasonable period of time after you notify the Eligibility and Enrollment Vendor. If you have a Limited Health Care FSA, you may make before-tax HSA Payroll Contributions effective on the same date that your Full Health Care FSA is converted to a Limited Health Care FSA. Upon conversion, all amounts in your Health Care FSA, regardless of when contributed, are “Limited.”

## Health Care FSA Contribution Limits

The minimum and maximum Health Care FSA contributions vary by Eligible Employee group and his or her Participating Company. See *Appendix A* for an explanation of Eligible Employee Group terms. See *Appendix B* for a listing of your Eligible Employee Group, Eligibility Waiting Period, and minimum and maximum Health Care FSA contribution amounts.

## Your Health Care FSA

If you elect to contribute to a Health Care FSA, an account will be set up in your name to keep a record of the before-tax contributions you make and the reimbursements you are entitled to receive. Your Health Care FSA is a bookkeeping account and is not funded; all reimbursements are paid from the Company's general assets.

## Eligible Dependents

Eligible expenses incurred on your behalf or on behalf of your Eligible Dependents may be reimbursed from your Health Care FSA. For this purpose, your *Eligible Dependents* are:

- Your spouse;
- A "qualifying child" as defined in the Code; **or**
- A "qualifying relative" as defined in the Code.

A *qualifying child* is an individual who:

- Is your child, brother, sister, stepbrother or stepsister or the descendant of any of these individuals;
- Is younger than the Eligible Employee, unless the child is permanently and totally disabled;
- Lives in your home for more than half of the year;
- Is a citizen, national or resident of the U.S. or a resident of Canada or Mexico;
- Is under the age of 19 at the end of the year or is a full-time student under the age of 24 at the end of the year, but there is no age limitation if the individual is totally and permanently disabled;
- Has not provided over half of his or her own support during the year; and
- Has not filed a joint tax return (other than only for claim of refund) with his or her spouse for the year.

A *qualifying relative* is an individual who:

- Is your child (or your child's descendant), brother, sister, stepbrother, stepsister, mother or father (or an ancestor of your mother or father), stepmother, stepfather, niece, nephew, aunt, uncle, son-in-law, daughter-in-law, mother-in-law, father-in-law, sister-in-law, brother-in-law, or any other individual who, for the calendar year, has your same principal place of abode in a manner that is not prohibited by local law;
- Receives over half of his or her support from you; and
- Is not your or anyone else's "qualifying child."

You may receive reimbursement of otherwise eligible expenses that you incur on behalf of your Domestic Partner (DP) or Legally Recognized Partner (LRP) and their dependent(s) only if your DP or LRP and their dependent(s) are a "qualifying child" or a "qualifying relative" for federal income tax purposes.

## Eligible Expenses

For eligible expenses to be reimbursed, they must have been incurred during the calendar year and while you are an active Participant in the Plan. An expense is incurred when the service that causes the expense is provided, not when you pay the expense. If you have paid the expense but the services have not yet been rendered, then the expense has not been incurred and cannot be reimbursed until after the service is rendered. If you incur an otherwise eligible expense while you are on an unpaid leave of absence, it is not reimbursable from your Health Care FSA since you are not an 'active Participant' in the Plan at that time. However, if you have elected to extend your participation in the Health Care FSA through COBRA, claims for expenses incurred during your COBRA period may be reimbursable.

Only Eligible Expenses that have not been reimbursed by another plan or insurance may be reimbursed. Contributions or premiums for coverage are not reimbursable from your Health Care FSA.

Eligible Expenses that may be reimbursed from your Health Care FSA depend on whether you are contributing to a Full Health Care FSA or a Limited Health Care FSA. (See the "Limitations Applicable to Health Care FSAs and HSA Participants" section on Page 21 for more information on a Full Health Care FSA and Limited Health Care FSA.)

Eligible Expenses that may be reimbursed from your *Limited* Health Care FSA are expenses incurred for:

- Services or treatments for dental care;
- Services or treatments for vision care; or
- Services or treatment for "preventive care." Preventive care is generally defined to include any service to the extent necessary (1) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (i.e., the individual is asymptomatic); (2) to prevent the recurrence of a condition from which the eligible individual has recovered; or (3) as part of a preventive care treatment program (e.g., smoking cessation programs). Preventive care does not include services or treatments that treat an existing condition.

Eligible Expenses that may be reimbursed from your *Full* Health Care FSA are expenses incurred for "medical care" within the meaning of Section 213(d) of the Code. Below is a *partial* list of eligible health care expenses for which you may be reimbursed from your Full Health Care FSA.

- Fees for services performed by licensed physicians, dentists, chiropractors, podiatrists, optometrists, opticians, psychologists, osteopaths, therapists, nurses and technicians
- Health care and dental deductibles, coinsurance and copayments
- Vision care, such as contact lenses (including saline solution and enzyme cleaner), eyeglasses, laser eye surgery and eye examinations
- Hearing care, such as hearing aids and hearing examinations
- Prescription drugs, including insulin and birth control pills or other prescribed contraceptives
- Vitamins and tonics prescribed by a doctor if not taken as a food supplement or to preserve general health

- Expenses resulting from treatment in hospitals, clinics and other licensed medical facilities
- Prosthetic devices, including artificial limbs, artificial teeth, crutches, dentures, eyeglasses and hearing aids
- Over-the-counter medicines
- Expenses resulting from illness and procedures including the following:
    - Acupuncture
    - Ambulance
    - Braces
    - Braille-books and magazines
    - Christian Science practitioners' fees
    - Developmentally disabled persons' cost for special home
    - Handicapped persons' special schools, care and special equipment
    - Immunizations
    - In-vitro fertilization
    - Lamaze classes
    - Orthopedic shoes
    - Oxygen
    - Routine physical exams
    - Seeing-eye dog and upkeep
    - Wheelchair

For more information, refer to IRS Publication 502, which may be available at your local IRS office or at www.irs.gov/formspubs/index.html on the Internet. However, you should use this IRS publication with caution because it was prepared for purposes of describing medical expenses that are deductible for federal income tax purposes, not for the purpose of determining which expenses are reimbursable from a Health Care FSA. Not all expenses that are deductible for federal income tax purposes are reimbursable from a Health Care FSA.

## Ineligible Expenses

Below is a *partial* list of health care expenses that are *not* eligible for reimbursement from your Full Health Care FSA:

- Any expenses paid by any health care plan or reimbursed by insurance
- Professional services and medical treatments
- Cosmetic surgery that is not related to an accident or congenital defect

- Medical treatment, services or medicine that is illegal in the location where you receive it
- Nonprescription drugs (other than insulin) for smoking cessation programs
- Weight reduction programs that are not for the purpose of curing any specific ailment or disease, but are for the purpose of improving the individual's appearance, health and sense of well-being
- Equipment and supplies:
    - Air conditioner, even if prescribed by a physician, if it is permanently attached to your home
    - Bottled water bought to avoid drinking fluoridated city water
    - Cosmetics
    - Special food or beverage substitutes
    - Sundries, such as toothpaste and other toiletries
    - Installation of power steering in an automobile
    - Mobile telephones
- Miscellaneous expenses:
    - Expenses you incurred before or after you participate in the Health Care FSA or expenses for which you were reimbursed by another plan
    - Antiseptic diaper services
    - Athletic club expenses to keep physically fit
    - Babysitting expenses to enable you to see your physician
    - Boarding school fees for a healthy child to enable you to recuperate from an illness or injury, even if prescribed by a physician
    - Change of environment trips to boost the morale of an ailing person, even if recommended by a physician
    - Dance lessons, even if recommended by a physician
    - Domestic help, even if recommended by a physician, although the cost for nursing duties of domestic help may be claimed
    - Funeral, cremation, burial, cemetery plot, monument or mausoleum expenses
    - Health programs offered by resort hotels, health clubs and gyms
    - Health care expenses of your former spouse
    - Premiums/contributions for life insurance policies, disability income policies or for double indemnity or waiver of premium for disability or hospital income policies

- Premiums/contributions for health care coverage such as through your spouse's employer or an individual carrier
- Scientology fees
- Transportation costs of a disabled person to and from work
- Traveling costs to look for a new place to work, even if recommended by a physician
- Tuition and travel expenses to send a problem child to a special school for a beneficial change in environment
- Veterinary fees
- Vitamins, unless prescribed by a physician
- Psychoanalysis undertaken to satisfy curriculum requirements of student
- Expenses of divorce, where a doctor of psychiatry recommends divorce
- Contributions to state disability funds
- Electrolysis
- Wigs, where not medically necessary for mental health
- Maternity clothes
- Hair transplants
- Mechanical exercise device not specifically prescribed by a doctor
- Religious cult deprogramming
- Cost of illegal drugs or nonprescription drugs
- Marriage counseling provided by clergymen
- Tattoos and ear piercing
- Chauffeur services
- Cosmetic dental work (for example, teeth whitening and caps)

*Note: If you receive reimbursement for an ineligible expense from your Health Care FSA, you are responsible for repaying the money.*

## How to File Health Care FSA Claims

Many of your Health Care FSA Claims for reimbursement can be processed automatically and others require that you submit a written Claim for reimbursement.

### *Automatic Processing of Your Health Care FSA Claims*

If you are enrolled in a Company-sponsored health care plan managed by a Participating Administrator (See the "Participating Administrators" section on the next page for a list of Participating Administrators), your out-of-pocket medical expenses under your health care plan, such as copayments, coinsurance and deductibles, will automatically be reimbursed from your

Health Care FSA. The automatic Claims process is convenient and saves time by reducing the need for you to file Health Care FSA reimbursement Claims with the Claims Administrator for your eligible out-of-pocket expenses for health care services covered by certain Company-sponsored health care plans. The Participating Administrators will electronically submit your reimbursement Claims directly to the Claims Administrator of the Plan.

If you incur eligible out-of-pocket health care expenses through a *nonparticipating* administrator you are required to file paper Claims for reimbursement.

*Participating Administrators*

Participating Administrators that will automatically submit Health Care FSA reimbursement Claims to the Claims Administrator are:

- UnitedHealthcare (medical, including CarePlus and Medical Plus)
- Blue Cross and Blue Shield of Illinois (medical)*
- CVS Caremark (prescription drug)
- *ValueOptions* (mental health/chemical dependency; mental health/substance abuse)
- United Behavioral Health (mental health/substance abuse)
- CIGNA Dental (dental)
- Aetna (Medical)
- Humana (Medical)
- EyeMed Vision Care (vision)*

**EyeMed Vision Care can only process copayments automatically. Therefore, you must submit a paper Claim for any additional out-of-pocket expenses incurred for vision services and/or products.*

If you do *not* wish to participate in automatic Claims processing or you choose to discontinue participation at any time, you must call the Healthcare FSA Claims Administrator (see the *Claims Administrator for the Plan* table in the “Contact Information” section on Page 64 for contact information) and decline to participate. Your participation will be terminated immediately. This action will not affect your continued participation in the Health Care FSA for the remainder of the calendar year – it will only affect how your Claims are filed.

### *Filing Written Claims for Processing of Your Health Care FSA Claims*

You must submit a paper Claim if you choose not to participate in automatic Claims processing or you incur eligible out-of-pocket medical care expenses at any time during the year through a nonparticipating administrator (for example, you purchase saline solution for your contact lenses from a local retailer). Since the local retailer is not a Participating Administrator, you must submit a paper Claim, along with your paid receipt, to receive a reimbursement check from your Health Care FSA.

Follow these steps to file a written Claim for reimbursement from your Health Care FSA:

- Pay the expense by its due date. Do not wait to pay the expense until you receive your reimbursement from your Health Care FSA.

- Obtain a claim form from the SHPS Internet site at www.myshps.com or by calling the SHPS Service Center (see the *Claims Administrator for the Plan* table in the "Contact Information" section on Page 64 for contact information).
- Provide a receipt from the health care provider. If your expense is partially covered by your health plan, provide a copy of your health plan's explanation of benefits (EOB). If you are filing a Claim for reimbursement of expenses related to your purchase of a prescription drug, the name of the drug must be included on a Claim for prescription reimbursement.
- Complete and submit your signed *Health Care Flexible Spending Request Form* and receipt(s) to the address on the bottom of the form. Claim forms and receipts also can be faxed to the number provided on the claim form (see the *Claims Administrator for the Plan* table in the "Contact Information" section on Page 64 for contact information).
- When mailing your claim form, be sure to keep a copy of the receipt and your claim form in case you are asked to provide more information about your Claim.
- Mail or fax your claim form and receipt(s) any time during the Plan Year and before March 31 of the following year after the year during which you contributed to your Health Care FSA.

## Reimbursement From Your Health Care FSA

### *Available Reimbursement Amounts*

The amount available for reimbursement from your Health Care FSA at any time throughout the Plan Year is the total amount elected for the Plan Year, *less* any reimbursements you already received for that Plan Year.

You cannot carry over a balance in your Health Care FSA from one Plan Year to the next. If you have not incurred enough eligible expenses by Dec. 31 to claim all deposits made to your Health Care FSA, the law requires you to forfeit any money remaining in your Health Care FSA.

You have until March 31 of the next year to file Claims for expenses incurred during the previous Plan Year while you were a Participant in the Plan. Claims must be received by March 31 of the following year.

Health Care FSA forfeitures and uncollected Health Care FSA benefits shall be used to offset any losses experienced by the Plan Administrator or the Company resulting from reimbursements to Participants in the Health Care FSA portion of the Plan that are in excess of Health Care FSA salary reductions and then to reduce the cost of administering the Dependent Care FSA portion of the Plan.

### *Receiving Reimbursement*

After your Claim for reimbursement is processed and approved, the Claims Administrator will send you a reimbursement check for eligible expenses incurred up to the amount you elected to contribute to your Health Care FSA, reduced by any reimbursements you have already received. Your reimbursement check is generally mailed within two weeks after it is processed and approved. Your reimbursement check will be attached to an Explanation of Benefits (EOB) that details the Claim payment.

You can choose to have your reimbursement amount electronically deposited directly into your checking or savings account. With electronic funds transfer (EFT) you can begin receiving your

Claim payments within a few days after your Claim is processed. If you provide the Claims Administrator with your email address, you will be provided notification of reimbursement activity and account activity statements. With email communications, you can receive a complete EOB statement (total expense paid, partial payment or full denial) whenever a Claim is processed.

If you would like to participate in EFT, you may elect direct deposit on the SHPS website at www.myshps.com or you may complete an *Electronic Funds Transfer Form* and mail it to:

SHPS, Inc.
Attention: AT&T Automatic Claims Processing
11405 Bluegrass Parkway
Louisville, KY 40299

You may obtain the *Electronic Funds Transfer Form* by accessing the SHPS Web site at www.myshps.com or by calling **800-283-3211**.

# DEPENDENT CARE FSA

## KEY POINTS

A. *The Dependent Care FSA is designed to help you pay for Eligible Dependent care expenses so you and your spouse (if applicable) can work or look for work.*

B. *The maximum amount you may contribute to a Dependent Care FSA in a calendar year depends on your federal income tax filing status, whether your spouse participates in a similar plan, and your and your spouse's earned income.*

The Dependent Care FSA is a separate program under the Plan that is set up to help you pay for Eligible Dependent care expenses for your Eligible Dependents so you and your spouse (if applicable) can *work* or *look for work*. If you are a BLS Special Represented Employee, you are not eligible to contribute to a Dependent Care FSA.

## Dependent Care FSA Contribution Limits

The *minimum* amount you may contribute to a Dependent Care FSA in a calendar year is $100.

The *maximum* amount you may contribute to a Dependent Care FSA in a calendar year depends on:

- Your filing status for federal income tax purposes.
- Whether your spouse participates in a similar plan offered by his or her employer.
- The earned income of you and your spouse.

### *Limitations Based on Federal Income Tax Filing Status*

The maximum amount you may contribute to a Dependent Care FSA in a calendar year is $5,000 if:

- Your filing status is single, head of household or married filing jointly.
- Your filing status is married filing separate, but only if all of the following apply:
  - You do not reside in the same household with your spouse during the last six months of the year.
  - Your home is the principal home for the dependent for whom you incur the dependent care expenses for at least six months during the year.
  - You provide over half of the cost of maintaining your household.

The maximum amount you may contribute to a Dependent Care FSA in a plan year is $2,500 if your filing status is *married filing separate* and you reside in the same household with your spouse.

### *Limitations Based on Spouse's Participation in Another Dependent Care FSA Plan*

If your spouse makes contributions to a similar dependent care reimbursement account through a plan offered by his or her employer, the combined maximum amount you and your spouse may contribute to both dependent care accounts cannot exceed $5,000.

### *Limitations Based on Earned Income*

Also, if you are married and filing a joint return, your Dependent Care FSA contribution is limited to the lesser of your earned income, your spouse's earned income or $5,000. However, if your spouse is a full-time student or is physically or mentally incapable of self-care, your spouse's monthly income is assumed to be $250 if you have one qualifying dependent, or $500 if you have two or more qualifying dependents.

If you are single, the maximum Dependent Care FSA contribution is limited to the lesser of your earned income or $5,000.

## Your Dependent Care FSA

If you elect to contribute to a Dependent Care FSA, an account will be set up in your name to keep a record of the before-tax contributions you make and the reimbursements you are entitled to receive. Your Dependent Care FSA is a bookkeeping account and is not funded; all reimbursements are paid from the Company's general assets.

To be eligible for reimbursement, your dependent care expenses must be employment-related, as described in the following table.

| If ... | Then ... |
|---|---|
| **You are single** | The care must be necessary in order for you to work or attend school* full time. |
| **You are married** | The care must be necessary for you and your spouse to work outside the home or for you to work while your spouse is:<br>• Looking for work<br>• A full-time student**<br>• Physically or mentally incapable of self-care |
| **You are divorced or separated** | You must have custody of your dependent to be eligible for reimbursement from the Dependent Care FSA. |

**The definition of "school" for Plan purposes means an educational organization that normally has a regular faculty and curriculum, and a regularly enrolled body of pupils or students in attendance at the place where its educational activities regularly are held.*

***"Full-time student" means a student for at least some part of each of five months during a calendar year, and for the number of hours considered to be a full-time course of study (if your spouse attends school only at night, he or she is not considered a full-time student).*

## Eligible Dependents

Eligible expenses incurred on behalf of your Eligible Dependents may be reimbursed from your Dependent Care FSA. For this purpose, your *Eligible Dependents* are:

- Your spouse if he/she is physically or mentally incapable of caring for himself/herself AND has the same residence as you for more than half the calendar year;
- A "qualifying child" who has not attained age 13 (the age limitations in the "qualifying child" definition, below, are not applicable for this purpose); **or**
- A "qualifying child" or "qualifying relative" who, in either case, is physically or mentally incapable of caring for himself/herself AND has the same residence as you for more than half the calendar year.

A *qualifying child* is an individual who:

- Is your child, brother, sister, stepbrother or stepsister or the descendant of any of these individuals;
- Lives in your home for more than half of the year (temporary absences resulting from special circumstances, such as education, illness, military service, etc., will not cause an individual to lose his or her status as a qualifying child);
- Is a citizen, national or resident of the U.S. or a resident of Canada or Mexico;
- Is under the age of 19 at the end of the year or is a full-time student under the age of 24 at the end of the year, but there is no age limitation if the individual is totally and permanently disabled; **and**

- Has not provided over half of his or her own support during the year.

Eligible expenses are reimbursable from your Dependent Care FSA. The age limitations applicable to your child for whom your eligible expenses can be reimbursed from your Dependent Care FSA are as follows:

- If your child is under the age of 13;
- If your child is under the age of 19 (24 if in school) and is physically or mentally incapable of self-care; **or**
- If your child, regardless of age, is totally and permanently disabled.

A *qualifying relative* is an individual who:

- Is your child (or your child's descendant), brother, sister, stepbrother, stepsister, mother or father (or an ancestor of your mother or father), stepmother, stepfather, niece, nephew, aunt, uncle, son-in-law, daughter-in-law, mother-in-law, father-in-law, sister-in-law, brother-in-law, or any other individual who, for the calendar year, has your same principal place of abode in a manner that is not prohibited by local law;
- Receives over half of his or her support from you; **and**
- Is not your or anyone else's "qualifying child."

You may receive reimbursement of otherwise eligible expenses that you incur on behalf of your Domestic Partner (DP) or Legally Recognized Partner (LRP) and their dependent(s) only if your DP or LRP and their dependent(s) are a "qualifying child" or a "qualifying relative" for federal income tax purposes.

## Eligible Expenses

For eligible expenses to be reimbursed, they must have been incurred during the calendar year and while you are an active Participant in the Plan. An expense is incurred when the service that causes the expense is provided, not when you pay the expense. If you have paid the expense but the services have not yet been rendered, then the expense has not been incurred and cannot be reimbursed until after the service is rendered. If you incur an otherwise eligible expense while you are on an unpaid leave of absence, it is not reimbursable from your Dependent Care FSA since you are not an 'active Participant' in the Plan at that time.

The following is a list of dependent care expenses eligible for reimbursement from your Dependent Care FSA:

- Amounts paid to a licensed care center if the care complies with local and state regulations and provides care for more than six individuals, such as a daycare center, preschool (less than kindergarten level), summer day camp or after-school care
- Costs incurred for care inside your home, such as a babysitter or home health care worker, but not for care provided by anyone considered your dependent for income tax purposes or your child under the age of 19
- Amounts paid for nonresidential dependent care or nursing or custodial care, but only if your Eligible Dependent lives with you at least eight hours a day
- Costs incurred for household services related to care of a qualifying dependent

- Social Security and other taxes you pay a care provider

For more information, refer to IRS Publication 503, which may be available at your local IRS office or at www.irs.gov/formspubs/index.html on the Internet. However, you should use this IRS publication with caution because it was prepared for purposes of describing dependent care expenses that are eligible for the dependent care tax credit, not for the purpose of determining which expenses are reimbursable from a Dependent Care FSA. Not all expenses that are eligible for the dependent care tax credit are reimbursable from a Dependent Care FSA.

## Ineligible Expenses

The following is a list of dependent care expenses *not* eligible for reimbursement from your Dependent Care FSA:

- Expenses incurred before or after you participate in the Dependent Care FSA or expenses for which you were reimbursed by another plan
- Expenses for care provided by anyone considered your dependent for income tax purposes, or by your child who is under the age of 19, are not eligible for reimbursement from your Dependent Care FSA
- Expenses for care provided by a facility that cares for more than six children if the facility is NOT licensed by state and local governments
- Amounts you claim as a tax credit on your federal income tax return for the calendar year
- Expenses for overnight camp expenses
- Expenses for transportation to and from your dependent care provider
- Tuition expenses for kindergarten level and above
- Expenses for a finder's fee for placement of a nanny or au pair

*Note: If you receive reimbursement for an ineligible expense from your Dependent Care FSA, you are responsible for repaying the money.*

## How to File Dependent Care FSA Claims

All Claims for reimbursement from your Dependent Care FSA must be submitted in writing. Follow these steps to file a Claim for reimbursement from your Dependent Care FSA.

- Pay the expense by its due date. Do not wait to pay the expense until you receive your reimbursement from your Dependent Care FSA.
- Obtain a claim form from the SHPS Internet site at www.myshps.com or by calling the SHPS Service Center (see the *Claims Administrator for the Plan* table in the "Contact Information" section on Page 64 for contact information.
- Obtain a receipt or an itemized statement with dates of services from the provider. You must include the signature and the tax identification number or Social Security Number of the care provider on the claim form. The completed claim form will serve as your dependent care receipt.

- Complete and submit your signed *Dependent Care Reimbursement Form* and receipt(s) to the SHPS address on the bottom of the form. Claim forms and receipts also can be faxed to the number provided on the claim form (see the *Claims Administrator for the Plan* table in the “Contact Information” section on Page 64 for contact information).
- When mailing your claim form, be sure to keep a copy of the receipt and your claim form in case you are asked to provide more information about your Claim.
- Mail or fax your claim form and receipt(s) any time during the Plan Year and before March 31 of the following year after the year during which you contributed to your Dependent Care FSA.

## Reimbursement From Your Dependent Care FSA

### *Available Reimbursement Amounts*

The amount available for reimbursement from your Dependent Care FSA at any time throughout the Plan Year is limited to the total amount contributed to your Dependent Care FSA at the time of your Claim, *less* any reimbursements you already received for that Plan Year. If your Claim is for more than your account balance, you will be reimbursed as additional contributions are made to your account.

You cannot carry over a balance in your Dependent Care FSA from one Plan Year to the next. If you have not incurred enough eligible expenses by Dec. 31 to claim all deposits made to your Dependent Care FSA, the law requires you to forfeit any money remaining in your Dependent Care FSA.

You have until March 31 of the next year to file Claims for expenses incurred during the previous Plan Year while you were a Participant in the Plan. Claims must be received by March 31 of the following year.

Dependent Care FSA forfeitures and uncollected Dependent Care FSA benefits shall be used to reduce the cost of administering the Dependent Care FSA portion of the Plan.

### *Receiving Reimbursement*

After your Claim for reimbursement is processed and approved, the Claims Administrator will send you a reimbursement check, up to the amount of your elected amount reduced by any reimbursements you have already received. Your reimbursement check is generally mailed within two weeks after it is processed and approved. Your reimbursement check will be attached to an Explanation of Benefits (EOB) that details the Claim payment.

You can choose to have your reimbursement amount electronically deposited directly into your checking or savings account. With electronic funds transfer (EFT) you can begin receiving your Claim payments within a few days after your Claim is processed. If you provide the Claims Administrator with your email address, you will be provided notification of reimbursement activity and account activity statements. With email communications, you can receive a complete EOB statement (total expense paid, partial payment or full denial) whenever a Claim is processed.

If you would like to participate in EFT, you may elect direct deposit on the SHPS website at www.myshps.com or you may complete an *Electronic Funds Transfer Form* and mail it to:

SHPS, Inc.
Attention: AT&T Automatic Claims Processing
11405 Bluegrass Parkway
Louisville, KY 40299

You may obtain the *Electronic Funds Transfer Form* by accessing the SHPS Web site at www.myshps.com or by calling **800-283-3211**.

### Dependent Care Tax Credit

The Dependent Care Tax Credit is a credit against your federal income tax liability. This credit is calculated as a percentage of your eligible annual dependent care expenses. In determining what your tax credit would be, you may take into account $3,000 of such expenses for one dependent or $6,000 for two or more dependents. Depending on your adjusted gross income, the percentage could be as much as 35 percent of your qualifying expenses (to a maximum credit of $1,050 for one dependent or $2,100 for two or more dependents). The maximum 35 percent rate is reduced by 1 percent (but not below 20 percent) for each $2,000 portion (or any fraction of $2,000) by which your adjusted gross income exceeds $15,000. The minimum credit for eligible expenses relating to one dependent is $600 and $1,200 for two or more dependents.

You may not claim a tax credit on your federal income tax return for any dependent care expenses for which you are reimbursed through your Dependent Care FSA.

The maximum amount of Dependent Care Tax Credit you may claim is reduced, dollar-for-dollar, by amounts contributed to your Dependent Care FSA. The amount contributed is reported on your W-2 form, although it is not included as taxable income.

Although it is generally true that a Dependent Care FSA provides greater tax advantages than the Dependent Care Tax Credit, you should talk to a tax advisor about the specific advantages and disadvantages of each of them. Refer to IRS Publication 503, which may be available at your local IRS office or at www.irs.gov/formspubs/index.html on the Internet.

## WHEN COVERAGE ENDS

If your employment ends, your participation in the Plan ends on the last day of the month in which your employment ends. However, you may elect to continue participation in the Health Care FSA if you continue making contributions as provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA), which would allow you to avoid a forfeiture of the funds remaining in your account. See the “COBRA Continuation Coverage” section on Page 38 for additional information about COBRA. You have until March 31 of the calendar year following the year during which you were a Participant in the Plan to submit Claims to your Health Care FSA and Dependent Care FSA for expenses *incurred while you were a Participant.*

# EXTENSION OF COVERAGE — COBRA

### KEY POINTS

*A. COBRA continuation coverage is a temporary extension of your Health Care FSA participation when participation would otherwise end because of a life event known as a Qualifying Event. You may not continue your BTPO, HSA Payroll Contribution, or Dependent Care FSA under COBRA.*

*B. You may desire to elect and pay for Health Care FSA COBRA continuation coverage to avoid forfeiture of any unused goal amount that exists at the time your participation would otherwise end.*

*C. You must notify the Eligibility and Enrollment Vendor of a Qualifying Event no later than 60 days after the later of the date on which the Qualifying Event occurs or loss of coverage resulting from the Qualifying Event. If you or your Qualified Beneficiary do not elect Health Care FSA COBRA continuation coverage within the 65-day election period using the procedure described in this section, you will lose your right to elect COBRA continuation coverage.*

*D. If you fail to make the required COBRA premium payments within the allowable time period, your COBRA continuation coverage will end and you will not be able to reenroll.*

## COBRA Continuation Coverage

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity to elect a temporary extension of Health Care FSA coverage (referred to as “continuation coverage” or “COBRA continuation coverage”) in certain instances when coverage under your Health Care FSA would otherwise end.

This section generally explains COBRA continuation coverage for your Health Care FSA, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The COBRA Administrator is the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the “Contact Information” section on Page 64 for contact information.

## What Is COBRA Continuation Coverage?

COBRA continuation coverage is a temporary extension of your Health Care FSA participation when participation would otherwise end because of a life event known as a Qualifying Event. You may not continue your BTPO, HSA Payroll Contributions, or Dependent Care FSA under COBRA. Specific Qualifying Events are listed later in this section. After a Qualifying Event occurs, and any required notice is provided to the COBRA Administrator, Health Care FSA COBRA continuation coverage must be offered to a Qualified Beneficiary, provided you have a positive Health Care FSA balance at the time of the Qualifying Event (taking into account all claims submitted before the date of the Qualifying Event). A Qualified Beneficiary may desire to elect and pay for Health Care FSA COBRA continuation coverage to avoid forfeiture of any unused goal amount that exists at the time participation or coverage would otherwise end.

You are a Qualified Beneficiary if you lose coverage under the Health Care FSA provisions of the Plan because of a Qualifying Event. Your spouse and dependents whose medical expenses are reimbursable under the Health Care FSA are each a Qualified Beneficiary if, because of a Qualifying Event, you lose coverage or their medical expenses are no longer reimbursable under the Health Care FSA provisions of the Plan. Only a Qualified Beneficiary may elect to continue their Health Care FSA coverage under COBRA. A Qualified Beneficiary who elects Health Care FSA COBRA continuation coverage must pay for Health Care FSA COBRA continuation coverage.

Ordinarily, the Health Care FSA continuation coverage that is offered will be the same coverage that the Qualified Beneficiary had on the day before the COBRA Qualifying Event occurred.

## COBRA Qualifying Events: When Is COBRA Coverage Available?

### *Eligible Employee*

If you are an Eligible Employee of a Participating Company and are a Participant in the Plan, you become a Qualified Beneficiary and have the right to elect Health Care FSA continuation coverage if you lose coverage under the Plan and you have a positive Health Care FSA balance at the time of the Qualifying Event because either one of the following two Qualifying Events occurs:

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

### *Spouse*

If you are the spouse of an Eligible Employee covered by the Program, you will become a Qualified Beneficiary and have the right to elect continuation coverage if you lose coverage under the Program because any of the following three Qualifying Events occurs:

- Your spouse dies.
- Your spouse's employment ends for any reason other than his or her gross misconduct or your spouse's hours of employment with the Participating Company are reduced.
- You become divorced or legally separated from your spouse.

**Note:** *If an Eligible Employee eliminates coverage for his or her spouse in anticipation of a divorce or legal separation and the divorce or legal separation occurs, then the actual divorce or legal separation will be considered a Qualifying Event, even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Eligibility and Enrollment Vendor within 60 days after the later of the divorce or legal separation or the date coverage terminates under the Program and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.*

### *Children*

A dependent child will become a Qualified Beneficiary and have the right to elect continuation coverage if the Eligible Employee loses eligibility for a Health Care FSA under the Program or the dependent ceases to be an Eligible Dependent whose expenses are no longer reimbursable under the Health Care FSA provisions of the Plan because any of the following four Qualifying Events occurs:

- The Eligible Employee-parent dies.

- The Eligible Employee-parent's employment ends for reasons other than gross misconduct or the Eligible Employee-parent's hours of employment with the Participating Company are reduced.
- The parents divorce or legally separate.
- The child ceases to be eligible as an Eligible Dependent child under the Health Care FSA.

### *FMLA*

Special COBRA rules apply if an Employee takes FMLA leave and does 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 Qualifying Event (i.e., an Employee may elect Health Care FSA COBRA coverage). In this case, the Employee and the Employee's Eligible spouse and/or dependents, if any, will be entitled to elect Health Care FSA COBRA coverage if the Eligible Employee was covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave).

As a result, Eligible Employees may elect COBRA coverage to be effective on the day after the date on which employment is terminated (even if coverage had been terminated during a leave) if the Employee was both:

- Covered under the Plan on the day before beginning the leave of absence.
- Terminated from employment within the first six months of the leave for any reason except gross misconduct.

## Important Notice Obligations

The Plan will offer Health Care FSA COBRA continuation coverage to you or a Qualified Beneficiary only after the Eligibility and Enrollment Vendor has been timely notified that a Qualifying Event has occurred.

### *Your Employer's Notice Obligations*

When the Qualifying Event is the end of employment, the reduction of hours of employment, or death of the Eligible Employee, the Company will notify the Eligibility and Enrollment Vendor of the Qualifying Event within 30 days of the event. The Eligibility and Enrollment Vendor will then notify you of your right to elect continuation coverage.

### *Your Notice Obligations*

For a Qualifying Event other than the end of employment, the reduction of hours of employment, or the death of the Eligible Employee, you or the Qualified Beneficiary are responsible for notifying the Eligibility and Enrollment Vendor. You or the Qualified Beneficiary must provide this notice, using the procedures specified in the "COBRA Notice and Election Procedures" section on Page 41, no later than 60 days after the date the event occurs. (See the "When Coverage Ends" section on Page 37 for more details.)

If you or a Qualified Beneficiary fail to provide this notice to the Eligibility and Enrollment Vendor during this 60-day notice period (using the procedures specified), the option to elect continuation coverage will not be offered to you, your spouse or your dependent children.

Once the Eligibility and Enrollment Vendor receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to you and/or the Qualified Beneficiary if there is a positive Health Care FSA balance at the time of the Qualifying Event. If you or the

Qualified Beneficiary timely elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that the Plan coverage would otherwise have been lost.

## COBRA Notice and Election Procedures

A COBRA election notification must be provided to the Eligibility and Enrollment Vendor within the time frames specified below.

> **Important: COBRA Notice and Election Procedures**
>
> You must provide all required notification or make your COBRA election no later than the last day of the required notification period by placing a telephone call to the Eligibility and Enrollment Vendor at the telephone number provided in the "Contact Information" section on Page 64 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. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section on Page 64 for contact information.
>
> When you call to provide notice or elect coverage, you must provide the name and address and last four digits of the Social Security number of the Eligible Employee covered under the Plan and the name(s) and address(es) and last four digits of the Social Security number of the Qualified Beneficiary(ies) affected. If your notice concerns a Qualifying Event, you also must identify the Qualifying Event as well as the date on which the Qualifying Event(s) occurred.

If continuation coverage is desired, you (the Eligible Employee) and/or your Qualified Beneficiary must elect continuation coverage, using the election procedures described in the "COBRA Notice and Election Procedures" section above within 65 days after Plan coverage ends or, if later, 65 days after the date the Eligibility and Enrollment Vendor mails a notice of the right to elect continuation coverage to your last known address. **If you or your Qualified Beneficiary do not elect continuation coverage within this 65-day election period by 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 Qualified Beneficiary rejects continuation coverage, he or she may change his or her mind and enroll anytime until the end of the 65-day election period by using the required election procedure.

Each Qualified Beneficiary may elect continuation coverage individually under the Plan. For example, your spouse may elect continuation coverage even if you do not elect it. Parents may elect to continue coverage on behalf of their dependent children only.

## Paying for COBRA Continuation Coverage

Generally, each Qualified Beneficiary may be required to pay the entire cost of COBRA continuation coverage. The amount a Qualified Beneficiary is required to pay may not exceed 102 percent of the cost of coverage under the Health Care FSA, which is generally 102 percent of the remaining goal amount. Your election notice from the Eligibility and Enrollment Vendor will include the cost of COBRA continuation coverage. When you elect COBRA coverage, you will receive an initial bill from the Eligibility and Enrollment Vendor. You must make your first payment for COBRA 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 and will include the cost of COBRA coverage from the date COBRA coverage begins through the end of the month after the month in which the bill is issued. Claims for reimbursement of your Health Care FSA may not be processed and reimbursed until you have elected COBRA coverage and have made the first payment. Any amounts reimbursed from your Health Care FSA during this period will be canceled retroactively if you do not elect COBRA coverage or coverage is canceled because you do not make timely payments. Bills for subsequent coverage will be issued monthly. Payment is due on the first day of each month for coverage during that month, subject to a 60-day grace period. If you don't make the full premium payment by the due date or within the 60-day grace period, your COBRA coverage will be canceled retroactively for all COBRA coverage included in the bill to the last day of the month for which the full premium has been paid, with no possibility of reinstatement.

All COBRA coverage payments must be made by check and must be mailed to the address included on your bill. Payment will not be accepted at any other location or through any other means. Your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment if your check is returned for insufficient funds or otherwise.

## How Long Does COBRA Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. Health Care FSA COBRA continuation coverage will cease at the end of the calendar year and cannot be continued the next calendar year.

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

COBRA continuation coverage will automatically terminate when any one of the following three events occurs before the end of the calendar year:

- The premium for your COBRA coverage is not paid in full within the allowable grace period.
- If for any reason, other than a Qualifying Event, the Plan would terminate coverage of a Participant not receiving continuation coverage (such as fraud).
- The Company terminates the Plan with respect to all Employees.

# HOW TO FILE A CLAIM AND APPEAL UNDER THE PLAN

### KEY POINTS

A. *You may file a Claim if you do not agree with the way your participation in, or benefits under, the Plan are administered.*

B. *A Claim regarding your request for reimbursement from your Health Care FSA or your Dependent Care FSA must be filed with the Claims Administrator. All other Claims under the Plan must be filed with the Eligibility and Enrollment Vendor.*

C. *A denied Claim may be appealed within 180 days after receipt of the notice of denial.*

D. *You must pursue all of your claim and appeal rights under the Plan before seeking legal recourse in a court of law.*

## Claim Filing Procedures

Your Claim for Benefits is reviewed and determined by the Claims Administrator, which is either SHPS or the Eligibility and Enrollment Vendor, depending on the nature of your claim.

***Health Care FSA and/or Dependent Care FSA Reimbursement Claims***

Claims for reimbursement from your Health Care FSA or Dependent Care FSA must be submitted to SHPS. Claim forms may be obtained from the SHPS Internet site at www.myshps.com or by calling the SHPS Service Center. Claim forms and receipts may be submitted to SHPS via fax or by mail. See the *Claims Administrator for the Plan* table in the "Contact Information" section on Page 64 for contact information.

***All Other Claims***

All Claims that do not relate to reimbursement from your Health Care FSA or Dependent Care FSA must be submitted in writing to the Eligibility and Enrollment Vendor. These include Claims relating to BTPO, before-Tax HSA Payroll Contributions, enrollment or participation in any part of the Plan, and Plan election changes. Claims relating to the maintenance or administration of the HSA established and maintained outside of the Plan with your HSA trustee or custodian are administered by your HSA trustee/custodian in accordance with the HSA trust or custodial document between you and your trustee/custodian, and are not governed by this Plan's claims and appeal procedures.

If the Eligibility and Enrollment Vendor denies your enrollment or participation in the Plan on the basis of ineligibility or denies your request to change your BTPO, before-Tax HSA Payroll Contribution, Health Care FSA or Dependent Care FSA elections, you may call or send written correspondence to the Eligibility and Enrollment Vendor to attempt to resolve the issue. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section beginning on Page 64 for contact information. If the issue is not resolved to your satisfaction, you may file a written Claim for Eligibility. You may use a form provided by the Eligibility and Enrollment Vendor for this purpose.

## Processing Your Claim

Once you submit your written Claim, including any documentation that supports your Claim, the Claims Administrator will notify you of its decision within 30 days after the date your Claim is received. The Claims Administrator may extend this period once (for up to 15 days) if it determines that special circumstances require more time to determine your Claim. You will be notified within the initial 30-day period if additional time is needed and of the special circumstances that necessitate the extra time. If an extension is required because the Claims Administrator needs additional information from you, you will have 45 days from the date you receive notification to provide that information. Once you have provided the information, the Claims Administrator will decide your Claim within the time remaining in the initial or extended review period of 30 or 45 days, whichever is applicable.

## If Your Claim Is Denied

If your Claim is approved, you will receive notice from the Claims Administrator. If your Claim is denied in whole or in part, you will be provided written notice of the denial from the Claims Administrator. A written denial notice will contain:

- Specific reason(s) for the denial.
- Specific reference(s) to the Plan provisions or legal provisions on which the denial is based.
- If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied on 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 material or information necessary to make your Claim for Eligibility acceptable and the reason the information is needed.
- A description of the procedure by which you may appeal the denial of your Claim.
- A statement concerning your right to file a civil action under the Employee Retirement Income Security Act of 1974, as amended (ERISA), after the required reviews have been completed.

## How to Appeal a Denied Claim

If your Claim is denied and you disagree with the decision, you may appeal the decision by filing a written request for review. You or your authorized representative must make the request within 180 days after receipt of the denial notice. You may inquire about the status of a Claim via letter or telephone at any time. However, these inquiries are not considered formal appeals. It is not necessary to make an informal inquiry before filing an appeal.

Your appeal is reviewed and determined by SHPS, the Eligibility and Enrollment Vendor or the Eligibility and Enrollment Appeals Committee (EEAC) depending on the nature of your appealed Claim.

### *Appeal of Denied Health Care FSA and/or Dependent Care FSA Reimbursement Claims*

Your appeal of a denied Claim for reimbursement from Your Health Care FSA or Dependent Care FSA must be submitted, in writing, to SHPS. Appeal forms may be obtained from the SHPS Internet site at [www.myshps.com](http://www.myshps.com) or by calling the SHPS Service Center. Appeal forms may be submitted

to SHPS via fax or by mail. See the *Claims Administrator for the Plan* table in the "Contact Information" section on Page 64 for contact information.

### *Appeal of Denied Claim Regarding BTPO or Before-Tax HSA Contributions*

Your appeal of a denied Claim relating to your BTPO or before-Tax HSA Contribution must be submitted, in writing, to the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section on Page 64 for contact information.

### *Appeal of Denied Claim for Eligibility or Participation in the Plan*

Your appeal of a denied Claim relating to eligibility or participation in any part of the Plan must be submitted, in writing, to the EEAC at:

AT&T Benefits Center
Eligibility and Enrollment Appeals Committee
P.O. Box 1407
Lincolnshire, IL 60069-1407

If you or your authorized representative sends a written request for review or appeal of a denied Claim, you or your representative has the right to:

- Send a written statement of the issues and any other comments, along with any new or additional evidence or materials, in support of your appeal.
- Request and receive, free of charge, documents that bear on your Claim, such as any internal rule, guideline, protocol or other similar criterion relied on in denying your Claim.
- Reasonable access to, and copies of, all documents, records and other information relevant to your Claim.

In your appeal, you should state, as clearly and specifically as possible, any facts that you think are relevant to your appeal. Your appeal must also state, as clearly and specifically as possible, all issues that relate to your Claim and all reasons why you believe the Claims Administrator's action is incorrect. You should include any new or additional evidence or materials in support of your appeal that you wish the appeal reviewer to consider. Such evidence or material must be submitted along with your written statement at the time you file your appeal.

An appeal regarding your eligibility or participation in the Plan will be reviewed and determined by members of the EEAC who were not involved in the decision to deny your initial Claim.

## Scope of Review — Appeal of Claim

During its review of an appeal of a denied Claim, the appeals reviewer shall:

- Take into account all comments, documents, records and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination on the Claim.
- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan documents.
- Follow reasonable procedures to ensure that the applicable Plan provisions are applied to the Claimant in a manner consistent with how such provisions have been applied to other similarly situated Claimants.

- Each of the appeal reviewers has the sole and complete discretionary authority to interpret and administer the applicable provisions of the Plan including the power and authority to determine all relevant facts and resolve issues relating to the interpretation and construction of all relevant terms of the Plan as they relate to Claims that they review, consider, and determine. Each appeal reviewer's decisions are conclusive and binding, and are not subject to further review under the Plan.

If the appeal of your Claim is denied, it is final and is not subject to further review. However, you may have further rights under ERISA, as provided in the "ERISA Rights of Participants" section below.

***Note:*** *A Claimant must pursue all the Claim and appeal rights described in this document before seeking any other legal recourse regarding Claims for Benefits.*

### Decisions on Appeals Involving Claims

The decision after the appeal of a denial of a Claim will be communicated in writing to the Claimant within 60 days after your appeal is received by the appeal reviewer. In the event that the appeal of the Claim is denied, the appeals reviewer will provide written notification to the Claimant which will include all of the following:

- The specific reason or reasons for the Adverse Benefit Determination
- Specific reference to pertinent Plan provisions on which the Adverse Benefit Determination was based
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the Claimant upon request
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's Claim for Benefits
- A statement of the Claimant's right to bring a civil action under ERISA Section 502(a)

## ERISA RIGHTS OF PARTICIPANTS

### Your ERISA Rights

The BTPO and the before-tax HSA Payroll Contributions provisions of this Plan are not governed by the Employee Retirement Income Security Act of 1974 (ERISA). However, the Health Care FSA and the Dependent Care FSA are subject to ERISA. As a Participant in either the Health Care FSA or the Dependent Care FSA, you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants shall be entitled to:

- Receive information about the Plan and the benefits offered under the Plan.

- 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 insurance contracts and collective bargaining agreements, and a copy of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports (Form 5500), which also are available at the Public Disclosure Room of the Employee Benefits Security Administration. These documents are usually available for review during normal working hours at the Plan Administrator's office. If Participants are unable to examine these documents there, they should write to the Plan Administrator, specify the documents to be examined and at which Participating Company work location they wish to examine them. Copies of the documents will be made available for examination at that work location within 10 days of the date the request was submitted.
- 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), updated SPD and Summary of Material Modifications. The Plan Administrator may make a reasonable charge for the copies. Participants or beneficiaries should write to the Plan Administrator.
- 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.
- Continue Health Care FSA contributions for yourself or Eligible Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event (see the "Extension of Coverage — COBRA" section on Page 38). You or your Eligible Dependents may have to pay for such coverage. Review this SPD and the other documents governing the Plan for the rules governing your COBRA continuation coverage rights.

## Prudent Actions by Plan Fiduciaries

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

## Enforce Your Rights

If your Claim for any Plan benefit 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. See the "How to File a Claim and Appeal Under the Plan" section beginning on Page 43 for more information.

Under ERISA, there are steps you can take to enforce the rights listed in the "Your ERISA Rights" section on Page 46. For instance, if you request a copy of the Plan or other Plan documents, including the latest annual report from the Plan, and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator. If you have a Claim for Benefits that is denied or ignored, in whole or in part, you may file suit in a state or 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 any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington, DC 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-3272.

## OTHER PROGRAM INFORMATION

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

### Privacy of Health Information

HIPAA provides you with certain rights in connection with the privacy of your health information. You have received a summary of those rights from the Plan. You may also view or print a copy of the Plan's summary of those rights from the Eligibility and Enrollment Vendor's Web site. Additionally, you may receive a free copy of the Claims Administrator's privacy of health information at any time upon request by contacting the Claims Administrator identified in the "Contact Information" section on Page 64.

### Qualified Medical Child Support Orders

The Plan will provide benefits by any qualified medical child support (QMCSO), as defined by ERISA Section 609(a). Generally, a QMCSO is an administrative agency or court-ordered judgment, decree, order or settlement agreement in connection with a state domestic relations law (including a community property law) that either:

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

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

A medical child support order has to satisfy certain specific conditions to be qualified. The Eligibility and Enrollment Vendor will notify you if the Company receives a medical child support order that applies to you and will provide you with a copy of the Plan's procedures used for determining whether the medical child support order is qualified. You also may contact the Eligibility and Enrollment Vendor directly at any time to receive a copy of these procedures free of charge.

If the Eligibility and Enrollment Vendor determines the order to be qualified, the Plan will comply with the provisions of the QMCSO. If a QMCSO is issued for your Child with respect to the Plan and you are eligible but not participating in the Plan at that time, you and your Child will be enrolled in the applicable provisions of the Plan in accordance with its terms and pay any required contributions.

## Newborn's and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## HIPAA Provisions for the Health Care FSA

A limited number of the Company's employees may have access to Plan participant's individually identifiable health information for purposes of administering the Health Care FSA. This health information is Protected Health Information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Company's ability to use and disclose PHI.

Protected health information (PHI) means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. Protected health information includes information of persons living or deceased.

The Company shall have access to PHI relating to the Health Care FSA only as permitted under the Plan or as otherwise required or permitted by HIPAA.

- The Health Care FSA may disclose to the Company information on whether an individual is participating in the Health Care FSA provisions of the Plan.
- The Health Care FSA may disclose Summary Health Information to the Company, provided that the Company requests the Summary Health Information for the purpose of modifying, amending, or terminating the Health Care FSA. "Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.
- Unless otherwise permitted by law, and subject to the conditions of disclosure described below and obtaining written certification as provided in the Plan, the Health Care FSA may disclose PHI to the Company, provided that the Company uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Company on behalf of the Health Care FSA, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do

not include functions performed by the Company in connection with any other benefit or benefit plan of the Company, and they do not include any employment-related functions. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Company be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

The Company agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Health Care FSA, the Company shall:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Health Care FSA, agrees to the same restrictions and conditions that apply to the Company with respect to PHI;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Health Care FSA available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Care FSA with HIPAA's privacy requirements;
- If feasible, return or destroy all PHI received from the Health Care FSA that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the adequate separation between the Health Care FSA and the Company (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

The Company further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Health Care FSA, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Company will report to the Health Care FSA any security incident of which it becomes aware.

The Company may provide PHI to employees of the Company whose employment responsibilities include administration of the Health Care FSA (and their superiors, who have a need to know such information), including payroll staff performing Health Care FSA functions, members of the EEAC, and any other Employee who needs access to PHI in order to perform Plan administration functions that the Company performs for the Health Care FSA (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals). No other employees shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Company performs for the Health Care FSA. In the event that any of these specified employees does not comply with the provisions of this section of the Plan, that employee shall be subject to disciplinary action by the Company for noncompliance pursuant to the Company's employee discipline and termination procedures.

The Company will ensure that these HIPAA provisions are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

## PLAN ADMINISTRATION

### Plan Administrator

The Plan Administrator is the named fiduciary of the Plan 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 make findings of fact, to determine the rights and status of Participants and others under the Plan, to decide 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 shall be final and conclusive on all people for all purposes of the Plan.

### 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 Plan, making findings of fact, determining the rights and status of Participants and others under the Plan and deciding disputes under the Plan. The *Plan Information* table on Page 53 indicates the functions performed by a third-party administrator for the Plan as well as the name, address and telephone number of each contractor.

The Plan shall be interpreted and administered in a manner that is consistent with the applicable provisions of the Code and ERISA, and to the extent not preempted by federal law and the laws of the State of Texas.

### Nondiscrimination in Benefits

The Code does not allow discrimination in favor of highly compensated Participants or key Employees with regard to some of the benefits offered under the Plan. The Plan Administrator may restrict the amount of nontaxable benefits provided to key Employees or highly compensated Participants so that these nondiscrimination requirements are satisfied.

Benefits provided under this Plan 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

AT&T Inc. intends to continue the Plan described within this SPD but reserves the right to amend or terminate the Plan or to amend or eliminate benefits under the Plan at any time. In addition, your Participating Company reserves the right to end its participation in the Plan. In any such event, you and other Participants may not be eligible to receive benefits as described in this SPD, and you may lose participation in the Plan. However, no amendment or termination of the Plan will diminish or eliminate any Claim for any benefit to which you may have become entitled before such amendment or termination, unless the termination or amendment is necessary for the Plan to comply with the law.

Although no Plan amendment or termination will affect your right to any benefit to which you have already become entitled, this does not mean that you will acquire a lifetime right to any Plan benefit, to eligibility for coverage under the Plan, or to the continuation of the Plan merely by reason of the fact that the Plan was in effect during your employment or at the time you received a benefit under the Plan or at any time thereafter.

## Limitation of Rights

Participation in the Plan does not give you a right to remain employed by the Company. Except as otherwise required by law or as allowed under the provision of the Plan, benefits provided under the Plan may not be assigned or alienated. This means that you may not sell, assign, pledge or otherwise transfer benefits under the Plan before the benefits are paid to you, nor are your Plan benefits subject to attachments, garnishment, execution or encumbrance of any kind before payment to you.

## Legal Action Against the Plan

If you wish to bring a 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 Claim and appeals process described in this SPD. A legal action should not be filed until you complete the Claim and appeals process described in this SPD. As part of the final level of that appeal process, you must raise all issues and state all reasons that provide a basis for your appeal. Legal action involving the Plan should be filed directly against the Plan. Process in legal actions concerning the provision of benefits under the Plan should be served on the Plan Administrator as provided in the following *Plan Information* table.

## Indemnification

AT&T Inc. agrees to indemnify and hold harmless any present or former employee of AT&T Inc. or any of its affiliates or subsidiaries to whom fiduciary, plan administration or trust fund operation or investment responsibilities are delegated, including but not limited to, members of any committees and their delegates responsible for plan administration and related responsibilities, against any and all claims, demands, rights, liabilities, damages, causes of actions, costs and expenses of whatsoever kind and nature (including plan administrator approved attorneys' fees and amounts paid in settlement of any claims) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith. The foregoing right to indemnification shall be in addition to such other rights as such employees may enjoy as a matter

of law or by reason of insurance coverage of any kind. Rights granted hereunder shall be in addition to and not in lieu of any rights to indemnification to which such employee may be entitled pursuant to the by-laws of AT&T Inc. or any of its affiliates or subsidiaries.

## Plan Information

| Plan Information | |
|---|---|
| **Plan Name** | AT&T Inc. Flexible Spending Account Plan (AT&T FSA), which includes the:<br>• Before-Tax Premium Option<br>• Before-Tax Health Savings Account (HSA) Payroll Contributions<br>• Health Care Flexible Spending Account (Health Care FSA)<br>• Dependent Care Flexible Spending Account (Dependent Care FSA) |
| **Plan Number** | 533 |
| **Plan Sponsor and Plan Administrator of the AT&T Flexible Spending Account Plan**<br>**(as defined by ERISA)** | AT&T Inc.<br>P.O. Box 132160<br>Dallas, TX 75313-2160<br>**210-351-3333** |
| **Name and Address of Employer** | Affiliates of AT&T Inc.<br>P.O. Box 132160<br>Dallas, TX 75313-2160<br>**210-351-3333** |
| **Plan Sponsor's Employer Identification Number** | 43-1301883 |
| **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 Plan as follows:<br>The Plan Administrator administers Claims and appeals for benefits under the Plan, on a contract basis with:<br>SHPS<br>FSA Processing<br>P.O. Box 14646<br>Louisville, KY 40512<br>**877-358-0302**<br>The Plan Administrator administers enrollment, eligibility and COBRA coverage under the Plan provisions, including the determination of initial Claims for Eligibility and appeals for Claim for Benefits involving eligibility, on a contract basis with:<br>Hewitt Associates LLC<br>100 Half Day Road<br>P. O. Box 1474<br>Lincolnshire, IL 60069-1474<br>**877-722-0020** |

***Table continued on next page***

<table>
<tr><th colspan="2">Plan Information</th></tr>
<tr><td>Agent for Service of Legal Process</td><td>Process in legal actions concerning the provision of benefits under the Plan should be served on the Plan Administrator, which is the agent for service of legal process, at:<br><br>AT&T Services Inc.<br>P.O. Box 132160<br>Dallas, TX 75313-2160<br><br>210-351-3333<br><br>Service of process also may be made upon a Plan Trustee.</td></tr>
<tr><td>Type of Plan</td><td>Welfare benefit plan that constitutes a cafeteria (salary redirection) plan organized under Section 125 of the Code.</td></tr>
<tr><td>Plan Year</td><td>Jan. 1 – Dec. 31</td></tr>
<tr><td>Plan Funding and Contributions</td><td>The Plan is funded solely through salary reductions. There is no trust that has been created to hold employee contributions to these Plans.</td></tr>
<tr><td>Payment of Benefits</td><td>Administrators:<ul><li>The Claims Administrator determines all Claims for Benefits under the Plan. The Claims Administrator has full discretionary authority to interpret the provisions of the Plan as they apply to entitlement to benefits.</li><li>The Eligibility and Enrollment Vendor, Hewitt Associates LLC (AT&T Benefits Center), makes the initial determination concerning eligibility for benefits under the Plan.</li><li>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 the provisions of the Plan as they apply to eligibility for benefits.</li></ul></td></tr>
<tr><td>Plan Records</td><td>All Plan records are kept on a calendar year basis beginning Jan. 1 and ending Dec. 31.</td></tr>
<tr><td>Collectively Bargained Plan</td><td>With respect to certain Eligible Employees, the Plan is maintained pursuant to one or more collective bargaining agreements, and, upon written request to the Plan Administrator, a copy of these collective bargaining agreements may be obtained by Participants who are eligible to participate in the Plan as a result of such collective bargaining agreements, or may be examined by such Participants as required pursuant to DOL Regulations Sections 2520.104b-1 and 2520.104b-30.</td></tr>
</table>

# PARTICIPATING COMPANIES

This section identifies the Participating Companies with Eligible Employees. These include Companies that no longer participate, but certain former Employees of these Companies remain eligible to participate in the Plan.

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

This table should not be used to determine if you personally are eligible to participate in the Plan. See the "Eligibility and Participation" section on Page 10 for more information on eligibility to participate in the Plan.

| **Participating Companies – AT&T Flexible Spending Account Plan** | |
|---|---|
| **Company Name** | **Eligible Employee Group** |
| Alascom, Inc. | • Management Employees |
| Ameritech Publishing, Inc. | • Management Employees |
| | • Bargained Employees – ADV-CWA |
| | • Nonmanagement Nonunion Employees |
| Ameritech Services, Inc. | • Management Employees |
| | • Midwest Region Core CWA |
| | • Midwest Region Core IBEW |
| | • Nonmanagement Nonunion Employees in the states of Indiana, Michigan, Ohio and Wisconsin – Midwest Region Core CWA |
| | • Nonmanagement Nonunion Employees in Illinois – Midwest Region Core IBEW |
| AT&T Advertising, L.P. | • Management Employees |
| AT&T Billing Southeast, LLC (formerly BellSouth Billing, Inc.) | • Management Employees |
| | • Bargained Employees -- BLS Represented |
| AT&T Capital Services, Inc. | • Management Employees |
| AT&T Consulting Solutions, Inc. (formerly Callisma) | • Management Employees |
| AT&T Corp. | • Management Employees |
| | • Bargained Employees – Legacy AT&T Corp. CWA |
| | • Bargained Employees – Legacy AT&T Corp. IBEW |
| | • Nonmanagement Nonunion Employees |
| AT&T Delaware Intellectual Property, Inc. | • Management Employees |

***Table continued on next page***

| Participating Companies – AT&T Flexible Spending Account Plan | |
|---|---|
| **Company Name** | **Eligible Employee Group** |
| AT&T Global Communication Services, Inc. (Includes Guam and Virgin Island Employees) | • Management Employees |
| AT&T Global Network Services LLC | • Management Employees |
| AT&T Government Solutions, Inc. | • Management Employees |
| AT&T Intellectual Property Management, Inc. (formerly BellSouth Intellectual Property Management Corporation) | • Management Employees |
| AT&T Intellectual Property Marketing, Inc. (formerly BellSouth Intellectual Property Marketing Corporation) | • Management Employees |
| AT&T Intelleprop, Inc. | • Management Employees |
| AT&T Labs, Inc. | • Management Employees<br>• Bargained Employees – BLS Represented<br>• Bargained Employees – Legacy AT&T Corp. CWA |
| AT&T Management Services, L.P. | • Management Employees |
| AT&T Messaging, LLC | • Management Employees<br>• Bargained Employees – SMSI |
| AT&T Mexico, Inc. | • Management Employees |
| AT&T Mobility Services LLC | • Management Employees<br>• AT&T Mobility-CWA |
| AT&T of the Virgin Islands, Inc. | • Management Employees |
| AT&T Operations, Inc. | • Management Employees<br>• Bargained Employees – BLS Represented<br>• Bargained Employees – East Region Core CWA<br>• Bargained Employees – Legacy AT&T Corp. CWA<br>• Bargained Employees – Legacy AT&T Corp. IBEW<br>• Bargained Employees – Southwest Region Core CWA |
| | ***Table continued on next page*** |

| Participating Companies – AT&T Flexible Spending Account Plan | |
|---|---|
| **Company Name** | **Eligible Employee Group** |
| AT&T Services, Inc. | • Management Employees<br>• Bargained Employees – BLS Represented<br>• Bargained Employees – East Region Core CWA and Premise Technician<br>• Bargained Employees – Legacy AT&T Corp. CWA<br>• Bargained Employees – Legacy AT&T Corp. IBEW<br>• Bargained Employees – Southwest Region Core CWA and Premise Technician<br>• Bargained Employees – West Region Core CWA and Premise Technician<br>• Bargained Employees – Midwest Region Core CWA and Premise Technician<br>• Bargained Employees – Midwest Region Core IBEW and Premise Technician |
| AT&T Solutions, Inc. | • Management Employees<br>• Bargained Employees – Legacy AT&T Corp. IBEW |
| AT&T Support Services Company Inc. | • Management Employees |
| AT&T Technical Services Company, Inc. | • Management Employees |
| AT&T Video Services, Inc. | • Management Employees<br>• Bargained Employees – ATTVS-SBVS District 6 CWA<br>• Bargained Employees – West Region Core CWA and Premise Technician |
| AT&T World Personnel Services, Inc. | • Management Employees |
| BellSouth Advertising & Publishing Corporation | • Management Employees<br>• Bargained Employees – BLS Represented<br>• Nonmanagement Nonunion Employees |
| BellSouth Communication Systems, LLC | • Management Employees<br>• Bargained Employees – BLS Represented |
| BellSouth Corporation | • Management Employees<br>• Bargained Employees – BLS Represented<br>• Nonmanagement Nonunion Employees |
| BellSouth Entertainment, LLC | • Management Employees |
| | ***Table continued on next page*** |

| Participating Companies – AT&T Flexible Spending Account Plan | |
|---|---|
| **Company Name** | **Eligible Employee Group** |
| BellSouth Long Distance, Inc. | • Management Employees<br>• Bargained Employees – BLS Represented<br>• Bargained Employees – BLS Special Represented |
| BellSouth Telecommunications, Inc. | • Management Employees<br>• Bargained Employees – BLS Represented<br>• Bargained Employees – BLS Special Represented<br>• Southeast Region NMNU (Premise Technicians and Dispatcher job titles) |
| Berry Network Inc. | • Management Employees<br>• L. M. Berry NMNU |
| Illinois Bell Telephone Company | • Management Employees<br>• Bargained Employees – Midwest Region Core CWA and Premise Technician<br>• Bargained Employees – Midwest Region Core IBEW and Premise Technician (also includes Engineering Assistants)<br>• Nonmanagement Nonunion Employees – Midwest Region Core IBEW |
| Indiana Bell Telephone Company, Inc. | • Management Employees<br>• Bargained Employees – Midwest Region Core CWA and Premise Technician<br>• Bargained Employees – Midwest Region Core IBEW and Premise Technician |
| Intelligent Media Ventures, LLC | • Management Employees |
| L.M. Berry and Company | • Management Employees<br>• L. M. Berry NMNU |
| Michigan Bell Telephone Company | • Management Employees<br>• Bargained Employees – Midwest Region Core CWA and Premise Technician<br>• Nonmanagement Nonunion Employees – Midwest Region Core CWA |
| Nevada Bell Telephone Company | • Management Employees<br>• Bargained Employees – West Region Core CWA and Premise Technician |
| | ***Table continued on next page*** |

| Participating Companies – AT&T Flexible Spending Account Plan | |
|---|---|
| **Company Name** | **Eligible Employee Group** |
| The Ohio Bell Telephone Company | • Management Employees |
| | • Bargained Employees – Midwest Region Core CWA and Premise Technician |
| Pacific Bell Directory | • Management Employees |
| | • Bargained Employees – PBD-IBEW Local 1269 |
| | • Bargained Employees – PBD-IBEW Local 2139 |
| | • Nonmanagement Nonunion Employees |
| Pacific Bell Information Services | • Management Employees |
| Pacific Bell Telephone Company | • Management Employees |
| | • Bargained Employees – PB-IBEW Local 1269 |
| | • Bargained Employees – PB-TIU Local 103 |
| | • Bargained Employees – West Region Core CWA and Premise Technician |
| PBD Holdings | • Management Employees |
| | • Bargained Employees – DGA-IBEW Local 1269 |
| | • DGA-NMNU |
| SBC Global Management Support, LLC | • Management Employees |
| SBC Global Services, Inc. | • Management Employees |
| | • AIS-NMNU |
| | • Bargained Employees – AIS-CA/NV (Datacomm Operation Bargained Employees in California/Nevada) |
| | • Bargained Employees – AIS-CWA (Datacomm Operations Employees located in Indiana, Michigan, Ohio and Wisconsin) |
| | • Bargained Employees – AIS-IBEW Local 21 (Datacomm Operations Employees located in Illinois and Indiana also includes Warehousers) |
| | • Bargained Employees – AIS-IBEW Local 58 (Datacomm Operations Employees in Michigan) |
| | • Bargained Employees – AIS-IBEW Local 494 (Datacomm Operations Employees in Wisconsin) |
| | • Bargained Employees – AIS-IBEW Local 134 (Datacomm Operations Employees in Chicago) |
| | • Bargained Employees – AIS-COS (Customer Operations Specialist located in Michigan) |

***Table continued on next page***

| Participating Companies – AT&T Flexible Spending Account Plan | |
|---|---|
| **Company Name** | **Eligible Employee Group** |
| SBC International, Inc. | • Management Employees |
| SBC Internet Services, Inc. | • Management Employees<br>• Southeast Region NMNU (Premise Technicians and Dispatcher job titles)<br>• Bargained Employees – East Region Core CWA (Premise Technician)<br>• Bargained Employees – Premise Technician, Dispatcher, Technical Support Representative II (Midwest Region Core CWA District 4)<br>• Bargained Employees – SBCIS-NIC and SBCISP-NIC<br>• Bargained Employees – Southwest Region Core CWA and Premise Technician<br>• Bargained Employees – Tier 1 DSL Customer Assistant<br>• Bargained Employees – West Region Core CWA (Premise Technician) |
| SBC Long Distance, LLC | • Management Employees<br>• Bargained Employees – SBLD-IBEW Local 21 |
| SNET Diversified Group, Inc. | • Management Employees |
| SNET Information Services, Inc. | • Management Employees<br>• Bargained Employees -- SNEIS-CWA |
| The Southern New England Telephone Company | • Management Employees<br>• Bargained Employees – East Region Core CWA |
| Southwestern Bell Advertising Group, Inc. | • Management Employees<br>• Bargained Employees – SWBAG<br>• Nonmanagement Nonunion Employees |
| Southwestern Bell Telephone Company | • Management Employees<br>• Bargained Employees – Southwest Region Core CWA and Premise Technician<br>• Nonmanagement Nonunion Employees (Confidential) |
| Southwestern Bell Yellow Pages, Inc. | • Management Employees<br>• Bargained Employees – SBYP<br>• Nonmanagement Nonunion Employees (Confidential) |
| | ***Table continued on next page*** |

| Participating Companies – AT&T Flexible Spending Account Plan | |
|---|---|
| **Company Name** | **Eligible Employee Group** |
| Stephens Graphics, Inc. | • Management Employees<br>• Bargained Employees – SGI Local 121C and Local 540M |
| TC Systems, Inc. | • Management Employees<br>• Bargained Employees – Legacy AT&T Corp. CWA |
| TCG of the Carolinas, Inc. | • Management Employees<br>• Bargained Employees – Legacy AT&T Corp. CWA |
| TCG Delaware Valley, Inc. | • Management Employees |
| TCG New Jersey, Inc. | • Management Employees<br>• Bargained Employees – Legacy AT&T Corp. CWA |
| TCG Rhode Island | • Management Employees<br>• Bargained Employees – Legacy AT&T Corp. CWA |
| TCG Services, Inc. | • Management Employees<br>• Bargained Employees – Legacy AT&T Corp. CWA |
| Teleport Communications Boston, Inc. | • Management Employees |
| Teleport Communications New York | • Management Employees<br>• Bargained Employees – Legacy AT&T Corp. CWA |
| Wisconsin Bell, Inc. | • Management Employees<br>• Bargained Employees – Midwest Region Core CWA and Premise Technician |

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

# DEFINITIONS

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

**Active Employee.** An Active Employee is an Employee who is on the Payroll (whether or not actually receiving pay) and who is performing services for his or her employer.

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

**Before-Tax Premium Option (BTPO).** The BTPO under the Plan enables Eligible Employees to pay contributions for Company-sponsored health care plans and certain welfare plans on a before-tax basis.

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

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

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

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

**Claims Administrator.** A Claims Administrator is any third-party administrator, 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 Plan. If no separate Claims Administrator has been designated by the Company or the Plan Administrator, the Plan Administrator will be the Claims Administrator for the Plan.

**COBRA.** COBRA refers to the Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272) as enacted April 7, 1986, and as subsequently amended from time to time.

**Code.** Code refers to the Internal Revenue Code of 1986, as it may be amended from time to time.

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

**Dependent Care Flexible Spending Account (Dependent Care FSA).** The Dependent Care FSA is an option that offers certain Eligible Employees the opportunity to pay, on a before-tax basis, for certain anticipated dependent care expenses that you incur so that the Eligible Employee and his or her spouse, if applicable, can work outside the home.

**Dependent Care Tax Credit.** See the "Dependent Care Tax Credit" section on Page 37 for information about the provisions of the Dependent Care Tax Credit.

**Eligibility and Enrollment Vendor.** The Eligibility and Enrollment Vendor (currently operating as the AT&T Benefits Center) is the third-party vendor to which the Plan Administrator has delegated responsibility under the Plan for eligibility determinations, enrollment administration, cost of coverage information, billing, COBRA administration, change of status event administration and the provision of general benefits information to Participants.

**Eligibility Waiting Period**. The Eligibility Waiting Period is the period after an Eligible Employee becomes employed by a Participating Company before he or she is eligible to enroll in the Plan. See *Appendix B*.

**Eligible Contributions**. Eligible Contributions are before-tax contributions under the Plan under the BTPO.

**Eligible Dependent.** See the “Eligible Dependent” sections on Pages 33 and 34 for an explanation as to who qualifies as an Eligible Dependent.

**Eligible Employee.** An Eligible Employee is an Employee of a Participating Company who satisfies the conditions for eligibility to participate in the Plan set forth in the “Eligibility and Participation” section on Page 10.

**Employee.** An Employee is 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 Participating Company.

**ERISA.** ERISA is the Employee Retirement Income Security Act of 1974, as it may be amended from time to time.

**FMLA.** FMLA is the Family and Medical Leave Act of 1993, as amended from time to time. Reference to any section or subsection of the FMLA includes references to any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

**HIPAA.** HIPAA is the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time.

**Health Care Flexible Spending Account (Health Care FSA)**. The Health Care FSA is an option under the Plan that offers certain Eligible Employees the opportunity to pay, on a before-tax basis, for certain anticipated out-of-pocket health care expenses that a health care plan does not cover.

**Health Savings Account (HSA).** A Health Savings Account (HSA) is an account available to certain Eligible Employees who participate in a high-deductible health plan from which eligible health care expenses can be reimbursed with before-tax dollars.

**Health Savings Account (HSA) Payroll Contributions**. HSA Payroll Contributions are before-tax contributions to an HSA that can be used to help pay for certain anticipated out-of-pocket health care expenses that a health plan does not cover.

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

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

**Participating Company**. Participating Company means the Company and/or subsidiary, affiliate or business unit of the Company that has elected to participate in the Plan, subject to approval provided in accordance with the AT&T Schedule of Authorizations. See the "Participating Companies" section on Page 55 for a list of the Participating Companies.

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

**Plan.** Plan means AT&T Flexible Spending Account Plan.

**Plan Administrator.** AT&T Inc. is the Plan Administrator of the AT&T Flexible Spending Account Plan.

**Plan Year.** Plan Year refers to the 12-month period beginning Jan. 1 and ending Dec. 31.

**Qualified Beneficiary.** A Qualified Beneficiary is an individual who satisfies the conditions for COBRA continuation coverage described in the "Extension of Coverage — COBRA" section on Page 38.

**Qualifying Event.** A Qualifying Event is an event that gives a Qualified Beneficiary the right to retain coverage under the Health Care FSA in accordance with COBRA.

**Regular Full-Time or Regular Part-Time Employee.** A Regular Employee is an individual who is classified as a "Regular Employee," whether full time or part time, by your employer that is a Participating Company in the Plan.

**Regular Limited Term Employee.** A Regular Limited Term Employee is an individual who is classified as a "Regular Limited Term Employee" by your employer that is a Participating Company in the Plan.

**Temporary Employee.** A Temporary Employee is an individual who is classified as a "Temporary Employee" by your employer that is a Participating Company in the Plan.

**Term Employee.** A Term Employee is an individual who is classified as a "Term Employee" by your employer that is a Participating Company in the Plan.

## CONTACT INFORMATION

Review the tables in this section for contact information for the various Plan administrators and vendors.


| Information for the Following Administrators and Vendors Is Included in This Section: | |
|---|---|
| **Eligibility and Enrollment Vendor:** AT&T Benefits Center | Page 65 |
| **Claims Administrator for the Plan:** SHPS | Page 67 |
| **Active Employee Address and Telephone Number Changes** | Page 67 |
| **AT&T Benefits Intranet and Internet Access**<br>In addition, information is provided on how to update your work address, home address and telephone numbers and how to access the AT&T Employee benefits intranet site. | Page 68 |

<table>
<tr><th colspan="2">Eligibility and Enrollment Vendor<br>(Also Responsible for Eligibility and Enrollment Appeals)</th></tr>
<tr><th colspan="2">AT&T Benefits Center</th></tr>
<tr><td>To Reach a Service Associate</td><td>Call the AT&T Benefits Center at 877-722-0020 (domestic) or +1-847-883-0866 (international) to enroll in the Plan or to inquire about:<br>• Eligibility.<br>• Cost of Coverage.<br>• Enrollment administration.<br>• General benefits information.<br>• Billing.<br>• COBRA.<br>• Change in Status Events.<br>AT&T Benefits Center service associates are available Monday through Friday from 7 a.m. to 7 p.m. Central time, except on some holidays. The Access Direct system is available 24 hours a day, seven days a week (except for periodic maintenance and on Sundays from 1 a.m. to noon Central time).<br>To speak to a service associate through Access Direct, you will need your AT&T Benefits Center user ID and password.</td></tr>
<tr><td>Internet Access</td><td>Access the AT&T Benefits Center Web site 24 hours a day at http://resources.hewitt.com/att.<br>To access the Web site, you will need your AT&T Benefits Center user ID and password. On the Web site, you can:<br>• View your current Plan coverage and contribution amounts.<br>• Find information on where to go to change your personal data and address information.<br>• Learn which changes you can make if you experience a change in status event, such as a birth or adoption, marriage or divorce, gain or loss of LRP. You can also learn when those changes would be effective.<br>• Access Plan documents.<br>• Preview how your benefits may change if you get married, retire or go on a leave of absence.</td></tr>
<tr><td colspan="2">Table continued on next page</td></tr>
</table>

<table>
<tr><th colspan="2">Eligibility and Enrollment Vendor<br>(Also Responsible for Eligibility and Enrollment Appeals)</th></tr>
<tr><th colspan="2">AT&T Benefits Center</th></tr>
<tr><td>Where to File a Claim or Appeal When You Are Denied the Opportunity to Enroll or Are Not Allowed to Enroll During a Specific Time Frame</td><td>Claims<br><br>If a request for enrollment is denied, you may file a Claim for Eligibility, which will be processed according to the procedures described in the “How to File a Claim and Appeal Under the Plan” section beginning on Page 43. The Eligibility and Enrollment Vendor has prepared a Claims Initiation Form (CIF), which you may request in order to help you file your Claim for Eligibility. Once prepared, submit your written Claim for Eligibility, along with any documentation that supports your Claim, to:<br><br>AT&T Benefits Center<br>Benefits Determination Review Team<br>P.O. Box 1407<br>Lincolnshire, IL 60069-1407<br><br>Appeals<br><br>If you wish to appeal a denied Claim for Eligibility, you may submit your written appeal to:<br><br>AT&T Benefits Center<br>Eligibility and Enrollment Appeals Committee<br>P.O. Box 1407<br>Lincolnshire, IL 60069-1407</td></tr>
<tr><td>Where to File First- and Second-Level Requests for Review When a Claim for Benefits Has Been Denied on the Basis of Eligibility or Enrollment</td><td>First-Level Request for Review<br><br>If your Claim for Benefits is denied on the basis of your eligibility or enrollment under the Plan, you may submit a first-level request for review to:<br><br>AT&T Benefits Center<br>Benefits Determination Review Team<br>P.O. Box 1407<br>Lincolnshire, IL 60069-1407<br><br>Second-Level Request for Review<br><br>If your first-level request for review is denied, you may submit a second-level request for review to:<br><br>AT&T Benefits Center<br>Eligibility and Enrollment Appeals Committee<br>P.O. Box 1407<br>Lincolnshire, IL 60069-1407<br><br>Procedures for submitting and processing appeals of Claims for Benefits denied on the basis of eligibility or enrollment can be found in the “How to File a Claim and Appeal Under the Plan” section beginning on Page 43.</td></tr>
</table>

<table>
<tr><th colspan="2">Claims Administrator for the Plan</th></tr>
<tr><th colspan="2">SHPS</th></tr>
<tr><td>Health Care FSA/Dependent Care FSA</td><td>For claim forms, access the SHPS Internet site at www.myshps.com or call the service center at:<br>800-283-3211 (domestic)<br>502-267-3399 (international)<br>800-952-0450 (hearing impaired)<br>Service associates are available Monday through Friday from 7 a.m. to 7 p.m. Central Time. The IVR is available 24 hours a day, seven days a week.<br>Submit claim forms and accompanying receipts to SHPS via fax at 866-643-2219 or by mail to:<br>SHPS<br>FSA Processing<br>P.O. Box 34700<br>Louisville, KY 40232<br>In addition, written request for review of a denied Claim should be sent to the address above.</td></tr>
</table>

| Active Employee Address and Telephone Number Changes |
|---|
| It’s important to keep your work and home addresses current because the majority of your benefits, Payroll or similar information is sent to these addresses. Please include any room, cubicle or suite number that will help make mail routing more efficient. |
| ***Table continued on next page*** |

| Active Employee Address and Telephone Number Changes | |
|---|---|
| For Employees with access to the Employee intranet, go to http://myintranet.att.com to review and/or update your: | |
| ***eLink* Users** | **Home address:**<br>• Go to **HROneStop** at **http://hronestop.att.com** and select **eLink (eCorp)** in the left navigation bar.<br>• Enter your ATTUID and AT&T Global Logon password. (If you do not know your password, please follow the instructions on the screen.)<br>• Once logged on, click **OK.**<br>• 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.)<br>• Select **Personal Information**.<br>• Select **Maintain Addresses and Phone Numbers.**<br>• To update your address, select **Edit.**<br>• Make any necessary changes, and click **Save.**<br>**Work address:**<br>• Go to **http://myintranet.att.com** on the Employee intranet.<br>• Review your work address information by looking up your name in the Webphone Directory section on the home page.<br>• If you have changes, contact your supervisor or eLink assistant. Remember to include any room, cubicle or suite number that will help make mail routing more efficient. For Employees without access to the Employee intranet, contact your supervisor or eLink assistant. |

| HROneStop and Internet Access |
|---|
| **Your Benefits section of HROneStop (Active Employees from work).** The Your Benefits section of HROneStop provides access to SPDs, administrator Web sites (which may include Provider directories and other tools) and current communications. To access this information, visit the Your Benefits section of **HROneStop** at **http://hronestop.att.com.** |
| **AT&T Employee and eligible former Employee benefits Internet site.** Go to the Your Benefits section of **http://access.att.com** (AT&T's secure Internet site for Employees and former Employees) for benefits information at home and at any time. Just go to **http://access.att.com** and follow the login instructions. |

# APPENDIX A: EMPLOYEE GROUP TERMS USED IN THIS SPD

Not all information in this SPD is applicable to every Employee. Some Plan provisions regarding eligibility and provisions of the Health Savings Account Payroll Contributions, Health Care Flexible Spending Account and Dependent Care Flexible Spending Account benefits differ depending on your bargained classification, the Company you work for and other factors. These differences are noted throughout this SPD. In the interest of brevity, any time there is an exception pertaining to a particular Company or Employee group covered by a bargained contract, the Company or Employee group is referred to by an acronym rather than an official Company or Employee group name. A complete list of Participating Company names is located in the "Participating Companies" section on Page 55. In addition, a complete list of the Employee groups referred to in this SPD and their associated terms (acronyms) is presented in the *Employee Group Terms Used in This SPD* table below.

| Employee Group Terms Used in This SPD | |
|---|---|
| **Term** | **Description of Employee Group** |
| **ADV-CWA** | Bargained Employee of Ameritech Publishing, Inc. who is represented by the Communications Workers of America (CWA), District 4, in accordance with the agreement dated Aug. 14, 2005<br>***Note:*** *ADV-CWA benefits are also extended to eligible nonmanagement nonunion Employees of Ameritech Publishing, Inc.* |
| **AIS-CA/NV** | Bargained Employee of SBC Global Services, Inc. doing business in California and Nevada (including a Special Appendix D Employee) who is represented by the CWA in accordance with the letter of agreement dated April 3, 2006 |
| **AIS-COS** | Bargained Employee of SBC Global Services, Inc. (Customer Operations Specialist) who is represented by the CWA in accordance with the agreement dated April 5, 2009 |
| **AIS-CWA** | Bargained Employee of SBC Global Services, Inc. who is represented by the CWA in accordance with the agreement dated Aug. 5, 2009 |
| **AIS-IBEW Local 21** | Bargained Employee of SBC Global Services, Inc. who is represented by the International Brotherhood of Electrical Workers (IBEW) Local 21 in accordance with the agreement dated June 28, 2009 |
| **AIS-IBEW Local 58** | Bargained Employee of SBC Global Services, Inc. who is represented by IBEW Local 58 in accordance with the agreement dated June 28, 2009 |
| **AIS-IBEW Local 134** | Bargained Employee of SBC Global Services, Inc. who is represented by IBEW Local 134 in accordance with the agreement dated June 28, 2009 |
| **AIS-IBEW Local 494** | Bargained Employee of SBC Global Services, Inc. who is represented by IBEW Local 494 in accordance with the agreement dated June 28, 2009 |
| **AIS-NMNU** | Employee of SBC Global Services, Inc. who is neither classified by their employer as a management Employee nor represented by a union |
| | ***Table continued on next page*** |

| Employee Group Terms Used in This SPD | |
|---|---|
| **Term** | **Description of Employee Group** |
| **AT&T Mobility-CWA** | Employee of AT&T Mobility, LLC who is represented by the CWA District 1, 2, 3, 4, 6, 7, 9 and 13 in accordance with the 2008 National Health Plan Agreement. |
| **ATTVS-SBVS District 6 CWA** | Bargained Employee of AT&T Video Services, Inc. who is represented by the CWA in accordance with the agreement dated Aug. 25, 2007 |
| **BLS Represented** | Bargained Employee who is represented by the CWA in accordance with the Southeast Region Core CWA 2009 agreement dated August 9, 2009 |
| **BLS Special Represented** | Bargained Employee who is represented by the CWA District 3:<br>• In accordance with the agreement dated Aug. 9, 2009, between the CWA and BellSouth Telecommunications, Inc. for Utility Operations<br>• In accordance with the agreement dated Aug. 7, 2005, between the CWA and BellSouth Telecommunications, Inc. for Internet Services<br>• In accordance with the agreement dated Jan. 1, 2006, between the CWA and BellSouth Long Distance, Inc.<br>• In accordance with the agreement dated May 15, 2006, between the CWA and Bellsouth Telecommunications, Inc. for National Directory and Customer Assistance |
| **DGA-IBEW Local 1269** | Bargained Employee of PBD Holdings who is represented by the International Brotherhood of Electrical Workers Local 1269 in accordance with the agreement dated Aug. 30, 2009 |
| **DGA-NMNU** | Bargained Employee of PBD Holdings who is neither classified by their employer as a management Employee nor represented by a union |
| **East Region Core CWA** | Bargained Employee who is represented by the CWA:<br>• In accordance with the East 2004 Core CWA labor agreement dated April 4, 2004, for the following Participating Companies: Southern New England Telephone Company; SNET Diversified Group, Inc.; AT&T Operations and AT&T Services, Inc.<br>• In accordance with the letter of agreement dated May 7, 2007, regarding Appendix F Employees of Southern New England Telephone Company whose job title is Premise Technician |
| **L. M. Berry NMNU** | Employee of L.M. Berry and Company and Berry Network, Inc. who is neither classified as a management Employee nor represented by a union. |
| **Legacy AT&T Corp. CWA** | Bargained Employee who is represented by the CWA in accordance with the 2009 Core CWA labor agreement dated April 5, 2009, by and between certain business operating units and divisions of AT&T Corp. and the CWA.<br>***Note:*** *Legacy AT&T Corp. CWA benefits are also extended to any eligible nonmanagement nonunion Employee of such business operating units and divisions of AT&T Corp.* |
| ***Table continued on next page*** | |

| Employee Group Terms Used in This SPD | |
|---|---|
| **Term** | **Description of Employee Group** |
| **Legacy AT&T Corp. IBEW** | Bargained Employee who is represented by the IBEW in accordance with the 2009 Core CWA labor agreement dated April 5, 2009, by and between certain business operating units and divisions of AT&T Corp. and the IBEW.<br>***Note:*** *Legacy AT&T Corp. IBEW benefits are also extended to any eligible nonmanagement nonunion Employee of such business operating units and divisions of AT&T Corp.* |
| **Midwest Region Core CWA** | Bargained Employee who is represented by the CWA District 4:<br>• In accordance with the Midwest Core CWA 2009 agreement dated April 5, 2009, for the following Participating Companies: Ameritech Services, Inc.; AT&T Services, Inc.; Illinois Bell Telephone Company; Indiana Bell Telephone Company, Inc; Michigan Bell Telephone Company; The Ohio Bell Telephone Company; SBC Internet Services, Inc.; and Wisconsin Bell, Inc.<br>• In accordance with the letter of agreement dated May 12, 2006, amending the Midwest 2004 Core CWA labor agreement regarding Special Appendix F Employees whose job title is Premise Technician<br>***Note:*** *Midwest Region Core CWA benefits are also extended to any eligible nonmanagement nonunion Employee of the Companies described above.* |
| **Midwest Region Core IBEW** | Bargained Employee who is represented by the IBEW AFL/CIO Local 21:<br>• In accordance with the agreement dated June 28, 2009, for the following Participating Companies: Ameritech Services, Inc.; AT&T Services, Inc.; Illinois Bell Telephone Company, including Engineering Assistants; and Indiana Bell Telephone Company, Inc.<br>• In accordance with the letter of agreement dated Dec. 19, 2006, amending the Midwest 2004 Core IBEW Labor Agreement regarding Special Appendix C Employees whose job title is Premise Technician<br>***Note:*** *Midwest Core IBEW benefits are also extended to any eligible nonmanagement nonunion Employee of Illinois Bell Telephone Company and Ameritech Services, Inc. in Illinois.* |
| **PBD-IBEW Local 1269** | Bargained Employee of Pacific Bell Directory who is represented by the IBEW Local 1269 in accordance with the agreement dated Aug. 6, 2005<br>***Note:*** *PBD-IBEW Local 1269 benefits also are extended to any eligible nonmanagement nonunion Employee of Pacific Bell Directory (North)* |
| **PBD-IBEW Local 2139** | Bargained Employee of Pacific Bell Directory who is represented by the IBEW Local 2139 in accordance with the agreement dated Aug 2, 2008<br>***Note:*** *PBD-IBEW Local 2139 benefits also are extended to any eligible nonmanagement nonunion Employee of Pacific Bell Directory (South)* |
| **PB-IBEW Local 1269** | Bargained Employee of Pacific Bell Telephone Company who is represented by the IBEW Local 1269 in accordance with the agreement dated July 26, 2009 |

***Table continued on next page***

| Employee Group Terms Used in This SPD | |
|---|---|
| **Term** | **Description of Employee Group** |
| **PB-TIU Local 103** | Bargained Employee of Pacific Bell Telephone Company who is represented by the Telecommunications International Union Local 103 in accordance with the agreement dated July 26, 2009 |
| **SBCIS-NIC** | Bargained Employee of SBC Internet Services, Inc. (excluding Tier 1) who is represented by the CWA in accordance with the National Internet Contract dated March 8, 2008 |
| **SBCISP-NIC** | Bargained Employee of SBC Internet Services, Inc. (excluding Tier 1) whose job title is Premise Technician and who is represented by the CWA in accordance with the National Internet Contract dated March 8, 2008 |
| **SBLD-CWA** | Bargained Employee of SBC Long Distance, LLC dba Pacific Bell Long Distance who is represented by the CWA |
| **SBLD-IBEW Local 21** | Bargained Employee of SBC Long Distance, LLC who is represented by IBEW Local 21 in accordance with the agreement dated June 26, 2005 |
| **SBYP** | Bargained Employee of Southwestern Bell Yellow Pages, Inc. who is represented by the CWA in accordance with the agreement dated Dec 4, 2004 |
| **SGI Local 121C and Local 540M** | Bargained Employee of Stevens Graphics, Inc. who is represented by the Teamsters Local 121C or Teamsters Local 540M in accordance with the agreement dated Feb. 15, 2009 |
| **SMSI** | Bargained Employee of AT&T Messaging LLC who is represented by the CWA in accordance with the agreement dated July 3, 2005 |
| **SNEIS-CWA** | Bargained Employee of SNET Information Services, Inc. dba SNET Yellow Pages who is represented by the CWA in accordance with the agreement dated May 25, 2004 |
| **Southeast Region NMNU** | Employee of BellSouth Telecommunications, Inc. or SBC Internet Services, Inc. (in the AT&T Southeast Region) whose job title is Premise Technician or Dispatcher and who is neither classified by their employer as a management Employee nor represented by a union |
| **Southwest Region Core CWA** | Bargained Employee who is represented by the CWA District 6:<br>• In accordance with the agreement dated April 5, 2009, for the following Participating Companies: Southwestern Bell Telephone, L.P.; SBC Advanced Solutions, Inc.; AT&T Operations, Inc.; AT&T Services, Inc.; and SBC Internet Services, Inc.<br>• In accordance with the letter of agreement dated June 16, 2006, amending the Southwest 2004 Core CWA Agreement regarding Special Appendix J Employees whose job title is Premise Technician<br>**Note:** Southwest Region Core CWA benefits are also extended to any eligible nonmanagement nonunion Employee of the Companies described above. |

***Table continued on next page***

| Employee Group Terms Used in This SPD | |
|---|---|
| **Term** | **Description of Employee Group** |
| **SWBAG** | Bargained Employee of Southwestern Bell Advertising Group, Inc. who is represented by the CWA in accordance with the agreement dated April 29, 2007<br><br>**Note:** SWBAG benefits are also extended to any eligible nonmanagement nonunion Employee. |
| **Tier 1 DSL Customer Assistant** | Bargained Employee of SBC Internet Services, Inc. whose job title is Customer Assistant and who is represented by the CWA in accordance with the agreement dated Aug. 15, 2006, as amended March 2, 2007 |
| **West Region Core CWA** | Bargained Employee who is represented by the CWA District 9:<br><br>• In accordance with the West 2009 Core CWA labor agreement dated April 5, 2009, for the following Participating Companies: Pacific Bell Telephone Company; Nevada Bell Telephone Company; AT&T Services, Inc.; and AT&T Video Services, Inc.<br><br>• In accordance with the letter of agreement dated April 3, 2006, amending the West 2004 Core CWA labor agreement regarding Special Appendix D Employees of SBC Global Services, Inc. doing business in California and Nevada<br><br>• In accordance with the letter of agreement dated May 31, 2006, amending the West 2004 Core CWA labor agreement regarding Special Appendix E Employees whose job title is Premise Technician<br><br>**Note:** West Region Core CWA benefits also are extended to any eligible nonmanagement nonunion Employee of the Companies described above. |

# APPENDIX B: ELIGIBILITY, ENROLLMENT, ELIGIBLITY WAITING PERIOD, AND CONTRIBUTION LIMITS MATRIX

| Eligible Employee Group | Eligibility to Enroll | Eligibility Waiting Period | Health Care FSA Contribution Limits | Dependent Care FSA Contribution Limits |
|---|---|---|---|---|
| **Management Employees (except Expatriate Employees)** | Regular Full-Time<br>Regular Part-Time<br>Temp Full-Time<br>Temp Part-Time<br>Term Full-Time<br>Term Full-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **Management Expatriate Employees**<br>***Exception: AT&T Government Solutions (AGS) Expatriates follow AGS benefits.**<br>**Except as noted.** | Regular Full-Time<br>Regular Part-Time<br>Temp Full-Time<br>Temp Part-Time<br>Term Full-Time<br>Term Full-Time | None | Minimum = $100<br>Maximum = $5,000 | Minimum = $100<br>Maximum = $5,000 |
| **Nonmanagement Nonunion Employees (NMNUs) with Management Level Benefits include:**<br>**AIS-CA/NV**<br>**AIS-NMNU**<br>**DGA-NMNU**<br>**Southeast Region NMNU** | Regular Full-Time<br>Regular Part-Time<br>Temp Full-Time<br>Temp Part-Time<br>Term Full-Time<br>Term Full-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **ADV-CWA** | Regular Full-Time<br>Regular Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $5,000 | Minimum = $100<br>Maximum = $5,000 |

***Table continued on next page***

| Eligible Employee Group | Eligibility to Enroll | Eligibility Waiting Period | Health Care FSA Contribution Limits | Dependent Care FSA Contribution Limits |
|---|---|---|---|---|
| **AIS-COS** | Regular Full-Time<br>Regular Part-Time<br>Temp Full-Time<br>Temp Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **AIS-CWA** | Regular Full-Time<br>Regular Part-Time<br>Temp Full-Time<br>Temp Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **AIS-IBEW Local 21** | Regular Full-Time<br>Regular Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **AIS-IBEW Local 58** | Regular Full-Time<br>Regular Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **AIS-IBEW Local 134** | Regular Full-Time<br>Regular Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **AIS-IBEW Local 494** | Regular Full-Time<br>Regular Part-Time | None | Minimum = $100<br>Maximum = $5,000<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **AT&T Mobility-CWA** | Regular Full-Time<br>Regular Part-Time | First of the month following completion of one month NCS | Minimum = $100<br>Maximum = $5,000 | Minimum = $100<br>Maximum = $5,000 |

***Table continued on next page***

| Eligible Employee Group | Eligibility to Enroll | Eligibility Waiting Period | Health Care FSA Contribution Limits | Dependent Care FSA Contribution Limits |
|---|---|---|---|---|
| **ATTVS-SBVS District 6 CWA** | Regular Full-Time<br>Regular Part-Time<br>Temp Full-Time<br>Temp Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **BLS Represented** | Regular Full-Time<br>Regular Part-Time | Upon 6 months seniority with coverage effective 1st of the month following your enrollment date. | Not Eligible | Minimum = $100<br>Maximum = $5,000 |
| **BLS Special Represented** | Regular Full-Time<br>Regular Part-Time | Not Applicable | Not Eligible | Not Eligible |
| **DGA-IBEW Local 1269** | Regular Full-Time<br>Regular Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **East Region Core CWA** | Regular Full-Time<br>Regular Part-Time<br>Temp Full-Time<br>Temp Part-Time | None | Minimum = $100<br>Maximum = $3,000 | Minimum = $100<br>Maximum = $5,000 |
| **L. M. Berry NMNU** | Regular Full-Time<br>Regular Part-Time | None | Not Eligible | Minimum = $100<br>Maximum = $5,000 |
| **Legacy AT&T Corp. CWA** | Regular Full-Time<br>Regular Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **Legacy AT&T Corp. IBEW** | Regular Full-Time<br>Regular Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **Midwest Region Core CWA** | Regular Full-Time<br>Regular Part-Time<br>Regular Limited Term Full-Time<br>Regular Limited Term Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |

***Table continued on next page***

| Eligible Employee Group | Eligibility to Enroll | Eligibility Waiting Period | Health Care FSA Contribution Limits | Dependent Care FSA Contribution Limits |
|---|---|---|---|---|
| **Midwest Region Core IBEW** | Regular Full-Time<br>Regular Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **PBD-IBEW Local 1269** | Regular Full-Time<br>Regular Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $3,000 | Minimum = $100<br>Maximum = $5,000 |
| **PBD-IBEW Local 2139** | Regular Full-Time<br>Regular Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **PB-IBEW Local 1269** | Regular Full-Time<br>Regular Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **PB-TIU Local 103** | Regular Full-Time<br>Regular Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **SBCIS-NIC**<br>**SBCISP-NIC** | Regular Full-Time<br>Regular Part-Time<br>Temp Full-Time<br>Temp Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $3,000 | Minimum = $100<br>Maximum = $5,000 |
| **SBLD-CWA** | Regular Full-Time<br>Regular Part-Time<br>Temp Full-Time<br>Temp Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $3,000 | Minimum = $100<br>Maximum = $5,000 |

***Table continued on next page***

| Eligible Employee Group | Eligibility to Enroll | Eligibility Waiting Period | Health Care FSA Contribution Limits | Dependent Care FSA Contribution Limits |
|---|---|---|---|---|
| **SBLD-IBEW Local 21** | Regular Full-Time<br>Regular Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $5,000 | Minimum = $100<br>Maximum = $5,000 |
| **SBYP** | Regular Full-Time<br>Regular Part-Time<br>Temp Full-Time<br>Temp Part-Time | None | Minimum = $100<br>Maximum = $3,000 | Minimum = $100<br>Maximum = $5,000 |
| **SGI Local 121C and Local 540M** | Regular Full-Time<br>Regular Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **SMSI** | Regular Full-Time<br>Regular Part-Time<br>Temp Full-Time<br>Temp Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **SNEIS-CWA** | Regular Full-Time<br>Regular Part-Time<br>Temp Full-Time<br>Temp Part-Time | None | Minimum = $100<br>Maximum = $3,000 | Minimum = $100<br>Maximum = $5,000 |
| **Southwest Region Core CWA** | Regular Full-Time<br>Regular Part-Time<br>Temp Full-Time<br>Temp Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| **SWBAG** | Regular Full-Time<br>Regular Part-Time<br>Temp Full-Time<br>Temp Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |

***Table continued on next page***

| Eligible Employee Group | Eligibility to Enroll | Eligibility Waiting Period | Health Care FSA Contribution Limits | Dependent Care FSA Contribution Limits |
|---|---|---|---|---|
| Tier 1 DSL Customer Assistant | Regular Full-Time<br>Regular Part-Time<br>Temp Full-Time<br>Temp Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |
| West Region Core CWA | Regular Full-Time<br>Regular Part-Time<br>Term Full-Time<br>Term Part-Time | None | Minimum = $100<br>Maximum = $10,000 | Minimum = $100<br>Maximum = $5,000 |

# APPENDIX C: QUALIFIED STATUS CHANGES MATRIX

This matrix indicates whether you are permitted to make changes to your Before-Tax Premium Option (“BTPO”), Health Care Flexible Spending Account (“Health Care FSA”) and Dependent Care Flexible Spending Account (“Dependent Care FSA”) coverage elections during a Plan Year (Jan. 1 to Dec. 31) as a result of a “Qualified Status Change” under the AT&T Flexible Spending Account Plan. In all cases where this chart indicates that you may make a change to your BTPO, Health Care FSA and/or Dependent Care FSA election(s), the election change must be on account of and consistent with the Qualified Status Change event. The Plan Administrator has the discretion to determine whether an election change is on account of and consistent with the Qualified Status Change event.

This matrix does not apply to your ability to change your coverage election for benefits under the medical, dental, vision, CarePlus, Medical Plus or AD&D plans in which you may be participating. You should refer to the applicable summary plan description to determine your ability to make changes to your elections under such plans. Also, this matrix does not apply to your ability to change your Before-Tax HSA Payroll Deductions, which may be changed at any time for any reason.

*Note: Refer to the bottom of the table for the definitions of the codes provided in the matrix.*

| Life Event | Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars) | | | | | Health Care Flexible Spending Account (Health Care FSA) | Dependent Care Flexible Spending Account (Dependent Care FSA) |
|---|---|---|---|---|---|---|---|
| | **Medical** | **Dental** | **Vision** | **CarePlus / Medical Plus** | **AD&D** | | |
| **Marriage** | AD, AS, C, DD, E, W | AD, AS, DD, E, W | AD, AS, DD, E, W | AD, AS, DD, E, W | AD, AS, DD, C, E, W | D, E, I | D, E, I |
| | **Notes:**<br>E, AD, AS – for newly eligible spouse and any dependent children of Employee or new spouse<br>DD, W – only if coverage is available under new spouse’s plan | | | | | **Notes:**<br>E, I – for spouse and spouse’s dependents<br>D – if new spouse has Health Care FSA | **Notes:**<br>E, I – for spouse’s dependents<br>D – if new spouse is not employed or has Dependent Care FSA election with spouse’s employer |

***Table continued on next page***

<table>
<tr><th rowspan="2">Life Event</th><th colspan="5">Before-Tax Premium Option<br>(Paying Monthly Contributions on a Before-Tax Dollars)</th><th rowspan="2">Health Care Flexible Spending Account (Health Care FSA)</th><th rowspan="2">Dependent Care Flexible Spending Account<br>(Dependent Care FSA)</th></tr>
<tr><th>Medical</th><th>Dental</th><th>Vision</th><th>CarePlus / Medical Plus</th><th>AD&D</th></tr>
<tr><td rowspan="2">Death of spouse, divorce, legal separation, or legal annulment</td><td>AD,C, DD, DS, E</td><td>AD, DD, DS, E</td><td>AD, DD, DS, E</td><td>AD, DD, DS, E</td><td>AD, DD, DS, C, E, W</td><td>D, E, I</td><td>D, E, I</td></tr>
<tr><td colspan="4">Notes:<br>E, AD – if lose coverage under spouse’s plan<br>DS<br>DD – only if dependents have coverage under spouse’s plan</td><td></td><td>Notes:<br>E, I – if lose Health Care FSA under spouse’s plan</td><td>Notes:<br>E, I – to accommodate newly eligible dependents<br>D – if dependent no longer eligible</td></tr>
<tr><td rowspan="2">Gain of dependent status, birth, adoption, placement for adoption</td><td>AD, AS, C,E, W</td><td>AD, AS, E, W</td><td>AD, AS, E, W</td><td>AD, AS, E, W</td><td>AD, AS, DD, DS, C, E, W</td><td>D, E, I</td><td>E, I</td></tr>
<tr><td colspan="4">Notes:<br>E, AD, AS – for newly eligible dependent child or any other dependent child<br>W – only if coverage is available under spouse’s plan</td><td></td><td>Notes:<br>D – if spouse has Health Care FSA</td><td>Notes:<br>E, I – to accommodate newly eligible dependents<br>D – if loss of eligibility due to spouse no longer working</td></tr>
<tr><td rowspan="2">Loss of dependent eligibility status</td><td>DD</td><td>DD</td><td>DD</td><td>DD</td><td>AD, AS, DD, DS, C, E,W</td><td>D</td><td>D</td></tr>
<tr><td colspan="4">Notes:<br>DD – may only drop dependent who lost eligibility</td><td></td><td></td><td></td></tr>
<tr><td>QMCSO requiring an Employee to cover a dependent or alternate payee</td><td>AD, C</td><td>AD</td><td>AD</td><td>AD</td><td>DNA</td><td>E,I</td><td>N</td></tr>
<tr><td colspan="8">Table continued on next page</td></tr>
</table>

| Life Event | Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars) | | | | | Health Care Flexible Spending Account (Health Care FSA) | Dependent Care Flexible Spending Account (Dependent Care FSA) |
|---|---|---|---|---|---|---|---|
| | Medical | Dental | Vision | CarePlus / Medical Plus | AD&D | | |
| **QMCSO requiring former spouse to cover a dependent or alternate payee under the spouse's coverage** | DD | DD | DD | DD | DNA | D | N |
| **Expiration of QMCSO** | W, DD, C | W, DD | W, DD | W, DD | DNA | W | W |
| **Death of covered dependent** | DD | DD | DD | DD | AD, AS, DD, DS, C, E, W | D | D |
| | **Notes:** DD – may only drop deceased dependent | | | | | | |
| **Gain of employment and benefit coverage by spouse or dependent** | DD, DS, W | DD, DS, W | DD, DS, W | DD, DS, W | AD, AS, DD, DS, C, E, W | D | D, E, I |
| | **Notes:** DD, DS, W – only with respect to Employee, spouse, or dependent who gains coverage under another employer's plan | | | | | **Notes:** D – if spouse has Health Care FSA | **Notes:** E, I – if newly eligible due to spouse's employment<br>D – if dependent added under spouse's Dependent Care FSA |

***Table continued on next page***

| Life Event | Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars) | | | | | Health Care Flexible Spending Account (Health Care FSA) | Dependent Care Flexible Spending Account (Dependent Care FSA) |
|---|---|---|---|---|---|---|---|
| | Medical | Dental | Vision | CarePlus / Medical Plus | AD&D | | |
| **Loss of employment and benefit coverage by spouse or dependent** | AD, AS,C, E | AD, AS, E | AD, AS, E | AD, AS, E | AD, AS, DD, DS, C, E, W | E, I | D, E, I |
| | **Notes:** AD, AS, E – only with respect to Employee, spouse, or dependent who lost coverage under another employer's plan | | | | | | **Notes:** E, I – to accommodate loss of coverage under spouse's Dependent Care FSA<br>D – if loss of eligibility due to spouse no longer working |
| **Dependent gains coverage under another employer's plan** | DD | DD | DD | DD | AD, AS, DD, DS, C, E,W | D | D, E, I |
| | | | | | | | **Notes:** E, I – if newly eligible due to dependent's parents' employment<br>D – if dependent added under spouse's Dependent Care FSA |

***Table continued on next page***

| Life Event | Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars) | | | | | Health Care Flexible Spending Account (Health Care FSA) | Dependent Care Flexible Spending Account (Dependent Care FSA) |
|---|---|---|---|---|---|---|---|
| | Medical | Dental | Vision | CarePlus / Medical Plus | AD&D | | |
| **Dependent loses coverage under another employer's plan** | AD, C, E | AD, E | AD, E | AD, E | AD, AS, DD, DS, C, E, W | E, I | D, E, I |
| | **Notes:** AD, E – only with respect to dependent who lost coverage under another employer's plan | | | | | | **Notes:** E, I – to accommodate loss of coverage under spouse's Dependent Care FSA<br>D – if loss of eligibility due to spouse no longer working |
| **Relocation triggering gain of plan benefit/ option eligibility** | AD, AS, E | AD, AS, E | AD, AS, E | AD, AS, E | AD, AS, DD, DS, C, E, W | N | D, E, I |
| | **Notes:** AD, AS, E – only if eligibility for coverage option is gained | | | | | | **Notes:** D, E, I – only if dependent care provider changes and charges a different rate |
| **Relocation triggering loss of plan benefit/ option availability or eligibility** | C, W | W | W | W | AD, AS, DD, DS, C, E, W | N | D, E, I |
| | **Notes:** W – only if eligibility for coverage option is lost | | | | | | **Notes:** D, E, I – only if dependent care provider changes and charges a different rate |

***Table continued on next page***

| Life Event | Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars) | | | | | Health Care Flexible Spending Account (Health Care FSA) | Dependent Care Flexible Spending Account (Dependent Care FSA) |
|---|---|---|---|---|---|---|---|
| | **Medical** | **Dental** | **Vision** | **CarePlus / Medical Plus** | **AD&D** | | |
| **Change in Employee's work schedule or employment status resulting in gain of benefit plan coverage** | AD, AS, E | AD, AS, E | AD, AS, E | AD, AS, E | AD, AS, DD, DS, C, E, W | E | E |
| | **Notes:** AD, AS, E – only if eligibility for coverage option is gained | | | | | **Notes:** E – only if eligibility for Health Care FSA is gained | **Notes:** E – only if eligibility for Dependent Care FSA is gained |
| **Change in Employee's work schedule or employment status resulting in loss of Employee benefit plan coverage** | C, DD, DS, W | DD, DS, W | DD, DS, W | DD, DS, W | AD, AS, DD, DS, C, E, W | D | D |
| | **Notes:** DD, DS, W – only with respect to Employee, spouse, and/or dependent who loses eligibility | | | | | **Notes:** D – only if eligibility for Health Care FSA is lost | **Notes:** D – only if eligibility for Dependent Care FSA is lost |
| **Change in spouse's or dependent's work schedule or employment status resulting in loss of eligibility under spouse's or dependent's employer's benefit plan** | AD, AS, C, E | AD, AS, E | AD, AS, E | AD, AS, E | AD, AS, DD, DS, C, E, W | E, I | D, E, I |
| | **Notes:** AD, AS, E – only with respect to Employee, spouse, or dependent who lost coverage under another employer's plan | | | | | | **Notes:** E, I – to accommodate loss of coverage under spouse's Dependent Care FSA<br>D – if loss of eligibility due to spouse no longer satisfying working requirements |

***Table continued on next page***

<table>
<tr><th rowspan="2">Life Event</th><th colspan="5">Before-Tax Premium Option<br>(Paying Monthly Contributions on a Before-Tax Dollars)</th><th rowspan="2">Health Care Flexible Spending Account (Health Care FSA)</th><th rowspan="2">Dependent Care Flexible Spending Account<br>(Dependent Care FSA)</th></tr>
<tr><th>Medical</th><th>Dental</th><th>Vision</th><th>CarePlus / Medical Plus</th><th>AD&D</th></tr>
<tr><td rowspan="2">Change in spouse’s or dependent’s work schedule or employment status resulting in gain of eligibility under spouse’s or dependent’s employer's benefit plan</td><td>DD, DS, W</td><td>DD, DS, W</td><td>DD, DS, W</td><td>DD, DS, W</td><td>AD, AS, DD, DS, C, E, W</td><td>D</td><td>N</td></tr>
<tr><td colspan="4">Notes:<br>DD, DS, W – only with respect to Employee, spouse, or dependent who gains coverage under another employer’s plan</td><td></td><td>Notes:<br>D – if spouse has Health Care FSA</td><td></td></tr>
<tr><td>Mid-year expiration of COBRA coverage from another employer (Employee, spouse, or dependent)</td><td>AD, AS, C, E</td><td>AD, AS, E</td><td>AD, AS, E</td><td>AD, AS, E</td><td>DNA</td><td>E, I</td><td>N</td></tr>
<tr><td rowspan="2">Decrease in coverage or cost increase under spouse’s or dependent’s employer’s benefit plan(s)</td><td>AD, AS, C*, E<br>*Per HIPAA, only if company contributions cease</td><td>AD, AS, E</td><td>AD, AS, E</td><td>AD, AS, E</td><td>AD, AS, DD, DS, C, E, W</td><td>N</td><td>E, I</td></tr>
<tr><td colspan="4">Notes:<br>AD, AS, E – if Employee, spouse, and/or dependent coverage under other employer’s plan is decreased or dropped</td><td></td><td></td><td>Notes:<br>E, I – if coverage under other employer’s Dependent Care FSA is eliminated or decreased</td></tr>
<tr><td colspan="8">Table continued on next page</td></tr>
</table>

| Life Event | Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars) | | | | | Health Care Flexible Spending Account (Health Care FSA) | Dependent Care Flexible Spending Account (Dependent Care FSA) |
|---|---|---|---|---|---|---|---|
| | Medical | Dental | Vision | CarePlus / Medical Plus | AD&D | | |
| **Increase in coverage or cost decrease under spouse's or dependent's employer's benefit plan(s)** | DD, DS, W | DD, DS, W | DD, DS, W | DD, DS, W | AD, AS, DD, DS, C, E, W | N | D |
| | **Notes:** DD, DS, W – if Employee, spouse, and/or dependent coverage under other employer's plan is added | | | | | | **Notes:** D – if coverage under other employer's Dependent Care FSA is elected |
| **Significant increase in cost of Employee's benefit package option** | AD, AS, C*, DD, DS, E, W<br>*Per HIPAA, only if Company contributions cease | AD, AS, DD, DS, E, W | AD, AS, DD, DS, E, W | AD, AS, DD, DS, E, W | AD, AS, DD, DS, C, E, W | N | N |
| | **Notes:** May increase election to match cost increase, OR<br>W with AD, AS, E - under another benefit package option providing similar coverage, OR<br>W, DD, DS - If no other benefit package providing similar coverage | | | | | | |

***Table continued on next page***

| Life Event | Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars) | | | | | Health Care Flexible Spending Account (Health Care FSA) | Dependent Care Flexible Spending Account (Dependent Care FSA) |
|---|---|---|---|---|---|---|---|
| | Medical | Dental | Vision | CarePlus / Medical Plus | AD&D | | |
| **Significant decrease in cost of Employee's benefit package option** | AD, AS, DD, DS, E, W | AD, AS, DD, DS, E, W | AD, AS, DD, DS, E, W | AD, AS, DD, DS, E, W | AD, AS, DD, DS, C, E, W | N | N |
| | **Notes:** May decrease election to match cost decrease, OR W, DD, DS with AD, AS, E – drop other benefit package option and add benefit package option with decreased cost | | | | | | |
| **A change in dependent care cost or coverage including changing day care provider (non-related)** | DNA | DNA | DNA | DNA | DNA | N | D, E, I |
| **Employee starts a leave of absence whether paid or unpaid, whether FMLA or non-FMLA** | DD, DS, W | DD, DS, W | DD, DS, W | DD, DS, W | AD, AS, DD, DS, C, E, W | D | D |
| **Employee returns from a leave of absence whether paid or unpaid, whether FMLA or non-FMLA** | AD, AS, E | AD, AS, E | AD, AS, E | AD, AS, E | AD, AS, DD, DS, C, E, W | E, I | E, I |

***Table continued on next page***

| Life Event | Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars) | | | | | Health Care Flexible Spending Account (Health Care FSA) | Dependent Care Flexible Spending Account (Dependent Care FSA) |
|---|---|---|---|---|---|---|---|
| | **Medical** | **Dental** | **Vision** | **CarePlus / Medical Plus** | **AD&D** | | |
| **Spouse or dependent starts an unpaid leave of absence (or FMLA leave) with resulting loss in eligibility under spouse's or dependent's employer's benefit plan** | AD, AS, C, E | AD, AS, E | AD, AS, E | AD, AS, E | AD, AS, DD, DS, C, E, W | E, I | D, E, I |
| | **Notes:** AD, AS, E – only with respect to Employee, spouse, or dependent who lost coverage under another employer's plan | | | | | | **Notes:** E, I – to accommodate loss of coverage under spouse's Dependent Care FSA<br>D – if loss of eligibility due to spouse no longer satisfying working requirements |
| **Employee or spouse becomes disabled** | N | N | N | N | AD, AS, C, DD, DS, E, W | N | D, E, I |
| | | | | | | | **Notes:** E, I – if coverage is lost under spouse's employer's Dependent Care FSA<br>D – if loss of eligibility due to spouse no longer satisfying working requirements |

***Table continued on next page***

| Life Event | Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars) | | | | | Health Care Flexible Spending Account (Health Care FSA) | Dependent Care Flexible Spending Account (Dependent Care FSA) |
|---|---|---|---|---|---|---|---|
| | Medical | Dental | Vision | CarePlus / Medical Plus | AD&D | | |
| **Spouse or dependent returns from an unpaid leave of absence with resulting gain in eligibility under spouse's or dependent's employer's benefit plan (or from FMLA leave)** | DD, DS, W | DD, DS, W | DD, DS, W | DD, DS, W | AD, AS, DD, DS, C, E, W | E, I | E, I |
| | **Notes:**<br>DD,DS, W – only with respect to Employee, spouse, or dependent who gains coverage under another employer's plan | | | | | | **Notes:**<br>E, I – if newly eligible due to spouse satisfying working requirements<br>D – to accommodate gain of coverage under spouse's employer's Dependent Care FSA |
| **Spouse starts an unpaid leave of absence (non-FMLA) without change in eligibility** | AD, AS, E | AD, AS, E | AD, AS, E | AD, AS, E | AD, AS, DD, DS, C, E, W | N | N |
| | **Notes:**<br>AD,AS, E – only with respect to Employee, spouse, or dependent who loses coverage under another employer's plan | | | | | | |
| **Spouse or dependent returns from an unpaid leave of absence (non-FMLA) without change in eligibility** | DD, DS, W | DD, DS, W | DD, DS, W | DD, DS, W | AD, AS, DD, DS, C, E, W | N | N |
| | **Notes:**<br>DD,DS, W – only with respect to Employee, spouse, or dependent who gains coverage under another employer's plan | | | | | | |

***Table continued on next page***

| Life Event | Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars) | | | | | Health Care Flexible Spending Account (Health Care FSA) | Dependent Care Flexible Spending Account (Dependent Care FSA) |
|---|---|---|---|---|---|---|---|
| | Medical | Dental | Vision | CarePlus / Medical Plus | AD&D | | |
| **Addition or significant improvement of benefit option to Employee's plan** | AD, AS, DD, DS, E, W | AD, AS, DD, DS, E, W | AD, AS, DD, DS, E, W | AD, AS, DD, DS, E, W | AD, AS, DD, DS, C, E, W | N | D with E, I |
| | **Notes:** DD, DS, W with AD, AS, E – may drop current benefit option and elect significantly improved benefit option<br>AD, AS, E – if not previously enrolled in a benefit option, may elect significantly improved benefit option | | | | | | **Notes:** D with E, I – may drop current option and elect significantly improved benefit option |
| **Addition of benefit option to spouse's or dependent's employer's benefit plans** | DD, DS, W | DD, DS, W | DD, DS, W | DD, DS, W | AD, AS, DD, DS, C, E, W | N | D |
| | **Notes:** DD, DS, W – if Employee, spouse, and/or dependent coverage under other employer's plan is added | | | | | | **Notes:** D – if coverage under other employer's Dependent Care FSA is elected |
| **Employee entitlement to Medicare/ Medicaid coverage** | C, W | C, W only if Medicaid provided Dental Coverage | C, W only if Medicaid provided Vision Coverage | C, W | N | D | N |
| | **Notes:** W – if Employee adds Medicaid coverage | | | | | | |
| ***Table continued on next page*** | | | | | | | |

| Life Event | Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars) | | | | | Health Care Flexible Spending Account (Health Care FSA) | Dependent Care Flexible Spending Account (Dependent Care FSA) |
|---|---|---|---|---|---|---|---|
| | Medical | Dental | Vision | CarePlus / Medical Plus | AD&D | | |
| **Employee loss of Medicare/Medicaid coverage** | AD, AS, C, E | AD, AS, C, E only if Medicaid provided Dental Coverage | AD, AS, C, E only if Medicaid provided Vision Coverage | | N | E, I | N |
| | **Notes:** AD, AS, E – if dependent or spouse loses Medicaid coverage | | | | | | |
| **Spouse/ dependent entitlement to Medicare/ Medicaid coverage** | DD, DS | DD, DS only if Medicaid provided Dental Coverage | DD, DS only if Medicaid provided Vision Coverage | DD, DS | N | D | N |
| | **Notes:** DD, DS – if dependent or spouse adds Medicaid coverage | | | | | | |
| **Spouse/ dependent loss of Medicare/ Medicaid coverage** | C, E, AD, AS | AD, AS, E only if Medicaid provided Dental Coverage | AD, AS, E only if Medicaid provided Vision Coverage | | N | E, I | N |
| | **Notes:** AD, AS, E – if dependent or spouse loses Medicaid coverage | | | | | | |

***Table continued on next page***

| Life Event | Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars) | | | | | Health Care Flexible Spending Account (Health Care FSA) | Dependent Care Flexible Spending Account (Dependent Care FSA) |
|---|---|---|---|---|---|---|---|
| | Medical | Dental | Vision | CarePlus / Medical Plus | AD&D | | |
| **Employee commences strike or lockout resulting in a change in benefit eligibility** | W | W | W | W | AD, AS, DD, DS, C, E, W | D | D |
| **Employee returns from strike or lockout resulting in a change in benefit eligibility** | AD, AS, E | AD, AS, E | AD, AS, E | AD, AS, E | AD, AS, DD, DS, C, E, W | E | E, I |
| **Spouse or dependent commences strike or lockout** | AD, AS, C*, E<br>*Per HIPAA, only if there is a loss in coverage | AD, AS, E | AD, AS, E | AD, AS, E | AD, AS, DD, DS, C, E, W | E, I | D |
| **Spouse or dependent returns from strike or lockout** | C*, DD, DS, W<br>*Per HIPAA, only if there is a loss in coverage | DD, DS, W | DD, DS, W | DD, DS, W | AD, AS, DD, DS, C, E, W | D | E, I |

***Table continued on next page***

| Life Event | Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars) | | | | | Health Care Flexible Spending Account (Health Care FSA) | Dependent Care Flexible Spending Account (Dependent Care FSA) |
|---|---|---|---|---|---|---|---|
| | Medical | Dental | Vision | CarePlus / Medical Plus | AD&D | | |
| **Significant curtailment or termination of Employee's coverage with or without a loss of coverage** | C, DD, DS, W | DD, DS, W | DD, DS, W | DD, DS, W | AD, AS, DD, DS, C, E, W | N | D, E, I |
| **Significant curtailment or termination of spouse's or dependent's coverage under spouse's or dependent's employer's benefit plan(s) with a loss of coverage when no similar coverage is available** | AD, AS, C, E | AD, AS, E | AD, AS, E | AD, AS, E | AD, AS, DD, DS, C, E, W | N | E, I |
| **Employee rehires within 30 days of termination** | Reinstate prior election; no changes allowed. | Reinstate prior election; no changes allowed. | Reinstate prior election; no changes allowed. | Reinstate prior election; no changes allowed. | Reinstate prior election; no changes allowed. | Reinstate prior election; no changes allowed. | Reinstate prior election; no changes allowed. |

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| Life Event | Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars) | | | | | Health Care Flexible Spending Account (Health Care FSA) | Dependent Care Flexible Spending Account (Dependent Care FSA) |
|---|---|---|---|---|---|---|---|
| | Medical | Dental | Vision | CarePlus / Medical Plus | AD&D | | |
| **Employee rehires after 30 days following termination** | AD, AS, C, E | AD, AS, E | AD, AS, E | AD, AS, E | AD, AS, E | E | E |
| **Non-AT&T spouse's or dependent's annual enrollment does not correspond with Employee's annual enrollment** | AD, AS, C*, DD, DS, E, W<br>*Per HIPAA, only if there is a loss in coverage | AD, AS, DD, DS, E, W | AD, AS, DD, DS, E, W | AD, AS, DD, DS, E, W | AD, AS, DD, DS, C, E, W | N | D, E, I |
| | **Notes:**<br>AD, AS, DD, DS, E, W – changes permitted to reflect corresponding changes in non-AT&T spouse's plan | | | | | | **Notes:**<br>D, E, I - changes permitted to reflect corresponding changes in non-AT&T spouse's Dependent Care FSA Plan |
| **Employee gains eligibility under another employer's group plan(s)** | DD, DS, W | DD, DS, W | DD, DS, W | DD, DS, W | AD, AS, DD, DS, C, E, W | N | D |
| | **Notes:**<br>DD, DS, W – if employee, spouse, and/or dependent coverage under other employer's plan is added | | | | | | **Notes:**<br>D – if coverage under other employer's Dependent Care FSA is elected |

***Table continued on next page***

| Life Event | Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars) | | | | | Health Care Flexible Spending Account (Health Care FSA) | Dependent Care Flexible Spending Account (Dependent Care FSA) |
|---|---|---|---|---|---|---|---|
| | Medical | Dental | Vision | CarePlus / Medical Plus | AD&D | | |
| **Employee loses eligibility under another employer's group plan(s)** | AD, AS, C, E | AD, AS, E | AD, AS, E | AD, AS, E | AD, AS, DD, DS, C, E, W | E | E, I |
| **Employee loss of other government or educational institution coverage such as tribal coverage, state health benefits risk pool, or foreign government plan** | AD, AS, C, E | AD, AS, E | AD, AS, E | AD, AS, E | DNA | N | N |
| **Spouse or dependent loss of other government or educational institution coverage such as tribal coverage, state health benefits risk pool, or foreign government plan** | AD, AS, C, E | AD, AS, E | AD, AS, E | AD, AS, E | DNA | N | N |
| **Employee, spouse or dependent meets or exceeds lifetime limit** | C, W | N | N | N | DNA | N | N |
| ***Table continued on next page*** | | | | | | | |

| Life Event | Before-Tax Premium Option (Paying Monthly Contributions on a Before-Tax Dollars) | | | | | Health Care Flexible Spending Account (Health Care FSA) | Dependent Care Flexible Spending Account (Dependent Care FSA) |
|---|---|---|---|---|---|---|---|
| | Medical | Dental | Vision | CarePlus / Medical Plus | AD&D | | |
| **Employee, spouse or dependent complete loss of employer subsidy from another employer** | C, E, AD, AS | N | N | N | DNA | N | N |

*The following is an explanation of the change codes used in this matrix.*

| | |
|---|---|
| *AD = Add Dependent(s)* | *DNA = Does Not Apply* |
| *AS = Add Spouse* | *DS = Drop Spouse* |
| *C = Change in coverage options* | *E = Enroll* |
| *D = Decrease/Drop* | *I = Increase* |
| *DD = Drop Dependent(s)* | *N = No change* |
| | *W = Waive/drop election* |