Cingular Wireless LLC

Other Important Information For Nonbargained and Bargained Employees

Summary Plan Description

This “Summary Plan Description” or “SPD” is effective for claims incurred on or after January 1, 2007. For claims incurred prior to that date, the SPDs dated January 1, 2006 or earlier, as applicable, together with any “Summaries of Material Modification” or “SMMs” shall govern.

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Overview – Other Important Information Section

This "Summary Plan Description" or "SPD" is effective for claims incurred on or after January 1, 2007. For claims incurred prior to that date, the SPDs dated January 1, 2006 or earlier, as applicable, together with any "Summaries of Material Modification" or "SMMs" shall govern.

The Employee Retirement Security Act of 1974 (ERISA) requires that certain kinds of benefit plans be described to the participants of those plans. The mandatory document required by ERISA is called a Summary Plan Description. This document, entitled the *Other Important Information* section, together with the various other sections that describe the actual benefits provided to you by Cingular Wireless LLC (the "Company"), constitutes the Summary Plan Description or "SPD" for your health and welfare benefits from the Company. The SPD provides summaries of the important features of the plans outlined below (hereinafter the following plans are collectively referred to as the "Plans") and explains the general requirements that you or your beneficiaries must meet to obtain benefits from the Plans. The SPD contains only a summary of the Plans that provide the benefits described herein. The contents of the SPD do not replace or override the plan documents. If any discrepancies arise between the contents of the SPD and the applicable plan document(s), the plan documents(s) are the final authority and will control in deciding any questions that may arise concerning the Plan(s). You should carefully consult this *Other Important Information* section along with the underlying benefit sections as this section contains important information that supplements the information contained in the underlying benefit sections.

These documents serve as the Summary Plan Description for the following Plans (all of which have Employer Identification Number 74-2955068):

Nonbargained Employees

Plan Name	Plan Number	Plan Type	Plan Year
Cingular Wireless Health and Welfare Benefits Plan for Nonbargained Employees	501	(See Below)	January 1 to December 31
• Medical Benefits	501	Welfare Benefit Plan providing medical, mental health/chemical dependency and pharmacy benefits	January 1 to December 31
• Dental Benefits	501	Welfare Benefit Plan providing dental benefits	January 1 to December 31
• Vision Benefits	501	Welfare Benefit Plan providing vision benefits	January 1 to December 31
• Life and AD&D Insurance	501	Welfare Benefit Plan providing life and accidental/death and dismemberment insurance	January 1 to December 31
• Employee Assistance Program (EAP)	501	Welfare Benefit Plan providing referrals and limited mental health benefit	January 1 to December 31
• Cingular Wireless Medical Plus Plan	503	Welfare Benefit Plan providing medical benefits for certain treatments	January 1 to December 31

Plan Name	Plan Number	Plan Type	Plan Year
• Cingular Wireless Nonbargained Disability Benefits Plan	504	Welfare Benefit Plan providing short term, basic long term and supplemental long term disability benefits	January 1 to December 31

Bargained Employees

Plan Name	Plan Number	Plan Type	Plan Year
Cingular Wireless Health and Welfare Benefits Plan for Bargained Employees	551	(See Below)	January 1 to December 31
• Medical Benefits	551	Welfare Benefit Plan providing medical, mental health/chemical dependency and pharmacy benefits	January 1 to December 31
• Dental Benefits	551	Welfare Benefit Plan providing dental benefits	January 1 to December 31
• Vision Benefits	551	Welfare Benefit Plan providing vision benefits	January 1 to December 31
• Life and AD&D Insurance	551	Welfare Benefit Plan providing life and accidental/death and dismemberment insurance	January 1 to December 31
• Employee Assistance Program	551	Welfare Benefit Plan providing referrals and limited mental health benefit	January 1 to December 31
• Cingular Wireless Medical Plus Plan	503	Welfare Benefit Plan providing medical benefits for certain treatments	January 1 to December 31
• Cingular Wireless Bargained Disability Benefits Plan	554	Welfare Benefit Plan providing short term, basic long term and supplemental long term disability benefits	January 1 to December 31

Employer/Plan Sponsor

The Plans offered by the Company are sponsored by:

Cingular Wireless LLC
5565 Glenridge Connector
Atlanta, Georgia 30342

Other related companies participate in the Plans as described in the separate benefit sections of the SPD. These include: Cingular Wireless Employee Services LLC and CCPR Services, Inc.

Optional Supplemental Insurance

Cingular makes available from time to time, optional and supplemental insurance policies. These insurance policies are underwritten by third party insurance companies. Cingular does not promote or sponsor these products and are they are not provided under any Cingular benefit plans. Currently, Long Term Care policies are available and fall into the category of optional supplemental insurance.

General Eligibility Provisions

For a description of who is eligible to participate in the various Plans summarized in these materials, you should consult the **Eligibility, Enrollment and Other Administrative Provisions** section of the SPD and the separate benefit sections. Individuals classified by the Company's worker classification procedures and personnel records as independent contractors, leased employees, temporary service employees or the employees of another company are not eligible to participate in any of the Plans.

Plan Administrator

The Administrative Committee of Cingular Wireless administers the Plans and is responsible for:

- Operation and administration of the Plans (except for purposes of formulating and managing the investment policies and controlling the assets of the funded benefit plans, which are responsibility of the Treasurer of the Company);
- Exclusive power to construe and to interpret the Plans and make all determinations, including, but not limited, to questions of eligibility for participation and for receipt of benefits;
- Determining the amount, the manner and the time of payment of benefits;
- Authorizing the payment of benefits;
- Carrying out the provisions of the Plans pertinent to the responsibilities of the Administrative Committee;
- Delegation of any of its fiduciary authority to determine and review claims; and
- Being the named fiduciaries of the Plans for purposes of operation and administration of the Plans.

The Administrative Committee, as the Plan Administrator, and any entity to whom the Administrative Committee delegates any of its authority regarding plan administration interpretation and the payment of and review of claims, such as the delegation described in the paragraph that follows, has the fullest exclusive discretionary authority to make all determinations under the Plans, including, but not limited to, the authority to construe and to interpret the Plans, to decide all questions of eligibility for the benefits (including any necessary factual determinations) and to determine the amount of such benefits; its decisions on all such matters and determinations are final and conclusive and shall be provided the fullest discretion provided by law.

Delegation of Responsibility

The Administrative Committee has delegated responsibility for claims determination and appeals determination to certain third parties as described below:

Plan Benefit	Delegate
Medical Benefits	United Healthcare
Behavioral Health Benefits	United Behavioral Health (effective January 1, 2006)
Pharmacy Benefits	Caremark
Dental Benefits	CIGNA
Vision Benefits	Vision Service Plan (VSP)
Disability Benefits	Gates McDonald (effective January 1, 2006)
Life Insurance	Prudential
EAP	United Behavioral Health (effective January 1, 2006)

The Administrative Committee has retained the authority to hear appeals of denied claims relating to basic eligibility to participate in the various benefit plans. See the section below entitled *How to File a Claim and/or Appeal a Denied Claim*.

Current Administrative Committee Members

Members of the Administrative Committee are appointed by the Chief Operating Officer, the Chief Financial Officer and the Executive Vice President of Human Resources (the "Senior Officers"). The Administrative Committee members may be substituted or removed from their positions at the sole discretion of the Senior Officers. They receive no compensation in their capacities as members, but receive compensation as employees of the Company. None of their compensation is paid from assets of the benefit Plans.

Plan Fiduciaries

The members of the Administrative Committee are the named fiduciaries for purposes of operation and administration of the Plans. However, the Administrative Committee has delegated the discretion to decide and review determinations of benefits to certain third parties as described above.

The Investment Committee is the named fiduciary for formulating the investment policies and managing/controlling the assets of the Plans that are funded. Among its duties, the Investment Committee appoints (and discharges) investment managers and trustees to manage and maintain custody of the assets of the Plans. The Investment Committee is also responsible for authorizing the payment of reasonable expenses for administering the Plans.

The members of the Investment Committee receive no extra compensation over and above their regular compensation from the Company. None of their compensation is paid from the assets of the benefit Plans.

Legal Service

The agent and address for service of legal process for the Plans is:

Secretary, Administrative Committee

Cingular Wireless
5565 Glenridge Parkway
Suite 1700
Atlanta, Georgia 30342

Trustee

The State Street Bank & Trust Company is the trustee of the assets of the benefit plans that are funded. The trustee's address is

State Street Corporation
Master Trust SWB5C
P.O. Box 351
Boston, Ma 02101

Benefit Payments/Asset Accumulation

In addition to the assets of the Plans which are in trust funds, some benefits are provided through insurance companies and/or through the general assets of the Company. Employee contributions, when required, are also used to provide benefits. Investment managers (appointed by Treasurer) invest the assets of the funded Plans. The investment performance of the investment managers is periodically reviewed by the Treasurer. The Administrative Committee or its delegates directs payments of benefits.

Plan Benefit	Benefits Source
Medical Benefits	Self-insured, company assets or trust funds*
Dental Benefits	Self-insured, company assets or trust funds*
Vision Care	Self-insured, company assets or trust funds
Disability Benefits	Short Term Disability: Self-insured, trust funds Basic and Supplemental Long Term Disability: Self-insured, trust funds
Medical Plus	Funded by employee contributions held in a trust fund
Life Insurance	Insured through Prudential
EAP	Self-insured, company assets or trust funds

*As an alternative to Plan benefits, employees in certain geographic areas may be permitted to enroll in and receive their medical or dental benefits through an HMO or other managed care alternatives. All questions regarding benefits, including but not limited to, benefit levels, coverage, policies, benefit summaries, claims determination and claims appeals will be the responsibility of the HMO or managed care alternative administrator, not the Company or its plans.

Assistance in Reading the English Language

If, due to language translation difficulties, you need assistance in interpreting various sections of the handbook, you may contact Human Resources. A Human Resources representative will be pleased to work with you to provide the necessary explanation of rights and obligations under the various Plans, as well as the procedures to be followed in obtaining needed assistance.

Modification, Amendment or Termination of Plans

The Company reserves the unilateral right to amend, modify or terminate the Plans for any reason at any time, retroactively or prospectively. Any changes or modifications can be applied to all participants or only to certain groups, such as former employees or retirees. This right also includes the ability to change the amount of any required employee, former employee, dependent, survivor or retiree contributions or premiums or any deductibles or co-pays for any type of benefits whether before or after the date of any employee's retirement. The changes described in this section may be applicable to the employees in the Nonbargained Retiree Medical Transition Groups (as those groups are described in the applicable Summary Plan Descriptions) as employees in those groups are not being vested into any certain level of benefits or level of retiree contributions or premiums for retiree benefits. Nothing herein shall be deemed or construed as a lifetime right to any benefits or level of benefits. This means, for example, that no individual will acquire a lifetime right to any benefit (or level of benefit) or to the continuation of any Plan benefit or benefit program or policy merely by reason of the fact that such Plan or benefit is in existence at the time of such individual's retirement. Any amendment may be made by the Board or Senior Officers (defined as the Chief Operating Officer, the Chief Financial Officer and the Executive Vice President – Human Resources); provided, any amendment that is reasonably expected to increase the cost of the Plan may be made only by the Board.

In the event of termination, the trust funds for any funded plans will be distributed in accordance with rules established by the Internal Revenue Service and in accordance with the provisions of the Plans.

Right to Continuation Coverage

Pursuant to "COBRA" or "USERRA", continuation of Plan benefits may be available to those individuals who, for a variety of reasons, would normally lose coverage, as described below. COBRA applies only to the health benefits offered under the Medical Plan, the Dental Plan, Vision Plan, the Medical Plus Plan and the EAP program. For purposes of administering COBRA, each of these plans is treated as a separate plan.

COBRA refers to a federal law that provides Employees (as defined in the Plans) and other "Qualified Beneficiaries" the opportunity to continue health coverage after a "Qualifying Event" that would otherwise result in such person losing coverage. "COBRA Continuation Coverage" means your right, or your Spouse's and Dependent's right (as those terms are defined in the Plans), to continue to be covered under the group health plans listed above.

A "Qualified Beneficiary" is any person who, as of the day before a Qualifying Event, is (a) an Employee of the Company covered under the Medical Plan, Vision Plan, Dental Plan, Medical Plus Plan or EAP program ("Covered Employees"), (b) the covered Spouse of the Covered Employee, or (c) a covered Dependent of the Covered Employee. In addition, a Child (as defined in the Plans) born to, placed for adoption or adopted by a Qualified Beneficiary who has elected COBRA is also a Qualified Beneficiary.

Employees and Dependents

COBRA Continuation Coverage may be continued for up to 18 months by Employees or Dependents in the case of loss of coverage due to the following Qualifying Events:

- Reduction in the Covered Employee's work hours; or
- The Covered Employee's termination of employment, except for discharge for gross misconduct as determined by the Company.

Dependents Only

COBRA Continuation Coverage may be continued for up to 36 months by Dependents following loss of Plan coverage due to the following Qualifying Events:

- Death of a Covered Employee;
- Divorce or legal separation from a Covered Employee;
- Termination of a Dependent's status as a Dependent under the terms of the Plans; or
- The Covered Employee's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare").

Disabled Employees and Covered Dependents

COBRA Continuation Coverage may be continued for up to 29 months from the date of termination of employment or reduction of hours by Covered Employees (and their Qualified Beneficiaries), provided that:

- The Qualified Beneficiary is determined to be disabled under the Social Security Act within 60 days of the commencement of COBRA Continuation Coverage;
- The Qualified Beneficiary notifies the Company of the disability within 60 days of the disability determination and before the end of the initial 18-month COBRA period; and
- In the case of COBRA Continuation Coverage that is extended beyond the 18-month continuation period because of disability, the COBRA Continuation Coverage will terminate on the earliest of the first day of the month that begins more than 30 days after it is determined that the Qualified Beneficiary is no longer disabled or the date Continuation Coverage would otherwise terminate. *You must notify the Company as soon as you cease to be disabled*.

Multiple Qualifying Events

If, following the occurrence of a qualifying event entitling a Dependent to 18 months of COBRA Continuation Coverage, a second qualifying event occurs, other than the Covered Employee's entitlement to Medicare, which is described below, the Dependent may continue his or her COBRA Continuation Coverage for an additional period not to exceed 36 months from the first qualifying event.

Qualified Beneficiaries will be notified in writing of eligibility for Continuation Coverage and the election procedures. To obtain Continuation Coverage, Qualified Beneficiaries must follow all instructions sent with the notice of eligibility. Generally, Qualified Beneficiaries will have 60 days from the date of notice to elect Continuation Coverage. During this 60-day election period, Qualified Beneficiaries must decide whether to continue their coverage by agreeing to pay the premiums on a monthly basis.

In the case of a termination or reduction of hours, death or entitlement to Medicare, and in certain other situations, the Company will furnish each Participant with written notification of the termination of coverage and his right to elect Continuation Coverage. When you are divorced, or your Dependent child loses eligibility, the Company has no way of knowing; **therefore, it is your responsibility and the responsibility of affected Dependents to notify the Company**

within 60 days of a divorce, legal separation, loss of a child's Dependent status under the Plan or the birth or adoption of a child. If this notice is not received within 60 days, the Dependent will permanently lose eligibility for the Continuation Coverage. If a Qualified Beneficiary is determined to be disabled within the first 60 days of the date COBRA Continuation Coverage commenced, that person must notify the Company of that determination within 60 days after the date of determination. (**Note**: this must be within the first 18 months after COBRA Continuation Coverage begins.)

Continuation Coverage will terminate immediately if any one of the following occurs:

(1) The Qualified Beneficiary fails to pay the premium in a timely manner, defined initially as within 45 days of the date of the COBRA election and thereafter within 30 days of each due date;
(2) The Qualified Beneficiary first becomes, after the date of election, covered under another group health plan (unless the Qualified Beneficiary is subject to pre-existing condition exclusions under that Plan);
(3) The Qualified Beneficiary first becomes, after the date of election, entitled to Medicare benefits. However, your covered Dependents may still continue their coverage if you become eligible for Medicare as described above;
(4) The expiration of the applicable COBRA Continuation Coverage period as described above;
(5) In the case of an extension of COBRA to 29 months due to disability, the month that begins more than 30 days after the date of the final determination under the Social Security Act that the Qualified Beneficiary is no longer disabled; or
(6) The Plan is amended or terminated.

Payments for Continuation Coverage are payable monthly no later than the due date, except for the first payment that is due within 45 days after the date on which you elect COBRA Continuation Coverage. Coverage will terminate retroactive to the due date without reinstatement privileges if payments have not been received within 30 days of the due date. The Company is not required to send you payment reminders or overdue notices. Required contributions for COBRA Continuation Coverage are 102% of the cost of Continuation Coverage for similarly situated Participants. However, if COBRA Continuation Coverage has been extended beyond 18 months due to disability, the COBRA premium will be equal to 150% of that cost.

As required under USERRA, Employees who are Participants on the date a Military Leave commences may continue health coverage for themselves and any Dependents who are Participants immediately prior to such leave. Continuation Coverage pursuant to USERRA will not extend beyond the earlier of:

(1) 18 months beginning on the date the USERRA Leave commences; or
(2) the date the Employee fails to return to active employment with the Company within the time prescribed by USERRA.

Under USERRA, if the USERRA Leave is less than 31 days, the contribution required for Continuation Coverage is the same as the contribution that would be required if such individual was in active service. For USERRA Leaves that extend at least 31 days, contributions required for Continuation Coverage will be the same as for COBRA Continuation Coverage. The Company may make certain modifications and/or enhancements to the legally provided USERRA provisions. You should consult the Cingular Wireless Leave of Absence policy for more complete information.

As provided for in the SPDs for the underlying Medical Plans, in some cases, benefits are extended to Registered Domestic Partners. While not legally required to do so, the Company intends to make available continuation coverage, similar to the COBRA continuation coverage described above and subject to the same requirements, to these qualifying individuals upon a Qualifying Event.

How to File a Claim and/or Appeal a Denied Claim Relating to Basic Eligibility of Participant

The following section describes the claims appeal process for each of the various benefits provided under the Plans. You will note that the process for each type of benefit, i.e., medical, dental, vision, etc. is administered by different vendors and generally differs between the types of benefits. The time limits for filing an appeal will be strictly adhered to and tardy appeals will not be heard. These appeal procedures are the sole process for appeal and must be exhausted before litigation steps are taken. Exhaustion of these appeal remedies is not optional should you choose to pursue litigation.

Appeals from Denials of Basic Eligibility for Benefits

If you are told that you or your dependents are not eligible to participate in any of the benefits covered by this Other Important Information section, then you should take the following steps to file a claim. Place your claim regarding basic eligibility to participate in writing and direct it to:

Cingular Wireless
Benefits Appeals
5565 Glenridge Connector
7th floor, Mailstop 770
Atlanta, GA 30342

You have one year from the date your coverage would have originally been effective to file an eligibility claim. Your claim will be determined within 90 days of receipt of your claim. If special circumstances require an extension, the Plan may take up to an additional 90 days to make an initial determination. You will receive written notification on the outcome of your claim. If you disagree with this determination, you have the right to file an appeal. To file an appeal, the Administrative Subcommittee of Cingular Wireless must receive your written request for an appeal within 60 days of the date of the denial letter from Cingular Benefits Operations. Your appeal should be directed to:

The Cingular Wireless Administrative Subcommittee
Cingular Wireless
Benefits Appeals
5565 Glenridge Connector
7th floor, Mailstop 770
Atlanta, GA 30342

Upon receipt of your request, you will receive a response from the Subcommittee within 60 days of the receipt of your appeal. If special circumstances require an extension, the Administrative Subcommittee may take up to an additional 60 days to make a determination on your appeal.

Dental Plans – CIGNA

The following information is provided by CIGNA.

When You Have A Concern Or Complaint

(For the purposes of this section, any reference to "you," "your," or "the insured" also refers to a representative or provider designated by you to at on your behalf, unless otherwise noted. We refers to Connecticut General or CIGNA)

We want you to be completely satisfied with Connecticut General and the care you receive. That's why we've established a process for addressing your concerns and solving your problems.

Start With Customer Service Department

We're here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call the following free number on your Connecticut General ID card and explain your concern to one of our Customer Service Department representatives. You can also express that concern by writing to the following:

CIGNA Dental
Attn: Appeals Department
P.O. Box 188044
Chattanooga, TN 37422

We'll do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we'll get back to you as soon as possible, but in any case within thirty (30) days.

If you are not satisfied with the result of a coverage decision, you can start the appeals procedure.

Appeals Procedure

Connecticut General has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to the Customer Service Department at the address shown above within one year of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask the Customer Service Department to register your appeal by calling the toll-free number on your Connecticut General ID card. You may also register your appeal by an arranged appointment or walk-in interview.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving medical necessity or clinical appropriateness will be considered by a heath care professional.

For level one appeals, we will respond in writing with a decision within thirty (30) calendar days after we receive the appeal. If the review cannot be completed within thirty (30) calendar days,

we will notify you in writing, on or before the thirtieth (30th) calendar day, of the reason for the delay, and the review will be completed within fifteen (15) calendar days after that.

You may request that the appeal process be expedited if the time frames under this process would seriously jeopardize your life or health or would jeopardize your ability to regain maximum functionality. Connecticut General, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Connecticut General will respond orally with a decision within seventy-two (72) hours, followed up in writing.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process for a level one appeal.

Most requests for a second review will be conducted by Connecticut General's Appeals Committee, which consists of a minimum of three (3) people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving medical necessity or clinical appropriateness, the committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by Connecticut General. You may present your situation to the committee in person or by conference call.

For level two appeals, we will acknowledge in writing that we have received your request and schedule a committee review. If the review cannot be completed within thirty (30) calendar days, you will be notified in writing on or before the fifteenth (15th) calendar day, and the review will be completed no later than forty-five (45) calendar days after receipt of your request. You will be notified in writing of the Appeal Committee's decision within five (5) business days after the committee meeting.

You may request that the appeal process be expedited if the time frames under this process would seriously jeopardize your life or health or would jeopardize your ability to regain maximum functionality. Connecticut General, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Connecticut General will respond orally with a decision within seventy-two (72) hours, followed up in writing.

Independent Review Procedure

If you are not fully satisfied with the decision of Connecticut General's level two appeal review regarding your medical necessity or clinical appropriateness issue, you may request that your appeal be referred to an independent review organization. The independent review organization is composed of persons who are not employed by Connecticut General or any of its affiliates.

There is no charge for you to initiate this independent review process. Connecticut General will abide by the decisions of the Independent Review Organization.

In order to request a referral to an independent review organization, the reason for the denial must be based on a medical necessity or clinical appropriateness determination by Connecticut General. Administrative, eligibility or benefit coverage limited or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Connecticut General Appeals Coordinator within one hundred (100) days of your receipt of Connecticut General's level two-appeal review denial. Connecticut General will then forward the file to the independent review organization.

The independent review organization will render an opinion within thirty (30) calendar days. When requested and when a delay would be detrimental to your medical condition, as determined by Connecticut General, the review shall be completed within no more than seventy-two (72) hours from receipt of all information necessary to complete the review.

The independent review program is a voluntary program arranged by Connecticut General.

Disability Plans – GatesMcDonald

Initial Determination

After you submit a claim for disability benefits to GatesMcDonald, GatesMcDonald will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case GatesMcDonald may have up to two (2) additional extensions of 30 days each to provide you such notification. If GatesMcDonald needs an extension, it will notify you prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of GatesMcDonald's notice requesting further information and an extension until GatesMcDonald receives the requested information does not count toward the time period GatesMcDonald is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from GatesMcDonald.

If GatesMcDonald denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because GatesMcDonald did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Appealing the Initial Determination

If GatesMcDonald denies your claim, you may appeal the decision. Upon your written request, GatesMcDonald will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to GatesMcDonald at the following address within 180 days of receiving GatesMcDonald's decision:

GatesMcDonald
ATTN: Cingular Appeals Manager
PO Box 183080
Columbus, OH 43218-3080

Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After GatesMcDonald receives your written request appealing the initial determination, GatesMcDonald will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and GatesMcDonald's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, GatesMcDonald will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

GatesMcDonald will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after GatesMcDonald's receipt of your written request for review, except that under special circumstances GatesMcDonald may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, GatesMcDonald will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from GatesMcDonald's notice to you of the need for an extension to when GatesMcDonald receives the requested information does not count toward the time GatesMcDonald is allowed to notify you of its final decision. You will be given a reasonable time period to provide the requested information from the date you receive the notice from GatesMcDonald.

If GatesMcDonald denies the claim on appeal, GatesMcDonald will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, GatesMcDonald will provide you free of charge with copies of documents, records and other information relevant to your claim.

Medical Plans – United HealthCare

The following information is provided by United HealthCare.

Filing a Claim for Benefits

If You Receive Covered Health Services from a Network Provider

United HealthCare pays Network providers directly for your covered health services. If a Network provider bills you for any service, contact United HealthCare. However, you are responsible for Copayments to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive covered health services from a non-Network provider, you are responsible for requesting payment through United HealthCare. You must file the claim in a format that contains all of the information required, as described below.

You must submit a request for payment of benefits within one year after the date of service. If a non-Network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you don't provide this information to United HealthCare within one year of the date of service, benefits for that health service will be denied or reduced, in Cingular's or United HealthCare's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.

If you provide written authorization to allow direct payment to a provider, all or a portion of any eligible expenses due to a provider may be paid directly to the provider instead of being paid to you. United HealthCare will not reimburse third parties who have purchased or been assigned benefits by Physicians or other providers.

Required Information

When you request payment of benefits, you must provide United HealthCare with all of the following information:

A. Employee's name and address.
B. The patient's name, age and relationship to the Employee.
C. The member {and Group} number stated on your ID card.
D. An itemized bill from your provider that includes the following:
   - Patient Diagnosis
   - Date(s) of service
   - Procedure Code(s) and descriptions of service(s) rendered
   - Charge for each service rendered
   - Provider of service Name, Address and Tax Identification Number
E. The date the injury or Sickness began.
F. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

United HealthCare will make a benefit determination as set forth below. Benefits will be paid to you unless either of the following is true:

A. The provider notifies United HealthCare that your signature is on file, assigning benefits directly to that provider.
B. You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

Benefit Determinations

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from United HealthCare within 30 days of receipt of the claim, as long as all needed information was provided with the claim. United HealthCare will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, United HealthCare will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from United HealthCare within 15 days of receipt of the claim. If you filed a pre-service claim improperly, United HealthCare will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, United HealthCare will notify you of the information needed within 15 days after the claim was received, and may request a one time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, United HealthCare will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45 days period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claims that Require Immediate Action

Urgent care claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72-hours after United HealthCare receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent care claim improperly, United HealthCare will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, United HealthCare will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- United HealthCare's receipt of the requested information; or
- The end of the 48 hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. United HealthCare will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

How To Appeal A Determination

To resolve a question, complaint, or appeal, just follow these steps:

What to Do First

If your question or concern is about a benefit determination, you may informally contact United HealthCare's Customer Service Department before requesting a formal appeal.

The telephone number is shown on your ID card.

Customer Service representatives are available to take your call during regular business hours, Monday through Friday. If your condition is urgent please refer to the Immediate Action section.

NOTE: If you are not satisfied with a benefit determination you may appeal it as described below, without first informally contacting United HealthCare's Customer Service Department. If you first informally contact United HealthCare's Customer Service Department and later wish to

request a formal appeal in writing, you should contact United HealthCare's Customer Service Department and request and appeal. A Customer Service representative will provide you with the appropriate address of United HealthCare.

What to Do Next

If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. United HealthCare will notify you of its decision regarding your written appeal within 31 days of receipt of all relevant information. If you are not satisfied with a benefit determination, you may appeal this decision as described below.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can ask United HealthCare in writing, using the following address, to formally reconsider your appeal:

United HealthCare Appeals
P. O. Box 740816
Atlanta, GA 30374-0816

If the appeal relates to a claim for payment, your request should include:
- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any new information to support your request for claim payment.

Your first appeal review request must be submitted to United HealthCare within 180 days after you receive the claim denial.

If you are not satisfied with the first level appeal decision of United HealthCare, you have the right to request a second level appeal from United HealthCare. Your second level appeal request must be submitted to United HealthCare in writing within 60 days from receipt of first level appeal decision.

Appeal Process

United HealthCare will appoint a qualified individual to resolve or recommend the resolution of the appeal. If your complaint is related to clinical matters, the review will be done by a health care professional who was not involved in the initial determination with appropriate expertise in the field. United HealthCare may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information.

Appeals Determinations

United HealthCare will send you written or electronic notification of its decision on non-urgent claims as follows:

Pre-Service Claims

For appeals of pre-service claims, the first level appeal will be conducted and you will be notified by United HealthCare of the decision within 15 days from receipt of a request for appeal of a denied claim.

The second level appeal will be conducted and you will be notified by United HealthCare of the decision within 15 days from receipt of a request for review of the first level appeal decision.

Post-Service Claims

For appeals of post-service claims, the first level appeal will be conducted and you will be notified by United HealthCare of the decision within 30 days from receipt of a request for appeal of a denied claim.

The second level appeal will be conducted and you will be notified by United HealthCare of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see "Immediate Action – Urgent Claim Appeals" below.

Cingular has delegated to United HealthCare the exclusive right to interpret and administer the provisions of the Plan. United HealthCare's decisions are conclusive and binding.

Please note that United HealthCare's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Urgent Claim Appeals

Your appeal may require immediate action if you or your physician judges that a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function. In these urgent situations:

The appeal does not need to be submitted in writing. You or your physician should call United HealthCare as soon as possible.

United HealthCare will notify you of the decision in writing or electronically within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

The complaint process for urgent situations does not apply to prescheduled treatments, therapies, surgeries or other procedures that United HealthCare does not consider to be urgent situations.

For urgent claim appeals, Cingular delegated to United HealthCare the exclusive right to interpret and administer the provisions of the Plan. United HealthCare's decisions are conclusive and binding.

Pharmacy Benefits – Caremark

The following information is provided by Caremark.

Pharmacy Benefit Appeal Process

If your claim for pharmacy benefits is denied, you may appeal the denial in writing within 180 days after the claim has been denied. To appeal the denied claim, you must provide Caremark, the Claims Administrator for the Pharmacy Benefit Plan, with a written letter. You should state the reasons why you feel your appeal should be approved and include any information supporting your appeal. Written appeals should be directed to:

Caremark, Inc.
Appeals Department
MC109
PO Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-689-3092

There is also a toll free phone number available only to physicians for urgent appeals only. This Toll Free Physician's phone number is: 1-866-443-1183.

Urgent appeals can be submitted only by physicians and will be completed within 72 hours per ERISA regulations. Urgent appeals may also be submitted via fax.

1st Level Appeal – Caremark's Appeal Department will conduct a full and fair review of your appeal and will notify you of the decision within 60 days or 120 days if special circumstances apply. You will be notified of the need for extension in writing if this should occur. The final decision will be in writing and will include the specific reasons and references to Plan provisions on which the decision is based.

2nd Level Appeal – If you are dissatisfied with the level one appeal decision, you may request a second review. Follow the same process for a level one appeal by submitting to Caremark in writing the reasons for the appeal. An independent review will be done by Caremark's Quality Department and you will be notified in writing of the Quality Committee's decision within 30 business days after the committee meeting.

ERISA requires that appeal decisions are completed as follows:

- Pre-service claims – within 15 days of receipt of a claim
- Post-service claims – within 30 days of receipt of a claim

Behavioral Health – United Behavioral Health

The following information is provided by United Behavioral Health.

Customer Service And Claims Submittal For Behavioral Health Benefits

Behavioral Health Services Administrator Designee:

United HealthCare
P.O. Box 740800
Atlanta, GA 30374-0800
Contact # for United Behavioral Health – 1-800-538-8101

Claims Submittal Address:

United HealthCare
P.O. Box 740800
Atlanta, GA 30374-0800

Claims Process

Claims for benefits for Behavioral Health benefits under the Plan are to be directed to the Administrator identified above.

Pre-Authorization & Utilization Review Of Benefit Claims

Behavioral Health Benefits under the Plan are subject to pre-authorization in all cases except for Emergency Services. United Behavioral Health must be notified of all emergency admissions within 24 hours following admission. In addition, all Behavioral Health Benefits are subject to utilization review requirements of the Plan as determined by the Administrator of those benefits.

Claims Processing & Payment

Claims for Behavioral Health Benefits must be submitted in writing, and supported by appropriate documentation and information, to the Administrator at the address noted above. Claims which are properly submitted will be processed and paid in accordance with the benefits of the Plan provided such benefits have met the Pre-Authorization and Utilization Review requirements of the Plan.

Address for Requests For Review Of Denied Claims

Name and Address For Review of Denied Claims:

United Behavioral Health
Appeals & Complaint Unit
P.O. Box 32040
Oakland, CA 94604
Fax: (415) 547-6259

If a Covered Person or any person making a claim on behalf of a Covered Person, including a Provider of Health Services, wishes to have a denied claim reviewed, a written Appeal must be sent to the address identified above within 180 days after the claim has been denied. In the event of an Urgent Claim appeal the Administrator will also accept an appeal by telephone.

A claimant will be afforded an opportunity to submit any information or documentation in support of the claim and appeal. United Behavioral Health takes all such submitted information into account in considering the appeal regardless of whether such information was submitted or considered in the initial consideration of the case.

Notice of a decision regarding a Medical Necessity Appeal will be provided within: 72 hours in the case of an Inpatient Appeal, 30 calendar days for an Outpatient Appeal. A listing of further appeal options and other rights will be included in the notice of the decision on the appeal.

United Behavioral Health as Claims Administrator has full discretionary authority to interpret the provisions of the Plan and to determine eligibility for and entitlement to Plan benefits. United Behavioral Health determines conclusively for all parties all questions arising under the Behavioral Health Plans, and any decision as Claims Administrator is final and not subject to further review.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact UBH in writing to formally request an appeal. If the appeal relates to a claim for payment, the request should include:

1. The patient's name and the identification number.
2. The date(s) of service(s).
3. The provider's name.
4. The reason the Covered Person believes the claim should be paid.
5. Any documentation or other written information to support the request for claim payment.
6. Your first level appeal request must be submitted to UBH within 180 days after you receive a claim denial at the following address:

United Behavioral Health
Appeals & Complaint Unit
P.O. Box 32040
Oakland, CA 94604
Fax: (415) 547-6259

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If the appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. UBH may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to the copies of all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

First Level Pre-service and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on the appeal as follows:

For appeals of pre-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied claim.

For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim.

For procedures associated with urgent claims, see ***Urgent Claim Appeals That Require Immediate Action*** below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal, see ***Second Level Pre-service and Post-service Claim Appeals*** below.

Please note that UBH's decision is based only on whether or not benefits are available for the proposed treatment or procedure.

Second Level Pre-service and Post-service Claim Appeals

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. The second level appeal request must be submitted to UBH within 60 days from receipt of the first level appeal decision.

For appeals of pre-service claims, the second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims, the second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

We have delegated to UBH the discretionary authority to interpret and administer the provisions of the Plan. UBH's appeal decision is final and binding.

Urgent Claim Appeals that Require Immediate Action

An appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function. In these urgent situations:

The appeal does not need to be submitted in writing. You or your Physician should call UBH as soon as possible.

UBH will provide you with a written or electronic determination within 72 hours following receipt of the request for review of the determination, taking into account the seriousness of your condition.

Life Insurance Benefits – Prudential Financial

Plan Benefits Provided by

The Prudential Insurance Company of America
751 Broad Street
Newark, New Jersey 07102

This Group Contract underwritten by The Prudential Insurance Company of America provides insured benefits under your Employer's ERISA plan(s). For all purposes of this Group Contract, the Employer/Policyholder acts on its own behalf or as an agent of its employees. Under no circumstances will the Employer/Policyholder be deemed the agent of The Prudential Insurance Company of America, absent a written authorization of such status executed between the Employer/Policyholder and The Prudential Insurance Company of America. Nothing in these documents shall, of themselves, be deemed to be such written execution.

The Prudential Insurance Company of America as Claims Administrator has the sole discretion to interpret the terms of the Group Contract, to make factual findings, and to determine eligibility for benefits. The decision of the Claims Administrator shall not be overturned unless arbitrary and capricious.

Claim Procedures

1. Determination of Benefits

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim, shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the plan. A written notice of the additional extension, the reason for the additional extension and the date by which the plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

(a) the specific reason(s) for the denial,

(b) references to the specific plan provisions on which the benefit determination was based,

(c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,

(d) a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals, and

(e) if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

2. Appeals of Adverse Determination

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to:

Prudential Insurance Company of America
290 West Mount Pleasant Avenue
Livingston, New Jersey 07039.

Your appeal must be submitted to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential shall make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

(a) the specific reason(s) for the adverse determination,

(b) references to the specific plan provisions on which the determination was based,

(c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request,

(d) a description of Prudential's review procedures and applicable time limits,

(e) a statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and

(f) a statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Rights and Protections

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated

summary plan description. The plan administrator may make a reasonable charge for the copies.

- 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.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare 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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which 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 your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Vision Plans – Vision Service Plan

The following information is provided by Vision Service Plan ("VSP").

COMPLAINTS AND GRIEVANCES

If Covered Person ever has a question or problem, Covered Person's first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer Covered Person's question and/or resolve the matter informally. If a matter is not initially resolved to the satisfaction of a Covered Person, the Covered Person may communicate a complaint or grievance to VSP orally or in writing by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Covered Persons also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) calendar days, a letter will be sent to the Covered Person to indicate VSP's expected resolution date. Upon final resolution, the Covered Person will be notified of the outcome in writing.

Claim Payments and Denials

A. Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of the receipt of the claim from the Covered Person or Covered Person's authorized representative. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

B. Request for Appeals: If a Covered Person's claim for benefits is denied by VSP in whole or in part, VSP will notify the Covered Person in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, Covered Person may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for benefits was denied, including the name of the VSP Enrollee, Member Identification Number of the VSP Enrollee, the Covered Person's name and date of birth, the name of the provider of services and the claim number. The Covered Person may state the reasons the Covered Person believes that the claim denial was in error. The Covered Person may also provide any pertinent documents to be reviewed. VSP will review the claim and give the Covered Person the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. Covered Person or Covered Person's authorized representative should submit all requests for appeals to:

VSP
Complaint & Grievance Unit
PO Box 997100
Sacramento, CA 95899-7100
(800) 852-7600

VSP's determination, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for appeal from the Covered Person or Covered Person's authorized representative.

If Covered Person disagrees with VSP's determination, he/she may request a second level appeal within sixty (60) calendar days from the date of the determination. VSP shall resolve any second level appeal within thirty (30) calendar days.

Under ERISA Section 502(a)(I)(B), Covered Person has the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

Non Alienation of Benefits

Except as expressly permitted by the Administrative Committee, no benefit under the Plans will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge and any attempt to do so shall be void.

Health Insurance Issuers

Current law requires the disclosure of the name, the address and the nature of provided services and benefits of each health insurance issuer associated with the Company's group health plans. The addresses listed below may NOT be the same address used for the appeal of denied claims under each Plan. For more information regarding the appeal processes associated with the Plans, you should review the preceding sections. If you are currently enrolled in an HMO, including a dental HMO, you should contact your applicable HMO for more information regarding appeal procedures.

Administrative and Claims Processing Services

The following insurance issuers provide administrative and claims processing services to the Medical Plans:

United Healthcare P.O. Box 740800 Atlanta, Georgia 30374	Vision Service Plan (VSP) VSP Corporate Headquarters 3333 Quality Drive Rancho Cordova, California 95670
Cigna Dental Connecticut General Life Insurance Company 900 Cottage Grove Road Hartford, Connecticut 06152	United Healthcare (Behavioral Health) P.O. Box 740800 Atlanta, Georgia 30374
Caremark, Inc. 2211 Sanders Road Northbrook, Illinois 60062	

Managed Care Alternatives

The Company offers managed care alternatives in addition to the company-sponsored medical plan options. Managed care claims administrators receive premium or administrative services payments each month from the Company for covered employees and are responsible for providing insured medical benefits or administrative services to participants who have elected such coverage. Addresses and contact information can be found in the Reference Library at https://netbenefits.fidelity.com/.

Your Rights Under ERISA (Model DOL Notice)

As a participant in any of the Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office, all documents governing the Plans, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request, copies of documents governing the operation of the Plans, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (form 5500 Series) and updated summary plan descriptions. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. ERISA require the Plan Administrator to give each participant a copy of a summary of this financial report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plans (if applicable) as a result of a qualifying event. Your or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plans on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan: You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under certain plans, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the

materials and pay you up to $110 day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may file suit in a federal court. The court will decide who should pay court costs and legal 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 call the Cingular Wireless Benefit Service Center at 1-877-421-5225 or contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Union Agreements

Certain benefits described in this Summary Plan Description reflect provisions agreed to in the applicable collective bargaining agreements with the Communication Workers of America.

Copies of the collective bargaining agreements are available to those covered by the agreement and to any other participant or beneficiary who submits a written request for a copy of the Plan Administrator. A reasonable charge may be made for copies in response to such written request.