Summary Plan Description

Important Benefits Information

SNET Vision Program

This summary plan description (SPD) is a guide for using the SNET Vision Program (Program), a component program offered under the AT&T Umbrella Benefit Plan No. 1 (Plan).

Please keep this SPD for future reference.

DISTRIBUTION

Distributed to active bargained employees of AT&T Companies listed in the "Participating Companies" section on Page 64 of the SPD who may be eligible to participate as described in the "Eligibility and Participation" section on Page 8.

NIN 78-17139

IMPORTANT INFORMATION

In all cases, the official documents for the Plan govern and are the final authority on the terms of the Plan and, if there are any discrepancies between the information in this SPD and the Plan, the Plan documents will control. 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 document is a summary plan description (SPD) for the SNET Vision Program (Program), a component program offered under the AT&T Umbrella Benefit Plan No. 1 (Plan). It replaces the previous SPD for the Program dated September 2004 and any summaries of material modifications (SMMs) to that SPD.

What action do I need to take?

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

How do I use this document?

It is important that you read this SPD to get a complete picture of your Benefits. It provides information about your vision Benefits, including:

- Eye Examinations.
- Prescription Lenses.
- Contact Lenses.
- Frames for prescription Lenses.

Questions?

If you have questions regarding your Program Benefits, eligibility or contributions, contact the applicable administrators. Contact information is provided in the Ç ontact Informationé section on Page 70.

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Appendix A: Laser Vision Correction Care

USING THIS SUMMARY PLAN DESCRIPTION

This summary plan description (SPD) is a guide for using the SNET Vision Program (Program), a component program offered under the AT&T Umbrella Benefit Plan No. 1 (Plan). The Plan was established Jan. 1, 2001, and incorporates a number of the health and welfare plans sponsored by AT&T Inc. and its subsidiaries. This SPD does not provide information regarding any other component program under the Plan.

This SPD provides information regarding eligibility and Benefits under the Program for Bargained Employees of Participating Companies listed in the “Participating Companies” section on Page 64. This SPD does not provide information for management Employees of the Participating Companies listed in the “Participating Companies” section or for employees of companies not listed in the “Participating Companies” section. Refer to the “Eligibility and Participation” section on Page 8 for information on your and your dependents’ eligibility to participate in the Program

This SPD provides information about Benefits for Eligible Employees (and their Eligible Dependents) in effect as of Jan. 1, 2010, including:

- Eye Examinations.
- Prescription Lenses.
- Contact Lenses.
- Frames for prescription Lenses.

In addition, the Program offers Visual Display Terminal (VDT) coverage, which automatically covers Eligible Employees enrolled in the Program who use a VDT as part of their work.

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 Program and the Benefits it provides.

Please be aware that your Ophthalmologist, Optometrist or Optician does not have a copy of your SPD and is not responsible for knowing or communicating your Benefits.

Please review this SPD and share it with your family members who also are covered under the Program. This SPD supersedes the prior version of the SPD for the Program dated September 2004 (NIN: 34117) and any summaries of material modifications (SMMs) to that SPD.

Terms Used in This SPD

Certain terms used in this SPD have specific meanings when applied to your vision care coverage. Terms that use initial capital letters, such as Participant and Eligible Dependent, are defined in the “Definitions” section beginning on Page 65. Understanding the defined terms will help you to better understand the information provided in this SPD.

“Plan” refers to the AT&T Umbrella Benefit Plan No. 1 (as well as all programs, including the SNET Vision Program, that are incorporated in the Plan).

"SNET Vision Program" or “Program” refers to the vision care program described in this SPD.

Company Labels and Employee Group Acronyms Used in This SPD

Most of the information in this SPD is applicable to all Eligible Employees. However, some Program provisions regarding eligibility, contributions, enrollment changes and Benefit levels may 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 64. 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 Group**
East Region Core CWA	Eligible Employees who are represented by the Communications Workers of America (CWA): • 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. • 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
SNEIS-CWA	Eligible Employees of SNET Information Services, Inc. dba SNET Yellow Pages who are represented by the CWA in accordance with the agreement dated May 25, 2004

ELIGIBILITY AND PARTICIPATION

KEY POINTS

A. *If you are a full-time or part-time Regular Employee or Term Employee, eligibility for coverage begins on the first day of the month in which you attain a Term of Employment of six months with a Participating Company.*

B. *Your Eligible Dependents are your Spouse or LRP and your Dependent Children who satisfy the Program’s eligibility requirements.*

C. *If you enroll in the Program and use a Video Display Terminal (VDT) as part of your job, you are automatically eligible for VDT Vision Care Benefits.*

This section summarizes the eligibility provisions of the Program for Eligible Employees and their Eligible Dependents. If, after reading this information, you have additional questions or wish to confirm eligibility, contact the Eligibility and Enrollment Vendor. Refer to the *Eligibility and Enrollment Vendor* table in the “Contact Information” section on Page 70 for contact information.

Eligible Employees

If you are a Bargained Employee who is classified by your employer as a full-time or part-time active Regular Employee or Term Employee in one of the Eligible Employee groups of a Participating Company, you are eligible to participate in the Program on the first day of the month in which you attain a Term of Employment of six months. Special eligibility rules apply to rehired retirees. Refer to the “Rehired Retirees” section below for the identity of the Eligible Employee groups of each Participating Company.

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

Rehired Retirees

Special rules apply if you have previously terminated from a member of the AT&T Controlled Group of Companies with eligibility for retiree coverage. Those rules are contained in the “AT&T Rehired Retiree Supplement” to the Plan. If you are being rehired after having qualified for retiree coverage from a member of the AT&T Controlled Group of Companies, contact the Eligibility and Enrollment Vendor and the supplement will be mailed to you at no cost to you. If you are a rehired retiree, the rules in the “AT&T Rehired Retiree Supplement” supersede the eligibility rules in this SPD. Refer to the *Eligibility and Enrollment Vendor* table in the “Contact Information” section on Page 70 for contact information.

Eligible Dependents

Your Eligible Dependents are:

- Your Spouse or your Legally Recognized Partner (LRP).
- Your unmarried Dependent Children or your Spouse's/LRP's unmarried Dependent Children through the end of the calendar year they reach the age of 23.
- Your unmarried disabled Child, provided all of the following conditions are met:
  - The Child becomes disabled as a result of a mental or physical disability before age 23.
  - You provide satisfactory evidence of such disability.
  - The Child remains disabled and you remain enrolled for coverage under the Program.

> **Important:** A physically or mentally adult disabled Child must be certified as an Eligible Dependent for coverage. You can do this by completing the application forms available from the Eligibility and Enrollment Vendor and submitting them for approval to the address on the forms. Refer to the “Certification of Disabled Dependents” section on Page 10 for details of the certification process.

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

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

Certification of Disabled Dependents

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

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

> **Important:** To avoid a break in your Eligible Dependent's coverage, it is best to contact the Eligibility and Enrollment Vendor three to six months before your Child reaches the age at which he or she is no longer eligible for vision coverage under the Program unless he or she is certified as being disabled.

Each of your unmarried disabled Children must provide satisfactory evidence of such disability upon request in order to be eligible for coverage under the Program. In addition, an independent medical examination of your unmarried disabled Child may be required.

ENROLLMENT AND CHANGES TO YOUR COVERAGE

KEY POINTS

A. *Coverage under the Program is not automatic; you must actively enroll in the Program to receive coverage for yourself and your Eligible Dependents.*

B. *You can enroll in the Program after your date of hire; during annual enrollment; after you experience certain change in status events; or prospectively, at any time during the year.*

C. *You may make changes to your existing coverage during the Plan Year as a result of a change in status event.*

D. *For more information on enrollment and changes to your coverage, contact the Eligibility and Enrollment Vendor.* *Refer to the* Eligibility and Enrollment Vendor *table on Page 71 for contact information.*

Levels of Coverage Under the Program

The Program offers the following three levels of coverage:

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

Refer to the “Eligible Dependents” section on Page 9 for information about who qualifies as your Eligible Dependent.

Enrollment for Newly Eligible Employees and Dependents

If you are a newly eligible Employee, you will receive enrollment materials from the Eligibility and Enrollment Vendor after you are hired that will include enrollment instructions and your share of the Cost of Coverage, if applicable. You need to follow the instructions on how to enroll.

If you do not receive your enrollment materials within 31 days after you are hired, you should contact the Eligibility and Enrollment Vendor. Refer to the *Eligibility and Enrollment Vendor* table on Page 71 for contact information.

Coverage is not automatic when you become newly eligible for coverage under the Program. You must actively enroll through the Eligibility and Enrollment Vendor. As part of your enrollment election, you may specify the level of coverage you desire and enroll your Eligible Dependents.

If you are classified by your employer as a Regular Employee or Term Employee (other than as a Term Employee of SNEIS), you may enroll yourself and your Eligible Dependents in the Program. You must enroll within 31 days of the later of your date of hire or the date on your enrollment materials for your coverage to be effective on the first day of the month in which you attain a Term of Employment of six months. Subject to the Pre-Tax Premium Option portion (PTPO) of your Company flexible spending account (FSA) plan, any applicable contributions may be deducted on a before-tax basis, unless you elect otherwise. If you enroll after the initial 31-day enrollment period but before you attain a Term of Employment of six months, your coverage will begin on the first day of the month in which you attain a Term of Employment of seven months. Otherwise, coverage under the Program is prospective and begins the first day of the month following your enrollment provided you have attained a Term of Employment of six months.

Coverage for your enrolled Eligible Dependents is effective on the date your coverage is effective, provided that the Eligibility and Enrollment Vendor is able to verify the dependents’ eligibility. Refer to the “Dependent Eligibility Verification” section on Page 13 for more information about the dependent eligibility verification process.

If you do not make an enrollment election when you are newly eligible for coverage, you will default to no coverage. An Employee who does not enroll during the initial enrollment period may enroll prospectively at a later date or during annual enrollment.

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

For details on prospective enrollment, annual enrollment or changes in coverage under the Program, refer to the çProspective Enrollmenté and çAnnual Enrollmenté sections below and the çChanges in Enrollment During the Yearé section on Page 14.

If you use a Video Display Terminal (VDT) as part of your job, you are automatically covered under the VDT vision care portion of the Program as long as you enroll in the Program and are an Active Employee. For details concerning VDT Vision Care Benefits, refer to the çVDT Vision Careé section on Page 30.

Prospective Enrollment

Prospective enrollment is available to all Participants except Employees or former Employees on Company extended coverage and COBRA Participants. Prospective enrollment allows you to enroll yourself and/or any Eligible Dependents outside of the specified enrollment periods (for example, the period specified for new hires, annual enrollment or as a result of a change in status event). When you do this, the effective date of the change in coverage will be the first day of the month following the date you request the change.

If you contribute toward the cost of your vision coverage, any additional required contributions resulting from your prospective enrollment must be paid on an after-tax basis until the first day of the next Plan Year. Refer to çThe Difference Between Before-Tax and After-Tax Contributionsé section on Page 23 for more information.

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

Annual Enrollment

Each fall, you will have the opportunity to make changes to your Program coverage during your annual enrollment period. You will receive information from the Eligibility and Enrollment Vendor that includes your enrollment dates and the benefits available to you. If you need to pay for coverage, you also will receive information regarding the Cost of Coverage. It is important that you review your annual enrollment materials and take any required action.

You can enroll online via the Eligibility and Enrollment Vendor Internet site or by calling the Eligibility and Enrollment Vendor. If you want to continue your current coverage, you generally do not need to take any action.

Once you are enrolled in the Program, you must remain enrolled and cannot elect a lower level of coverage through the last day of the Plan Year following the second annual enrollment period unless you experience a change in status event. Refer to the çChanges in Enrollment During the Yearé section on Page 14 for more information.

> **Important:** If, at the end of the second annual enrollment period, you have not taken any action to change your enrollment election or cancel your coverage for the next two-year period, you will automatically be reenrolled in the same coverage you had during the prior two-year period and a new two-year enrollment period will begin.

Any changes made during annual enrollment will be effective as of Jan. 1 of the next Plan Year.

If you are an Active Employee, any applicable contributions will automatically be deducted from your paycheck on a before-tax basis unless you elect to have them deducted on an after-tax basis. If you are not an Active Employee, you must pay any applicable contributions on an after-tax basis.

Dependent Eligibility Verification

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

- Determine if your dependent is eligible for Program coverage. Review the ÇEligible Dependentsé section on Page 9 for the rules that pertain to dependent eligibility.
- Call the Eligibility and Enrollment Vendor or access the Eligibility and Enrollment Vendor Web site to enroll your dependent.
- Your dependent will be conditionally enrolled and provided Program coverage contingent on your providing documents that verify the dependentê eligibility for coverage under the Program.
- Shortly after you enroll a dependent in the Program, a Dependent Eligibility Verification Kit will be mailed to your home address on record with the Company. The Dependent Eligibility Verification Kit will contain instructions for submitting documents that verify your dependentê eligibility for Program coverage, including a list of the documents that would meet this requirement. For example, if you are enrolling a Child, you will be required to provide a copy of a birth certificate or other specified document that establishes the Childê relationship to you. You must provide the required documentation to establish that your dependent is eligible to be enrolled in the Program before the date specified by the Eligibility and Enrollment Vendor in the Dependent Eligibility Verification Kit. If you do not provide the required documentation and, therefore, do not establish your dependentê eligibility before the stated deadline, your dependent will not be eligible for coverage. Coverage for the dependent will be terminated retroactively to the date the dependentê Program coverage began.
- If coverage is terminated retroactively, your dependent will not be eligible for Benefits under the Program for that period. You may be personally liable for the cost of any claims incurred by your ineligible dependent. In addition, your dependent will not be eligible for COBRA continuation coverage under the Program, and no certificate of creditable coverage for this period of Program coverage will be provided. This means that your dependent will not receive the protections provided under law for individuals who have had group health plan coverage. Refer to the ÇERISA Rights of Participantsé section on Page 56 for more information on these protections.

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

***Note:** Enrollment of an ineligible dependent in the Program constitutes Benefits fraud and is a violation of the AT&T Code of Business Conduct. The Company will refer suspected fraudulent enrollments to AT&T Asset Protection for investigation, which may result in legal action and*

financial consequences. If you are an Active Employee, you may be subject to employment disciplinary action, up to and including dismissal.

Dual Enrollment

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

<table>
<tr><th>Dual Enrollment Rules for Employees
(If applicable, refer also to the “Dual Enrollment Rules for Rehired Retirees” table below.)</th></tr>
<tr><td>If your eligible Spouse/LRP is an Employee, you and your eligible Spouse/LRP are allowed to:
• Enroll separately and enroll each other and other Eligible Dependents under the Program.
• Enroll in separate programs. Each may enroll all Eligible Dependents at the same time, or you may split the Eligible Dependents between two programs. For example, you may enroll in the Program, and your Spouse may enroll in another vision program sponsored by the Company. You each may enroll all Eligible Dependents, or you may cover some Eligible Dependents under the Program and some under another vision program sponsored by the Company.
• Enroll jointly, that is, you may enroll your Spouse/LRP as a dependent (or vice versa) and cover all Eligible Dependents under the Program.</td></tr>
<tr><td>If your eligible former Spouse/former LRP is an Employee, you and your eligible former Spouse/former LRP are allowed to:
• Enroll Eligible Dependents under the Program, that is, each of you may enroll all Eligible Dependents at the same time, or you may split the Eligible Dependents between you.
• Enroll Eligible Dependents under another vision program sponsored by the Company, that is, each of you may enroll all Eligible Dependents at the same time, or you may split the Eligible Dependents between you.
Important: Under no circumstance are you and your former Spouse/LRP permitted to provide coverage to each other or to dependents who are not eligible to be covered under the Program. Refer to the “Eligible Dependents” section on Page 9 for further information.</td></tr>
</table>

Dual Enrollment Rules for Rehired Retirees
The rules discussed in the table above also apply to rehired retirees. In addition, as a rehired retiree, you may not be enrolled at the same time as both an active and retired Employee in this Program or another vision program sponsored by a member of the AT&T Controlled Group of Companies.

Changes in Enrollment During the Year

If you experience a qualified change in your family status, a change that makes you or your dependent eligible for a special enrollment period or your employment classification changes (collectively referred to as çhange in status events ĝ; you will be eligible to change your Program coverage for you and/or your Eligible Dependents during the course of your two-year enrollment period, provided that:

- The change you make is consistent with the change in status event.

- You contact the Eligibility and Enrollment Vendor within the required time period as described in the applicable “Family Status Changes” section below and “Special Enrollment Period” and “Change in Employment Classification” sections on Page 16.

Refer to the “Change in Status Events” section beginning on Page 17 for a complete list of change in status events and the changes you are allowed to make if you experience a change in status event.

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

Your eligibility to change your Program coverage election when you experience a change in status event during a Plan Year is in addition to your right to enroll prospectively at any time during a Plan Year or to make changes in your coverage election during annual enrollment. Refer to the “Prospective Enrollment” and the “Annual Enrollment” sections on Page 12 for more information.

Family Status Changes

You can change your coverage category (for example, changing from individual to individual plus one) during the Plan Year if you have a qualified change in your family status (for example, adoption or marriage). Changes to your coverage as a result of a qualified family status change other than a change on account of death must be made within 31 days of the change in status event for the change in coverage to be effective retroactive to the date the event occurred.

To make a change, contact the Eligibility and Enrollment Vendor. Refer to the *Eligibility and Enrollment Vendor* table on Page 71 for contact information. The Eligibility and Enrollment Vendor will advise you as to which changes are permissible. If you do not provide the notification within the time frames noted above, your coverage change will become effective on the first day of the month following the date you contact the Eligibility and Enrollment Vendor.

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

If any contributions are adjusted as a result of your change in status event, the new contributions are effective the first day of the month following the date you contact the Eligibility and Enrollment Vendor to request the change in your coverage. However, if you are an Active Employee making before-tax contributions for your vision coverage pursuant to your Company FSA plan, the amount of your before-tax contributions will not change, even if the required contributions for your new coverage are more or less, unless your change in status event also is a qualified status change under your Company FSA plan. Refer to the “The Difference Between Before-Tax and After-Tax Contributions” section on Page 23 for more information on before-tax and after-tax contributions. Although generally similar, not all change in status events under the Program are considered qualified status changes under your Company FSA plan. If you have questions, contact the Eligibility and Enrollment Vendor. Refer to your Company FSA SPD for a description and list of events that are considered qualified status changes.

Special Enrollment Period

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

- You declined vision coverage for yourself or your Eligible Dependents during annual enrollment, or when you first became eligible to enroll in the Program because you had coverage through another group health plan or other health insurance coverage and that coverage ends (or if the other employer stops contributing toward the other coverage for you or your dependents). If this happens, you may be able to enroll yourself and your Eligible Dependents for vision coverage in the Program provided that you request enrollment within 31 days after the other coverage ends (or after the other employer stops contributing toward the other coverage).
- You declined vision coverage and later gain a new Eligible Dependent through marriage, birth, adoption or placement for adoption. If this happens, you may be able to enroll yourself and your Eligible Dependents for vision coverage in the Program during a special enrollment period, provided that you request enrollment within 31 days after the event.

To request special enrollment or obtain more information, contact the Eligibility and Enrollment Vendor. Refer to the “Contact Information” section on Page 70 for contact information.

Change in Employment Classification

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

The following table summarizes how a change in your employment classification may affect your benefits.

Situation	Corresponding Change in Benefits
You change from a Bargained Employee to a Management Employee classification	Your participation in the Program will terminate on the last day of the month in which you change from a Bargained Employee classification to a Management Employee classification. You will receive enrollment materials from the Eligibility and Enrollment Vendor describing the vision care benefits available to you as a Management Employee and enrollment instructions.

Table continued on next page

Situation	Corresponding Change in Benefits
You change from being classified as a full-time or part-time Employee scheduled to work at least 25 hours a week to a part-time Employee scheduled to work fewer than 25 hours a week	You may remain in the Program by paying the required contribution. You will receive a confirmation of coverage (COC) describing your contributions based on your current coverage in your new status. Before-tax payroll deductions will begin the first of the month following your employment classification change. If you do not contact the Eligibility and Enrollment Vendor within 31 days after the change in your employment classification, any change in coverage will be effective the first day of the month following the date you contact the Eligibility and Enrollment Vendor. You will be also offered the opportunity to elect COBRA continuation coverage. ***Note:*** *If you were hired before Jan. 1, 1981, and have been continuously employed by the Company, you do not pay for vision coverage regardless of the number of hours you are scheduled to work each week. Your coverage will not change.*
You change from being classified as a part-time Employee scheduled to work fewer than 25 hours a week to a full-time or part-time Employee scheduled to work 25 hours or more a week	If you were previously enrolled, you may remain enrolled in the Program or make changes to your current coverage category. You will receive a confirmation of coverage (COC) describing your contributions based on your current coverage in your new status. If you were not previously enrolled, you may enroll provided that, as of the month of enrollment, you have attained a Term of Employment of at least six months. If you do not contact the Eligibility and Enrollment Vendor within 31 days after the change in your employment classification, any change in coverage will be effective the first day of the month following the date you contact the Eligibility and Enrollment Vendor.

Change in Status Events

The table in this section specifies the situations that are considered change in status events and identifies changes to your coverage elections during a Plan Year that are consistent with the change in status events available under the Program.

This table does not apply to your ability to change your before-tax/after-tax contribution election under the Company FSA plan in which you may be participating. Although you may be able to make changes to your vision coverage, you may still be required to continue contributions under the before-tax contribution option under your Company FSA plan. Refer to your FSA plan SPD or the *Eligibility and Enrollment Vendor* table on Page 71 for additional information.

Election changes resulting from a change in status may be made if all of the following conditions are met:

- The Employee has a change in status.
- The Employee, Spouse, LRP or dependent experiences a change in eligibility as a result of the change in status.
- The election change satisfies the consistency requirement.

  A change in status complies with the consistency requirement only if the change corresponds to a change in status that affects eligibility for coverage under the Program. For example, if

you marry, you may waive your Program coverage , but only if you gained eligibility and enrolled in your Spouse's or LRP's plan.

Note: *Refer to the bottom of the table for the definitions of the codes provided in the "Changes Permitted Under the Program" column of the table.*

Change in Status Event	Changes Permitted Under the Program
Marriage or legally recognized partnership	AD, AS, DD, E, W
Death of Spouse/LRP, divorce, legal separation, legal annulment or dissolution of legally recognized partnership	AD, DD, DS, E
Gain of dependent status, birth, adoption, placement for adoption in your home, addition of stepchild in your home or gain of legal guardianship	AD, AS, E, W
Loss of dependent eligibility status for the Program	DD
QMCSO requiring an Employee to cover a dependent or alternate payee	AD, E
QMCSO requiring a Spouse/LRP to cover a dependent	DD, DS
Expiration of a QMCSO	DD
Death of dependent covered under the Program	DD
Gain of employment or benefit coverage by Spouse/LRP or dependent	DD, DS, W
Loss of employment or benefit coverage by Spouse/LRP or dependent	AD, AS, E
Dependent gains coverage under former Spouse's/LRP's employer's plan	DD
Dependent loses coverage under former Spouse's/LRP's employer's plan	AD, E
Change in Employee's work schedule or employment status resulting in gain of benefit Program coverage	AD, AS, E
Change in Employee's work schedule or employment status resulting in loss of Employee benefit Program coverage	DD, DS, W
Change in Spouse's/LRP's or dependent's work schedule or employment status resulting in loss of eligibility under Spouse's/LRP's or dependent's employer's health benefit plan	AD, AS, E
Change in Spouse's/LRP's or dependent's work schedule or employment status resulting in gain of eligibility under Spouse's/LRP's or dependent's employer's health benefit plan	DD, DS, W
Midyear expiration of COBRA coverage from another employer (Employee's Spouse/LRP or other dependent)	AD, AS, E
Change in coverage or cost increase under Spouse's/LRP's or dependent's employer's health benefit plan	AD, AS, E
Change in coverage or cost decrease under Spouse's/LRP's or dependent's employer's health benefit plan	DD, DS, W
Significant increase in cost of Employee's benefit package option	AD, AS, DD, DS, E, W
Significant decrease in cost of Employee's benefit package option	AD, AS, DD, DS, E, W
	Table continued on next page

Change in Status Event	Changes Permitted Under the Program
Employee starts a leave of absence whether paid or unpaid, FMLA or non-FMLA	DD, DS, W
Employee returns from a leave of absence whether paid or unpaid, FMLA or non-FMLA	AD, AS, E
Spouse/LRP or dependent starts an unpaid leave of absence (or FMLA leave) with resulting loss in eligibility under Spouse's/LRP's or dependent's employer's health benefit plan	AD, AS, E
Spouse/LRP or dependent returns from an unpaid leave of absence with resulting gain in eligibility under Spouse's/LRP's or dependent's employer's health benefit plan (or from FMLA leave)	DD, DS, W
Spouse/LRP or dependent starts an unpaid leave of absence (non-FMLA leave) without change in eligibility	AD, AS, E
Spouse/LRP or dependent returns from an unpaid leave of absence (non-FMLA leave) without change in eligibility	DD, DS, W
Addition or significant improvement of benefit option to Employee's plan	AD, AS, E
Addition of benefit option to Spouse's/LRP's or dependent's employer's health benefit plan	DD, DS, W
Employee entitlement to Medicaid providing vision coverage	E, W
Employee loss of Medicaid providing vision coverage	AD, AS, E
Spouse/LRP or dependent entitlement to Medicaid providing vision coverage	DD, DS
SpouseLRP or dependent loss of Medicaid coverage providing vision coverage	AD, AS, E
Employee begins strike or lockout resulting in change in benefit eligibility	W
Employee returns from strike or lockout resulting in a change in benefit eligibility	AD, AS, E
Spouse/LRP or dependent begins strike or lockout	AD, AS, E
Spouse/LRP or dependent returns from strike or lockout	DD, DS, W
Significant curtailment or termination of Employee's coverage with or without a loss of coverage	DD, DS, W
Significant curtailment or termination of Spouse's/LRP's or dependent's coverage under Spouse's/LRP's or dependent's employer's health benefit plan with a loss of coverage when no similar coverage is available	AD, AS, E
Employee is rehired after 30 days following termination whether or not within same Plan Year*	AD, AS, E
Spouse's/LRP's or dependent's annual enrollment does not correspond with Employee's annual enrollment	AD, AS, DD, DS, E, W
Employee gains eligibility under another employer's group health plan	DD, DS, W
Employee loses eligibility under another employer's group health plan	AD, AS, E

Table continued on next page

Change in Status Event	Changes Permitted Under the Program
Employee's loss of other government or educational institution coverage, such as tribal coverage, state health benefits risk pool or foreign government plan	AD, AS, E
Spouse/LRP 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, E
Employee's, Spouse's/LRP's or dependent's complete loss of employer subsidy from another employer	AD, AS, E

**When an Employee is rehired within 30 days of termination within the same Plan Year, prior coverage is reinstated.*

The following is an explanation of the change codes used in the "Changes Permitted Under the Program" column of this table.

AD = Add dependent(s)	*DS = Drop Spouse/LRP*	*E = Enroll*
AS = Add Spouse/LRP	*DD = Drop dependent(s)*	*W = Waive/drop election*

Company-Extended Coverage for Employees on Active Duty with the Uniformed Services

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

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

If qualified to continue coverage pursuant to USERRA, Employees may elect to continue coverage under the Program by notifying the Eligibility and Enrollment Vendor in advance and providing payment of any required contribution for the vision coverage. This may include the amount the Company normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time fewer than 31 days, the Employee may not be required to pay more than the regular contribution amount for continuation of vision coverage.

An Employee may continue Program coverage under USERRA for up to the lesser of the 24-month period beginning on the date of the Employee's absence from work or the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues vision coverage, if the Employee returns to a position of employment, the Employee's vision coverage and that of the Employee's Eligible Dependents will be reinstated under the Program. No exclusions or waiting period may be imposed on an Employee or the Employee's Eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of Military Service.

This is a brief overview of the provisions of USERRA. For information concerning coverage for Employees who are absent from employment by reason of service in the Uniformed Services and their Eligible Dependents, contact the Eligibility and Enrollment Vendor. Refer to the *Eligibility and Enrollment Vendor* table on 71 for contact information.

Continuation of Vision Benefits During an FMLA Leave

During an FMLA leave, the Company must maintain your group vision program coverage for up to 12 weeks of leave (up to the amount normally paid by the Company under the same terms and conditions as applicable to similarly situated Active Employees who are not on FMLA leave). The Company will automatically advance any required Employee contributions for your group vision program coverage on your behalf while you are on an FMLA leave.

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

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

Continuation of Coverage Under COBRA

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

For More Information

For more information about FMLA leave, see your supervisor or call **888-722-1787** and say ÇFMLA.éFMLA leave information is also available on the HROneStop Web site at **http://hronestop.att.com**. At the HROneStop home page, select the *Your Time & Attendance* tab, then the *Family Medical Leave Act* section. The site contains information on FMLA qualifying events, eligibility requirements, details on the application process, and other helpful resources.You may also send correspondence to:

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

Telephone Number

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

Hours of Operation

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

You also will find additional information about FMLA leaves from work on HROneStop at **http://hronestop.att.com** or from home at **http://access.att.com.**

CONTRIBUTIONS

How much you pay toward the Cost of Coverage for you and your Eligible Dependents depends on your employment classification (e.g., full-time or part-time) and the level of coverage in which you are enrolled.

The following table summarizes the amount you pay toward the Cost of Coverage under the Program in terms of a percentage of the applicable Premium Equivalent Rate.

Contribution Rules		
If Your Employment Classification Is ...	**Percentage of the Premium Equivalent Rate for You and Your Covered Dependents...**	
	The Company Pays	**You Pay**
Full-time Regular Employee or Term Employee	100%	0%
Part-time Regular Employee with an original hire date on or before Dec. 31, 1980, and you have been continuously employed by the Company	100%	0%
Part-time Regular Employee or Term Employee hired or rehired on or after Jan. 1, 1981, and scheduled to work 25 or more hours a week	100%	0%
Part-time Regular Employee or Term Employee hired or rehired on or after Jan. 1, 1981, and scheduled to work 17 or more hours per week but less than 25 hours a week	50%	50%
Part-time Regular Employee or Term Employee hired or rehired on or after Jan. 1, 1981, and scheduled to work less than 17 hours a week	0%	100%

The Company pays the full cost for VDT coverage for all eligible Employees who are enrolled in vision coverage under the Program.

Premium Equivalent Rates and Contributions

The Premium Equivalent Rates and contribution amounts for each Plan Year are determined annually by the Company at its sole discretion and will be announced during annual enrollment. Refer to your enrollment materials for information concerning the Premium Equivalent Rate and the contribution amount that apply to you. You also may obtain an electronic or printed personalized contribution statement through the Eligibility and Enrollment Vendor. Refer to the *Eligibility and Enrollment Vendor* table on Page 71 for contact information.

Before-Tax and After-Tax Contributions

If you are an Active Employee, your Program contributions will automatically be deducted from your pay on a before-tax basis upon enrolling in the Program, if you are eligible under your Company FSA plan (unless you enroll through prospective enrollment or elect after-tax contributions). If you do not want these contributions deducted on a before-tax basis, you must elect to have them deducted on an after-tax basis. Even if you are eligible to change your Program coverage to an option with lower or higher contributions because you experience a change in status event or you prospectively enroll, you cannot change the amount of your before-tax contributions unless you experience a qualified status change as defined in your Company FSA

plan. Although generally similar, not all change in status events under the Program are considered qualified status changes under your Company FSA plan. Refer to your Company FSA plan SPD for more information on before-tax contributions and for a description and list of events that are considered qualified status changes.

If you are not an Active Employee, you must pay your Program contributions on an after-tax basis.

The Difference Between Before-Tax and After-Tax Contributions

The following definitions explain the differences between before-tax and after-tax benefit contributions (if applicable). Please review both definitions to ensure that if you are required to make contributions, you understand how they are being deducted from your paycheck and the rules that apply.

Before-Tax Contributions

Your Company FSA plan allows you to pay applicable contributions on a before-tax basis. When your contributions for participation in the Program are deducted from your paycheck *before* federal, state and local (if applicable) income taxes are taken out, they are known as before-tax contributions. Your before-tax contributions lower your taxable income; therefore, you pay less in taxes. Your contributions are automatically deducted from your paycheck on a before-tax basis.

You may elect, during your initial or annual enrollment period (or when you have a qualified status change such as marriage, divorce or the birth of a Child), to have your contributions deducted on an after-tax basis. According to IRS rules, the before-tax or after-tax nature of your contributions cannot be changed outside annual enrollment unless you experience a qualified status change and make a new enrollment election (to add or drop coverage) within 31 days of the change. However, if your contributions are deducted from your paycheck on a before-tax basis and you choose to drop any enrolled dependents or cancel coverage outside an enrollment period or *without* experiencing a qualified status change, the amount of your before-tax contributions will not change even if the required contributions for your new coverage are either increased or decreased. Also, if the contribution amount for your new coverage is greater than your before-tax contribution, the additional amount will be deducted from your paycheck on an after-tax basis.

> **Important:** Although generally similar, not all change in status events under the Program are considered qualified status changes under your Company FSA plan. Refer to your Company FSA SPD for a description and list of events that are considered qualified status changes.

After-Tax Contributions

When your contributions for participation in the Program are deducted from your paycheck after federal, state and local (if applicable) income taxes are taken out, they are known as after-tax contributions. Because these contributions are taken out after your applicable federal and state income taxes have been deducted, you pay income taxes on the amount of your contributions.

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

Tax Consequences of Legally Recognized Partner Coverage

The Companyê level of contribution toward Program coverage for an LRP and an LRPê Children is the same as the Companyê contribution for coverage of a Spouse and the Spouseê Children.

However, when an LRP or the LRPê Children are covered under the Program, the Company must include the Cost of Coverage as taxable income on your annual tax reporting statement, unless you provide information each year that your covered dependents qualify as tax dependents under the Code. The amount reported as taxable income on your annual tax reporting statement is based on the total Cost of Coverage under the Program, including any before-tax contributions that you have paid for an LRP and his or her Children. This amount is subject to federal, FUTA and FICA income tax withholding.

Employees on Leave of Absence

If you are on an approved leave of absence, you will receive a notice explaining what coverage you are eligible to continue and whether you will be required to pay any contributions to continue this coverage. Contributions are paid directly to the Eligibility and Enrollment Vendor on a monthly basis. Billing notices are produced monthly and payment is due on the first day of the month of coverage. For example, the bill you receive on June 15 is for coverage for the month of July, and payment is due by July 1. If you have questions concerning billing or payment of your contribution, contact the Eligibility and Enrollment Vendor. Refer to the *Eligibility and Enrollment Vendor* table on Page 71 for contact information.

> **Important:** You have a 60-day grace period from the day your payment is due to make your payment before coverage is terminated. Failure to pay all required contributions will result in loss of coverage effective the first day of the month in which any required contributions are not paid. You will be ineligible to reenroll until you return from your leave of absence.

Individuals Covered Through COBRA

If your Eligible Dependents are continuing coverage through COBRA, they will be required to pay for their coverage through direct billing. Refer to the Ęxtension of Coverage ÑCOBRAé section on Page 44 for more information about COBRA rights.

Direct billing will be handled through the Eligibility and Enrollment Vendor. If you have questions concerning billing or payment of your contribution, contact the Eligibility and Enrollment Vendor. Refer to the *Eligibility and Enrollment Vendor* table on Page 71 for contact information.

If after reading the information in this section you have additional questions or wish to confirm the contribution provisions or contribution amounts that apply to you, contact the Eligibility and Enrollment Vendor. Refer to the *Eligibility and Enrollment Vendor* table on Page 71 for contact information.

WHEN COVERAGE ENDS

In general, Program coverage for you and/or your Eligible Dependents ends on the last day of the month during which certain events resulting in your loss of eligibility occur.

The information provided in the table on the following page describes the circumstances under which Program coverage ends for you and/or your Eligible Dependents. In addition, you will find highlights of the steps that you or your Eligible Dependents must follow in each of these circumstances if you want to continue coverage.

Event	What Happens to Coverage
Disability	If you are receiving short-term disability benefits from a Company-sponsored short-term disability program (STD Program) and you were eligible to participate in this Program immediately before commencing STD Program benefits, your Program coverage continues as if you were actively at work. After your STD Program benefits end, you and your Eligible Dependents who are enrolled for vision coverage under the Program immediately before the cessation of your STD Program benefits may be eligible to continue Program coverage under COBRA. Refer to the “Extension of Coverage — COBRA” section on Page 44 for more information on COBRA.
Employment ends	In the event your employment ends with a Participating Company for any reason other than gross misconduct, you and your Eligible Dependents who are enrolled for vision coverage under the Program immediately before the cessation of your employment may be eligible to continue coverage under COBRA. Refer to the “Extension of Coverage — COBRA” section on Page 44 for more information on COBRA. You may also be eligible for an extension of vision coverage if you terminate employment under a severance or force adjustment program or agreement that provides for such an extension. You will be notified following your termination of employment if the severance or force adjustment program or agreement under which you terminated employment provides for an extension of vision coverage.
Retirement	If you retire from the Company, you and your Eligible Dependents who are enrolled in the Program immediately before your retirement are eligible to continue coverage under the Program as provided under COBRA. Refer to the “Extension of Coverage — COBRA” section on Page 44 for more information on COBRA.
Death	If you die, the coverage under the Program for your surviving Eligible Dependents will end on the last day of the month during which your death occurs. Following your death, your surviving Eligible Dependents who are Qualified Beneficiaries may elect to continue vision coverage under COBRA. If elected, the COBRA continuation coverage will be effective as of the first day of the first month following the month during which you die. Refer to the “Extension of Coverage — COBRA” section on Page 44 for more information. To report a death, call the Fidelity Service Center at **800-416-2363.**
Leave of absence	If you are on an approved leave of absence, you will receive a notice explaining the coverage that you and your Eligible Dependents are eligible to continue and whether you will be required to pay for this coverage. Refer to the “Leave of Absence” section on Page 26 for additional information. If Company-provided coverage is not available during your leave, you may continue coverage under COBRA. Refer to the “Extension of Coverage — COBRA” section on Page 44.
Dependent becomes ineligible	Program coverage for your Eligible Dependent ends on the last day of the calendar year or month, as applicable, in which your Eligible Dependent no longer meets the eligibility requirements. Your Eligible Dependent may continue coverage under COBRA. Refer to the “Extension of Coverage — COBRA” section on Page 44 for more information on COBRA. Refer to the "Eligible Dependents" section on Page 9 for information on when coverage for your Eligible Dependents ends.

Table continued on next page

Event	What Happens to Coverage
Required contributions not paid	Program coverage ends if you stop making any required contributions. Coverage will end on the last day of the month for which the required contributions were paid in full.
Cancellation of coverage	Program coverage ends for you and your Eligible Dependents on the last day of the month during which Program coverage is canceled. If Program coverage is canceled, you may be eligible for COBRA. Refer to the “Extension of Coverage — COBRA” section on Page 44 for more information on COBRA.
Promotion	If you are promoted to a management or a nonmanagement nonunion position with the Company, Program coverage ends for you and your Eligible Dependents on the last day of the month in which the promotion occurs. You and your covered Eligible Dependents may, however, be eligible for Company-sponsored vision coverage under the vision program that is applicable to your new employment classification.
Termination of Program	If the Company terminates the Program, coverage under the Program ends for you and your Eligible Dependents on the last day of the month in which the Program is terminated.

COBRA

You and your covered Eligible Dependents may be eligible to elect COBRA coverage when Program coverage ends. In considering whether to elect COBRA, you should take into account that a failure to continue your group health coverage will affect future rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), such as: (1) the right to obtain medical coverage from either group health plans or individual insurance policies without being subject to preexisting condition exclusions and (2) special enrollment rights. Refer to the “Extension of Coverage — COBRA” section beginning on Page 44 for information regarding your rights to elect COBRA continuation coverage.

Leave of Absence

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

All coverage that continued while you were on leave will continue when you return to work, provided that you pay any required contributions by the required due dates. If you do not continue coverage under the Program while you are on your LOA and would like to reenroll upon your return to work, you must contact the Eligibility and Enrollment Vendor to determine whether you are eligible. Refer to the *Eligibility and Enrollment Vendor* table on Page 71 for contact information. Rules governing your right to reenroll upon your return to work from your LOA are set forth in the “Change in Status Events” section beginning on Page 17.

If you are an Employee currently on active military leave as a result of executive order, certain special provisions may apply. Refer to the “Company-Extended Coverage for Employees on Active Duty with the Uniformed Services” section on Page 20 for information.

If you take an LOA under the Family and Medical Leave Act of 1993 (FMLA), special provisions apply. Refer to the “Continuation of Vision Benefits During an FMLA Leave” section on Page 21 for information.

YOUR PROGRAM BENEFITS

KEY POINTS

A. *The Program provides Benefits for covered services or supplies provided by Network Providers and Non-Network Providers.*

B. *Each time you need vision care, you decide whether to use a Network Provider or a Non-Network Provider.*

C. *Program Benefits differ depending on whether you choose a Network Provider or a Non-Network Provider.*

D. *Generally, your out-of-pocket expenses are lower when you use Network Providers.*

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

If you use a Network Provider, your out-of-pocket expenses will usually be lower than if you use a Non-Network Provider and you won't have to file any Claims. A Network Provider listing is available at no charge from the Claims Administrator upon request.

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

Accessing Network Providers

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

When you need vision care services, you choose which Provider you want to use. You'll generally pay less out of pocket when you use a Network Provider. To find out which Providers in your area are Network Providers, contact the Claims Administrator. Refer to the *Claims Administrator for the Program* table in the "Contact Information" section on Page 70 for contact information.

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

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

What You Need to Know About Network Providers

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

Covered Services and Supplies

The Program pays scheduled Benefits for:

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

The limits on the Benefits available within a 12- or 24-month period apply separately to you and each of your covered Eligible Dependents. For a routine Examination, the 12-month period begins on the date of your or your covered Eligible Dependent's routine Examination. For a Frame, prescription Lenses or prescription Contact Lenses, the 12- or 24-month period, as applicable, begins on the date that you or your covered Eligible Dependent orders the Frame, the prescription Lenses or prescription Contact Lenses. The limits apply regardless of whether you use a Network Provider or a Non-Network Provider.

Refer to the "VDT Vision Care" section on Page 30 for information concerning the Schedule of Benefits and limitations under the VDT Vision Care portion of the Program.

VISION CARE BENEFITS UNDER THE PROGRAM

The following table summarizes the Benefits pr ovided under the Program for Employees and Eligible Dependents.

Summary of Vision Care Benefits		
Services/Supplies	**Network Provider (Percentages below are applied to the Allowable Amount)**	**Non-Network Provider (Program pays up to...)**
Routine Vision Examination (once every 12 months, with dilation as necessary)	Program pays 100% after $15 Copayment.	$40
Standard Plastic Lenses (Once every 12 months)		
• Single Vision	Program pays 100% after $10 Copayment.	$25
• Bifocals	Program pays 100% after $10 Copayment.	$35
• Trifocals	Program pays 100% after $10 Copayment.	$45
• Lenticular	Program pays 100% after $10 Copayment.	$90
Lens Options For example, tints, progressive, scratch-resistant, antireflective coating, etc.	Program pays $0. Although lens options are not covered by the Program, discounts may be available by Network Providers as part of their agreement with the Claims Administrator.	$0
Contact Lenses (Once every 12 months) ***Allowance includes supplies only***		
• Conventional	$10 Copayment; $115 allowance	$80
• Disposable	$10 Copayment; $115 allowance	$80
• Medically necessary	Program pays 100% after $10 Copayment	$155
Frames (Once every 24 months)	$10 Copayment; $105 allowance	$35

Note: *The Program does not pay any Benefits toward the cost of laser vision correction care. However, you may be eligible for discounts for laser vision correction care that are not part of the Program. Refer to Appendix A for more information.*

An Example of Vision Care Benefits

Let's assume you need an Examination and new eyeglasses. This table shows how the Program would cover these services when you use a Network Provider or a Non-Network Provider.

An Example of Vision Care Benefits				
Service/Supplies	Provider's Charge	Network Provider	Non-Network Provider	
		You Pay	You Pay (difference between what the Program will pay and the Provider's charge)	Program Pays
Routine Examination (with dilation as necessary)	$90	$15	$50	$40
Standard Plastic Lenses				
Single	$70	$10	$45	$25
Frames	$140	$35	$105	$35
Total	$300	$60	$200	$100

In this example, for an Examination and new single-vision eyeglasses, you pay:

- $60 if you use Network Providers.
- $200 if you use Non-Network Providers.

VDT VISION CARE

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

Important: Only Active Employees are eligible for this coverage.

Receiving VDT Benefits

To obtain VDT Vision Care Benefits, you simply make an appointment with a vision Provider. You may be required to complete a VDT questionnaire, which is available through the Claims Administrator. Refer to the *Claims Administrator for the Program* table on Page 73 for contact information.

If you are receiving care from a Network Provider, the Program will pay him or her directly for covered charges. If you are receiving care from a Non-Network Provider, you will be reimbursed according to the Non-Network Provider level of Benefits described in the *Summary of VDT Vision Care Benefits* table on Page 31.

Covered VDT Services and Appliances

The Program will cover the following VDT Benefits:

- VDT vision Examination – Analysis of the eyes and related structures to identify problems or abnormalities while operating a VDT. Examinations are covered once every 12 months.

- Eyeglass Lenses ÑEyeglass Lenses normally prescribed for use, such as single intermediate focal Lenses. Lenses are covered up to one pair per 12-month period, if needed.
- Eyeglass Frames ÑSpecial VDT eyeglass Frames are covered once every 24 months. If you select a Frame that is more expensive than allowed, you will be responsible for paying the difference in cost.

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

Schedule of Benefits for VDT Vision Care

Summary of VDT Vision Care Benefits		
Services/Supplies	**Network Provider (Percentages below are applied to the Allowable Amount)**	**Non-Network Provider (Program pays up to...)**
Routine Vision Examination (once every 12 months, with dilation as necessary)	Program pays 100% after $10 Copayment.	$40
Frames (once every 24 months)	$10 Copayment; $105 allowance	$25
Standard Plastic Lenses (once every 12 months)		
• Single	Program pays 100% after $10 Copayment	$25
• Bifocals	Program pays 100% after $10 Copayment	$35
• Trifocals	Program pays 100% after $10 Copayment	$45
• Lenticular	Program pays 100% after $10 Copayment	$90
Lens Options (for example, tints, progressive, scratch-resistant coating, etc.)	Program pays $0. Although lens options are not covered by the Program, discounts may be available by Network Providers as part of their agreement with the Claims Administrator.	$0

How VDT Benefits Coordinate With Regular Vision Benefits

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

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

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

WHAT THE PROGRAM DOES NOT COVER

The Program does not cover certain vision care services, supplies or expenses. These are called exclusions. The list of exclusions presented in this section applies to Network Providers and Non-Network Providers. If you have questions about whether a vision care service or supply is covered under the Program, contact the Claims Administrator.

- Special, experimental or unusual treatments, including Orthoptic Training, Vision Training, Subnormal Vision Aids, aniseikonic Lenses or Tonography
- Medical and/or surgical treatment of the eye, eyes or supporting structures
- Examinations or corrective eye wear required by the Company as a condition of employment
- Services provided as a result of any Workersê Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof
- Plano (nonprescription) Lenses and/or nonprescription Contact Lenses
- Two pairs of glasses in lieu of bifocals
- Services or materials covered or available through other benefits programs such as HMOs or the SNET Eyeglass Program
- Replacement of lost or broken eyeglass Lenses and Frames covered under the Program more frequently than at 12- and 24-month intervals
- Charges for vision care services or supplies submitted for an individual not covered under the Program
- Follow-up care, care kits, cleaners, solutions and later office visits
- Drugs or any other medication
- Lens options (although Lens options are not covered by the Program, discounts may be available from Network Providers as part of their agreement with the Claims Administrator.)
- Services or supplies not prescribed by a licensed Optometrist or Ophthalmologist or facility
- Additional charges for blended or progressive multifocal Lenses, cosmetic coated or laminated Lenses, whether or not medically necessary
- Examinations performed or Lenses and Frames ordered either:
  - Before the individual became covered under the Program, or
  - After termination of the individualês coverage under the Program

HOW TO FILE A CLAIM FOR ELIGIBILITY TO ENROLL OR PARTICIPATE IN THE PROGRAM

KEY POINTS

A. You may file a Claim for Eligibility with the Eligibility and Enrollment Vendor if your or your dependent's Program enrollment or participation is denied due to ineligibility.

B. Written notice of the decision on a Claim for Eligibility will be provided by the Eligibility and Enrollment Vendor.

C. The decision of the Eligibility and Enrollment Vendor on a Claim for Eligibility may be appealed to the Eligibility and Enrollment Appeals Committee within 180 days after receipt of the notice of denial from the Eligibility and Enrollment Vendor.

Claim for Eligibility Filing Procedures

If the Eligibility and Enrollment Vendor denies your or your dependent's enrollment or participation in the Program on the basis of ineligibility, you may call or send written correspondence to the Eligibility and Enrollment Vendor to resolve the issue. Refer to the *Eligibility and Enrollment Vendor* table in the "Contact Information" section beginning on Page 70 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.

You must submit your written Claim for Eligibility, along with any documentation that supports your Claim for Eligibility, to:

AT&T Benefits Center
Benefits Determination Review Team
P.O. Box 1407
Lincolnshire, IL 60069-1407

Once you submit your written Claim for Eligibility, the Eligibility and Enrollment Vendor will notify you of its decision within 30 days after the date your Claim for Eligibility is received. The Eligibility and Enrollment Vendor may extend this period once (for up to 15 days) if it determines that special circumstances require more time to determine your Claim for Eligibility. 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 Eligibility and Enrollment Vendor 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 Eligibility and Enrollment Vendor will decide your Claim for Eligibility within the time remaining in the initial or extended review period of 30 or 45 days, whichever is applicable.

If Your Claim for Eligibility Is Denied

You may treat your Claim for Eligibility as denied if you receive a written notice from the Eligibility and Enrollment Vendor that denies your Claim for Eligibility in whole or in part. If you receive a written notice from the Eligibility and Enrollment Vendor that your Claim for Eligibility is denied, the notice will contain:

- Specific reasons for the denial.

- Specific references to the Program 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 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 to the Eligibility and Enrollment Appeals Committee.
- 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 for Eligibility

If your Claim for Eligibility for your or your dependent's eligibility to enroll or participate in the Program 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 for Eligibility 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. A written request for review must be sent directly to the Eligibility and Enrollment Appeals Committee (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 of a denied Claim for Eligibility, you or your representative has the right to:

- Send a written statement of the issues and any other comments, 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 for Eligibility, such as any internal rule, guideline, protocol or other similar criterion relied on in denying your Claim for Eligibility.
- Reasonable access to, and copies of, all documents, records and other information relevant to your Claim for Eligibility.

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 for Eligibility and all reasons why you believe the Eligibility and Enrollment Vendor's action is incorrect. You should include any new or additional evidence or materials in support of your appeal that you wish the EEAC to consider. Such evidence or material must be submitted along with your written statement at the time you file your appeal.

Members of the EEAC who were not involved in the decision to deny your initial Claim for Eligibility will decide the appeal.

A review and decision on your appeal will be made within 60 days after your appeal is received. The EEACê decision on your appeal will be in writing and will include the specific reasons and references to the Program provisions on which the decision is based.

The EEAC has been delegated sole and complete discretionary authority to interpret and administer the applicable provisions of the Program, including the power and authority to determine all relevant facts and resolve issues relating to the construction of all relevant terms of the Program as they relate to Claims for Eligibility. The EEACê decisions are conclusive and binding, and are not subject to further review by the named fiduciary under the Program.

If your appeal is denied, it is final and is not subject to further review by the EEAC. However, you may have further rights under ERISA, as provided in the ÇERISA Rights of Participantsé section on Page 56.

HOW TO FILE A CLAIM FOR BENEFITS UNDER THE PROGRAM

KEY POINTS

A. *A Claim for Benefits must be filed to receive reimbursement when you go to a Non-Network Provider; you are not required to file a Claim for Benefits when you use a Network Provider.*

B. *When a Claim for Benefits is submitted, the Claims Administrator will give written notification if the Claim for Benefits is denied or more time is needed to review it.*

C. *If an Adverse Benefit Determination is made on the Claim for Benefits, the written notification will include an explanation of the determination and how to appeal it.*

D. *An Adverse Benefit Determination may be appealed at any time within 180 days after the Claimant's receipt of notice of the Adverse Benefit Determination.*

E. *A Claimant must pursue all of the Claim and appeal rights under the Program before seeking legal recourse on a Claim for Benefits.*

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

Claim for Benefits Filing Procedures

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

If you choose to go to a Non-Network Provider when you need vision care, you must file a Claim for Benefits for covered services or supplies provided under the Program. The Provider will collect payment from you at the time of service or bill you. Claims for Benefits for expenses incurred by using a Non-Network Provider must be submitted to the Claims Administrator using the Claims Administratorê claim form. The Claims Administrator will reimburse you for covered services or supplies and will send you an EOB. You can request a claim form by contacting the Claims Administrator. You can also download a claim form from the Claims Administratorê Web site. Refer to the *Claims Administrator for the Program* table in the ÇContact Informationé section on Page 70 for contact Information.

All Claims for Benefits should be sent to:

> EyeMed Vision Care
> P.O. Box 8504
> Mason, OH 45040-7111
> Attn: Claims Department

Note: *In no case will a Claim for Benefits be paid if filed more than 12 months from the date of the service or the purchase of the supply.*

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

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

Time Period for Initial Determinations on Claims for Benefits

In the event that an Adverse Benefit Determination is made on a Claim for Benefits, the Claims Administrator will notify the Claimant of such a determination within 30 days after receipt of the Claim for Benefits or within 45 days after receipt of the Claim for Benefits if the Claims Administrator:

- Determines that an extension is necessary as a result of matters beyond the control of the Program; and
- Notifies the Claimant during the initial 30-day period after receipt of the Claim for Benefits of the circumstances that necessitate the extension and the date by which the Claims Administrator expects to make a decision.

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

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

If an Adverse Benefit Determination Is Made on a Claim for Benefits

In the event an Adverse Benefit Determination is made on a Claim for Benefits, the Claims Administrator will provide written notification of that determination. The notification of the Adverse Benefit Determination, which may be in the form of an explanation of benefits (EOB), will include all of the following:

- The specific reason or reasons for the Adverse Benefit Determination.
- Specific reference to pertinent Program provisions on which the Adverse Benefit Determination was based.
- A description of any additional material or information necessary to perfect the Claim for Benefits and an explanation of why the material or information is needed.
- Appropriate information as to the steps to be taken if the Claimant wishes to appeal an Adverse Benefit Determination.
- A statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on a second-level appeal.
- 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 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.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Program to the Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

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

A Claimant may file an appeal if:

- An Adverse Benefit Determination has been made on a Claim for Benefits.
- The Claimant believes that the Benefits to which you're entitled have not been provided under the Program.

To assist a Claimant in deciding whether to appeal an Adverse Benefit Determination or in preparing an appeal, a Claimant shall be provided, upon written request to the Claims Administrator and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim for Benefits.

An appeal of an Adverse Benefit Determination (excluding an Adverse Benefit Determination based on ineligibility to enroll or participate) must be made by a Claimant in writing and submitted to the Claims Administrator at:

EyeMed Vision Care
4000 Luxottica Place
Mason, OH 45040-7111
Attn: Quality Assurance Department

An appeal of an Adverse Benefit Determination based on ineligibility to enroll or participate must be made by a Claimant in writing and submitted to the Eligibility and Enrollment Vendor. Refer to the *Eligibility and Enrollment Vendor* table in the "Contact Information" section on Page 70 for the appropriate address.

An appeal of an Adverse Benefit Determination must be made within 180 days after the Claimant receives notification of the Claims Administrator's Adverse Benefit Determination on the Claim for Benefits.

The Claimant has the right to:

- Review pertinent Program documents that may be obtained from the Plan Administrator. Refer to the *Plan Information* table on Page 61 for contact information.
- Send the Claims Administrator a written statement of the issues, written comments, documents, records or other information relating to the Claim for Benefits.

The Claims Administrator will review the first-level and second-level appeals of an Adverse Benefit Determination unless the Adverse Benefit Determination was based on your or your dependent's ineligibility to enroll or participate in the Program. If the Adverse Benefit Determination was based on ineligibility to enroll or participate, the first-level appeal will be reviewed by the Eligibility and Enrollment Vendor and the second-level appeal will be reviewed by the Eligibility and Enrollment Appeals Committee (EEAC).

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

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

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

The second-level appeal of an Adverse Benefit Determination (excluding an Adverse Benefit Determination based on ineligibility to enroll or participate) should be submitted to the Claims Administrator at the address stated above in this section. A second-level appeal of an Adverse Benefit Determination based on ineligibility to enroll or participate should be submitted to the

EEAC through the Eligibility and Enrollment Vendor. Refer to the *Eligibility and Enrollment Vendor* table in the “Contact Information” section on Page 70 for the appropriate address.

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

Decisions on Appeals Involving Claims for Benefits

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

- The specific reason or reasons for the Adverse Benefit Determination.
- Specific reference to pertinent Program provisions on which the Adverse Benefit Determination was based.
- 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).
- 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.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Program to the Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Scope of Review – Claims for Benefits

During its review of an appeal of an Adverse Benefit Determination, the Claims Administrator (or the Eligibility and Enrollment Vendor and the Eligibility and Enrollment Appeals Committee (EEAC) with respect to the appeal of an Adverse Benefit Determination based on ineligibility to enroll or participate in the Program) shall:

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

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

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

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

In any case, as an Employee or Eligible Dependent covered under the Program, you may have further rights under the Employee Retirement Income Security Act of 1974, as amended (ERISA). Refer to the "ERISA Rights of Participants" section on Page 56.

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.*

COORDINATION OF BENEFITS

KEY POINTS

A. Coordination of Benefits applies if you or your Eligible Dependents are covered by more than one group plan that provides benefits for vision care services and supplies.

B. Certain rules determine which plan pays first and which pays second.

Receiving Benefits From Other Coverage

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

When Coordination of Benefits Applies

The Program contains a provision called "coordination of benefits" (COB). This feature coordinates benefits from all group plans covering you and your covered Eligible Dependents to prevent duplication of vision care benefit payments. Under COB, the total benefits paid by all plans combined will not exceed 100 percent of the Allowable Amount of your vision care expenses. Refer to the "How COB Works" section on Page 42 for additional information.

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

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

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

Determining Which Plan Pays First

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

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

COB for Eligible Dependent Children

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

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

COB If the Parents Are Divorced or Legally Separated

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

- If there is such a decree or QMCSO, the plan covering the parent who has that responsibility will be the primary plan.

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

Refer to the "Qualified Medical Child Support Orders" section on Page 58 for additional information on a QMCSO.

How COB Works

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

When the Program is the primary plan, it will pay Benefits as specified in the Program. If the Program is the secondary plan, then:

- The Program will coordinate benefits with the primary plan to ensure that the benefits payable under both plans do not exceed 100 percent of the Participant's allowable expenses.
- If service frequency maximums apply, the services covered under the primary plan will be counted toward the frequency maximum under the Program.

Example: How COB Works

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

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

RIGHT OF RECOVERY AND SUBROGATION

The purpose of the Program is to provide to you and your covered Eligible Dependents Benefits that are not provided by any third party. The Program doesn't cover vision care services that are necessary as the result of an illness or injury for which a third party is liable as a result of negligence, wrongful acts or omissions. If Benefits have been paid by the Program in such a situation, the following shall apply:

- The Program shall be entitled (or subrogated) to all of your rights and your covered Eligible Dependents' rights of recovery against such third party to the extent of the reasonable value of the Benefits provided under the Program. In general, subrogation means that instead of you and your covered Eligible Dependents having the right to recover Benefits from a third party, the Program is substituted in place of you and your covered Eligible Dependents to seek such a recovery.
- You and your covered Eligible Dependents agree to reimburse the Program for the reasonable value of all Benefits received under the Program out of any actual recoveries received by you or your covered Eligible Dependents from any third party (other than the Participant's family members).

Affected Payments and Recoveries

The Program's subrogation and reimbursement rights shall apply to any recoveries that may be received or are actually received by you or your covered Eligible Dependents, including, but not limited to, all of the following:

- Any payments as a result of a settlement or judgment or otherwise made by, or on behalf of, a third party or his or her insurance company, or made under an uninsured or underinsured motorist coverage
- Any payments under workers' compensation, no-fault or other state-mandated motor vehicle insurance
- Any vision care payments made as a result of coverage under any automobile, school or homeowners' insurance policy
- Any other payments from any source designed or intended to compensate you or your covered Eligible Dependents for injuries sustained as a result of negligence or alleged negligence of a third party

The Benefits provided by the Program are secondary to any coverage under no-fault or similar insurance.

Your Obligations

You and your covered Eligible Dependents are required to cooperate fully and perform all actions necessary to secure the Program's right of recovery and subrogation, including:

- Granting a lien on any monies recovered from a third party equal to the reasonable value of Benefits provided by the Program and assigning to the Program an amount equal to the reasonable value of Benefits provided by the Program.
- Refraining from taking any action or negotiating any agreement with any third party that may prejudice the Program's rights hereunder.

- Refraining from assigning any rights to recover vision care expenses from any tort-feasor or other person or entity to any other party, including your minor Children, without the express prior written consent of the Plan Administrator.
- Not incurring any expenses on behalf of the Program in pursuit of the Programê rights. (Court costs or attorneysê fees may not be deducted from the Programê recovery without the prior express written consent of the Program.)

In the event you or your covered Eligible Dependents fail or refuse to honor these terms, the Program shall be entitled to recover any cost incurred in enforcing these terms and conditions.

Lien on Proceeds

The Programê recovery and subrogation rights are a prior lien against any proceeds recovered by a Participant. These rights will not be defeated nor reduced by the application of any so-called çMade-Whole Doctrine,é çRimes Doctrineé or any other such doctrine purporting to defeat the Programê recovery rights by allocating the proceeds exclusively to nonmedical expense damages.

OBLIGATION TO REFUND

You or your covered Eligible Dependents must refund to the Program any Benefits paid to the extent either:

- Such Benefits were not paid in accordance with the terms of the Program (improper payments).
- Such Benefit payments exceed the Benefits that should have been paid by the Program (excess payments).

You and your covered Eligible Dependents must assist the Program in getting any refund when requested if the refund is due from another person or organization. You and your covered Eligible Dependents remain responsible for any improper or excess payments made to you, your covered Eligible Dependents or providers under the Program.

If you, your covered Eligible Dependents or any other person or organization fails to promptly refund the full amount of any Benefits improperly or excessively paid, the Claims Administrator may reduce the amount of any future Benefits that are payable to or on behalf of you or your covered Eligible Dependents under the Program, in accordance with applicable law. The reductions will equal the amount of the required refund. The Program may have other rights in addition to the rights to reduce future Benefits.

EXTENSION OF COVERAGE ÑCOBRA

KEY POINTS

A. *COBRA continuation coverage is a temporary extension of group health coverage when coverage would otherwise end because of a life event known as a Qualifying Event.*

B. *COBRA continuation coverage is the same coverage that the Program gives to other Participants under the Program who are not receiving COBRA continuation coverage.*

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 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. Generally, you may be required to pay the entire cost of COBRA continuation coverage, which may not exceed 102 percent of the cost to the group health plan. If you are eligible for COBRA premium assistance, you will be required to pay only 35 percent of the cost of your COBRA continuation coverage for a period of up to nine months. 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 retirees and their families the opportunity to elect a temporary extension of health coverage (referred to as "continuation coverage" or "COBRA continuation coverage") in certain instances when coverage under a group health plan would otherwise end.

The Program is a group health plan subject to COBRA. You do not have to show that you are insurable to elect COBRA continuation coverage. However, you will have to pay the entire premium for your continuation coverage.

This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This section provides only a summary of your COBRA continuation rights. For more information about your rights and obligations under the Program and under federal law, you can request a copy of the Plan document from the Plan Administrator. Refer to the *Plan Information* table on Page 61 for the address and telephone number of the Plan Administrator.

The COBRA Administrator is the Eligibility and Enrollment Vendor. Refer to the *Eligibility and Enrollment Vendor* table in the "Contact information" section on Page 70 for contact information.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a temporary extension of group health coverage when coverage would otherwise end because of a life event known as a Qualifying Event. Specific Qualifying Events are listed later in this section. After a Qualifying Event occurs, and any required notice is provided to the COBRA Administrator, COBRA continuation coverage must be offered to each person who is a Qualified Beneficiary. A Qualified Beneficiary is someone who will lose coverage under the Program because of a Qualifying Event. Depending on the type of Qualifying Event, Participants who are covered under the Program on the day before the Qualifying Event occurs may be Qualified Beneficiaries. Certain newborns, newly adopted Children and alternate recipients under Qualified Medical Child Support Orders (QMCSOs) also may be Qualified Beneficiaries. This is discussed in more detail in the "Children Born to or Placed for Adoption With the Covered Eligible Employee During COBRA Period" section on Page 54 and the "Alternate Recipients Under Qualified Medical Child Support Orders" section on Page 55. Only Qualified Beneficiaries may elect to continue their group health plan coverage under COBRA. Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Continuation coverage is the same coverage that the Program gives to other Participants under the Program who are not receiving continuation coverage. Ordinarily, the continuation coverage that is offered will be the same coverage that the Qualified Beneficiary had on the day before the COBRA Qualifying Event occurred. Each Qualified Beneficiary who elects continuation coverage will have the same rights under the Program as other Participants covered under the Program, including annual enrollment and special enrollment rights. If the coverage is modified for similarly situated Participants or dependent Children, then COBRA coverage will be modified in the same way.

Specific information describing the coverage to be continued under the Program is contained elsewhere in this document and the Plan document. For more information about your rights and obligations under the Program, you can get a copy of the Plan document by requesting it from the Plan Administrator. Refer to the *Plan Information* table on Page 61 for the address and telephone number of the Plan Administrator.

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 Program, you become a Qualified Beneficiary and have the right to elect continuation coverage if you lose coverage under the Program 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 or Legally Recognized Partner

If you are the Spouse or Legally Recognized Partner 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 four Qualifying Events occurs:

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

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

Children

Children who are covered under the Program will become Qualified Beneficiaries and have the right to elect continuation coverage if they lose group health coverage under the Program because any of the following five 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 or the parents' partnership dissolves.
- The Eligible Employee-parent becomes entitled to Medicare benefits (Part A, Part B or both).
- The Child ceases to be eligible as an Eligible Dependent Child under the Program.

In addition, an Eligible Dependent Child who is born to or placed with you for adoption during a period of continuation coverage will become a Qualified Beneficiary if he or she is enrolled in your continued coverage.

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 and the Employee's Qualified Beneficiaries may elect COBRA coverage). In this case, the Employee and the Employee's Eligible Dependents, if any, will be entitled to elect COBRA coverage if both of the following conditions are met:

- They were covered under the Program on the day before the FMLA leave began (or became covered during the FMLA leave).
- They will lose Program coverage within 18 months from the date employment is terminated because of the Employee's failure to return to work. (This means that some individuals may be entitled to elect COBRA coverage at the end of an FMLA leave even if their coverage ended during the leave.)

As a result, 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 a Company group health plan on the day before beginning the leave of absence that provides Company-extended coverage for a period of six months.
- Terminated from employment within the first six months of the leave for any reason except gross misconduct.

If COBRA coverage is elected, the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA Qualifying Events of termination of employment and reduction of hours will apply. Refer to the "How Long Does COBRA Continuation Coverage Last?" section on Page 52 for more information.

Important Notice Obligations

The Program will offer COBRA continuation coverage to Qualified Beneficiaries 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, death of the Eligible Employee or the entitlement of the Eligible Employee for Medicare (Part A, Part B or both), the Company will notify the Eligibility and Enrollment Vendor of the Qualifying Event within 30 days of the event.

Your Notice Obligations

If your Eligible Dependent loses coverage under the Program as a result of divorce, legal separation, partnership dissolution or the Child's loss of dependent status under the Program, then you (the Eligible Employee) or your Eligible Dependent is responsible for notifying the Eligibility and Enrollment Vendor of the divorce, legal separation, partnership dissolution or the Child losing dependent status. You or your Eligible Dependent must provide this notice, using the procedures specified in the "COBRA Notice and Election Procedures" section on Page 49, no later than 60 days after the later of (i) the date the event occurs or (ii) the date coverage terminates under the Program, which is generally at the end of the month in which the COBRA Qualifying Event occurs. (Refer to the "When Coverage Ends" section on Page 24 for more details.)

If you or your Eligible Dependent fail to provide this notice to the Eligibility and Enrollment Vendor during this 60-day notice period (using the procedures specified), any Eligible Dependent who loses coverage will not be offered the option to elect continuation coverage. If you or your Eligible Dependent fail to provide this notice to the Eligibility and Enrollment Vendor and if any Claims for Benefits are mistakenly paid for expenses incurred after the date coverage should have terminated upon the divorce, legal separation, partnership dissolution or a Child losing dependent status, then you or your Eligible Dependent will be required to reimburse the Program for any Claims for Benefits so paid.

If the Eligibility and Enrollment Vendor is provided with timely notice of a Qualifying Event that has caused a loss of dependent coverage, then the Eligibility and Enrollment Vendor will send a COBRA enrollment notice to the last known address of the dependent. The Eligibility and Enrollment Vendor also will notify you (the Eligible Employee) and your Qualified Beneficiary of the right to elect continuation coverage after it receives notice of the following events that result in a loss of coverage:

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

Refer to the "Required Notification of Eligibility for Other Coverage" section on 52 for information regarding additional notice obligations that apply to a Qualified Beneficiary who is receiving COBRA premium assistance.

COBRA Notice and Election Procedures

All COBRA 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 ÇContact Informationé section on Page 70 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. Refer to the *Eligibility and Enrollment Vendor* table in the ÇContact Informationé section on Page 70 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 Program 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 or second Qualifying Event, if applicable, as well as the date on which the Qualifying Event(s) occurred.
>
> If your notice concerns the disability of a Qualified Beneficiary, you also must include the name of the disabled Qualified Beneficiary, the date when the Qualified Beneficiary became disabled and the date the Social Security Administration made its determination. You will be required to provide documentation to support eligibility.

Once the Eligibility and Enrollment Vendor receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each Qualified Beneficiary. For each Qualified Beneficiary who timely elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that the Program coverage would otherwise have been lost.

You (the Eligible Employee) and/or your Qualified Beneficiary must elect continuation coverage, using the election procedures described in the ÇCOBRA Notice and Election Proceduresé section above within 65 days after Program 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 ÇCOBRA Notice and Election Proceduresé section above, you will lose your right to elect continuation coverage, unless you are eligible to elect COBRA continuation coverage during a special secondary COBRA election period that is provided for in limited circumstances under this Program.**

If 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.

Also, if you are an Employee or former Employee and are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) under the Trade Act of 2002, you are entitled to a second opportunity to elect COBRA continuation coverage for yourself and any eligible family member who did not already elect coverage. You must make this election,

The Trade Adjustment Assistance Reform Act of 2002 (TAA Reform Act), a section of the Trade Act of 2002, created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired individuals who are receiving pension payments from the Pension Benefit Guaranty Corporation (eligible individuals). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65 percent of premiums (80 percent for coverage months on and after May 1, 2009 and prior to Jan. 1, 2011) of paid for qualified health insurance, including COBRA continuation coverage. If you have questions about the new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at **866-628-4282** (TDD users: **866-626-4282**). More information about the TAA Reform Act also is available at **www.doleta.gov/tradeact/2002act_index.cfm** (U.S. Department of Labor Employment and Training Administration Web site).

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 payment of Benefits under the Program may not be processed and paid until you have elected COBRA coverage and have made the first payment. Any Benefits paid 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 donê 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.

COBRA Premium Assistance Under ARRA

If you have had an involuntary termination of employment between Sept. 1, 2008, and Dec. 31, 2009, and you or your beneficiaries are not eligible for other medical coverage, then you and your beneficiaries may be eligible for COBRA premium assistance. The premium assistance is a 65 percent reduction in your premium payments for a period of up to nine months (that is, you and your beneficiaries would be required to pay only 35 percent of the premium amount that would otherwise be payable; the rest of the premium will be paid by the federal government). You will be provided with more detailed information when you receive your notification of COBRA coverage.

The COBRA premium assistance is **not** provided automatically. You and your beneficiaries must apply for it with the Eligibility and Enrollment Vendor. Whether you are eligible for the COBRA premium assistance or not is determined under federal statute. The Eligibility and Enrollment Vendor will make an initial determination as to your eligibility for the COBRA premium assistance. If your request for COBRA premium assistance is denied by the Eligibility and Enrollment Vendor, you may file an application with the United States Department of Labor for an expedited review (generally 15 days) of your eligibility. Please note that a Claim for COBRA premium assistance will not go through the Programê usual Claim process. The Department of Labor will make the final determination as to your eligibility, and the Program will abide by their decision.

Additional information can be found at the Web site for the United States Department of Labor:

http://www.dol.gov/ebsa/faqs/faq-cobra-premiumreductionEE.html

Or you may call the United States Department of Labor for further information. Check your local telephone book for the number of the office in your area.

Required Notification of Eligibility for Other Coverage

If, after a Qualified Beneficiary elects COBRA continuation coverage and while the Qualified Beneficiary is paying the reduced COBRA premium, the Qualified Beneficiary becomes eligible for other group health plan coverage or Medicare, the Qualified Beneficiary must contact the Eligibility and Enrollment Vendor to advise it of the other coverage. If a Qualified Beneficiary fails to provide this notification, the Qualified Beneficiary may be subject to an obligation to repay the Internal Revenue Service for the amount of the COBRA premium reductions realized after the Qualified Beneficiary became eligible for the other plan coverage and pay a ten percent federal income tax penalty on the amount of such premium reductions.

How Long Does COBRA Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. The maximum duration for COBRA coverage is described in this section. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the "Termination of COBRA Coverage Before the End of the Maximum Coverage Period" section on Page 54.

36 Months

When the Qualifying Event is your death, legal separation, divorce, dissolution of your partnership, your becoming entitled to Medicare or your dependent Child becoming ineligible for the Program, the maximum coverage period for your Qualified Beneficiaries is 36 months from the date of the COBRA Qualifying Event.

18 Months (Extended Under Certain Circumstances)

When the Qualifying Event is the end of employment or reduction in hours, the maximum continuation coverage period for you or your Qualified Beneficiaries is 18 months from the date of termination or reduction in hours. There are three ways in which this 18-month period of COBRA continuation coverage can be extended:

- **Disability Extension.** An 11-month extension of coverage may be available if any of the Qualified Beneficiaries in your family becomes disabled. All of the Qualified Beneficiaries who have elected COBRA continuation coverage will be entitled to the 11-month disability extension if one of them is qualified for the 11-month extension. The Social Security Administration (SSA) must formally determine under Title II (Old Age, Survivors and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the Qualified Beneficiary was disabled at some time before or during the first 60 days of COBRA continuation coverage, and you must notify the Eligibility and Enrollment Vendor of this fact using the notification procedure identified in the "COBRA Notice and Election Procedures" section on Page 49. You must provide this notification within 60 days of the later of the SSA's determination or the beginning of COBRA coverage and before the end of the first 18 months of COBRA continuation coverage. The disabled individual does not need to enroll for coverage in order for the other Qualified Beneficiary family members to be covered. In the event the disabled party does not continue COBRA coverage but the other Qualified Beneficiaries remain covered under COBRA, only 102 percent of the premium may be charged for months 19 through 29. If notice of the disability is not provided using the required procedure and within the required period, there will be no disability extension of COBRA continuation coverage. If the Qualified Beneficiary is determined by the SSA to be no longer disabled, you

must notify the Eligibility and Enrollment Vendor within 30 days of the SSA's determination by using the notice procedure specified in the "COBRA Notice and Election Procedures" section on Page 49. COBRA coverage for all Qualified Beneficiaries will terminate as of the first day of the month that is more than 30 days after the SSA's determination that the Qualified Beneficiary is no longer disabled, provided it is after the initial 18-month period. The Program reserves the right to cancel COBRA coverage retroactively and will require reimbursement of all Benefits paid after the first day of the month that is more than 30 days after the SSA's determination.

- **Second Qualifying Event.** An extension of up to 18 months of COBRA continuation coverage will be available to Qualified Beneficiaries who elect continuation coverage if a second Qualifying Event occurs during the 18- or 29-month coverage period following an Employee's termination of employment or reduction in hours. The maximum amount of COBRA continuation coverage available when a second Qualifying Event occurs is 36 months. The second Qualifying Event must be an event that would provide a 36-month COBRA continuation coverage period, such as the death of a covered Eligible Employee or a Child ceasing to be eligible for Program coverage. For the extension period to apply, notice of the second COBRA Qualifying Event must be provided to the Eligibility and Enrollment Vendor within 60 days after the later of the date of the second Qualifying Event or the date on which coverage would end by using the notification procedure specified in the "COBRA Notice and Election Procedures" section on Page 49. If the procedure is not followed or notice is not given within the required 60-day period, there will be no extension of COBRA continuation coverage resulting from a second Qualifying Event.
- **Medicare Extension.** If a COBRA Qualifying Event that is a termination of employment or reduction of hours occurs within 18 months after the Employee becomes entitled to Medicare, the maximum coverage period for the Qualified Beneficiaries will end three years from the date on which the Employee became entitled to Medicare (but the covered Employee's maximum coverage period remains 18 months).

Special Extension for TAA-Eligible Individuals and PBGC Recipients

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

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

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

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

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

COBRA continuation coverage for you (the Eligible Employee) or any of your Qualified Beneficiaries will automatically terminate when any one of the following six events occurs before the end of the maximum coverage period:

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

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

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

A Child born to, adopted by or placed for adoption with a covered Eligible Employee during a period of continuation coverage is considered to be a Qualified Beneficiary, provided that, if the covered Eligible Employee is a Qualified Beneficiary, the covered Eligible Employee has elected continuation coverage for himself or herself. The Child's COBRA coverage begins when the Child is enrolled in the Program and lasts for as long as COBRA coverage lasts for other family members of the Eligible Employee. To be enrolled in the Program, the Child must satisfy the otherwise applicable Program requirements (for example, age).

Annual Enrollment Rights and HIPAA Special Enrollment Rights

Qualified Beneficiaries who have elected COBRA coverage will be given the same opportunity available to similarly situated Active Employees to add or eliminate coverage for Eligible Dependents at annual enrollment, as applicable. In addition, the Health Insurance Portability and Accountability Act's (HIPAA) special enrollment rights will apply to those who have elected COBRA coverage. HIPAA, a federal law, gives a person already on COBRA coverage certain rights to add coverage for Eligible Dependents, if such person acquires a new Eligible Dependent (through marriage, birth, adoption or placement for adoption) or if an Eligible Dependent declines coverage because of other coverage and later loses such coverage as a result of certain qualifying reasons. Except for certain Children described in the "Children Born to or Placed for

Adoption With the Covered Eligible Employee During the COBRA Period" section on Page 54, Eligible Dependents who are enrolled during a special enrollment or annual enrollment, as applicable, do not become Qualified Beneficiaries. Their coverage will end at the same time that coverage ends for the person who elected COBRA coverage and later added them as Eligible Dependents.

Alternate Recipients Under Qualified Medical Child Support Orders

A Child of yours (the Eligible Employee's) who is receiving Benefits under the Program pursuant to a Qualified Medical Child Support Order received by the Eligibility and Enrollment Vendor during your (the Eligible Employee's) period of employment with the Participating Company is entitled to the same rights under COBRA as a dependent Child of yours, regardless of whether that Child would otherwise be considered your dependent.

When You Must Notify Us About Changes Affecting Your Coverage

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. While you are an Active Employee, your address in the system of the Eligibility and Enrollment Vendor will be used to send COBRA notices. Refer to the *Active Employee Address and Telephone Number Changes* table in the "Contact information" section on Page 70 for information on how to keep your address current while you are an Eligible Employee. For former Employees, if your address changes, you must promptly report your address change by calling the Pension Service Center. Refer to the *Pension Service Center* table in the "Contact Information" section on Page 70 for contact information. If you are not eligible to receive a pension plan benefit, or have already received your entire pension plan benefit in a lump sum and are not eligible for a retiree death benefit from your pension plan, contact the Eligibility and Enrollment Vendor to update your home address. Refer to the *Eligibility and Enrollment Vendor* table on Page 71 for contact information.

Also, for all Participants, if your marital status changes or if a covered Eligible Dependent ceases to be eligible for coverage under the Program terms, you, your Spouse, Legally Recognized Partner or Eligible Dependent must promptly notify the Eligibility and Enrollment Vendor to remove that Eligible Dependent from your coverage and provide the appropriate mailing address for mailing your Eligible Dependent's COBRA notice. Such notification is necessary to protect COBRA rights for your Spouse, Legally Recognized Partner or Eligible Dependent. In addition, you must notify us if a disabled Employee or family member is determined to be no longer disabled. Once your Eligible Dependent is enrolled in COBRA coverage, he or she must promptly report any address changes by calling the Pension Service Center. Refer to the *Pension Service Center* table in the "Contact Information" section on Page 70 for contact information. If you are not eligible to receive a pension plan benefit, or have already received your entire pension plan benefit in a lump sum and are not eligible for a retiree death benefit from your pension plan, contact the Eligibility and Enrollment Vendor to update your home address. Refer to the *Eligibility and Enrollment Vendor* table on Page 71 for contact information.

For More Information

Contact the Eligibility and Enrollment Vendor if you, your Spouse, Legally Recognized Partner, Eligible Dependent or Qualified Beneficiaries have any questions about this section or COBRA. You also may contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's Web site at **http://www.dol.gov/ebsa**.

Contact Information

For contact information for the Eligibility and Enrollment Vendor, refer to the *Eligibility and Enrollment Vendor* table in the "Contact Information" section on 70. For contact information for the Plan Administrator, refer to the *Plan Information* table in the "Plan Information" section on Page 61.

ERISA RIGHTS OF PARTICIPANTS

Your ERISA Rights

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants shall be entitled to:

- Receive information about the Plan, the Program 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 coverage (including vision coverage under this Program) for yourself or Eligible Dependents if there is a loss of coverage under the Program as a result of a Qualifying Event (refer to the "Extension of Coverage – COBRA" section on Page 44). You or your Eligible Dependents may have to pay for such coverage. Review this SPD and the other documents governing the Plan or this Program for the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of any exclusionary periods of coverage for preexisting conditions under this Program if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Program, 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 preexisting 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 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.

Under ERISA, there are steps you can take to enforce the rights listed in the “Your ERISA Rights” section on Page 56. 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. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous.

Assistance With Your Questions

If you have 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 Program and various laws that may impact your right to Benefits under the Program.

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 70.

HIPAA Certification

HIPAA places limits on preexisting condition exclusion periods under a health care plan and requires that a health care plan, including the Program, provide covered individuals with proof of their period of health care plan coverage, referred to as "creditable coverage." The proof of creditable coverage is generally provided through a written certificate generated by the health care plan that serves as evidence of the individual's health coverage.

If you leave the Company and are hired by another employer that has a preexisting condition exclusion in its health care plan, HIPAA provides that your creditable coverage under the Program will reduce the preexisting condition exclusion period of your new health care plan as long as you have not had a break in coverage of more than 63 days. The information on the certificate of creditable coverage provided by the Program will be used in this context to demonstrate your period of creditable coverage under the Program.

A certificate of your creditable coverage under the Program will be automatically issued when:

- You leave the Company.
- You or your Eligible Dependent loses coverage under the Program.
- Your or your Eligible Dependent's COBRA coverage ends.
- You or your covered Eligible Dependent becomes eligible for coverage under another plan.

In addition, a certificate of your creditable coverage under the Program will be provided to you promptly upon request while you have coverage under the Program and for up to 24 months after you leave the Company. If you need a certificate, please contact the Eligibility and Enrollment Vendor. Refer to the *Eligibility and Enrollment Vendor* table in the "Contact Information" section on Page 70 for contact information.

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

Qualified Medical Child Support Orders

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

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

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

A medical child support order has to satisfy certain specific conditions to be qualified. The Eligibility and Enrollment Vendor will notify you if the Company receives a medical child support

order that applies to you and will provide you with a copy of the Program's procedures used for determining whether the medical child support order is qualified. 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, your Child named in the order will be eligible for Program coverage as required by the order. You must then enroll the Child in the Program and pay any applicable contributions for coverage. Also, if a QMCSO is issued for your Child and you are eligible but not participating in the Program at that time, you and your Child will be enrolled in the Program and pay any applicable contributions.

Mandatory Portability Agreement

The Mandatory Portability Agreement (MPA) covers Employees who were in a covered position with a former Bell System Company on Dec. 31, 1983. If the MPA is applicable to you and modifies your length of service and/or your date of hire, the MPA could affect certain provisions of the Program. For more information on the MPA and whether you are covered under its terms, please contact the Pension Service Center. Refer to the *Pension Service Center* table in the "Contact Information" section on Page 70 for contact information.

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 61 indicates the functions performed by a third-party administrator for the Program as well as the name, address and telephone number of each contractor.

The Program 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 Program will not discriminate in any of the following ways:

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

Unclaimed Benefits

If any Benefits payable under the Program are unclaimed, the amount of Benefits will be retained in the Trust, as applicable, and will not escheat or revert to any party but may, in the discretion of the Plan Administrator, be used to offset future contributions to the Program.

Amendment or Termination of the Plan and Program

AT&T Inc. intends to continue the Plan and the Program described within this SPD but reserves the right to amend or terminate the Plan or Program or to amend or eliminate Benefits under the Plan and Program at any time. In addition, your Participating Company reserves the right to end its participation in the Plan or Program. In any such event, you and other Participants may not be eligible to receive Benefits as described in this SPD, and you may lose Benefits coverage. However, no amendment or termination of the Plan or Program 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 or Program to comply with the law.

Although no Plan or Program 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 or Program Benefit, to eligibility for coverage under the Plan or Program, or to the continuation of the Plan or Program merely by reason of the fact that the Plan or Program was in effect during your employment or at the time you received a Benefit under the Plan or Program or at any time thereafter.

Limitation of Rights

Participation in the Plan or Program 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 Program, Benefits provided under the Program may not be assigned or alienated. This means that you may not sell, assign, pledge or otherwise transfer Benefits under the Program before the Benefits are paid to you, nor are your Program 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 Program or your right to receive any Benefits under the Plan or Program, 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 or Program 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 *Plan Information* table on the next page.

Plan Information

Plan Information	
Plan Name	AT&T Umbrella Benefit Plan No. 1 — SNET Vision Program
Plan Number	600
Plan Sponsor and Plan Administrator of the AT&T Umbrella Benefit Plan No. 1 (as defined by ERISA)	AT&T Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333**
Name and Address of Employer	Affiliates of AT&T Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333**
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 Program as follows: AT&T Inc. administers appeals for vision Benefits under the Program on a contract basis with: EyeMed Vision Care P.O. Box 8504 Mason, OH 45040-7111 Attn: Quality Assurance **800-638-4288** AT&T Inc. administers Claims for vision Benefits under the Program on a contract basis with: First American Administrators P.O. Box 8504 Mason, OH 45040-7111 Attn: Claims Department **800-638-4288** AT&T Inc. administers enrollment, eligibility and COBRA coverage under the Program provisions, including the determination of initial Claims for Eligibility and appeals for Claim for Benefits involving eligibility, on a contract basis with: Hewitt Associates LLC 100 Half Day Road P.O. Box 1474 Lincolnshire, IL 60069-1474 **877-722-0020**

Table continued on next page

Plan Information	
Agent for Service of Legal Process	Process in legal actions concerning the provision of Benefits under the Program should be served on the Plan Administrator, which is the agent for service of legal process, at: AT&T Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333** Service of process also may be made upon a Plan Trustee.
Type of Plan	Welfare benefit plan offering group vision Benefits
Plan Year	Jan. 1–Dec. 31
Plan Trustee	AT&T Voluntary Employee Beneficiary Association Trust Frost National Bank 100 W. Houston St. P.O. Box 2950 San Antonio, TX 78299
Plan Funding and Contributions	Certain Participating Company Employees and former Employees share in the cost of the Program. Certain costs associated with providing Benefits under the Program may be paid through the AT&T Voluntary Employee Beneficiary Association Trust, a trust set up under Code Section 501(c)(9). The Program is self-insured; Program Benefits are not paid by insurance.

Table continued on next page

Plan Information	
Payment of Benefits	Administrators: • The Claims Administrator determines all Claims for Benefits under the Program. The Claims Administrator has full discretionary authority to interpret the provisions of the Program as they apply to entitlement to Benefits. • Although the Claims Administrator pays Claims under the Program on behalf of the Company, the Claims Administrator does not insure or guarantee that Claims will be paid. Rather, the Claims Administrator relies on the Company, either directly or from funds made available for this purpose from the AT&T Voluntary Employee Beneficiary Association Trust, to provide it with enough money to pay the Claims. The Claims Administrator cannot pay the Claims if the Company does not provide the money to the Claims Administrator. Benefits are paid by the Company as described in the "Plan Funding and Contributions" row on the previous page. • The Eligibility and Enrollment Vendor, Hewitt Associates LLC (AT&T Benefits Center), makes the initial determination concerning eligibility for Benefits under the Program. • 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 Program as they apply to eligibility for Benefits.
Plan Records	All Plan records are kept on a calendar year basis beginning Jan. 1 and ending Dec. 31.
Collectively Bargained Plan	The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of the collective bargaining agreement may be obtained by Participants whose rights are governed by such collectively bargained agreement upon written request to the Plan Administrator, and a copy also is available for examination by Participants as required by U.S. Department of Labor Regulation Sections 2520.104b-1 and 2520.104b-30.

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 Program.

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

This table should not be used to determine if you personally are eligible to participate in the Program. Refer to the “Eligibility and Participation” section on Page 8 for more information on eligibility to participate in the Program.

Participating Companies – SNET Vision Program	
Company Name	**Eligible Employee Group**
AT&T Operations, Inc.	Bargained Employees – East Region Core CWA and Premtech
AT&T Services, Inc.	Bargained Employees – East Region Core CWA and Premtech
SBC Internet Services, Inc.	Bargained Employees – East Region Core CWA (Premtech)
SNET Diversified Group, Inc.	Bargained Employees – East Region Core CWA and Premtech
SNET Information Services, Inc.	Bargained Employees – SNEIS-CWA
The Southern New England Telephone Company	Bargained Employees – East Region Core CWA and Premtech

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

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).

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 Program Benefit, including any such denial, reduction, termination of, or failure to provide or make a payment that is based on a determination of a Participant's eligibility to participate in the Program.

Allowable Amount. Allowable Amount is the portion of a Provider's charge that is eligible for reimbursement either in full or in part. Any amount by which the Provider's charge exceeds the Allowable Amount is not reimbursable under the Program.

AT&T Controlled Group of Companies. The group of companies composed of any corporation, general or limited partnership, limited liability company, joint venture, association or unincorporated trade, business or other entity of any kind, of which more than 80 percent of the outstanding voting stock or other controlling interests are owned, directly or indirectly by AT&T Inc.

Bargained Employee. A Bargained Employee is an Employee:

- Whose job title and classification are included in a collective bargaining agreement between a Participating Company and a union; or
- Whose job title and classification, by agreement between a union and a Participating Company, have been excluded from a collective bargaining agreement represented by the union, but for whom the Company has elected to provide bargaining unit benefits.

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

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

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

Child(ren). Child(ren) include your own children, children placed for adoption in your home, children you have legally adopted, your stepchildren (including the children of your LRP) who reside in your home, and children for whom either you or your Spouse/LRP is legal guardian and who reside in your home.

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

Claim for Eligibility. A Claim for Eligibility is a written request for 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 Program.

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 Program. 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 Program.

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.

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

Coordination of Benefits. Coordination of Benefits is a common health insurance plan provision that applies to persons covered under two or more group health plans. The purpose of Coordination of Benefits is to ensure that you receive benefits from both plans but no more than the total covered charges you incurred.

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

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

Dependent Child(ren). Generally your Child qualifies as a Dependent Child if you provide more than half of your Child's total support during the calendar year. Total support includes amounts spent to provide food, housing, clothing, education, medical, dental and vision care, recreation, transportation and similar necessities. However, in the case of a Dependent Child of divorced or separated parents, the parent who has custody of the Dependent Child for the greater part of the year (the custodial parent) is generally treated as the parent who provides more than half of the Dependent Child's support, even if the custodial parent did not provide more than half of the support. In the case of joint custody, it would be the parent who claims the Dependent Child as a dependent for Federal income tax purposes, in the case of a Qualified Medical Child Support Order (QMCSO), it would be the parent as ordered in the QMCSO.

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 Program 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.

Eligible Dependent. An Eligible Dependent is an individual who satisfies the eligibility conditions for participation in the Program described in the "Eligible Dependents" section on Page 9.

Eligible Employee. An Eligible Employee is an Employee of a Participating Company who satisfies the conditions for eligibility to participate in the Program set forth in the "Eligibility and Participation" section on Page 8.

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.

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

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.

Frames. Frames are standard eyeglass frames adequate to hold two prescription Lenses.

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

Legally Recognized Partner (LRP). A Legally Recognized Partner or LRP is any individual who:

- Is a Registered Domestic Partner (RDP), or
- Has entered into a same-gender relationship with an Employee pursuant to and in accordance with state or local law, such as marriage, civil union or another legally recognized arrangement that provides similar legal benefits, protections and responsibilities under state law to those afforded to a spouse.

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

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

Low Vision Devices. Low Vision Devices are Lenses or optical devices such as hand-held magnifiers and other high-magnification devices for a person with little correctable sight.

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.

Network Provider. A Network Provider is any Ophthalmologist, Optometrist or Optician who acts as an independent contractor for the Claims Administrator, who has agreed to limit his or her charges to Participants for most covered services and supplies and who is qualified and duly licensed or certified by the state in which he or she is located to furnish services to Participants.

Non-Network Provider. A Non-Network Provider is any Ophthalmologist, Optometrist or Optician who is qualified and duly licensed or certified by the state in which his or her office is located to furnish services to Participants but who is neither a member nor a participant in the Claims Administrator's Vision Care Network.

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

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

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

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

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

Participating Company. Participating Company means the Company and/or subsidiary, affiliate or business unit of the Company that has elected to participate in the Program, subject to approval provided in accordance with the AT&T Schedule of Authorizations. Refer to the "Participating Companies" section on Page 64 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 Umbrella Benefit Plan No. 1.

Plan Administrator. AT&T Inc. is the Plan Administrator of AT&T Umbrella Benefit Plan No. 1.

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

Premium Equivalent Rate. The Premium Equivalent Rate is the projected average cost of the vision coverage for a specified coverage tier, such as "individual" or "individual plus one," that is determined midyear in the Calculation Year for the subsequent Plan Year based on the Program expenses and census for the Plan Year preceding the Calculation Year. The paid claims data from the Claims Administrator shall be used along with enrollment data to project the Premium Equivalent Rates actuarially for the upcoming Plan Year.

Provider. A Provider is a Network Provider or a Non-Network Provider, as applicable.

Qualified Beneficiary. A Qualified Beneficiary is an individual who satisfies the conditions for COBRA continuation coverage described in the ÇExtension of Coverage ÑCOBRAé section on Page 44.

Qualified Medical Child Support Order (QMCSO). Qualified Medical Child Support Order or QMCSO is defined in the ÇOther Program Informationé section on Page 57.

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

Registered Domestic Partner (RDP). A Registered Domestic Partner or RDP is any individual with whom an Employee has entered into a domestic partnership that has been registered with a governmental body pursuant to state or local law authorizing such registration.

Regular Employee. A Regular Employee is an individual who is classified as a ÇRegular Employeeé by your employer which is a Participating Company in the Program.

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

Spouse. Spouse means the person to whom you are legally married, including marriage in common law.

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

Temporary Employee. A Temporary Employee is an individual who is classified as a ÇTemporary Employeeé by your employer that is a Participating Company in the Program.

Term Employee. A Term Employee is an individual who is classified as a ÇTerm Employeeé by your employer that is a Participating Company in the Program.

Tonography. Tonography is the continuous measurement of intraocular pressure by means of a recording tonometer and is used to detect the presence or absence of glaucoma.

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

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

CONTACT INFORMATION

Review the tables in this section for contact in formation for the various Program administrators and vendors, and descriptions of certain administrative practices that they use.

Information for the Following Administrators and Vendors Is Included in This Section:	
Eligibility and Enrollment Vendor: AT&T Benefits Center	Page 71
Claims Administrator for the Program: EyeMed Vision Care	Page 73
Active Employee Address and Telephone Number Changes	Page 75
AT&T Benefits Intranet and Internet Access 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 75
Pension Service Center: Contact the Pension Service Center to: • Report a change of address and/or phone number for a former Employee • Report a death • Inquire about Term of Employment	Page 76

<table>
<tr><th colspan="2">Eligibility and Enrollment Vendor
(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 Program or to inquire about:
• Eligibility.
• Cost of Coverage.
• Enrollment administration.
• Network Providers.
• General Benefits information.
• Billing.
• COBRA.
• Change in Status Events.
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).
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.
To access the Web site, you will need your AT&T Benefits Center user ID and password. On the Web site, you can:
• View your current vision coverage and contribution amounts.
• View your dependent coverage.
• Find information on where to go to change your personal data and address information.
• Learn which changes you can make if you experience a change in status event, such as a birth or adoption, marriage or divorce, gain or loss of an LRP. You can also learn when those changes would be effective.
• Access plan and Program documents.
• Preview how your Benefits may change if you get married, retire or go on a leave of absence.</td></tr>
<tr><td colspan="2" align="right">Table continued on next page</td></tr>
</table>

Eligibility and Enrollment Vendor (Also Responsible for Eligibility and Enrollment Appeals)	
AT&T Benefits Center	
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	**Claims** 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 for Eligibility to Enroll or Participate in the Program" section beginning on Page 33. 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: AT&T Benefits Center Benefits Determination Review Team P.O. Box 1407 Lincolnshire, IL 60069-1407 **Appeals** If you wish to appeal a denied Claim for Eligibility, you may submit your written appeal to: AT&T Benefits Center Eligibility and Enrollment Appeals Committee P.O. Box 1407 Lincolnshire, IL 60069-1407
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	**First-Level Request for Review** If your Claim for Benefits is denied on the basis of your eligibility or enrollment under the Program, you may submit a first-level request for review to: AT&T Benefits Center Benefits Determination Review Team P.O. Box 1407 Lincolnshire, IL 60069-1407 **Second-Level Request for Review** If your first-level request for review is denied, you may submit a second-level request for review to: AT&T Benefits Center Eligibility and Enrollment Appeals Committee P.O. Box 1407 Lincolnshire, IL 60069-1407 Procedures for submitting and processing appeals of Claims for Benefits denied on the basis of eligibility or enrollment can be found in the "How to File a Claim for Benefits Under the Program" section beginning on Page 35.
Disabled Dependent Verification Process	To establish or continue a Child's eligibility for continued vision coverage as a disabled Eligible Dependent beyond the applicable age limit, you must contact the AT&T Benefits Center to receive the required forms for certification and follow the instructions on the forms. In addition, the AT&T Benefits Center will periodically solicit for disabled Eligible Dependent status verification.

Claims Administrator for the Program	
EyeMed Vision Care	
To Reach a Service Associate	**800-638-4288** Monday through Saturday, from 7 a.m. to 10 p.m. Central time, and Sunday, from 10 a.m. to 7 p.m. Central time.
Internet Access	**http://www.eyemedvisioncare.com** Access the EyeMed Web site for information about the Program. When you access the Web site for the first time, you will be asked to register. After you have completed the registration, you will have immediate access to the site. Through **www.eyemedvisioncare.com**, you can: • Locate a Provider. • Check eligibility. • Find Benefits information. • Download a Non-Network claim form.
How to Determine if a Provider is a Network Provider or to Obtain a List of Network Providers in Your Area	To determine if a Provider is a Network Provider or to obtain a list of AT&T Select Network Providers in your area, go online to: • **http://www.eyemedvisioncare.com/memweb/ProviderLocator?ClientId=ATT** - (AT&T specific EyeMed Provider Web site — registration is not required to look up Network Providers) • **http://www.eyemedvisioncare.com** (the EyeMed Web site — registration is required to look up Network Providers). • The Your Benefits section of HROneStop at **http://hronestop.att.com** (AT&T Employee benefits intranet site). • The Your Benefits section of **http://access.att.com** (AT&T's secure Internet site for Employees and former Employees). • **http://resources.hewitt.com/att/** (the Eligibility and Enrollment Vendor Web site). Or call the EyeMed customer service center at the telephone number provided in the "To Reach a Service Associate" section of this table. *Note: When inquiring at a Provider's office if they are in the EyeMed Network, please make sure you verify that they are in the "EyeMed Select Network for AT&T".*

Table continued on next page

<table>
<tr><th colspan="2">Claims Administrator for the Program</th></tr>
<tr><th colspan="2">EyeMed Vision Care</th></tr>
<tr><td>How to File a Claim for Benefits</td><td>If you use Non-Network Providers, you will have to file a Claim for Benefits. Refer to the “How to File a Claim for Benefits Under the Program” section on Page 35 for information concerning the Program’s procedures for submitting and processing Claims and appeals.
• Claim forms are available through http://www.eyemedvisioncare.com (the EyeMed Web site — registration is required).
• The EyeMed Customer Service Center at the telephone number provided in the “To Reach a Service Associate” section of this table.
To use a Claim form, you must:
• Complete the Claim Transmittal form.
• Mail the form and the vision care bills to the address on the form.
Important: Claims for Benefits must be submitted no later than 12 months from the date of the service or the purchase of the supply. Claims for Benefits submitted after the filing deadline will not be considered for reimbursement.
Remember to keep a copy of your Claim for Benefits for your records.</td></tr>
<tr><td>Where to File a Claim for Benefits</td><td>EyeMed Vision Care
P.O. Box 8504
Mason, OH 45040-7111
Attn: Claims Department</td></tr>
<tr><td>Where to File Appeals of a Denied Claim for Benefits Other than a Claim for Benefits Denied on the Basis of Eligibility or Enrollment</td><td>EyeMed Vision Care
4000 Luxottica Place
Mason, OH 45040-7111
Attn: Quality Assurance Department
Procedures for submitting and processing Claims for Benefits and appeals from denied Claims for Benefits can be found in the “How to File a Claim for Benefits Under the Program” section on Page 35.</td></tr>
</table>

<table>
<tr><th colspan="2">Active Employee Address and Telephone Number Changes</th></tr>
<tr><td colspan="2">It’s important to keep your work and home addresses current because the majority of your benefits, payroll or similar information is sent to these addresses. Please include any room, cubicle or suite number that will help make mail routing more efficient.
For Employees with access to the Employee intranet, go to http://myintranet.att.com to review and/or update your:</td></tr>
<tr><td>eLink Users</td><td>Home address:
• Go to HROneStop at http://hronestop.att.com and select eLink (eCorp) in the left navigation bar.
• Enter your ATTUID and AT&T Global Logon password. (If you do not know your password, please follow the instructions on the screen.)
• Once logged on, click OK.
• On the eCORP home page, click on the Employee Services tab. (Note: Please be sure the far right-hand scroll bar is all the way to the top.)
• Select Personal Information.
• Select Maintain Addresses and Phone Numbers.
• To update your address, select Edit.
• Make any necessary changes, and click Save.

Work address:
• Go to http://myintranet.att.com on the Employee intranet.
• Review your work address information by looking up your name in the Webphone Directory section on the home page.
• If you have changes, contact your supervisor or eLink assistant. Remember to include any room, cubicle or suite number that will help make mail routing more efficient. For Employees without access to the Employee intranet, contact your supervisor or eLink assistant.</td></tr>
</table>

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.

<table>
<tr><th colspan="2">Pension Service Center</th></tr>
<tr><td colspan="2">For Eligible Employees and former Employees and any other individuals (e.g., COBRA dependents), contact the Pension Service Center, as follows:</td></tr>
<tr><td>To Reach a Service Associate or Access the Interactive Voice Response System (IVR) to:
• Report a change of address or telephone number (for former Employees).*
• Report a death.
• Inquire about your Term of Employment</td><td>Fidelity Service Center:
800-416-2363 (domestic)
Dial your country's toll-free AT&T Direct access number, then enter 800-416-2363 (international)
888-343-0860 (hearing-impaired)
Service associates are available Monday through Friday, from 7:30 a.m. to 11 p.m. Central time. The IVR is available 24 hours a day, seven days a week.
You will need your pension and savings plan service center PIN and Social Security number/customer ID when you call to speak to a service associate or to access the IVR.</td></tr>
<tr><td>Internet</td><td>http://netbenefits.fidelity.com (Fidelity NetBenefits® Web site). You will need your Fidelity Service Center PIN and Social Security number/customer ID to access your account.</td></tr>
<tr><td>Mailing Address</td><td>Fidelity Service Center
P.O. Box 770003
Cincinnati, OH 45277-0065</td></tr>
<tr><td colspan="2">*If you are not eligible to receive a pension plan benefit, or have already received your entire pension plan benefit in a lump sum and are not eligible for a retiree death benefit from your pension plan, contact the AT&T Benefits Center to update your home address. Refer to the Eligibility and Enrollment Vendor table on Page 71 for contact information.</td></tr>
</table>

APPENDIX A: LASER VISION CORRECTION CARE

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

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