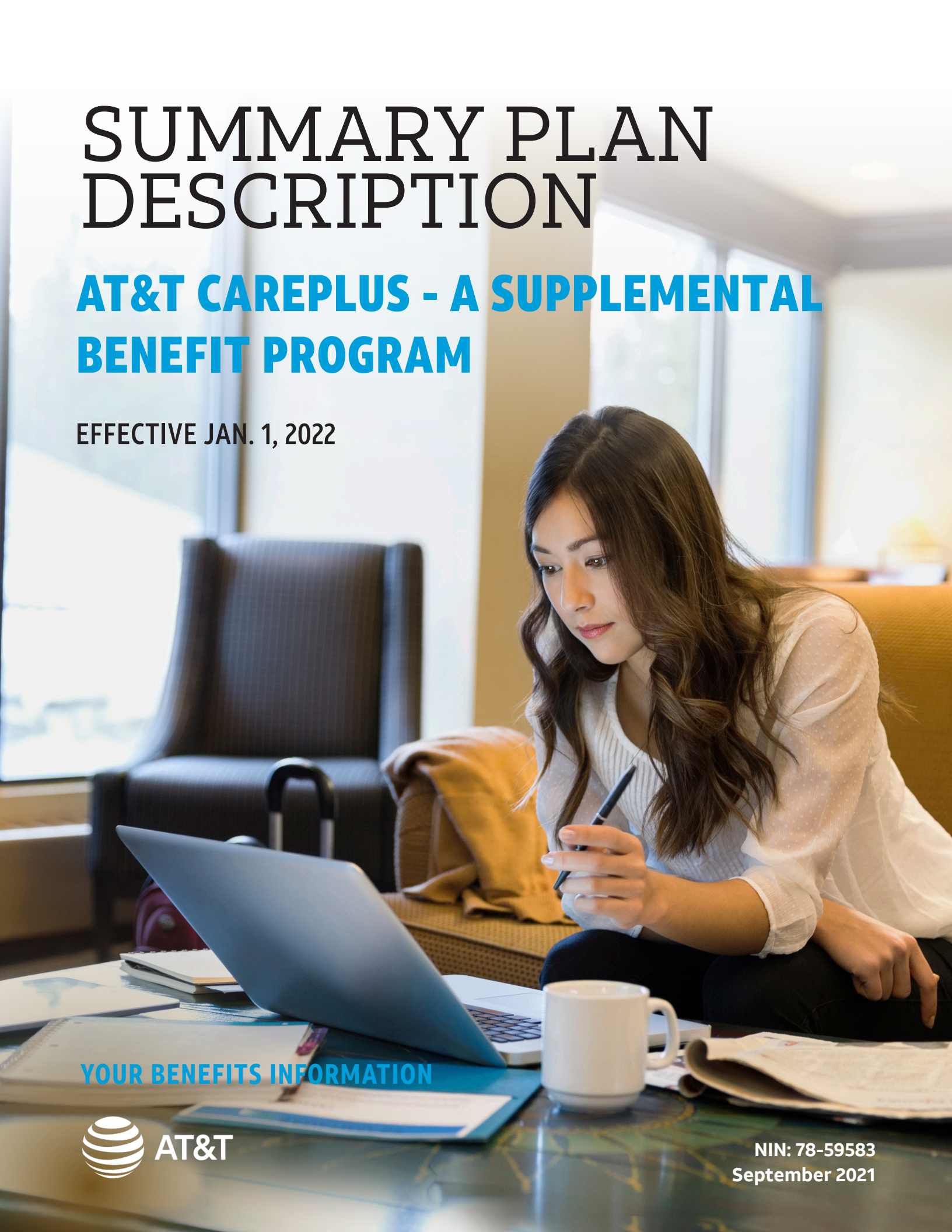
SUMMARY PLAN DESCRIPTION

AT&T CAREPLUS - A SUPPLEMENTAL BENEFIT PROGRAM

EFFECTIVE JAN. 1, 2022



YOUR BENEFITS INFORMATION

AT&T

NIN: 78-59583
September 2021

IMPORTANT INFORMATION

This Summary Plan Description (SPD) was written for easy readability. In all cases, the official Plan documents govern and are the final authority on Plan terms. If there are any discrepancies between the information in this SPD and Plan documents, Plan documents will control. AT&T Inc. reserves the right to terminate or amend any and all of its employee benefits plans or programs at any time for any reason. Participation in a Plan is neither a contract, nor a guarantee of future employment.

What Is This Document?

This SPD is a guide to your Program benefits. This SPD, together with the SMMs issued for this Program, constitute your SPD for this Program, as well as the AT&T Umbrella Benefit Plan No. 3 (Plan) with respect to benefits provided under this Program. See the **"Eligibility and Participation"** section for more information about Program eligibility.

This document contains a summary in English. If you have difficulty understanding this document, please contact the AT&T Benefits Center at **877-722-0020.**

Este documento contiene un resumen, en inglés. Si usted tiene dificultad en entender este documento, por favor póngase en contacto con AT&T Benefits Center, **877-722-0020.**

What Information Do I Need to Know to Use This SPD?

Eligibility, participation, benefit provisions, forms of payment and other Program provisions depend on certain factors such as your:

- Employment status (for example full-time or part-time)
- Job title classification
- Employer
- Service history (for example, hire date, Termination Date or Term of Employment)

To understand how the various provisions affect you, you will need to know the above information. The Benefits Administrator can provide these details. See the **"Contact Information"** section for more information on how to contact the Benefits Administrator.

What Action Do I Need to Take?

You should review this Summary Plan Description (SPD). Keep your SPDs and Summaries of Material Modification (SMMs) for your future reference. They are your primary resource for questions about your benefits.

How Do I Use This Document?

As you read this SPD, pay special attention to the key points at the beginning of most major sections and shaded boxes that contain helpful examples and important notes. While AT&T has provided these tools to help you better understand the Program, it is important that you read the SPD in its entirety, so that you can understand the Program details. Throughout this SPD, there are cross references to other relevant sections in the SPD. You will find opportunities to easily navigate to other sections within the SPD. Specific tables within sections are italicized for easy reference. If you are viewing the SPD online, you may click on cross-referenced sections and the Table of Contents to navigate to more information within the SPD. If you are viewing the printed version of this SPD, you may locate these sections by using the Table of Contents.

The icons below, used throughout this SPD, provide you information on and access to resources outside of this SPD. It is important to remember that any information provided outside of this SPD is not part of the SPD. Where information is provided by these external links that does not match the information provided to you within this SPD, the SPD content will govern.

 Mailing Address Information

 **Phone Numbers**

 **Fax Numbers**

 **External Website Information** (NOTE: Information within these external links is not part of this SPD)

AT&T has provided these tools to help you better understand the Program, and it is important that you read this SPD in its entirety so that you can understand the Program details.

Questions?

If you have questions about information in this SPD or your SMM, call the administrator listed in the **"Contact Information"** section.

Si usted tiene preguntas acerca de la información incluida en este SPD o su SMM, llame al administrador mencionado en la sección de **"Contact Information."**

HIGHLIGHTS

This document describes changes to CarePlus effective Jan. 1, 2022, except as noted below.

- The Contribution holiday is ending. Nominal contributions have been added. See the **"Contributions"** section for more information.
- You must enroll to have CarePlus coverage, except for Management Employees. See the **"Enrollment and Changes to Your Coverage"** section for more information.
- The Experimental Services section has been amended to remove Intravenous Immune Globulin (IVIG) and Nplate® (romiplostim) and to revise the description of Axium neurostimulator. See the **"Experimental Services"** section for more information.
- The Base Medical Program definition has been amended. See the **"Definitions"** section for more information.

The changes previously described in the following SMMs are now incorporated in this document:

- AT&T CarePlus - A Supplemental Benefit Program and AT&T Eligible Former Employee CarePlus - A Supplemental Benefit Program, Effective July 1, 2021 - NIN 78-56198
  - See the **"Experimental Services"** section for more information on the following benefits:
    - Cala Trio™ for Essential Tremor
    - CustomFlex™ Artificial Iris for eye reconstruction for those with aniridia
  - See the **"Expanded Services"** section for more information on the following benefits:
    - Payment for Certain Dependent Back-Up Care for Active Employees
    - Wellthy Veterans Services
    - reSET® and reSET-O® to supplement substance abuse outpatient therapy
    - Supportive Parenting for Anxious Childhood Emotions (SPACE) program to help parents of children and adolescents with anxiety disorders and obsessive-compulsive disorder (OCD)

USING THIS SUMMARY PLAN DESCRIPTION

USING THIS SUMMARY PLAN DESCRIPTION

KEY POINTS

- *The AT&T Umbrella Benefit Plan No. 3 (Plan) is a welfare benefit plan providing coverage for health and welfare benefits through component Programs.*
- *This is a Summary Plan Description (SPD) for the AT&T Umbrella Benefit Plan No. 3 (Plan) with respect to Benefits under the AT&T CarePlus – A Supplemental Benefit Program (Program).*
- *This document is an SPD for a portion of the Plan that applies to eligible Active Management, Bargained and Nonmanagement Nonunion Employees of Participating Companies.*

This Summary Plan Description (SPD) is a component program under the AT&T Umbrella Benefit Plan No. 3 (Plan). The Plan was established on Jan. 1, 2014, when it was split from the AT&T Umbrella Benefit Plan No. 1, which was established on Jan. 1, 2001, and incorporates certain welfare plans sponsored by AT&T Inc. Benefits under the Plan are provided through separate component programs. A program is a portion of the Plan that provides benefits to a particular group of participants or beneficiaries. Each program under the Plan applies to a specified set of benefits and group of Employees.

This SPD is a legal document that provides comprehensive information about the AT&T CarePlus – A Supplemental Benefit Program (Program).

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

You can find information about the options available to you in this SPD. Keep this SPD with your important papers and share it with your covered dependents.

Use this SPD to find answers to your questions about your Program Benefits in effect as of Jan. 1, 2022, unless otherwise noted. This SPD replaces all previously issued SPDs and Summary of Material Modifications (SMMs) for the portion of the Program covered in this SPD. To learn whether this SPD describes the Program provisions that apply to you, see the **"Eligibility and Participation"** section.

Section References

Many of the sections of this SPD relate to other sections of the document. You may not obtain all of the information you need by reading only one section. It is important that you review all sections that apply to a specific topic. Also, see the footnotes and notes embedded in the text. They further clarify content, offer additional information or identify exceptions that apply to certain Covered Persons. These notes are important to fully understand Program Benefits.

Terms Used in This SPD

Certain words and terms are capitalized in this SPD. Some of these words and terms have specific meaning (see the **"Definitions"** section for their meaning).

Program Responsibilities

Your Physician or other health care Providers are not responsible for knowing or communicating your Benefits. They have no authority to make decisions about your Benefits under the Program. This Program determines Covered Services and Benefits available. The Plan Administrator has delegated the exclusive right to interpret and administer applicable provisions to Program fiduciaries. Their decisions, including in the claims and appeal process, are conclusive and binding and are not subject to further review under the Program. Neither the Program, its administrators, nor its fiduciaries make health care decisions, and they do not determine the type or level of care or Course of Treatment for your personal situation. Only you and your Physician or other health care Providers determine the treatment, care and services appropriate for your situation.

CONTENTS

UNDERSTANDING ELIGIBILITY

ELIGIBILITY AND PARTICIPATION

KEY POINTS

- *You and your dependents are eligible for coverage under this Program if you meet the eligibility requirements described in this section.*
- *Your eligibility rules are based on your Participating Company and employment classification, the date you terminate employment, service history and disability status.*

Eligibility at a Glance

This section includes information to help you determine if you are eligible for this Program. Review the **"Enrollment Levels of Coverage"** section for the level of coverage (e.g., Individual or Individual plus one or more) available under the Program. To determine if your dependents are eligible for this Program, see the **"How to Determine if Your Dependents are Eligible for this Program"** section.

In order to determine your eligibility for the Program, you will need to know your employment classification and, if applicable, your affiliation with any bargaining unit or population group of a Participating Company or former Participating Company provided in your Base Medical Program.

Enrollment in the Program is not automatic. You and your dependents must be enrolled in the Program to receive coverage. See the **"Enrollment and Changes to Your Coverage"** section for information on how and when to enroll and the effective dates of coverage.

Eligible Employees

You are an Eligible Employee if you are eligible for a Base Medical Program.

Eligible Former Disabled Employees

If you are a former Employee and are approved to receive long-term disability (LTD) benefits under a program sponsored by a Participating Company, you continue to be eligible for Program coverage for as long as you meet all of the following:

- You were enrolled in Program coverage at the time you were first approved to receive LTD benefits and remain continuously enrolled.

- You continue to meet the eligibility requirements for your Base Medical Program. See the Eligibility and Participation section of your Base Medical Program SPD for eligibility requirements.
- You continue to be approved to receive LTD benefits under a program sponsored by a Participating Company.

In addition, if you are a former Bargained Employee of an East or Midwest Region Company, you are eligible for continued coverage under the Program without regard to whether you are approved to receive long-term disability (LTD) Benefits under a program sponsored by a Participating Company if you were enrolled in Program coverage and both of the following are true:

- You terminated employment from a Participating Company after exhausting disability benefits under a Company-sponsored disability benefit program.
- At the time you exhausted such disability benefits, your Term of Employment was 15 or more years with one or more Participating Companies.

All other eligibility requirements specified above apply.

Rehired Eligible Former Employees

Special eligibility rules apply if you previously terminated employment from a member of the AT&T Controlled Group of Companies with eligibility for Post-Employment Benefits other than as a result of disability and you are subsequently rehired by a member of the AT&T Controlled Group of Companies (Rehired Retiree). These special rules establish the conditions under which you may be eligible for Program coverage following your re-employment.

If you are rehired after having qualified for coverage as an Eligible Former Employee, or are currently a Rehired Retiree the provisions of the AT&T Rehired Eligible Former Employee Supplement supersede the rules in this section of the SPD.

To access the *AT&T Rehired Eligible Former Employee Supplement*, go to:

https://DirectPath.dcatalog.com/v/SMM---ATT-Rehired-Eligible-Former-Employee-Supplement/.

You will not be eligible for benefits from a program under AT&T Umbrella Benefit Plan No. 1 while you are an Active Employee except in certain limited circumstances.

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

How to Determine if Your Dependents Are Eligible for This Program

Review this section to determine if your dependents are eligible to enroll in the Program. Coverage for your Eligible Dependents is not automatic. **You must enroll your dependents if you want them to be covered under the Program.**

Unless your dependent's eligibility for coverage is due to surviving dependent status, military orders under Military Service Leave for those called to involuntary active duty by Presidential Executive or continuation of coverage under COBRA, your dependent(s) cannot be enrolled in the

Program, unless you are also enrolled. You may not cover a Spouse and a Partner as Eligible Dependents under the Program at the same time. In addition, there may be restrictions on whether you can cover another Employee or Eligible Former Employee as a dependent under this Program. See the **"Dual Enrollment"** section for more information.

The Company reserves the right to verify eligibility of any enrolled dependents. See the **"Dependent Eligibility Verification"** section for more information. Once a dependent is enrolled, it is your responsibility to contact the Eligibility and Enrollment Vendor to cancel coverage whenever you have a dependent that is no longer eligible, including, for example, when you are divorced. Refer to the **"Enrollment and Changes to Your Coverage"** section for more information.

If one of your dependents does not meet the eligibility requirements of the Program, the Program will not pay Benefits for any expenses incurred for that dependent. Also, if the Program pays Benefits for a dependent while the dependent is ineligible, you may be required to reimburse the Program for all such payments.

NOTE: If coverage for your dependent is based upon the terms of a Qualified Medical Child Support Order (QMCSO), see the **"Alternate Recipients Under Qualified Medical Child Support Orders"** section for coverage information.

Eligible Dependents

Except for dependents classified as Class II Dependents and dependents of Eligible Former Disabled Employees, if your dependent is eligible under your Base Medical Program, he or she is also eligible for coverage under the Program. For example, if your Partner is eligible under your Base Medical Program, your Partner is also eligible under the Program. Similarly, if your Disabled Child(ren) is eligible under your Base Medical Program, he or she is eligible under the Program. Refer to the Eligible Dependent section of your Base Medical Program SPD for the Eligible Dependent provisions that apply to you. Class II Dependents are not eligible under the Program.

If you are an Eligible Former Disabled Employee, your Eligible Dependents receive coverage under the Program if they were enrolled in Program coverage at the time you were first approved to receive LTD benefits, remain continuously enrolled and continue to meet the eligibility requirements for your Base Medical Program.

Dependent Eligibility Verification

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

In order to enroll your dependent, you must do so through the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section for contact information.

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

The dependent eligibility verification package will contain instructions for submitting documents that verify your dependents' eligibility for coverage, including a list of documents that would meet this requirement. For example, if you are enrolling a Child, you will be required to provide a copy of a birth certificate and/or other specified document that establishes the Child's relationship to you.

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

If you provide the required documentation within the required timeframe and the Eligibility and Enrollment Vendor has reviewed your documents and approved the eligibility of your dependent, coverage under the Program will become effective as of the first of the month following the date you requested enrollment, or earlier if pursuant to Annual Enrollment or a qualified status change as described under the Program.

For more information on dependent eligibility and documentation required for verification, go to:

https://directpath.dcatalog.com/v/Dependent-Eligibility-Verification/

By clicking the link above, you are leaving the SPD and are going to a third-party managed website to view information and materials that are not part of the SPD.

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

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

NOTE: Enrollment of an ineligible dependent in the Program constitutes benefits fraud and violates the AT&T Code of Business Conduct. The Company will refer suspected fraudulent enrollments to AT&T Asset Protection for investigation, which may result in legal action and financial consequences.

Eligible Dependent Exceptions

All Eligible Dependents who were enrolled in coverage under the Program as of Dec. 31, 2017 will be treated as Eligible Dependents under this Program. This means that they will be eligible for the Program without the need to reenroll or complete Dependent Eligibility Verification, except that, factors causing a loss of eligibility under the Program will be governed by the provisions provided in this Program (e.g., age 26 age out for Children). Disabled dependents and Class II dependents who lose coverage will be required to meet the Eligible Dependent Rules before they are allowed to reenroll.

Certification of Disabled Dependents

It is necessary to certify that your Child(ren) is disabled in order to obtain extended eligibility under the Program. Your disabled dependent will not receive Benefits under the Program if you fail to certify his or her disabled status. Review this section carefully to understand the steps necessary for certification (and recertification). In addition, you should refer to your Base Medical Program SPD for more information on the timing of your dependent's disability.

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

Program coverage for a Disabled Child(ren) begins when the Child(ren) is certified. Coverage is not retroactive for medical expenses incurred before certification.

IMPORTANT: It is best to contact the Eligibility and Enrollment Vendor three to six months before the Child reaches age 26. Failure to timely certify your dependent prior to age 26 will result in a break in Program coverage.

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

Surviving Dependent Coverage

If you are enrolled in the Program as of your date of death, coverage for your enrolled dependent(s) will continue through the month in which your death occurs. Following your death, your Eligible Dependents who are enrolled as of your date of death will continue to be eligible for coverage under the Program under the same provisions that apply to their eligibility for survivor coverage under the Base Medical Program for which the surviving dependent is eligible. For more information regarding survivor coverage, refer to the SPD for your Base Medical Program. The election to continue coverage under the Program will be separate from any election made under your Base Medical Program. In addition, your surviving dependent(s) covered as of the date of your death will have the option to continue Program coverage through COBRA, as provided by federal law.

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

Dual Enrollment

The Program is designed to provide coverage for you and your Eligible Dependents. However, the Program has rules limiting Dual Enrollment.

The Program does not permit you or your dependent to be enrolled in the Program under more than one eligibility status, for example, as an Employee or Eligible Former Employee and as a Eligible Dependent, at the same time. A dependent also cannot be enrolled as the dependent of more than one individual at the same time.

Enrollment Levels of Coverage

The Program offers the following levels of coverage:

- Individual – You enroll yourself only;
- Individual plus one or more – You enroll yourself and one or more Eligible Dependents.

See the **"Eligible Dependents"** section above for information on who qualifies as an Eligible Dependent.

ENROLLMENT AND CHANGES TO YOUR COVERAGE

ENROLLMENT AND CHANGES TO YOUR COVERAGE

KEY POINTS

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

  - Your address changes.
  - You have a change in enrollment.
  - You receive a Qualified Medical Child Support Order (QMCSO).
  - You or a covered dependent enrolls in Medicare.
  - An enrolled dependent loses eligibility for any reason, such as divorce or attaining a certain age.

Enrollment at a Glance

The *Enrollment Rules for You* table below indicates the enrollment opportunities for which you and your dependents are eligible, as well as the time frames for electing coverage and making changes. For more detailed information regarding types of enrollment, see the sections following the *Enrollment Rules for You* table.

You don't need to be *enrolled* in a Base Medical Program to sign up, but you must enroll in CarePlus to receive any CarePlus benefits.

You and your family members can make an election not to participate during your enrollment period. Employees who are covered by a collective bargaining agreement will not be enrolled automatically.

Enrollment Rules for You

	Enrollment
Newly Eligible Enrollment	You must enroll for coverage to become effective. You must do so within 31 days of the later of your hire date or the date appearing on your enrollment materials for coverage to be effective on your date of hire, or as provided under the applicable collective bargaining agreement, respectively.
Annual Enrollment	You must enroll during Annual Enrollment for coverage to be effective on the first day of the following Plan Year.
Prospective Enrollment	You may enroll prospectively at any time during the year provided you are eligible for Prospective Enrollment under your Base Medical Program.
Change-in-Status Enrollment	See the **"Change-in-Status Enrollment"** section.

Annual Enrollment

Annual Enrollment occurs each fall. During enrollment, you will be notified of the coverage options available to you for the next Plan Year. Your enrollment materials will also include information on coverage assigned to you, which will become effective if you do not make an election. Coverage begins Jan. 1 of the following Plan Year.

IMPORTANT: If you have a Change-in-Status Event on or after Sept. 1 and want to change your coverage, you need to make two elections:

1) Change your current coverage in effect through the end of the Plan Year, and

2) Update your Annual Enrollment elections for coverage beginning Jan 1.

You can enroll online via the Eligibility and Enrollment Vendor website or by calling the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section for contact information.

Prospective Enrollment

Prospective Enrollment means the ability to drop or add coverage for yourself or a dependent outside of Annual Enrollment, newly eligible enrollment or Change-in-Status Events. You may enroll prospectively at any time during the year provided you are eligible for Prospective Enrollment under your Base Medical Program.

Change to current coverage or newly elected coverage resulting from Prospective Enrollment are effective on the first day of the month following the request for enrollment.

Change-in-Status Enrollment

Circumstances often change. You may get married, welcome a Child to the family, lose benefits under another employer's medical plan or you or an enrolled dependent may take a leave of absence. These important events are called Change-in-Status Events and the Program allows you to change your enrollment when you experience Change-in-Status Events. See the **"Change-in-Status Events"** section for more information on events that are considered Change-in-Status Events.

- Your ability to change your Program enrollment when you experience a Change-in-Status Event during a Plan Year is in addition to Annual Enrollment and other enrollment opportunities determined under your Base Medical Program. Refer to the Change-in-Status Events section in your Base Medical Program SPD for information.

Notice of A Change-In-Status Event

It's important to consider how a change will impact your benefits. If a Change-in-Status Event occurs and you want to change your enrollment choices, you must inform the Eligibility and Enrollment Vendor within the time period specified under your Base Medical Program. While the time period varies, it is generally 31 days after the event. Refer to the Change-in-Status Events section in your Base Medical Program SPD for information.

Exceptions include the following:

- If you or an enrolled dependent gains or loses eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage, you must inform the Eligibility and Enrollment Vendor within 60 days of the gain or loss of coverage.
- If you or a covered dependent dies, the Fidelity Service Center should be notified *as soon as possible* at **800-416-2363** to initiate the appropriate changes to Program enrollment.

The Effective Date of Your Change-In-Status Enrollment

It is very important that you notify the Eligibility and Enrollment Vendor within the time frames stated above when requesting a change to your enrollment. Your eligibility to make a change and the effective date of your change in enrollment depends on when you request that change.

To change your enrollment, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section for contact information.

Your change in enrollment request is subject to review by the Eligibility and Enrollment Vendor. This review could have an impact on the effective date of your enrollment. For example, if you request enrollment for your newly eligible Child, your enrollment is subject to the same rules that apply to newly Eligible Employees and dependents, including the Dependent Eligibility Verification Process. Therefore, it is especially important to submit the necessary documents that prove eligibility for your dependent in a timely manner. Failure to submit the documents on time may delay his or her effective date of coverage under the Program beyond the effective dates listed below. See the **"Dependent Eligibility Verification"** section for more information.

If you request your enrollment change within the specified time frame and you provide all documentation requested by the Eligibility and Enrollment Vendor within the time required, your new enrollment will become effective on:

- The date of the Change-in-Status Event in the case of birth, adoption or placement for adoption; or
- The first of the month after the event for all other Change-in-Status Events.
- If you do not notify the Eligibility and Enrollment Vendor within the specified time period, your ability to make a change to your enrollment outside of Annual Enrollment, Prospective Enrollment or another Change-in-Status Event will be determined by the provisions of your Base Medical Program. Refer to the Enrollment and Changes to Your Coverage section in your Base Medical Program SPD for information. See the **"Eligibility and Participation"** section for information on other enrollment opportunities.

Your Change in Status May Affect Your Tax Treatment of Your Contributions

A change in enrollment may lead to an adjustment to your required contributions and may also affect the tax treatment of your new contribution amount. For information about how your specific enrollment change may affect the amount of your contributions, contact the Eligibility and Enrollment Vendor.

IMPORTANT: This section does not contain information about your right to change the amount of your before-tax contribution. The section outlines your right to change your Program coverage enrollment only. For more information on how contributions are affected by Change-in-Status Events, please see the **"Before-Tax and After-Tax Contributions"** section.

Enrollment Rules for Your Dependents

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

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

Your dependent enrollment elections can be made:

- During Annual Enrollment— for coverage beginning the first day of the following Plan Year.
- At any time during the year with coverage beginning at a later date if you are eligible for Prospective Enrollment under your Base Medical Program.

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

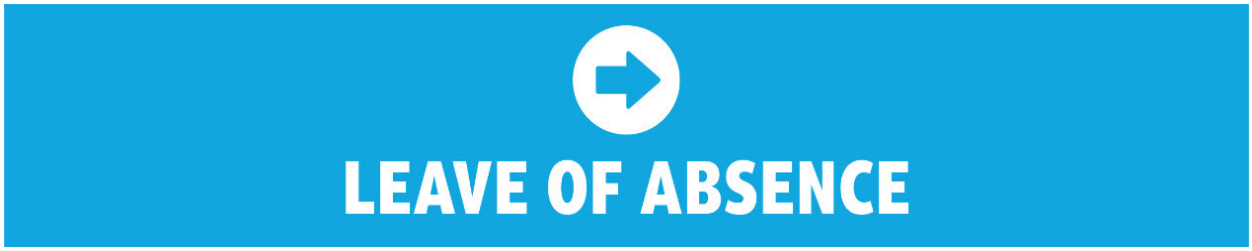
IMPORTANT: If you are denied enrollment in the Program, you have the right to file a Claim for Eligibility. See the **"How to File a Claim for Eligibility"** section for information.

Permissible Change-in-Status Enrollment Events

Change-in-Status Events permit you to change your Program enrollment. For a detailed description of each of these events, see **"Appendix A"** *Change-in-Status Events*. The permitted enrollment changes reflected in **"Appendix A"** *Change-in-Status Events* are based on the terms and conditions of the Program and are consistent with federal law. The Plan Administrator has the discretion to determine whether or not a requested enrollment change is consistent with the event. See the Status Change Codes legend at the end of the tables in **"Appendix A"** *Change-in-Status Events* for an explanation of the codes used in the tables.

There are certain requirements that your change in enrollment request must meet in order to be permitted under the Program.

- The enrollment change must be on account of and consistent with the event, and
- The Change-in-Status Event must affect eligibility and coverage under the Program.



LEAVE OF ABSENCE

KEY POINTS

- *Special rules apply if you are on a leave of absence. You may be required to pay for coverage that continues during your leave of absence.*
- *If you do not continue coverage while on a leave of absence, you may be required to re-enroll upon your return to work.*

Your eligibility for continued coverage under this Program depends on the type of absence and, in some cases, on the duration of your leave. If you are on an approved leave of absence, you will receive a notice explaining what coverage you are eligible to continue while on leave. If you continue coverage, you must make all contributions during the required time frame to avoid interruption of your benefits. If you do not continue coverage under the Program while you are on your leave of absence, you must re-enroll upon your return to work by contacting the Enrollment and Eligibility Vendor and speaking to a representative. All coverage that continued while you were on leave will be continued when you return to work unless your eligibility has changed, for example, a change in your position results in eligibility for a different benefit program.

Special rules apply if you are absent from work by reason of Military Service or on a leave of absence subject to the Family and Medical Leave Act (FMLA leave). These rules are covered in the next two sections.

Because your coverage generally will be continued until the end of the month in which your active employment ends, a leave of absence that begins and ends in the same month will not affect your eligibility for coverage, but you may be required to re-enroll for coverage upon your return to work in order to continue your coverage uninterrupted.

Extended Coverage for Employees on Active Military Duty

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

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

If you are qualified to continue coverage pursuant to USERRA, you may elect to continue your coverage under this Program by notifying the Eligibility and Enrollment Vendor in advance and providing payment of any required contribution for this coverage. This may include the amount the Company normally pays on your behalf. If your Military Service is for a period of time shorter than 31 days, you will not be required to pay more than your regular contribution amount for your coverage under this Program.

You may continue your coverage under USERRA for up to the shorter of:

- The 24-month period beginning on the day of your absence from work due to Military Service.
- The day after the date on which you fail to apply for, or return to, a position of employment with the Company.

Regardless of whether you continue coverage under this Program while in Military Service, if you return to employment with the Company, your coverage and coverage for your Eligible Dependents will be reinstated under the Program. No exclusions or waiting period will be imposed in connection with this reinstatement unless a sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of Military Service.

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

Extended Coverage While on an FMLA-Protected Absence or on FMLA

During a leave covered by FMLA leave, the Company will maintain your coverage under the Program for up to 12 weeks of leave on the same terms and conditions as applicable to similarly situated Active Employees who are not on FMLA leave. If you receive pay while on an FMLA Leave, your required contributions will continue to be taken from your pay. If you do not receive pay while on an FMLA Leave, you will be billed and required to pay your required contributions.

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

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

Continuation of Coverage under COBRA

If you do not return to active employment after your FMLA leave ends or you notify the Company

that you do not intend to return after the end of your FMLA leave, you will be eligible to continue coverage through COBRA. The period of COBRA coverage will begin on the earlier of:

- The date your FMLA leave ends if you do not return to active employment.
- The date you notify the Company that you do not intend to return after the end of your FMLA leave.

For More Information

FMLA leave information is available on the HROneStop Website at **https://www.e-access.att.com/hronestop/group/hr-onestop/fmla-home.** The website contains information on FMLA Qualifying Events, eligibility requirements, details on the application process, and other helpful resources. If you are not at work, you will be able to find additional information about FMLA leaves at **access.att.com** or email support at **OneStopLeaves@amcustomercare.att-mail.com**.

You may also send correspondence to:

HR Corporate Attendance & Leave Management
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.

CONTRIBUTIONS

KEY POINT

- *You and your Eligible Dependents will pay for Program coverage in 2022 due to the end of the contribution holiday.*

You will receive information about contributions during Annual Enrollment for any year you can enroll in the Program and any time the Eligibility and Enrollment Vendor determines that you have a Change-in-Status Event that allows you to make an enrollment change. Refer to your enrollment materials for information concerning the contribution amount that applies to you. You may also obtain an electronic or printed personalized contribution statement at any time through the Eligibility and Enrollment Vendor. These documents are considered to be a component of your

SPD. See the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section for contact information.

Contribution Policy

You are required to pay a monthly contribution equal to the Cost of Coverage to participate in the Program. The Company does not contribute toward the Cost of Coverage. See the table below for the contribution rules.

Contribution Rules	
Regular and Term Employee (less than 6 months Term of Employment)	**Individual:** $1 per month until further notice **Individual + one or more:** $3 per month until further notice Puerto Rico Employee contributions are after-tax only.
Regular and Term Employee (at least 6 months Term of Employment)	**Individual:** $1 per month until further notice **Individual + one or more:** $3 per month until further notice Puerto Rico Employee contributions are after-tax only.
Temporary Employee	If Eligible (see the **"Eligibility and Participation"** section for eligibility information) **Individual:** $1 per month until further notice **Individual + one or more:** $3 per month until further notice Puerto Rico Employee contributions are after-tax only.
Note	*Some Employee classifications may not apply (for example, Term). See the **"Eligible Employees"** section for your specific eligibility requirements.* *Individuals on COBRA are required to pay $1.02 per month for Individual coverage and $3.06 per month for Family coverage.*

How Contributions Are Made

Contributions are deducted from your paycheck. If your contributions are not deducted, for example, if you are on an unpaid leave of absence (LOA), you will be billed and direct payments will be required, generally through check or money order. If the Eligibility and Enrollment Vendor makes this service available, you may choose to have your contributions automatically withdrawn from your checking or savings account. If you are direct billed, the Eligibility and Enrollment Vendor may permit you to pay your contributions up to one year in advance. Contact the Eligibility and Enrollment Vendor to determine what options are available to you. See the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section for contact information.

If you are an Employee, your contributions will be deducted from your paycheck on a before-tax basis, unless you elect to make your contributions on an after-tax basis. If you are an Employee who is subject to income tax in Puerto Rico, your contributions may be made only on an after-tax basis.

IMPORTANT: You have a 60-day grace period from the day your payment is due to make your payment before coverage is terminated. Failure to pay all required contributions for both you and any covered dependents will result in loss of coverage retroactive to the last day of the month for which full payment was received. Coverage will be canceled and you may not be eligible to re-enroll until the next Annual Enrollment or limited to Prospective Enrollment only unless you experience a Change-in-Status Event that permits you to enroll sooner. In addition, if you are making contributions toward coverage under any other Company health and life insurance plans, coverage under those health and life plans will be canceled as well, and you may not be able to re-enroll in those plans, if at all, until the next Annual Enrollment unless you experience a Change-in-Status Event that permits you to enroll sooner. You should contact the Eligibility and Enrollment Vendor for more information. See the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section for contact information.

EXAMPLE: If your monthly contributions are medical $400, vision $50 and supplemental life insurance $150 for a total of $600 and you pay through March in full but have $150 left to pay toward your contributions for April coverage, coverage for medical, vision and supplemental life insurance will be terminated effective April 1, if payment of the remaining $150 balance is not made in full by May 31.

Before-Tax and After-Tax Contributions

If you are an Active Employee, your Program contributions will automatically be deducted from your pay on a before-tax basis upon enrolling in the Program. If you do not want these contributions deducted on a before-tax basis, you must elect after-tax contributions when you enroll.

If you are a rehired former Employee, your contributions will be deducted from your paycheck on a before-tax basis, unless you elect to make your contributions on an after-tax basis. If you are a rehired former Employee who is subject to income tax in Puerto Rico, your contributions may be made only on an after-tax basis.

If your contributions are paid on a before-tax basis, your ability to make changes to these contributions mid-year is governed by the AT&T Flexible Spending Account (FSA) Plan. As a result, even if you are eligible to change your medical coverage to an option with lower or higher contributions due to a Change-in-Status Event or Prospective Enrollment, you cannot change the amount of your before-tax contributions unless you experience a Qualified Status Change event as defined in the FSA Plan. Refer to the **FSA Plan SPD** for more information on before-tax contributions and for a list of events that are considered Qualified Status Change events.

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

Tax Consequences of Coverage for Partners and Their Dependents

The Company's level of contribution toward Program coverage for a Partner and a Partner's Child(ren) is the same as the Company's contribution for coverage of a Spouse and a Spouse's Child(ren).

However, when a Partner or a Partner's Child(ren) are covered under the Program, and your relationship is not recognized as a marriage under the applicable state law or federal law, the Company may be required to 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 Internal Revenue 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 contributions that you have paid for a Partner and any of his or her Child(ren). This amount is subject to federal, FICA income and any applicable state and local tax withholding.

Employees on Leave of Absence

If you are on an approved leave of absence (LOA), you will receive a notice explaining what Program coverage you are eligible to continue. The Eligibility and Enrollment Vendor will send you a monthly bill for required contributions. Payment is due on the first of the month for the following month of coverage. For example, the bill you receive on June 15 applies to coverage for the month of July. Payment is due by July 1.

If you have questions concerning billing or payment of your contribution, contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section for contact information.

IMPORTANT: You have a 60-day grace period from the day your payment is due to make payment before coverage is terminated. Failure to pay all required contributions will result in loss of coverage retroactive to the last day of the month for which full payment was received. You may not be eligible to re-enroll until you return from your LOA. If you do not continue coverage under the Program while you are on LOA and you would like to re-enroll upon your return to work, you must contact the Eligibility and Enrollment Vendor to determine if you are eligible. If you are eligible to re-enroll, you will also receive enrollment materials from the Eligibility and Enrollment Vendor upon your return to work.

Individuals Covered Through COBRA

If you or your Eligible Dependents are continuing coverage through COBRA, you or your Eligible Dependents will be required to pay for the coverage through the direct billing process administered by the Eligibility and Enrollment Vendor. See the **"Extension of Coverage - COBRA"** section for more information about COBRA rights. Additional information on paying for COBRA coverage is provided in the **"Paying for COBRA Continuation Coverage"** subsection. See the **"How Contributions are Made"** section for details on the direct billing process. If you have questions concerning billing or payment of COBRA continuation coverage, you can contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section for contact information.

YOUR SUPPLEMENTAL BENEFIT PROGRAM BENEFITS

Program Benefits

The Program is an optional, supplemental benefit program. The Program provides Experimental and Expanded Benefits. The Experimental Services provided under the Program provide financial protection against the high cost of certain specified medical treatments which are Experimental or Investigational Services and are generally not covered by most medical programs. See the **"Experimental Services"** section below for more information. The Program also provides benefits that are not Experimental or Investigational Services under the Expanded Services provisions which the Company has determined are beneficial to Participants. See the **"Expanded Services"** section for more information.

Conditions for Program Benefits

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

- You are a Covered Person, which means you meet all eligibility requirements for Program coverage and are properly enrolled for coverage;
- You continue to meet all of the eligibility requirements for the Benefit and all required contributions for your coverage are paid timely;
- You receive the Covered Services while your Program coverage is in effect – after you meet eligibility requirements and before coverage ends, as described in the **"When Coverage Ends"** section;
- For Expanded Services, you meet any additional eligibility requirements for these Benefits;
- You receive Prior Approval if required; and
- You or your Provider submit a timely claim for benefits.
- You submit a timely and complete form for reimbursement as described in the **"Submit a Claim or Reimbursement Form"** section.

If You Are Enrolled in a High Deductible Health Plan and Participate in a Health Savings Account (HSA)

Covered Expenses under this Program are subject to and count toward your Annual Deductible under your Base Medical Program, if you are enrolled in a Company Sponsored High Deductible Health Plan and contribute to a Health Savings Account (HSA). If you are subject to the deductible, you will not be able to receive payment for these Covered Expenses until you meet your applicable Annual Deductible under your Base Medical Program. Covered Expenses under this Program will count toward your Base Medical Program Annual Deductible as well as your Base Medical Program Annual Out-of-Pocket Maximum under a Company Sponsored High Deductible Health Plan. At the time you incur Covered Expenses, you will receive a request to confirm if you are contributing to an HSA, and Covered Expenses under this Program will be processed based on your response.

Prior Approval and Notification Requirements

Prior Approval Requirements

You must receive Prior Approval from the Benefits Administrator, unless the description of the Covered Service specifically states that Prior Approval is not required, to have Covered Expenses paid under the Program (except Emergency Services). You must receive written confirmation of approval **before** you incur expenses in connection with a Covered Service. For Experimental Services, this includes evaluation or acceptance into a treatment program. If you do not receive the required Prior Approval, the procedure or service will not be covered. If a second Covered Service is necessary, notice must be provided to the Benefits Administrator at least 72 hours in advance and approval received prior to commencement of the second procedure. Otherwise, no Benefits will be paid for the second procedure or service.

To request Prior Approval, you or your Provider must contact the Benefit Administrator's customer service center. See the **"Contact Information"** section for the toll-free telephone number.

You will be asked to provide the following:

- A complete diagnosis of your condition.
- Where required under the Program, an Explanation of Benefits or Claim denial showing that the Covered Service is not covered under your Base Medical Program or other medical coverage, or benefits available under your Base Medical Program or other coverage have been exhausted.
- The recommended procedure or treatment.
- The complete name of the facility where the treatment or procedure will be performed.
- The treatment protocol.

As noted above, unless there is a specific provision stating that Prior Approval is not required, you must receive written confirmation of approval before you receive treatment or services in connection with a Covered Service. If you do not receive Prior Approval, the procedure or service will not be covered, except for those procedures designated as an Emergency in the Experimental Services section below.

Notification Requirements

While Prior Approval is not required for Covered Services designated Emergency, the Benefits Administrator must be notified within three business days of the date on which the Emergency Covered Service is performed. Failure to make this required Notification within the three-day time frame will result in a reduction of $500 in Benefits that would otherwise be payable.

If a second Covered Service is necessary, Notification must be provided to the Benefits Administrator at least 72 hours prior to commencement of the second procedure. Otherwise, no Benefits will be paid for the second procedure or service. Prior Approval of the second procedure or service is also required as described above.

Some expenses are not Covered Expenses under any circumstances. For a list of these types of expenses, refer to the **"What Is Not Covered Under CarePlus"** section.

Provider Requirements

Providers must meet the following requirements, as applicable:

- The facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and/or by the Healthcare Facilities Accreditation Program (HFAP).
- The facility must be appropriately licensed by all necessary/required regulatory bodies.
- The Physician administering the Experimental or Investigational Services must be board-certified in the relevant specialty by a member of the American Board of Medical Specialties.

- The treatment being administered is in accordance with protocols consistent with those conducted pursuant to an FDA, NIH, NCI, or Cancer-cooperative group approved Phase I, II or Phase III Clinical Trial.
- The Program, through its attempt to identify criteria for Covered Services or Approved Providers, does not represent or warrant the level, degree or quality of the services provided.

Acceptance as a Candidate for a Covered Service

Your Physician and the facility that performs the procedure determine your acceptance as a candidate for a Covered Service. Neither your enrollment in this Program nor approval of a procedure or service for Benefits is a guarantee of any of the following:

- Your acceptance as a candidate for a Covered Service.
- Admission to any treatment program.
- The availability of specific accommodations from any Provider of service, regardless of whether the accommodations or services are approved or not.

Some expenses are not Covered Expenses under any circumstances. For a list of these types of expenses, refer to the **"What Is Not Covered Under CarePlus"** section.

Determining Benefit Amounts

Benefits are provided for Necessary Treatments as determined by the Benefits Administrator. The amount of Benefits paid for Necessary Treatment is affected by whether the Provider is an Approved Provider.

The Program will cover 100 percent of the Negotiated Rate for the Covered Service for which you have received Prior Approval, as determined by the Benefits Administrator, unless stated otherwise in the description for the Covered Service. Emergency Services covered by the Program are covered at the amount determined by the Benefits Administrator.

Submit a Claim or Reimbursement Form

You or your Provider, depending on the service received, must submit a timely and complete claim or reimbursement form to receive Benefits under this Program. You can find forms at the AT&T CarePlus site (**https://careplus.att.com/forms/**).

EXPERIMENTAL SERVICES

EXPERIMENTAL SERVICES

Experimental Services provide coverage for certain specified experimental or investigational medical treatments, referred to as Covered Services. Covered Services are limited to those designated by the Company and may be added, removed or modified at any time and for any reason at the sole discretion of the Company.

Covered Services are reviewed at least annually. During this review, a procedure or treatment may be eliminated from coverage if, for example, it is determined that the procedure or treatment has become covered under most medical plans as mainstream medical care and is no longer considered investigational or experimental in nature.

Except for procedures that are designated as Emergency on the *Experimental Services* tables below, you must receive Prior Approval from the Benefits Administrator for all Covered Services, or Benefits will not be payable. See the **"Prior Approval and Notification Requirements"** section for information on this requirement.

Participants who have coverage for any Experimental Service under their Base Medical Program are not eligible for Benefits for the same service under this Program. For information how this may impact coverage of a Service under this Program you can contact the Benefit Administrator's customer service center. See the **"Contact Information"** section for the toll-free telephone number.

The following list of Covered Services is current as of Jan. 1, 2022.

Cancer: Diagnosis, Staging and Management

Autologous Stem Cell (including bone marrow and stem cells derived from bone marrow, peripheral blood, umbilical cord blood, ex vivo expanded cord blood) Transplant w/HDC (for Cancer):

- Breast Cancer
- Brain Cancer (Pediatric)
- Desmoplastic Small Round Cell Tumor
- Fibrosarcoma
- Osteosarcoma

Allogeneic Stem Cell (including stem cells derived from bone marrow, peripheral blood, umbilical cord blood, ex vivo expanded cord blood or more than one umbilical cord blood, i.e., 'double cord') Transplant w/HDC: • Advanced Renal Cell Carcinoma • Advanced Melanoma • Breast Cancer • Bony/Soft Tissue Sarcoma • Systemic Mastocytosis • Neuroblastoma • Systemic Mastocytosis
Tandem (Autologous followed by Autologous or Allogeneic) Stem Cell (including stem cells derived from bone marrow, peripheral blood, umbilical cord blood, ex vivo expanded cord blood or more than one umbilical cord blood, i.e., double cord): • Multiple Myeloma • Lymphomas (Hodgkin's and non-Hodgkin's) • Acute Leukemias
Active Immunotherapy and/or Vaccines for treatment of: • Melanoma • Non-Small Cell Lung Cancer • Ovarian Cancer • Prostate Cancer • Other Cancers
Gene Transfer Therapy for treatment of: • Breast cancer • Glioma • Leukemias • Lymphoma • Multiple Myeloma • Oropharyngeal Cancers • Chronic lymphocytic leukemia • For indications approved by: FDA, NIH/NHLBI, NCI Phase I, II or Phase III Clinical Trials

F-18 fluorodeoxyglucose (FDG) Positron Emission Tomography, often referred to as FDG-PET, when used in the diagnosis, staging, and subsequent management of malignant solid tumors and myelomas, including cervical cancer and prostate cancer
Active Breathing Control (ABC) as adjunct to radiation therapy for breast and lung cancer
Hyperthermic instillation chemoperfusion for treatment of cancer of: • Bladder • Colon, rectum, anus • Peritoneum
Transarterial Chemoembolization (TACE) for treatment of malignant liver tumors that are secondary to other cancers
Local or focal hyperthermia as an adjunct to chemotherapy for treatment of • Cutaneous, subcutaneous, non-invasive or superficial cancer of the bladder • Cervical cancer • Cancer of the rectum or anus
Emerging treatments or therapies for cancer and other severe, life-threatening diseases, when: • Conducted pursuant to an FDA, NIH, NCI, or Cancer-cooperative group approved Phase I, II or Phase III Clinical Trial. In the event a covered person is not formally a participant in the approved Clinical Trial, such treatment or therapy must be administered under the direction of a physician, follow the protocols and procedures utilized in the trial and be delivered at a facility that has been designated as a participant under the approved FDA, NIH, NCI, or Cancer-cooperative group for Phase I, II or Phase III Clinical Trial • Where the illness is encountered so infrequently that no formal trials exist, if the proposed treatment is considered promising care by knowledgeable experts in the field and is supported by evidence of efficacy in the peer reviewed literature, such treatment will be allowed when performed within a facility that actively participates in approved FDA, NIH, NCI, or Cancer-cooperative group Phase I, II or Phase III Clinical Trials.
Radiofrequency Ablation (RF): • Lung Cancer • Metastatic Bone Cancer (palliation) • Prostate Cancer

Photodynamic Therapy (PDT): • Bladder Cancer • Cutaneous Malignant Metastases e.g., Breast Cancer • Tumors of Tracheobronchial Tree • Nonmalignant Neoplasms of the Breasts (Fibroadenomas)
Brachytherapy for Treatment of Malignant Brain Tumors
Circulating Tumor Cell Assay
In vitro chemosensitivity testing for management, staging and treatment selection
Thermal (laser) coagulation for treatment of benign breast tumors
Implantable beta-emitting microspheres for treatment of malignant liver tumors that are secondary to other cancers
DelCATH Percutaneous Hepatic Perfusion (PHP) System for delivering high-dose melphalan chemotherapy to treat liver tumors
Confocal Endomicroscopy to detect and evaluate malignant and pre-malignant cells during standard esophagoscopy
Reflectance Confocal Microscopy to detect and evaluate suspicious moles and dermal lesions
Computer-controlled, multi-spectral dermoscopy (e.g. Melafind) to detect and evaluate potentially malignant and pre-malignant dermal lesions
EarlyCDT-Lung screening blood test for early detection of lung cancer
Electromagnetic Navigational Bronchoscopy for enhanced visualization of lung lesions

Pathwork® Tissue of Origin Test or Response DX™ Tissue of Origin Test used to determine the type of cancer cells in tumors of unknown origin
ThermoDox for treatment of primary and secondary liver cancer
MRI/Ultrasound Image Fusion for image-guided prostate biopsy
NanoKnife Electroporation for hepatocellular carcinoma and pancreatic cancer
Intraoperative Radiation Therapy and Stereotactic Body Radiation Therapy for multiple cancer types: • Brain and spinal tumors • Renal cell carcinoma • Colorectal cancer • Adrenal metastases • Lymph node metastases • Non small-cell lung cancer • Pancreatic cancer
Pelareorep (Reolysin) as an adjunct to chemotherapy or radiation therapy for numerous cancers including, but not limited to: • Head and neck • Ovarian • Soft tissue sarcoma
Liquid Biopsy, a new screening tool to detect cellular debris or oncoDNA from routine blood samples to stage and manage cancer
Multiparametric MRI, an MRI technique to visualize the prostate gland in order to aid in prostate cancer detection

Mental Diseases and Disorders

Deep Brain Stimulation (DBS) for treatment of Major Depressive Disorder (MDD) and Obsessive Compulsive Disorder (OCD)
Akili Labs EndeavorEx AR/VR Gaming - Video game-based treatments for Attention Deficit Hyperactivity Disorder
Monarch electrical transcutaneous nerve stimulator - Trigeminal nerve stimulator (TMS) that provides non-invasive mild electrical stimulation to the brain during sleep. Manages the behavior of children ages 7-12 diagnosed with ADHD as an alternative to medication. Requires prescription

Autoimmune, Immune-mediated and Collagen Vascular Diseases

Autologous Stem Cell (including bone marrow) Transplant w/HDC for Additional (non-cancer) Indications: • Recessive Dystrophic Epidermolysis Bullosa (rDEB) • Systemic Lupus Erythematosus • Systemic Sclerosis • Rheumatoid Arthritis • Juvenile Rheumatoid Arthritis • Dermatomyositis • Polymyositis • Crohn's Disease • Ulcerative Colitis
Rituxan (rituximab) and Truxima (Rituximab-abbs) (Anti B-Cell) Therapy for (Expanded list of indications-Immune Modulation): • Systemic Lupus Erythematosus • Systemic Sclerosis
Prochymal (remestemcel-L) for treatment of acute graft-versus-host disease

Off-label use of Selzentry (maraviroc), an HIV treatment, for the prevention of graft-versus-host during stem cell transplants
Low-Level Laser Therapy (LLLTI) to Treat Mouth Lesions Caused by Pemphigus Vulgaris - Use of low-power lasers to treat lesions in the mouth caused by pemphigus vulgaris, an autoimmune disorder

Multiple Sclerosis

Autologous Stem Cell (including bone marrow) Transplant w/HDC
Anti-T-Cell Monoclonal Antibodies
T-Cell Receptor Therapy
Transcranial Direct Current Stimulation for Multiple Sclerosis - Non-invasive brain stimulation that delivers weak, constant electrical current directly to the head via electrodes for management of multiple sclerosis
Portable Neuromodulation Stimulator Therapy (PoNS®) for treatment of Balance Disorder - Device which delivers electrical impulses to two cranial nerves for balance

Infectious Diseases (including HIV / AIDS)

FibroSure® laboratory test for diagnosis and management of chronic infection with hepatitis C virus (HCV) or hepatitis B virus (HBV)
Interferon Therapy for: • HIV and AIDS-Related Complex • Cytomegalic Virus (CMV) • Varicella Zoster Virus
Gene Transfer Therapy for treatment of: • HIV/AIDS

Hereditary Syndromes

Gene Transfer Therapy for treatment of: • Cystic Fibrosis • Muscular Dystrophy • Hereditary anemias • Hereditary and idiopathic thrombocytopenias
Phase I, II or III Clinical Trials, when approved or sponsored by the FDA, NIH, or recognized cooperative groups, for diagnosis and/or treatment of: • Muscular Dystrophy (MD)
BMT/Stem Cell Transplant for Treatment of Recessive Dystrophic Epidermolysis Bullosa
AmpliChip® Cytochrome P450 Genotype Assay to characterize metabolizing efficiency of CYP2D6 and CYP2C19 catalytic enzymes

Verigene® Warfarin Metabolism Nucleic Acid Test to characterize sensitivity to warfarin (Coumadin®)
Thymus/Parathyroid Transplant for infants with complete or partial DiGeorge Syndrome
Gene-Based Testing and Genetic Counseling for Marfan Syndrome
Vyndagel (Tafamidis) for adult patients with stage 1 TTR-FAP designed to delay neurologic impairment
Participation in clinical trials for exon skipping compounds that allow production of functional proteins for Duchenne muscular dystrophy Includes coverage of: • Exondys 51 (Eteplirsen), the first drug approved to treat patients with Duchenne muscular dystrophy (DMD)
GMI-1070 for treatment of vaso-occlusive crisis in patients with sickle cell disease
Sparsentan, a self-administered, dual mechanism (ARB and ERB), small-molecule drug for treatment of focal segmental glomerulosclerosis (FSGS)

Diabetes

TempTouch for Prevention of Diabetic Ulcers
Allogeneic Islet Cell Transplant
Targeted Renal Therapy with the Benephit™ Catheter for cardio-renal syndrome

Multi Frequency Vibrometry, a sensory test used to quantify and monitor risk of foot ulcers due to diabetic neuropathy by measuring the ability to perceive vibration applied to the feet
Extracorporeal Shock Wave Treatment (ESWT) - A device to accelerate the body's healing response for use in the treatment of diabetic foot ulcers
Eversense Continuous Glucose Monitoring System - Implantable continuous glucose monitoring (CGM) system that connects to a mobile application and continuously monitors blood sugar for 90-day periods. The system reads blood sugar levels every five minutes, and the smart transmitter vibrates so the patient knows if blood glucose is high or low and can take appropriate action. For patients age 18 or over who have been diagnosed with diabetes. Coverage includes the sensor placement procedure and the device. Coverage does not include a mobile device or associated services

Cardiovascular Procedures, Devices and Therapies

Gene Transfer Therapy for treatment of cardiovascular disease
Dynamic Cardiomyoplasty
Muscle Tissue Replacement (Stem Cell Transplant) for treatment of: • Heart Failure • Ischemic Heart Disease
Patent Foramen Ovale (PFO) closure devices for prevention of migraine headaches
Aquapheresis for treatment of hypervolemia due to congestive heart failure (CHF)
Watchman® left atrial appendage (LAA) closure technology for atrial fibrillation (AFIB)
Pericardial Reconstruction using CorMatrix (ECM) to repair the pericardium following open heart surgery

Transesophageal Echocardiography (TEE) for monitoring patients in the CICU following heart surgery
Crossing and Re-entry Catheter-Based System for coronary chronic total occlusion (CTO)
Implantable wireless monitor for management of Chronic Heart Failure in patients with NYHA Class III heart failure
Pediatric artificial mitral valve for use as a last resort in Child(ren) diagnosed with mitral valve disease
Coronary sinus reducer stent for patients with refractory angina who are not candidates for conventional revascularization procedures
C-Pulse heart assist system to reduce cardiac workload in heart failure patients
LifeVest, a wearable cardioverter defibrillator for Child(ren) at risk for sudden cardiac arrest, who are not candidates for implantable devices
Micra Transcatheter Pacing System (TPS), a leadless cardiac pacemaker that is implanted directly into the right ventricle
Continuous Remote Monitoring for Management of Heart Failure that includes coverage of services to read-out and utilize data generated by previously implanted cardiac devices
CADence™ - Tests using in-office handheld device for rapid identification of patients with significant risk from Coronary Artery Disease (CAD). CADence™ is a non-invasive, reusable, radiation-free, fast, and portable device comprised of a digital stethoscope used to record intra-arterial turbulence, with integrated sensors used to record electrical activity of the heart. It works by pairing acoustic and electrocardiogram (ECG) signals
AUM Cardiovascular - Test for functional heart assessment to identify patients with obstructive coronary artery disease

Cardiac Contractility Modulation – An implantable device to treat Chronic Heart Failure patients who are not eligible for Cardiac Resynchoronization Therapy. The device controls the force of a heartbeat as opposed to the rhythm
Barostim Neo™ Implantable Pulse Generator for Heart Failure – To be eligible the patient must be diagnosed with heart failure — based on Food and Drug Administration Guidelines — and have a prescription from a Physician. Not for patients indicated for Cardiac Resynchronization Therapy according to AHA/ACC/ESC guidelines. Coverage includes the placement procedure and the device as well as parts and battery replacement

Other Vascular Procedures, Devices and Therapies

MERCI Embolic Retriever (for acute cerebral blood clots/stroke)
Rheos Baroreflex HTS ™ for treatment of uncontrolled hypertension
Radiofrequency Ablation of renal nerves for treatment of refractory hypertension
Stent retrievers (e.g., Medtronic's Solitaire or Stryker's Trevo ProVue) for treatment of embolic stroke of the basilar artery and other large cerebral vessels
RESPeRATE for treatment of Hypertension - A device that helps lower high blood pressure through relaxing constricted blood vessels using slow paced breathing

Ophthalmologic Procedures, Devices and Therapies

Corneal Stem Cell Transplant
Retisert™ intravitreal implant for treatment of macular edema

Epi-Rad 90 (strontium-90 brachytherapy) for treatment of neovascular macular degeneration
Femtosecond Laser for cataract surgery
Drug-Eluting Contact Lenses for treatment of glaucoma
OrCam MyEye, a wearable vision-assist device that combines a miniature camera mounted on eyeglasses along with an ear piece and processing unit
Telescopic contact lens integrated with 3D television eyeglasses (smart glasses) for patients with age-related macular degeneration
Subretinal implant phototransducer (Alpha IMS) for individuals with significant loss of visual field due to hereditary retinal degeneration
LipiFlow® - Topical thermal pulsation system for treatment of the leading cause of Dry Eye. The LipiFlow® System from TearScience is an FDA-approved thermal pulsation treatment system that provides both inner and outer lid therapy for MGD. It provides a precise application of simultaneous heat and massage to the inner and outer eyelids using vectored thermal pulsating eyepieces called activators, which effectively clears blockages in the Meibomian glands
Punctal Plug-based Delivery Systems for Glaucoma - Treatment for Open-Angle Glaucoma (OAG) that delivers accurate and consistent dosage of topical prostaglandin medication to the eye. A punctal plug, or lacrimal plug, is a small medical device that is inserted into the tear duct (puncta) of an eye to block the duct and prevent the drainage of liquid from the eye. Punctal plugs offer a novel, versatile, and non-invasive delivery method for providing sustained delivery of medications to patients with glaucoma
CustomFlex™ Artificial Iris – CustomFlex™ Artificial Iris is a custom iris prosthesis, for both medical and aesthetic reconstruction of the eyes with complete or partial aniridia. It gives the eye color as well as protection by creating an artificial pupil that reduces the amount of light entering the eye.

Orthopedic Procedures, Devices and Therapies

Extendable endoprostheses for reconstruction of pediatric long bone skeletal defects (e.g., Repiphysis™)
Intradiscal Electrothermal Therapy (IDET) for chronic discogenic back pain
Vertebral Arthroplasty using prosthetic intervertebral discs: • Cervical • Lumbar
Hand Transplant to replace all or part of a person's hand
Comprehensive Treatment for Mandibular Disorders: • Partial or total joint replacement surgery • EMG biofeedback • Low-load prolonged-duration stretch (LLPD) devices (e.g., Dynasplint®) • Passive rehabilitation therapy (PRS) devices (e.g., TheraBite®)
Reciprocating Gait Orthoses (ReWalk and eLegs Systems) for mobility after spinal cord injury
Sodium Hyaluronate Injections for osteoarthritis of the shoulder
DEKA prosthetic arm system for patients with upper limb amputation
IlluminOss System, bone stabilization system to treat and reduce risk of pathologic fractures in long bones due to metastatic bone disease
Sacroiliac joint fusion (SJF) for treatment of sacroiliac joint dysfunction that is a direct result of joint disruption and degenerative sacroiliitis resulting in chronic low-back pain

Activated Collagen Scaffold, a collagen based bioinductive implant, about the size of a postage stamp, delivered arthroscopically through a small incision at the site of rotator cuff tendon injury
Reactiv8, a small implanted device reported to assist in the maintenance of relief from chronic low back pain

Neurologic Procedures, Devices and Therapies

Magnetoencephalography for evaluation of: • Stroke • Multiple Sclerosis • Brain function • Learning disorders • Psychiatric conditions
Botulinum Toxin (Botox) for: • Severe Paradoxical Vocal Cord Movement with demonstrated functional airway obstruction • Trismus and Stridor in Amyotropic Lateral Sclerosis • Refractory Gastroparesis (Idiopathic and Diabetic)
Comprehensive Treatment for Occipital Neuralgia and Cervicalgia including occipital nerve injection and the following: • Neurectomy, rhizotomy, or decompression surgery • Radiofrequency ablation • Implantable Neurostimulator device • Electrostimulation

Emerging Clinical Trials, when approved or sponsored by the FDA, NIH, or recognized Neurologic-cooperative groups, for diagnosis and/or treatment of: • Alzheimer's Disease • Amyotrophic Lateral Sclerosis (ALS) • Traumatic brain or spinal cord injury • Acute stroke • Neurodegenerative diseases • Hereditary neurologic disorders
Deep Brain Stimulation for Tourette's Syndrome to reduce the frequency and severity of motor symptoms
NeuroFlo™ to restore cerebral blood flow during acute ischemic stroke using a dual-balloon aortic catheter system
TheraSuit® to improve proprioception (pressure on joints, ligaments and muscles), reflexes and physiological muscle synergies for Child(ren) with Cerebral Palsy
Neuromodulation Therapy to reduce severity of cluster headaches
ExAblate MRI-guided Focused Ultrasound for treatment of essential tremor
Ear Implant for treatment of Meniere's disease
Auditory brainstem implant for patients with neural and sensorineural hearing loss who are not candidates for cochlear implant
Electrode-embedded garment (Mollii) for the treatment of pain and loss of function due to chronic acute muscle spasms in patients with traumatic brain injury (TBI), palsy, and other spasms
Implanted electrical nerve block system (Altius) for the treatment of chronic amputation pain

Wearable early warning system (Brain Sentinel) that detects impending onset of generalized tonicclonic seizures (GTC) seizures and provides remote alerts to notify caregivers of GTC seizure events
Hernicore (condoliase), a proteolytic enzyme that is injected into a herniated intervertebral disc to reduce or eliminate pressure on the trapped spinal root, providing a non-surgical alternative for treatment of lumbar disc herniation
Axium neurostimulator, an implanted neurostimulator system that delivers electrical stimulation to the dorsal root ganglion of the spinal nerve for peripheral causalgia (nerve damage)
Brain Implant to Restore Sense of Touch, an electric implant that stimulates the brain and allows spinal cord injury patients to feel pressure-like sensations in the fingers of a robotic arm
EYE-SYNC Virtual Reality Eye Tracker, a mobile vision tracking assessment technology for initial screening and monitoring of patients sustaining concussion
Non-invasive Vagus Nerve Stimulation (nVNS), which stimulates the vagus nerve through a hand-held device placed at the root of the patient's neck for management of cluster headache and migraine
Stereotactic Laser Ablation (SLATE) for the Treatment of Epilepsy - Stereotactic laser ablation for the treatment of refractory temporal lobe epilepsy uses thermal therapy to necrotize or coagulate soft tissue with the goal to ablate the mesiotemporal structures, including the amygdala and the hippocampus. Laser ablation is a procedure that uses a laser to remove abnormal tissue
Topical Transcranial Magnetic Stimulation Devices for Treatment of Migraine - Noninvasive, topical devices delivering transcranial magnetic stimulation for the prevention and treatment of migraines
Mente Autism - Portable headband with earphones that detects certain undesirable EEG signals and responds with stimuli that initiates desirable EEG signals; to improve social behaviors in children with autism
Transcranial Magnetic Stimulation (TMS) - Noninvasive procedure that uses magnetic fields to stimulate electrical activity in the brain for use in adolescents under the age of 12 in the treatment of migraines
Personal Kinetigraph™ (PKG™) Watch to measure tremors related to Parkinson's disease - A wrist-worn device that monitors movement symptoms and processes them through a special algorithm that allows providers to measure and modify treatment for Parkinson's disease. The device also reminds the patient to take their medication. The device is for patients ages 46-83 that have been diagnosed with Parkinson's disease

Cala Trio™ for Essential Tremor (ET) – Cala Trio™ for Essential Tremor is a non-surgical therapy option to treat ET and reduce hand tremors. Cala Trio™ works through a wristband, using electrodes to send electrical stimulation to nerves in the brain to disrupt patient-specific tremor signals that cause hand tremors. A patient has two therapy sessions a day, 40 minutes each.

Respiratory & Pulmonary Procedures, Devices and Therapies

Bronchothermoplasty for treatment for adult asthma
Nitric Oxide Breath Testing for diagnosis and management of asthma and other pulmonary diseases
Xolair (Omalizumab) for off-label use to treat milk and peanut allergies
Endobronchial Valves for Lung Volume Reduction (LVR) for emphysema as an alternative to conventional LVR
Thoracoscopic Laser Ablation of Pulmonary Bullae for emphysema as an alternative to conventional LVR
Hyperbaric Oxygen Therapy (HBOT) for patients with thermal or chemical pulmonary damage and cerebral edema
Drug-Eluting Sinus Stents for steroid delivery following functional endoscopic sinus surgery (FESS)
Portable Inhaled Nitric Oxide Device (Nitrosyl) for the treatment of pulmonary arterial hypertension
Bronchial thermoplasty, an endobronchial treatment for refractory asthma

Computed Tomography (CT) for Early Detection of Chronic Obstructive Pulmonary Disease (COPD) - Lung screening with computed tomography for patients at risk of developing COPD. CT is a test that uses a computer and a special type of X-ray to take pictures of the inside of your body
RhinAer® Procedure for Treatment of Chronic Rhinitis - A non-invasive procedure that reduces symptoms of Chronic Rhinitis

Sleep Disorders

Ebb Insomnia Therapy for Management of Insomnia - A cooled headband that reduces the time to both fall asleep and enter deeper, restorative sleep
Nasal Expiratory Positive Airway Pressure Device for Obstructive Sleep Apnea - Discreet and disposable nasal expiratory positive airway pressure device that helps maintain positive pressure in the airway
Remede System for Central Sleep Apnea - Implantable nerve stimulator that activates the diaphragm to simulate natural breathing

Gastroenterologic Procedures, Devices and Therapies

Wireless Esophageal pH Monitoring
LINX™ Reflux Management System for prevention of esophageal reflux and other symptoms of Gastroesophageal reflux disease (GERD)
Electroacupuncture, the application of pulsating electrical current through acupuncture needles to treat chronic constipation and possibly gastroparesis

Innovative Health IB-Stim - A topical nerve stimulator used to block the pain related to irritable bowel syndrome (IBS) in adolescents. Available for Eligible Dependent children ages 11-18 diagnosed with IBS. Requires a prescription
Cognitive Behavioral Therapy for Irritable Bowel Syndrome (IBS) - Educating patients on the diagnosis, setting treatment goals and teaching thinking and behavioral skills to help manage IBS. Helps an IBS patient identify and manage the factors that cause IBS flareups. Includes 10 sessions annually. Requires diagnosis of IBS
Plenity® - A space-occupying weight loss device ingested to create a full feeling and prevent overeating. You must have a body mass index (BMI) over 30 to be eligible. Requires annual recertification of BMI over 30

Genitourinary Procedures, Devices and Therapies

ExAblate MRI-guided focused ultrasound for non-invasive ablation of uterine fibroids (MR-guided Focused Ultrasound to treat uterine fibroids)
Neurovascular reconstruction of cavernous nerve bundles following radical retropubic prostatectomy, involving unilateral or bilateral graft of sural nerve(s)
Lyrette/Renessa® System for relief from stress urinary incontinence using radiofrequency micro-remodeling of the bladder and urethra
Injectable Bulking Agents for fecal incontinence

Other Health Care Services

Complementary & Alternative Medicine (CAM) Continue coverage for the following CAM services: • Acupuncture for chemotherapy-induced nausea, chronic headache, and cancer-related fatigue • Massage Therapy or Relaxation Therapy for palliative care in cancer patients. • Biofeedback Therapy for headache, including migraine • Continue Coverage for Transcendental Meditation for patients with heart disease or hypertension
Augmentative and Alternative Communication (AAC) Devices for individuals unable to communicate using speech (for participants who do not have coverage for this service under their Base Medical Program)
Esteem Hearing Prosthesis for patients with sensorineural hearing loss
Full and Partial Face Transplant for patients with severe facial disfigurement
Whole Genomic Testing and Related Interpretation for Pediatric Odyssey Coverage includes interpretation of results, but is limited to nationally recognized pediatric undiagnosed and rare disease programs as determined by the CarePlus coordinator
Reproductive tissue cryopreservation to preserve the reproductive functions of females and males who may undergo aggressive radiation and chemotherapy by harvesting and cryopreserving ovarian/testicular tissue or eggs/sperm
3D printing of human collagen and bone prosthetics to produce prosthetics used in facial reconstructive surgery (mandible, maxilla, ear, nose, forehead)
Episona's Seed - Male Fertility Test, a new test for male infertility that identifies epigenetic variant in DNA that suggest male factor infertility risk and poor embryo quality

Facial Reanimation Surgery - Surgical procedure to correct congenital facial paralysis and facial paralysis caused by trauma or disease
Low-Level Laser Therapy (LLLTI) to Treat Mouth Lesions Caused by Pemphigus Vulgaris - Use of low-power lasers to treat lesions in the mouth caused by pemphigus vulgaris, an autoimmune disorder
Low-Level Laser Therapy (LLLTI) for Temporomandibular Joint Disorder (TMJ) - Use of low-power lasers to treat symptoms of pain and discomfort caused by TMJ disorder. TMJ disorders are problems with the jaw joint that may include pain, tender jaws or muscles, popping or clicking in the jaw joint, ear pain, headache or limited jaw movement
IMPORTANT: Designated Emergency Covered Services, including but not limited to artificial heart procedures, the Mini-VAD, 2nd Generation VAD, Artificial Heart/Left Ventricular assist device, NeuroFlow™ dual balloon catheter and the Merci retriever procedure, may be approved by the Program Benefits Administrator retrospectively. Notification is required within 3 business days of the Emergency Covered Service being performed. Failure to provide timely Notification to the Benefits Administrator of a Designated Emergency Covered Service will result in a $500 reduction in the Benefits that would otherwise be payable.

Additional Information About Experimental Services

Transportation Benefit

Experimental Services provide coverage for travel expenses for the patient if they are reasonable expenses incurred in the course of travel (for example, airline tickets, rental car, cabs, hotel, meals and laundry/dry cleaning). The following allowances apply:

- Professional air ambulance transportation for the patient to the facility is covered where an approved Covered Service occurs when it is deemed to be necessary by the Benefits Administrator.
- $10,000 travel allowance is available for a companion(s) to accompany the patient to a facility for an approved Covered Service, if the companion lives at least 50 miles from the facility where the Covered Service occurs.

Reimbursement for expenses for the patient and a companion is available for the following and are subject to tax where applicable:

- Lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to a total of $100 for the patient and the companion combined.
- If the patient is an enrolled dependent minor Child, the transportation expenses of up to two companions will be covered, and lodging and meal expenses will be reimbursed up to the $100 per diem rate (total) for all three individuals combined.

EXPANDED SERVICES

The Company, in its sole discretion, may expand benefits offered under the Program to include any benefits determined by the Company to be beneficial to Program participants. The Company retains the unilateral right to change, modify, amend and discontinue the expanded benefits offered under the Program in its sole discretion.

The following services are covered under the Expanded Services Benefit:

Hearing Aid Benefit

The Program will reimburse up to $4,000 toward the purchase of hearing aid(s) for routine hearing loss during a rolling 36-month period beginning on the first date of purchase. See the table below for information on how the rolling 36-month period is calculated.

This benefit is available only if you are eligible for Expanded Benefits and the following conditions are met:

- You have exhausted your Base Medical Program benefits for hearing aids or benefits for hearing aids under other health coverage you are enrolled in; or,
- If you have no Base Medical Program benefits or coverage under another health plan to exhaust, then the hearing aid must be determined by an Audiologist to be medically necessary.

This benefit is limited to the cost of the hearing aid. This benefit does not cover any of the following:

- Office visits with an Audiologist
- Diagnostic or routine hearing exams
- Hearing aids provided for cosmetic purposes
- Hearing aid repairs
- Replacement batteries

How the Hearing Aid Benefit Under the Program Is Calculated

The Program will reimburse up to $4,000 toward the purchase of a hearing aid(s) not considered for coverage under your Base Medical Program benefits for hearing aids or benefits for hearing aids under other group health coverage you are enrolled in. Any cost share (deductible, co-pay, or coinsurance) paid by the participant in connection with receiving the Base Medical Program benefits for hearing aids or benefits for hearing aids under other group health coverage you are

enrolled in is not eligible for reimbursement under the Program. The chart below shows the calculation of the benefit payable under the Program.

		Base Medical Program pays	Participant Pays	The CarePlus Program reimburses
Full cost of hearing aids	**$6,000**			
Deductible under Base Medical Program – Participant obligation and not eligible for reimbursement under CarePlus			**$500**	
Balance	**$5,500**			
Base Medical Program pays 80% of balance after deductible is met up to $1,000 max		**$1,000**		
Participant pays 20% coinsurance of balance (up to OOP max) after deductible is met			**$1,100**	
Balance eligible for consideration under CarePlus	**$3,400**			
The CarePlus Program reimburses up to $4,000 of remaining balance				**$3,400**
Balance	**$0**			
Participant pays any outstanding balance after Medical and CarePlus Programs have paid			**$0**	
TOTALS		**$1,000**	**$1,600**	**$3,400**

How the Rolling 36-Month Period Is Calculated

Hearing appliances (hearing aids) are subject to a $4,000 reimbursement cap within a 36-month rolling period. The example below shows how the reimbursement formula works.

Date	What Happened	Result
Jan. 5, 2010	Hearing appliance purchased at $350. The 36-month rolling period for the $1,000 hearing appliance Benefit begins.*	Total Benefit used: $350 Total Benefit remaining through Jan. 4, 2013: $650
April 1, 2012	Hearing appliance purchased: $350.	Total Benefit used: $700 Total Benefit remaining through Jan. 4, 2013: $300

Date	What Happened	Result
Jan. 5, 2013	A new 36-month rolling period begins.	The hearing appliance reimbursement amount is reset to $1,000
March 5, 2015	Hearing appliance purchased at $500. A new 36-month rolling period begins.	Total Benefit used: $500 Total Benefit remaining through March 4, 2018: $500
**The $1,000 is calculated beginning from the first date of purchase indicated on the bill. It does not reset until 36 months later.*		

Determining Benefit Amounts

As this Benefit is only paid as a supplemental reimbursement, you must first purchase your hearing aid and then request reimbursement from your health coverage providing Benefits for basic medical expenses. This requirement applies whether you have hearing aid benefits under any other medical coverage or not. The Explanation of Benefits or its equivalent you receive regarding your base medical coverage must be included in the claim submitted to the Benefits Administrator. Prior Approval is not required for the hearing aid benefit, but all required documentation must be submitted in order to avoid a delay. If you do not have other medical coverage from any source, you may still receive reimbursement under this Benefit, however, you will be required to provide documentation obtained from an Audiologist, that a hearing aid is Medically Necessary for you.

You can find the *CarePlus Hearing Aid Claim Form* at the AT&T CarePlus site (**https://careplus.att.com/forms/**) and refer to it for detail regarding requirements for submitting a reimbursement claim.

By clicking the link above, you are leaving the SPD and are going to a third-party managed website to view information and materials that are not part of the SPD.

Preventive Care Services

The Program will reimburse certain Program participants, those who are not enrolled in any other plan or program that provides any coverage for Preventive Care, for the cost of Preventive Care Services. Preventive Care focuses on evaluating your current health status when you are symptom-free and taking the necessary steps to maintain your health. Appropriate Preventive Care will vary from person to person based on age, gender and other risk factors, including family history. Consult with your Provider to discuss medical appropriateness and frequency for your individual situation. Special Program provisions apply when you receive Preventive Care that qualifies as Preventive Care Services under the Program. If the Program participant has coverage for Preventive Care under any other plan or program in which they are enrolled, they are not eligible for coverage for Preventive Care Services under this Program.

Preventive Care Services, except Preventive Care Drugs, are those Covered Services that are determined by the Benefits Administrator to provide Preventive Care and are included in the Benefits Administrator's preventive care policy. Coverage is provided for Preventive Care Drugs under the Expanded CarePlus Benefit, but only as described in the **"Preventive Care Drugs"** section below.

The fact that a service is coded by a Provider as preventive care does not determine whether the service is covered as a Preventive Care Service. At a minimum, Preventive Care Services include the Preventive Care required pursuant to the provisions of the Patient Protection and Affordable Care Act (PPACA). The Covered Services considered Preventive Care Services will change from time to time as new medical evidence emerges and evidence-based recommendations change.

Covered Services that are Preventive Care Services in some circumstances may also be provided for purposes other than the routine preventive care covered as Preventive Care Services. When this occurs, these services are not covered as Preventive Care Services. Examples of services that can be Preventive Care Services in some circumstances but not others include mammograms, colonoscopies and blood tests such as cholesterol tests.

Information concerning whether specific services are Preventive Care Services should be obtained from the Benefits Administrator. The current guidelines for Preventive Care Services under the Program can be obtained by accessing the Benefits Administrator's website, or you can receive a copy, free of charge, by calling the Benefits Administrator's customer service at the toll-free number found in the **"Contact Information"** section. As these guidelines may change from time to time, it is important to receive up-to-date information on what the Benefits Administrator has determined to be Preventive Care Services.

Special coverage provisions apply to Preventive Care Services. Expenses incurred by a Program participant for Preventive Care Services will be reimbursed at 100 percent of the Allowed Charge, without participant cost sharing, but only when you receive Preventive Care Services on an outpatient basis from an Approved Preventive Care Provider. Benefits for Preventive Care Services are subject to other Program requirements, such as setting and appropriateness. No coverage is provided for Preventive Care Services if you receive these services from a Provider that is not an Approved Preventive Care Provider, unless an Approved Preventive Care Provider is not available within 30 miles of your home ZIP code.

Preventive Care Drugs

Preventive Care Services include certain Prescription Drugs. Special benefit provisions apply when you receive Prescription Drugs that qualify as Preventive Care Drugs under the Program.

The drugs that are covered by the Program as Preventive Care Drugs are drugs determined by the Benefits Administrator based on the requirements of the PPACA. The drugs covered under the Preventive Care Drugs provisions will change from time to time as new medical evidence emerges and evidence-based recommendations change. The drugs considered Preventive Care Drugs in some circumstances may also be provided for purposes other than routine preventive care. When this occurs, these drugs are not covered as Preventive Care Drugs by the Program. To obtain a list of these drugs, you may access it on the AT&T Benefits Center website or call the Benefits Administrator to request a copy free of charge. See the **"Contact Information"** section for contact information.

Examples of Preventive Care Drugs covered by the Program include:

- Folic acid vitamins prescribed due to Pregnancy or as a daily supplement for women planning to become pregnant.
- Contraceptives approved by the Food and Drug Administration prescribed to keep you from becoming pregnant.
- Aspirin prescribed as heart-attack prevention.
- Iron supplementation for Child(ren) ages six to 12 months who are at risk for iron deficiency anemia.
- Oral fluoride supplementation for Child(ren) older than six months whose primary water source is deficient in fluoride.
- Tobacco cessation intervention for anyone who uses tobacco.
- Immunizations such as Hepatitis A, Hepatitis B, Pneumococcal, Diphtheria, Tetanus, Pertussis, etc. (Immunizations are typically billed and covered as part of a Physician's office visit and not separately as a Prescription Drug benefit.)
- Vitamin D for adults age 65 and older living in community dwellings, who are at increased risk for falls.
- Bowel preparation medications for adults age 50 through 74 for colorectal cancer screenings.
- Medications for primary prevention of breast cancer.

Subject to the requirement that you must have a prescription, when a medication is covered as a Preventive Care Drug, the Program will provide benefits without cost-sharing. Medications are not covered as a Preventive Care Service if not purchased through an Approved Preventive Services Provider.

If you are enrolled in any other plan or program that provides any coverage for Preventive Care, you are not eligible for coverage for Preventive Care Drugs under this Program.

If you have questions about Preventive Care Drugs, you may contact the Benefits Administrator. See the **"Contact Information"** section for information.

How to Obtain Benefits for Preventive Care Services and Drugs

Prior Approval by the Benefits Administrator is not required before receiving a Preventive Care Service. However, if you intend to request Program benefits for a Preventive Care Service, it is recommended that you contact the Benefits Administrator to determine if the service will be eligible for coverage before you incur the expense. For example, the Benefits Administrator can help you determine if you are eligible for coverage of Preventive Care Services under the Program or if the service is a Preventive Care Service.

A determination by the Benefits Administrator that the Program participant, whose expenses are submitted for reimbursement, does not have any coverage for Preventive Care under another plan or program in which the Program participant is enrolled will be required before benefits for Preventive Care Services will be paid under the Program. The Benefits Administrator will

determine that you have no other health coverage that provides benefits for Preventive Care before approving your Claim. In determining whether or not you have other health coverage that provides benefits for any Preventive Care, the Benefits Administrator will rely on (1) records maintained by the Eligibility and Enrollment Vendor that reflect whether you are enrolled in medical coverage under a Company-sponsored program or (2) a written attestation of the fact that you are not enrolled in other health coverage that provides benefits for any Preventive Care. The Program does not cover Preventive Care Services or Preventive Care Drugs if coverage is available for Preventive Care under any other plan or program in which you are enrolled.

No Coordination of Benefits applies with regard to coverage of Preventive Care Services provided under the Program, which means if you are enrolled in any other plan or program that covers Preventive Care, regardless of what services are covered, the Program will not pay for Preventive Care Services.

Either you or your Approved Preventive Care Provider may submit a Claim for the Preventive Care Services you received, except Preventive Care Drugs, to the Benefits Administrator. Payment can be made directly to the Approved Preventive Care Provider or to you. To obtain benefits for Preventive Care Drugs, you must submit a Claim to the Benefits Administrator for reimbursement. Contact the Benefits Administrator for information about the documentation needed to process your Claim for Preventive Care Services.

NOTE: Unless specifically modified in this **"How to Obtain Benefits for Preventive Care Services and Drugs"** section, all other provisions of the Program apply, including, for example, Claim filing limits as described in the SPD.

Dental Services Provided in a Medical Care Facility

The Program will reimburse participants for Dental Services Provided in a Medical Care Facility, as described in this section, when a Physician, not a dentist, certifies that dental treatment in an outpatient or inpatient Medical Care Facility is necessary to safeguard the life or health of the patient.

To be eligible for this benefit, Participants cannot be enrolled in any other plan or program that provides any coverage for facility charges or associated medical care incurred in connection with dental care provided in a Medical Care Facility. Only the Medical Care Facility charge and charges for associated medical services are covered under the Program. The dental procedure(s) will not be eligible for payment of Program Benefits. If a participant is enrolled in coverage under an AT&T sponsored dental program, a separate claim for dental benefits must be submitted to the dental program.

The following special provisions apply to Benefits payable for Dental Services Provided in a Medical Care Facility:

- Care must be provided at an Approved Medical Care Facility. No coverage is provided for services received from a Provider that is not an Approved Medical Care Facility.
- The Benefit payable under the Program will be 80% of the Allowed Charge determined by the Benefits Administrator.

How to Obtain Benefits for Dental Services Provided in a Medical Care Facility

Participants must obtain Prior Approval from the Benefits Administrator before receiving Dental Services Provided in a Medicare Care Facility. If Prior Approval is not obtained, no Benefits will be payable under the Program.

In order to provide such Prior Approval, the Benefits Administrator must first determine that:

- The required physician certification has been received;
- Services will be provided in an Approved Facility; and
- The Participant does not have any medical coverage for facility charges or associated care incurred in connection with dental care provided in a Medical Care Facility.

In determining whether the Participant has other coverage, the Benefits Administrator will rely on (1) the Eligibility and Enrollment Vendor records concerning your enrollment in medical coverage under a Company-sponsored program, or (2) your written attestation.

No Coordination of Benefits applies with regard to coverage of Dental Services Provided in a Medical Care Facility provided under the Program. If you are enrolled in any other plan or program that covers outpatient or inpatient services in a Medical Facility related to a dental procedure, regardless of any out-of-pocket expenses you may be responsible for, the Program will not pay for Dental Services Provided in a Medical Care Facility.

Either you or your Approved Medical Care Facility may submit a Claim for Dental Services Provided in a Medical Care Facility. Payment can be made directly to the Approved Medical Care Facility or to you. Contact the Benefits Administrator for information about the documentation needed to process your Claim.

NOTE: Unless specifically modified in this **"Dental Services Provided in a Medical Care Facility"** section, all other provisions of the Program apply, including for example, Claim filing limits and integration with the AT&T Medical Program Annual Deductible for Participants who contribute to a Health Savings Account as described in the AT&T Flexible Spending Account Plan SPD.

Service Animals

Coverage for charges from a certified organization to purchase a Service Animal that is specifically and individually trained to perform tasks in order to benefit individuals with blindness, deafness, paraplegia or quadriplegia.

Service Animal for purposes of this provision is defined in the American's With Disabilities Act, as a dog that has been individually trained to do work or perform tasks for an individual with a disability. The task(s) performed by the dog must be directly related to the person's disability.

Participants must obtain Prior Approval from the Benefits Administrator. If Prior Approval is not obtained, no Benefits will be payable under the Program.

No Coordination of Benefits applies with regard to coverage of this service under the Program. If you are enrolled in any other plan or program that provides any coverage for this service, you are not eligible for this coverage under the Program, regardless of any out-of-pocket expenses for which you may be responsible.

You can find the *CarePlus Service Animal Request Form* at the AT&T CarePlus site (**https://careplus.att.com/forms/**) and refer to it for detail regarding requirements for submitting a reimbursement claim.

By clicking the link above, you are leaving the SPD document and are going to a third-party managed website to view information and materials that are not part of the SPD.

Preventive Care for Patients at Risk of Hereditary Conditions

Coverage is provided for preventive care for patients with specific genetic mutations that put them at higher risk of developing metastatic disease as described below.

The following surgeries are covered when recommended by a Physician:

- Mastectomy for patients with BRCA 1/2 mutation
- Oophorectomy for patients with BRCA 1/2 mutation
- Gastrectomy for patients with CDH1 mutation
- Thyroidectomy for patients with MEN 2A and 2B mutation
- Colectomy for patients with familial juvenile polyposis
- Preventive ultrasound for ovarian cancer screening in BRCA 1/2 positive patients

Participants must obtain Prior Approval from the Benefits Administrator. If Prior Approval is not obtained, no Benefits will be payable under the Program.

No Coordination of Benefits applies with regard to coverage of this service under the Program. If you are enrolled in any other plan or program that provides any coverage for this service, you are not eligible for this coverage under the Program, regardless of any out-of-pocket expenses for which you may be responsible.

Wigs for Patients Receiving Chemotherapy or With Alopecia

Coverage for the purchase of a wig of up to $300 per year per patient for individuals diagnosed with cancer who are receiving chemotherapy or diagnosed with alopecia.

Participants must obtain Prior Approval from the Benefits Administrator. If Prior Approval is not obtained, no Benefits will be payable under the Program.

No Coordination of Benefits applies with regard to coverage of this service under the Program. If you are enrolled in any other plan or program that provides any coverage for this service, you are not eligible for this coverage under the Program, regardless of any out-of-pocket expenses for which you may be responsible.

Doula Services

Coverage for the services of a certified Doula during pregnancy and childbirth to assist with birth planning, massage, comfort measures, reassurance and encouragement.

Participants must obtain Prior Approval from the Benefits Administrator. If Prior Approval is not obtained, no Benefits will be payable under the Program.

No Coordination of Benefits applies with regard to coverage of this service under the Program. If you are enrolled in any other plan or program that provides any coverage for this service, you are not eligible for this coverage under the Program, regardless of any out-of-pocket expenses for which you may be responsible.

You can find the *CarePlus Doula Request Form* at the AT&T CarePlus site (**https://careplus.att.com/forms/**) and refer to it for detail regarding requirements for submitting a reimbursement claim.

By clicking the link above, you are leaving the SPD document and are going to a third-party managed website to view information and materials that are not part of the SPD.

Childbirth Classes

Coverage for childbirth classes offered through a Hospital, Physician's office or other Medical Care Facility, such as a Lamaze class, where women learn coping strategies, breathing and movement techniques.

Participants must obtain Prior Approval from the Benefits Administrator. If Prior Approval is not obtained, no Benefits will be payable under the Program.

No Coordination of Benefits applies with regard to coverage of this service under the Program. If you are enrolled in any other plan or program that provides any coverage for this service, you are not eligible for this coverage under the Program, regardless of any out-of-pocket expenses for which you may be responsible.

You can find the *CarePlus Childbirth Classes Request Form* at the AT&T CarePlus site (**https://careplus.att.com/forms/**) and refer to it for detail regarding requirements for submitting a reimbursement claim.

By clicking the link above, you are leaving the SPD document and are going to a third-party managed website to view information and materials that are not part of the SPD.

Occupational, Physical or Speech Therapy

Up to 30 visits each of occupational therapy, physical therapy or speech therapy are covered as described below.

The Participant must have been diagnosed by a Physician and the Physician must determine that therapy is an appropriate course of treatment based on Medical Necessity for the Participant.

The Participant must first exhaust all benefits available under their Base Medical Program for the therapy and provide proof to the Benefits Administrator that no additional benefit is available from their Base Medical Program before a benefit will be paid.

Participants must obtain Prior Approval from the Benefits Administrator. If Prior Approval is not obtained, no Benefits will be payable under the Program.

NOTE: Unless specifically modified in this section, all other provisions of the Program apply, including for example, Claim filing limits and integration with the AT&T Medical Program Annual Deductible for Participants who contribute to a Health Savings Account as described in the Base Medical Program SPD.

Vaccines Required for International Travel

The Program will reimburse the cost of vaccinations for international travel, whether oral or by injection, as long as the expense is incurred prior to travel, the vaccine is on the Centers for Disease Control and Prevention (CDC) recommended vaccines for citizens traveling from the U.S. to a country to which the Participant is travelling, at the time scheduled for travel and the vaccination is not covered in any amount under the Participant's Base Medical Program. The CDC recommendations vary by country and sometimes by season so Prior Approval is required before

you receive the vaccination. Verification that the vaccine is included on the CDC list is required for coverage of the vaccine. Examples of vaccinations that may be covered if all requirements are met include cholera, Japanese encephalitis, Rabies, Typhoid fever, and Yellow fever. An Approved Provider is not needed to obtain this benefit. Only the cost of the vaccine and its administration will be reimbursed under this Program. Charges for an office visit will not be covered under this Program. Participants must obtain Prior Approval from the Benefits Administrator. If Prior Approval is not obtained, no Benefits will be payable under the Program. Prior Approval for vaccinations covered under this benefit provision is obtained by contacting the Benefits Administrator and receiving express confirmation that the vaccine is covered for the travel planned and the period of travel.

No Coordination of Benefits applies with regard to coverage of this service under the Program. If you are enrolled in any other plan or program that provides any coverage for international travel vaccinations, you are not eligible for this coverage under the Program, regardless of any out-of-pocket expenses for which you may be responsible.

Exercise Devices with Functional Electrical Stimulation for Management of Muscle Atrophy Due to Paralysis

Stationary exercise devices with functional electrical stimulation for use in the home that stimulate exercise-like motions to remediate muscle atrophy in patients with neuromuscular impairments due to paralysis. Functional electrical stimulation applies small electrical pulses to paralyzed muscles to restore or improve their function.

The Participant must have been diagnosed by a Physician with a neuromuscular impairment due to paralysis, and the Physician must determine that exercise therapy is an appropriate course of treatment for the Participant.

No Coordination of Benefits applies with regard to coverage of this service under the Program. If you are enrolled in any other plan or program that provides any coverage for this service, you are not eligible for this coverage under the Program, regardless of any out-of-pocket expenses for which you may be responsible.

Participants must obtain Prior Approval from the Benefits Administrator. If Prior Approval is not obtained, no Benefits will be payable under the Program. See the Prior Approval and Notification Requirements section for further information.

NOTE: Unless specifically modified in this section, all other provisions of the Program apply, including for example, Claim filing limits and integration with the AT&T Medical Program Annual Deductible for Participants who contribute to a Health Savings Account as described in the Base Medical Program SPD.

Laser Therapy for Focal Hyperhidrosis

Low-level laser therapy for patients with excessive underarm sweating.

The Participant must have been diagnosed with Focal Hyperhidrosis by a Physician and the Physician must determine that therapy is an appropriate course of treatment for the Participant.

No Coordination of Benefits applies with regard to coverage of this service under the Program. If you are enrolled in any other plan or program that provides any coverage for this service, you are not eligible for this coverage under the Program, regardless of any out- of-pocket expenses for which you may be responsible.

Participants must obtain Prior Approval from the Benefits Administrator. If Prior Approval is not obtained, no Benefits will be payable under the Program. See the Prior Approval and Notification Requirements section for further information.

NOTE: Unless specifically modified in this section, all other provisions of the Program apply, including for example, Claim filing limits and integration with the AT&T Medical Program Annual Deductible for Participants who contribute to a Health Savings Account as described in the Base Medical Program SPD.

Smart Inhaler Device for Asthma and Chronic Obstructive Pulmonary Disease

A smart device that attaches to an inhaler to track medication usage. You must be under a Physician's care for Asthma or Chronic Obstructive Pulmonary Disease to obtain this benefit.

Participants must obtain Prior Approval from the Benefits Administrator. If Prior Approval is not obtained, no Benefits will be payable under the Program.

No Coordination of Benefits applies with regard to coverage of this service under the Program. If you are enrolled in any other plan or program that provides any coverage for this service, you are not eligible for this coverage under the Program, regardless of any out-of-pocket expenses for which you may be responsible.

NOTE: Unless specifically modified in this section, all other provisions of the Program apply, including for example, Claim filing limits and integration with the AT&T Medical Program Annual Deductible for Participants who contribute to a Health Savings Account as described in the Base Medical Program SPD.

Diagnosis and Treatment of Learning Disabilities in Children

Coverage is provided for biofeedback, brain mapping, electroencephalogram (EEG) and digital analysis to diagnose, treat, and manage learning disabilities for enrolled Eligible Dependent children who have been identified as displaying evidence of a learning disability. Documentation

must be provided to the Benefits Administrator, which can be either 1) an evaluation from a medical professional acting within the scope of their license that the child is displaying evidence of a learning disability, or 2) evidence that the child is engaged in the special education referral process conducted by an educational institution based on evidence of a learning disability.

No Coordination of Benefits applies with regard to coverage of this service under the Program. If you are enrolled in any other plan or program that provides any coverage for this service, you are not eligible for this coverage under the Program, regardless of any out-of-pocket expenses you may be responsible for.

Participants must obtain Prior Approval from the Benefits Administrator. If Prior Approval is not obtained, no Benefits will be payable under the Program. See the Prior Approval and Notification Requirements section for further information. For purposes of this service only, documentation that meets the requirement above will be considered to meet the requirement for a diagnosis of the child's condition.

Note: Unless specifically modified in this section, all other provisions of the Program apply, including for example, Claim filing limits and integration with the Base Medical Program Annual Deductible for Participants who contribute to a Health Savings Account as described in the Base Medical Program SPD.

Assistive Smart Glasses: Aira, eSight, NuEyes, Orcam

The Program will reimburse you for the purchase of one pair of assistive smart glasses from one of the vendors identified above as well as monthly standard rate for services, including repairs or other servicing that are billed as part of the standard rate. The glasses must aid low/no-vision Participants in daily life; Physician certification that the Participant has low/no vision is required. The maximum reimbursement is $6,000 per lifetime for the servicing, SIM cards and glasses. Prior approval is required.

Durable Medical Equipment

Reimbursement is provided for durable medical equipment (DME) as specified below.

Reimbursement is provided only for DME specifically listed below and subject to the applicable requirements.

Participants must obtain Prior Approval from the Benefits Administrator to receive reimbursement for DME under the Program. If Prior Approval is not obtained, no Benefits will be payable under the Program. See the **"Prior Approval and Notification Requirements"** section for further information.

If you are enrolled in any other plan or program, other than CarePlus, that provides coverage for the DME you are seeking coverage for, you are not eligible for reimbursement under this Program, regardless of any out-of-pocket expenses you may incur and have responsibility to pay.

IMPORTANT: Unless specifically modified in this section, all other provisions of the Program apply. This includes, for example, Claim filing limits and integration with the Base Medical Program Annual Deductible for Participants who contribute to a Health Savings Account, as described in the Base Medical Program SPD.

Mobility Scooter and Standing Frame

A Participant, diagnosed with a permanent physical disability requiring use of a wheelchair, is eligible for reimbursement of the cost of a Mobility Scooter and/or Standing Frame. To be eligible for reimbursement, the Participant must provide a Physician's attestation or letter of medical necessity by a Physician specifying use of a wheelchair is required due to a permanent disability. A maximum reimbursement of $1,000 for a scooter and $5,000 for a standing frame is available from the Program once every three Plan Years. No repairs or accessories will be covered.

Lasik Corrective Vision Surgery

The Program will reimburse up to $3,000 per lifetime for Lasik corrective eye surgery if a Participant has impaired vision. The reimbursement can be applied to the first eye surgery or a touch-up required to maintain vision. Prior authorization is required.

Proteus Hepatitis C Adherence Pill

Edible device that monitors and encourages medication adherence in patients diagnosed with Hepatitis C. This device consists of a sensor worn on the torso and an ingestible sensor attached to the medication that the patient is taking. The sensor, which is the size of a grain of sand, transmits a signal when the medication reaches the stomach and then passes naturally through the digestive system. The information on the sensor then transmits the medication adherence to a connected device, like a smart phone. The utilization data is shared with the Physician in real time.

To be eligible, the patient must provide proof of Base Medical Program denial. Prior authorization and a Physician's diagnosis of Hepatitis C are required. The Physician must also determine that the patient is at risk for non-adherence to medication requirements, and confirm that he will track and document adherence, and contact the patient if any doses are missed.

miraDry® for Hyperhidrosis (significant excessive sweating)

Treatment of hyperhidrosis — by means of the topical application of microwave energy — using the miraDry® device to heat and destroy axillary sweat glands. Treatments must be administered in a Physician's office, lasts about one hour, and require local anesthesia. Prior approval and a Physician's diagnosis of hyperhidrosis are required.

Transportation Benefit Related to Cancer Treatment

Reimbursement for travel expenses for the patient, if they are reasonable expenses incurred in the course of travel (for example, coach class airline tickets, rental car, rideshare/cab, hotel, and

meals), is provided if your Base Medical Program does not provide any travel benefits for cancer treatment. Coverage is available if you travel more than 120 miles from home to use a Network Provider for treatment of cancer.

Reimbursement for expenses for the patient and a companion is available where all the following conditions are met and are subject to tax where applicable:

- Transportation of the patient and one companion who is traveling with the patient to the Network Provider for the purposes of an evaluation, treatment, or follow-up that is a Covered Health Service under your Base Medical Program. An Explanation of Benefits issued under your Base Medical Program may be required to establish coverage of these Services.
- Eligible Expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to $50 for one person or up to a total of $100 for the patient and the companion combined.
- If the patient is an enrolled dependent minor Child, the transportation expenses of up to two companions will be covered, and lodging and meal expenses will be reimbursed up to the $100 per diem rate (total) for all three individuals combined.
- Travel and lodging expenses are only available if the patient resides more than 120 miles from the Network Provider.
- Travel and lodging expenses are only available when the evaluation, treatment, or follow-up procedures/services require travel and or lodging for five or more continuous days. Maximum of 15 days of lodging reimbursement per cancer diagnosis. The Transportation Benefit Related to Cancer, provided under this section, is not available to individuals who are Medicare Eligible (i.e., eligible for Medicare as your primary coverage over the Base Medical Program).

There is a combined overall lifetime maximum Benefit of $10,000 for each Covered Person for all travel expenses reimbursed under CarePlus for travel and lodging for the Covered Person and/or companion(s).

Participants must obtain Prior Approval from the Benefits Administrator. If Prior Approval is not obtained, no Benefits will be payable under the Program.

No Coordination of Benefits applies with regard to coverage of this service under the Program. If you are enrolled in any other plan or program that provides any coverage for this service, you are not eligible for this coverage under the Program, regardless of any out-of-pocket expenses for which you may be responsible.

Post-transplant Home Custodial Care

The Program will reimburse expenses for Custodial Care (non-health related Services, such as assistance in activities of daily living including but not limited to feeding, dressing, bathing, transferring, and ambulating) for a Covered Person following an organ or tissue transplant covered under the Base Medical Program. Covered expenses are considered non-medical care and limited to a maximum of $20/hour for 24 hours/day up to a maximum of 15 days. Any custodial care, regardless of number of hours, received within a 24-hour period will count as a day. This

benefit is only available if ordered by a Physician and arranged through a licensed custodial care facility/agency. The amount reimbursed is subject to tax, where applicable.

Participants must obtain Prior Approval from the Benefits Administrator. If Prior Approval is not obtained, no Benefits will be payable under the Program.

No Coordination of Benefits applies with regard to coverage of this service under the Program. If you are enrolled in any other plan or program that provides any coverage for this service, you are not eligible for this coverage under the Program, regardless of any out-of-pocket expenses for which you may be responsible.

AccendoWave for Pain Management

AccendoWave offers a clinically validated non-opioid alternative for pain management designed to be used in coordination with other pain management approaches. The product will be prescribed by a Physician for extending treatment at home after they received this treatment while inpatient. The product consists of a tablet, electroencephalography (EEG) headband, and AccendoWave software. The tablet plays a variety of different content while the headband measures the electrical activity in the brain. The content varies based on the patient's pain level, noted from the headband. The patient can also rate whether the distraction alleviated the discomfort felt. The tablet will then play more of what helps the patient's body relax and reduce the pain.

The Program will reimburse up to $300 for the first month of treatment. Participants must obtain Prior Approval from the Benefits Administrator. If Prior Approval is not obtained, no Benefits will be payable under the Program. See the **"Prior Approval and Notification Requirements"** section for further information.

Tecla Communication Assistance for Limited Mobility

The Tecla-e is a light touch button that is also compatible with standard ability switches including the joystick, Buddy Button, Chin Switch, Micro Light Switch, Pillow Switch and Sip-and-Puff switch. The joystick can activate four different devices depending on the direction it is moved. If it moves to the left, it can activate one device, while moving backwards can activate another one. The Buddy Button is a wired switch featuring a round activation surface used to send commands to your Tecla. It has an auditory "click" and tactile feedback to inform you the button has been pressed. You can control devices with hand, arm, or head movement using the Buddy Button. The Chin Switch can be positioned anywhere around the neck, and has a flexible plastic tubing that can be tailored to the user. Nodding your head down onto the contact surface will activate the switch, catered for those with limited directional head movement. It also has an auditory "click" and tactile feedback. The Micro Light Switch is a small activation surface that only requires a light touch to activate. Like the others, it has an auditory "click" and tactile feedback. This is meant for those with limited hand or finger movement, or for use with slight shoulder or neck motion. The Pillow Switch features a soft foam activation surface, which is perfect for use in bed or in a wheelchair. It can be used with hands, arms, shoulders, or head. The Sip-and-Puff Switch is activated with a "sip" or "puff" of the mouth with the included small mouthpiece. This is for those with little to no neck movement, or in addition to other switches for customized control.

The Participant must have been diagnosed with muscular dystrophy, cerebral palsy, brain injury, stroke, spinal cord injury, multiple sclerosis, ALS or Parkinson's disease by a Physician. The

Program will reimburse up to $1000 per lifetime. Participants must obtain Prior Approval from the Benefits Administrator. If Prior Approval is not obtained, no Benefits will be payable under the Program. See the **"Prior Approval and Notification Requirements"** section for further information.

reSET® and reSET-O®

Coverage is provided for reSET® and reSET-O®, which are 12-week (90-day and 84-day, respectively) digital programs that provide access to cognitive behavioral therapy, interactive learning, and support as an adjunct to participating in outpatient treatment. reSET-O® is meant to be used together with buprenorphine in outpatient treatment. reSET® and reSET-O® intend to increase retention in the outpatient treatment program and are available as an application on any Android/iOS device. A prescription is required.

Participants must obtain Prior Approval from the Benefits Administrator. If Prior Approval is not obtained, no Benefits will be payable under the Program.

No Coordination of Benefits applies with regard to coverage of this service under the Program. If you are enrolled in any other plan or program that provides any coverage for this service, you are not eligible for this coverage under the Program, regardless of any out-of-pocket expenses for which you may be responsible.

Supportive Parenting for Anxious Childhood Emotions (SPACE)

Coverage is provided for the Supportive Parenting for Anxious Childhood Emotions (SPACE) program. The SPACE program aims to help parents treat children and adolescents diagnosed with anxiety disorders and obsessive compulsive disorder (OCD). Parents attend the treatment sessions to learn skills and tools to help their child overcome their anxiety. The treatment focuses on changes that parents can make to their own behaviors, rather than making their child change. The two main focuses are to have the parent respond more supportively to their anxious child and to reduce the accommodations they have been making to the child's symptoms.

Participants must obtain Prior Approval from the Benefits Administrator. If Prior Approval is not obtained, no Benefits will be payable under the Program.

No Coordination of Benefits applies with regard to coverage of this service under the Program. If you are enrolled in any other plan or program that provides any coverage for this service, you are not eligible for this coverage under the Program, regardless of any out-of-pocket expenses for which you may be responsible.

Wellthy Veterans Services

The Program will reimburse participants for services provided for veterans by **Wellthy** (wellthy.com/att). These services include case management and benefit and treatment navigation. These services help veterans and caregivers:

- Gain access to benefits and providers
- Navigate VA and private benefits and coverage
- Find the right emotional support programs
- Smooth the transition from the military to private citizenship

No Coordination of Benefits applies with regard to coverage of this service under the Program. If you are enrolled in any other plan or program that provides any coverage for this service, you are not eligible for this coverage under the Program, regardless of any out-of-pocket expenses for which you may be responsible.

You can find the *CarePlus Wellthy Request Form* at the AT&T CarePlus site (**https://careplus.att.com/forms/**) and refer to it for detail regarding requirements for submitting a reimbursement claim.

By clicking the link above, you are leaving the SPD document and are going to a third-party managed website to view information and materials that are not part of the SPD.

Payment for Certain Dependent Back-Up Care Provided by Bright Horizons

IMPORTANT: Only applies to the AT&T CarePlus – A Supplemental Benefit Program. It does not apply to the AT&T Eligible Former Employee CarePlus Program.

CarePlus will pay for certain Care Event days (defined below) provided by Bright Horizons for you and your dependents who are enrolled in AT&T CarePlus. Bright Horizons provides back-up care for certain employees. Such care is emergency care for you and your family when the primary care solution is not available, when you are an Employee Actively at Work. This means you are actively working for the Company and use care so you can work for the Company. (Note: If you are on a leave of absence and are unable to care for your child(ren), you can utilize this Benefit so your spouse/partner can work.)

Bright Horizons provides a network of eligible centers and in-home caregivers. In-center care includes the placement of a child or children in a Network Center where availability is based per location. Reservations can be made in increments of one day, which are a maximum of 10 hours per day. In-home care includes the placement of a caregiver in your home or the home of an adult care recipient. Care is confirmed based on caregiver availability. Reservations require a minimum of four hours and a maximum of 10 hours per day.

One Care Event day is defined as a single day of in-center care for your child(ren) at a Network Center, or one caregiver for one day of in-home care for your child(ren) at your home or for an eligible adult at your home or the home of the adult that is being cared for.

Eligibility

*You **and** your dependents must be enrolled in AT&T CarePlus to be able to use these Care Event days.* See the Eligibility at a Glance and Enrollment at a Glance sections of the *AT&T CarePlus – A Supplemental Benefit Program* Summary Plan Description for more information.

As a CarePlus participant, CarePlus will pay for up to *five Care Event days* through AT&T CarePlus each year for your eligible dependents enrolled in CarePlus. These days are referred to as Back-Up Care days on the Bright Horizons website.

You can initiate requests for these Bright Horizon's services by visiting the designated website (**clients.brighthorizons.com/att**) or mobile application, or by calling **855-591-9857.** You will need to create a user account prior to requesting service from Bright Horizons.

IMPORTANT: If there is not an available care center or in-home care provider in the Bright Horizons network that is accessible by the employee when and where needed, no subsidized Back-Up care coverage is available.

NOTE: If you are eligible for, and have elected to participate in, the AT&T Flexible Spending Account Plan's Dependent Care Flexible Spending Account (FSA) you may be eligible to receive reimbursement for any out-of-pocket expenses incurred when using Bright Horizons, but that are not eligible for payment through CarePlus. To be eligible for such reimbursement you must meet the requirements of an Eligible Expense for Eligible Dependents for purposes of the Dependent Care FSA. See the **AT&T Flexible Spending Account Plan** SPD for details.

Co-payment

Based on the table below, you are responsible for the co-payment amount to be paid directly to Bright Horizons on the date of service or the last date of service if multiple days are booked at one time. If you choose to cancel a confirmed reservation, cancellations processed after 5:00 PM local time the day prior to the reservation will incur a non-refundable co-payment for one day of care. Additionally, your available Care Events under your account will be reduced by one.

Taxation

The fair market value of the Back-Up Care services you use provided through Bright Horizons, less any co-payment you are responsible to Bright Horizons for, is taxable compensation to you and is subject to applicable federal, state, local, social security, Medicare, and other applicable payroll withholding. Taxable compensation and related payroll withholding will appear on your paystub and be reported to you on IRS Form W-2. The current fair market value amounts are shown below.

Type of Back-Up Care	Co-payment to Bright Horizons	Fair Market Value (Before co-payment is Applied)[2]
In-Center Care	$15 per day for one child, or $25 per day for a family (2 or more children)	$93 per child per day
In-Home Well Child Care	$4 per hour per caregiver[1]	$179 per caregiver per day
In-Home Adult	$4 per hour per caregiver[1]	$271 per caregiver per day
In-Home Mildly Ill Child Care	$4 per hour per caregiver*	$279 per caregiver per day

[1]In-home care applies a four-hour minimum and 10-hour maximum, which is considered one Care Event.

[2]The taxable amount for care is reduced by the applicable co-pay (e.g. FMV minus (-) co-payment).

[3]A caregiver may support up to a maximum of three care recipients unless (i) the care recipient is a special needs care recipient or (ii) the Participant requests multiple caregivers. The caregiver fee is determined by the number of caregivers and each caregiver counts as a Care Event day.

WHAT IS NOT COVERED UNDER CAREPLUS

The Program does not cover certain types of expenses under any circumstances, such as:

- Charges for care, services, treatment supplies or hospitalizations that began before your effective date of coverage or after coverage has ended, except for Hospital room and board charges as a Hospital inpatient if you are already confined to a Hospital when your coverage ends.
- Charges incurred for services or supplies payable under Workers' Compensation or similar laws.
- Charges payable under a Participating Company's disability benefit program.
- Charges paid or payable under any government law or regulation.

- Care, services, treatment or supplies available from or covered by any governmental agency or plan.
- Charges incurred for care, services, treatment or supplies other than those confirmed in writing by the Benefits Administrator as Necessary Treatment.
- Charges incurred for care, services, treatment or supplies for which there is no legal obligation to pay or for which no charge will be made in the absence of this Program's Benefits.
- Charges for physiotherapy or speech therapy that is educational in nature except as therapies specifically designated as a Covered Service.
- Charges for holistic medicine care, services, treatment or supplies.
- Charges for care, services, treatment or supplies related to an underlying condition or a non-covered procedure or service rendered concurrently with a Covered Service.
- Charges during a continuous Hospital confinement that began before your effective date of coverage.
- Charges that exceed the lesser of the Benefit determined by the Benefits Administrator as payable by the Program for a Covered Service or Expanded Benefit or actual billed charges.
- Charges for care, services, treatment or supplies that are payable under your Medical, Dental or Vision Plan not specifically identified as payable under the Program.
- Charges for care, services, treatment or supplies not otherwise billed by the facility.
- Services or supplies provided other than those defined under this Program.

CLAIMS AND APPEAL PROCEDURES

KEY POINTS

- *Two types of Claims may be made and appealed under the Program: Claims for Eligibility and Claims for Benefits.*
- *If your Claim is denied, you may appeal the decision within 180 days of receipt of the denial notice. It is important to follow the claims and appeal procedures below.*
- *You must file your Appeal within the time limit stated.*
- *You must exhaust all Appeal processes offered by the Program before filing a lawsuit.*

You, your covered dependents or duly authorized persons have the right under ERISA and the Plan (including the Program) to file a written Claim for Eligibility or Claim for Benefits under the Program.

The following sections describe the procedures used by the Program to process a Claim for Eligibility or a Claim for Benefits, along with your rights and responsibilities. These procedures were designed to comply with the rules of the United States Department of Labor (DOL) concerning a Claim for Eligibility or Claim for Benefits. It is important that you follow these procedures to make sure you receive the full extent of your Benefits under the Program. You may file suit in federal court if you are denied eligibility or benefits under the Program. However, you must complete all available claims and appeal processes offered under the Program before filing suit.

IMPORTANT: If you have completed all of the claims and appeal procedures explained in the following sections and your Appeal is denied, you have the right to file suit in federal court if you are denied eligibility to participate or if you are denied benefits under the Program.

Claims for Eligibility

When to File a Claim for Eligibility

If you or your dependents attempt to enroll or participate in the Program and are told you or your dependent is not eligible to enroll or participate in the Program, you may call the Eligibility and Enrollment Vendor to attempt to resolve the issue. See the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section. If the issue is not resolved to your satisfaction, you may file a written Claim for Eligibility.

IMPORTANT: The Eligibility and Enrollment Vendor should only be contacted for denials related to enrollment or participation in the Program.

For benefit-related situations, you will need to contact the Benefits Administrator. Please see the **"Claims for Benefits"** section for the Claim for Benefits process.

You are responsible for initiating the Claim for Eligibility process. The Claim for Eligibility process does not begin until you have provided a written Claim, as outlined below.

How to File a Claim for Eligibility

To file a Claim for Eligibility, you must submit your written Claim for Eligibility, along with any documentation that supports your Claim for Eligibility, to the Eligibility and Enrollment Vendor at

the address listed in the **"Contact Information"** section. To submit a Claim for Eligibility you must file a completed Claims Initiation Form (CIF) or other written document asserting your Claim, along with any supporting documentation, with the Eligibility and Enrollment Vendor. A CIF is available from the Eligibility and Enrollment Vendor on request.

The Eligibility and Enrollment Vendor will notify you of its decision within 30 days of the date it receives your Claim for Eligibility. The Eligibility and Enrollment Vendor may extend this period once (for up to 15 days) if it determines that special circumstances require more time to decide your Claim for Eligibility. If this happens, you will receive a written notice of the special circumstances requiring the extra time and when to expect a response.

If the Eligibility and Enrollment Vendor requires additional information from you in order to determine your Claim for Eligibility, you will receive notification and you will have 45 days from the date you receive the notification to provide the information. The Eligibility and Enrollment Vendor's decision time period will be suspended until you provide the requested information, up to 45 days.

Once the information is received, the Eligibility and Enrollment Vendor will decide your Claim within the time remaining in the initial 30-day or extended 45-day review period, whichever applies.

If you do not respond to the request for information, your Claim for Eligibility will be determined based on the available information, but you may appeal this decision.

The following table summarizes the Program's Claim for Eligibility decision time frame:

Activity	Deadline
Eligibility and Enrollment Vendor decides on Claim	30 days from the date the Eligibility and Enrollment Vendor receives your initial Claim for Eligibility
Time period is extended if Eligibility and Enrollment Vendor determines special circumstances require more time	Up to 15 additional days after the initial 30-day period
You must provide additional information requested by the Eligibility and Enrollment Vendor	45 days from the date you receive notice from the Eligibility and Enrollment Vendor stating that additional information is needed

What Happens If Your Claim for Eligibility Is Denied

Your Claim for Eligibility is denied when the Eligibility and Enrollment Vendor sends written notice that denies your Claim for Eligibility in whole or in part or if you do not receive notice of the denial within the time periods described above. A written denial notice will contain:

- Specific reasons for the denial.
- Specific references to the Program provisions upon which the denial is based.
- If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination and that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request.

- If applicable, a description of any additional information needed to make your Claim for Eligibility acceptable and the reason the information is needed.
- A description of the Program's Appeal procedures.
- A statement of your right to file a civil action under ERISA after you have exhausted all opportunities to appeal under the Program.

How to Appeal a Denied Claim for Eligibility

If your Claim for Eligibility is denied and you disagree with the decision, you may appeal the decision by filing a written request for review. To appeal the Claim, you or your authorized representative must file a written Appeal with the Eligibility and Enrollment Vendor within 180 days of receipt of the denial notice. A special form is not required; however, you may contact the Eligibility and Enrollment Vendor and obtain an Appeal form. A service representative also can provide the appropriate address to direct your Appeal.

See the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section for contact information.

If you or your authorized representative submit an Appeal of a denied Claim for Eligibility, you or your representative has the right to:

- Send a written statement of the issues and any other comments. Be sure to clearly state any facts and/or reasons you believe should be considered and include any documents, records or other information relating to your Appeal.
- Include any new or additional evidence or materials that support your Appeal. This information must be provided with your written statement when you file your Appeal.
- Request and receive, free of charge, documents relevant to your Claim for Eligibility, such as any internal rule, guideline, protocol or other similar criterion relied on in denying your Claim for Eligibility.
- Reasonable access to and copies of all documents, records and other information relevant to your Claim for Eligibility.

Internal Appeals Process

Eligibility and Enrollment Appeals Committee (EEAC) members, who were not involved in the initial decision to deny your Claim for Eligibility, will review and decide your Appeal. In the review of your Appeal, the EEAC will not afford deference to the denied Claim.

The EEAC will notify you of its decision within 60 days of the date of receipt of your Appeal. The EEAC can extend this period once (for up to 60 days) if special circumstances require more time to decide your Appeal. If this happens, you will receive a written notice of the special circumstances requiring the extra time and when to expect a response.

The EEAC's decision on your Appeal will be in writing and will include the specific reasons and references to Program provisions relied on to make the decision. The EEAC's decision will include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your Claim for Eligibility. The EEAC has been delegated the exclusive right to interpret and administer applicable provisions

of the Program, and its decisions are conclusive and binding and are not subject to further review under the Program. If your Appeal is denied, it is final and is not subject to further review. However, you may have further rights under ERISA, as described in the **"ERISA Rights of Participants and Beneficiaries"** section.

The following table summarizes the Program's Appeal for Eligibility decision time frame:

Activity	Deadline
You request a review of a denied Claim for Eligibility	180 days from receipt of a denial notice
Eligibility and Enrollment Appeals Committee (EEAC) decides on Appeal	60 days from the date the EEAC receives your Appeal
Time period is extended if EEAC determines special circumstances require more time	Up to 60 days after the initial 60-day period

Claims 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. You must file your Appeal within the time limit stated below.

How to File a Claim for Benefits

You, your covered dependents or an authorized representative have the right under ERISA and the Plan (including the Program) to file a written Claim for Benefits. A Claim for Benefits is the initial request that is made to the Benefits Administrator for Benefits under the Program. In some cases, the initial Claim for Benefits is filed by the Provider, and in other instances, you have the responsibility to file the initial Claim for Benefits or make certain that the Provider files it on your behalf.

Generally, an enrollment or eligibility request is not a Claim for Benefits. Such a request is considered a Claim for Eligibility. Please see the **"Claims for Eligibility"** section for more information. If, however, your initial request is denied on the basis that you are not eligible to participate in the Program, it may be a Claim for Benefits.

The following describes the procedures the Program uses to process Claims for Benefits, along with your rights and responsibilities. These Claims for Benefits procedures comply with the rules of the Department of Labor (DOL). It is important that you follow these procedures to make sure that you receive full Program Benefits. This section provides you with information about how and when to file a Claim for Benefits:

- If you receive Services from an Approved Provider your Claim for Benefits generally will be filed by the Provider. The Program pays the Provider directly. If an Approved Provider sends you a bill for the balance owed for any Service, contact the Benefits Administrator.

Different Process for Dependent Back-Up Care Claims for Payment

IMPORTANT: Questions regarding payments by CarePlus for Dependent Back-Up Care or if you believe you have not been provided with Benefits that you are entitled to receive then you have the right, as described in the Claims for Benefits section, to file a written Claim for Benefits. Claims for Benefits and Appeals for Benefits related to Dependent Back-Up Care must be directed to:

AT&T Benefits Center
CarePlus Dependent Back-Up Care Vendor Manager
Dependent Care Claims & Appeals
P.O. Box 7105
Rantoul, IL 61866-7105

Claim Filing Limits

You or your Approved Provider must submit your Claim for Benefits within 120 days after the end of the calendar year in which you receive the Services.

You are responsible for the timeliness of the Claim for Benefits and these timing requirements still apply. If you or your Provider do not file a Claim for Benefits within this time period, Benefits will be denied or reduced at the Benefits Administrator's discretion. If your Claim for Benefits relates to an inpatient stay, the date of Service is the date your inpatient stay ends. If your Claim for Benefits relates to an inpatient stay, the date of Service is the date your inpatient stay ends.

Information to Include in Your Claim for Benefits

When you file a Claim for Benefits, you must provide certain information as shown in the following table.

Information to Include in Your Claim for Benefits

- Employee's or former Employee's name and address
- Patient's name, age and relationship to the Employee or former Employee
- Member number stated on your ID card
- Itemized bill from your Provider that includes the following:
  - Patient diagnosis
  - Date(s) of Service
  - Procedure code(s) and descriptions of Service(s) rendered
  - Charge for each Service provided
  - Service Provider's name, address and tax identification number
- Date the Injury or Illness began
- Statement that indicates if you are enrolled for other coverage. If so, you must include the name of the other carrier(s)

As part of the Claim for Benefits, the Benefits Administrator may require the individual who received Services to have an examination performed by an appropriate agent or independent contractor as often as the Benefits Administrator determines necessary.

The Benefits Administrator may ask for additional information to support your Claim for Benefits. If so, you will receive this request in writing.

Payment of Benefits

The Benefits Administrators are responsible for administration of a Claim for Benefits. The Benefits Administrator will make a determination of the Program's applicability to your Claim for Benefits. See the *Benefits Administrator* table in the **"Contact Information"** section for information about Claim forms and procedures.

The Benefits Administrator will make a Benefit determination as set forth in the **"Benefit Determinations"** section. Once a Claim for Benefits is approved, Benefits will be paid directly to you unless either:

- The Provider notifies the Benefits Administrator that you authorized payment directly to the Provider.
- You make a written request for payment to be made directly to the Provider when you submit your Claim for Benefits.

The Benefits Administrator will not reimburse third parties who have purchased or been assigned Benefits by Physicians or other Providers.

Benefit Determinations

Post-Service Claims

A Post-Service Claim is a Claim for Benefits you or your Provider file after Services have been received. If your Post-Service Claim is denied, in whole or in part, the Benefits Administrator will provide you a written notice of its determination within 30 days of receipt of the Claim for Benefits. The Benefits Administrator may extend this period once (for up to 15 days) if it

determines that special circumstances require more time to decide your Claim for Benefits. If this happens, you will receive a written notice of the special circumstances requiring the extra time prior to the lapse of the 30-day period as well as the date by which you should expect a response.

If the Benefits Administrator requires additional information from you in order to determine your Claim for Benefits, you will receive notification prior to the lapse of the 30-day period and you will have 45 days from the date you receive the notification to provide the information. The Benefits Administrator's decision time period will be suspended until you provide the requested information, up to 45 days.

Once the information is received, the Benefits Administrator will decide your Claim for Benefits within 15 days of the date the information is received.

If you do not respond to the request for information, your Claim for Benefits will be determined based on the available information, but you may appeal this decision. If your Claim for Benefits is denied, in whole or in part, you will receive a notice explaining the denial and identifying the Program provisions that the denial is based on, as well as the Claim Appeal procedures.

Pre-Service Claims

A Pre-Service Claim is a Claim for Benefits where the Program requires approval of the Benefit in advance of obtaining medical care. If your Pre-Service Claim is submitted properly, the Benefits Administrator will provide written notice of its determination within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after its receipt of the Claim for Benefits. The Benefits Administrator may extend this period once (for up to 15 days) if it determines that special circumstances require more time to decide your Claim for Benefits. If this happens, you will receive a written notice of the special circumstances requiring the extra time prior to the lapse of the 15-day period as well as the date by which you should expect a response.

If you file a Pre-Service Claim improperly, the Benefits Administrator will notify you of how to correct it within five days of receipt of the Pre-Service Claim.

If the Benefits Administrator requires additional information from you in order to determine your Pre-Service Claim, you will receive notification within 15 days after the Benefits Administrator receives your Pre-Service Claim. You will have 45 days from the date of the notification to provide the information. The Benefits Administrator's decision time period will be suspended until you provide the requested information, up to 45 days.

Once the information is received, the Benefits Administrator will decide your Pre-Service Claim within 15 days of its receipt of the additional information. If your Claim for Benefits is denied, in whole or in part, you will receive a notice explaining the denial and identifying the Program provisions that the denial is based on, as well as the Appeal procedures.

If you do not respond to the request for information within the 45-day period, your Claim for Benefits will be determined based on the available information, but you may appeal this decision.

Urgent Care Claims That Require Immediate Action

An Urgent Care Claim is a Claim for Benefits or Services for which the Program requires you to obtain Preauthorization before the Covered Person receives medical care and a delay in receiving the Service could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function or, in the opinion of a Physician with knowledge of

the Covered Person's medical condition, cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim for Benefits. The Benefits Administrator will defer to your attending Provider's determination that your Claim is an Urgent Care Claim within the meaning described above. In these situations:

- The Benefits Administrator will provide written, electronic or verbal notice of the determination as soon as possible, taking into account the medical exigencies, no later than 72 hours after receipt of the Claim.
- If the Benefits Administrator provides notice verbally, a written or electronic confirmation will follow within three days.

If you file an Urgent Care Claim improperly or additional information is necessary to process the Urgent Care Claim, the Benefits Administrator will notify you of how to correct it or of the required information as soon as possible, but not later than 24 hours of receipt of the Urgent Care Claim. You will have 48 hours to provide the requested information.

The Benefits Administrator will notify you of a determination as soon as possible, but no later than 48 hours after the earlier of:

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

If your Urgent Care Claim is denied, in whole or in part, you will receive a notice explaining the denial and identifying the Program provisions on which the denial is based, as well as the Appeal procedures.

Concurrent Care Claims

Concurrent Care is a type of Benefit offered under the Program that involves an ongoing Course of Treatment provided over a period of time or a specified number of treatments. A reduction or termination of previously approved Concurrent Care (other than by Program amendment or termination) before the end of the period of time or utilization of the specified number of treatments is an Adverse Benefit Determination for which you may file an Appeal.

The Benefits Administrator will notify you in advance if your previously approved Concurrent Care will be reduced or terminated so that you may file an Appeal before the reduction or termination. Your Concurrent Care will continue to be covered, pending the outcome of the internal Appeal. This means that the Program cannot terminate or reduce Concurrent Care without providing advance notice and the opportunity for review.

If you make a request to extend Concurrent Care at least 24 hours before the end of the approved treatment and your request to extend treatment is an Urgent Care Claim, as defined above, the Benefits Administrator will make a determination within 24 hours of receipt of your request.

If your request for Concurrent Care is not made at least 24 hours before the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the time frames described above. If your Concurrent Care was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent

circumstance, your request will be considered a new Claim and decided according to Post-Service or Pre-Service Claim time frames, whichever applies.

What Happens If Your Claim for Benefits Is Denied

If your Claim for Benefits is denied, in whole or in part, it is an Adverse Benefit Determination. An Adverse Benefit Determination is any denial, reduction or termination of a Benefit, or a failure to provide or make a payment (in whole or in part) for a Benefit, including any based on your eligibility to participate in the Program, a determination that the Service is not a Benefit under the Program, a Network exclusion or other limitation on Benefits under the Program, a determination that a Service is Experimental, Investigational or not Medically Necessary or appropriate. You have the right to appeal any Adverse Benefit Determination under the procedures described below.

If your Claim for Benefits is denied, in whole or in part, the Benefits Administrator will provide you with written or electronic notification of the Adverse Benefit Determination that will include:

- Information sufficient to identify the Claim (including the date of Service, the health care Provider), the Claim amount (if applicable), a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.
- Specific reasons for the denial.
- Specific references to the Program provisions upon which the denial is based.
- If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination and that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request.
- If applicable, an explanation of the scientific or clinical judgment for the determination, applying the Program's terms to your medical circumstances or a statement that this explanation will be provided free of charge upon request.
- If applicable, a description of any additional information needed to make your Claim for Benefits acceptable and the reason the information is needed.
- A description of the Program's Appeal procedures.
- A statement of your right to file a civil action under ERISA after you have exhausted all opportunities to appeal under the Program.

You or your authorized representative can appeal the denied Claim for Benefits within the time limits set forth in this section for the applicable type of Claim. If you wish to appeal a denied Pre-Service Claim or Post-Service Claim, you must contact the applicable Benefits Administrator in writing. You or your Provider may appeal a denied Urgent Care Claim by calling the Benefits Administrator or filing a written Appeal.

Your Appeal must be submitted to the Benefits Administrator within 180 days following receipt of the notice of the denial of your Claim for Benefits or the date your Claim for Benefits is deemed denied.

IMPORTANT: If your Claim for Benefits is denied on the basis of eligibility to enroll or participate in the Program, you should follow these procedures; however, your Appeal must be filed with the Eligibility and Enrollment Vendor. (See the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section.)

The Appeal will take into account all comments, documents, records and other information you submit relating to the Claim for Benefits, without regard to whether such information was submitted or considered in the initial Benefit determination. If you wish, you or your authorized representative may review the appropriate Plan documents and submit written information supporting your Claim for Benefits to the Benefits Administrator or Plan Administrator.

If you have received Preauthorization for an ongoing Course of Treatment, you will continue to be covered for that Concurrent Care, pending the outcome of the internal Appeal. This means that the Program cannot terminate or reduce any ongoing Course of Treatment without providing advance notice and the opportunity for review.

You have the right to, upon request and free of charge, reasonable access and copies of all documents, records or other information relevant to your Claim for Benefits. You must make this request in writing. You will be able to review your file and present information as part of the Appeal.

The Benefits Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan in connection with your Claim, as well as any new or additional rationale to be used in reaching the decision. You will be given this information in advance of the date the notice of final Appeal decision is made to give you a reasonable opportunity to respond.

How to File an Appeal for Benefits

You can file a written Appeal if your Claim is denied, in whole or in part. To file an Appeal, you must send a written summary to the Benefits Administrator with all of the following information:

- Your name
- Patient's name and patient's identification number from his or her medical ID card
- Dates of Service
- Provider's name
- A summary of the issue, including the reason you believe the Claim for Benefits should be paid
- All relevant documents, such as letters, Explanation of Benefits (EOBs) and statements

See the *Benefits Administrator* table in the **"Contact Information"** section for more information.

The Benefits Administrator will decide your Appeal based on whether the Program provides Benefits for the proposed treatment or procedure and the amount of such Benefits. You and your Provider decide the appropriateness of pending health Services.

Internal Appeals

Your Appeal will be assigned to a qualified individual or committee who has had no involvement with the denial of your Claim for Benefits. If your Appeal is related to clinical matters, the review will include a consultation with a health care professional who has appropriate expertise in the field and who was not involved in the denial of your Claim for Benefits. The Benefits Administrator can also seek the expertise of other medical professionals to resolve your Claim. You must consent to this referral and to sharing your pertinent medical information.

Pre-Service and Post-Service Claim Appeals

There are two levels of internal Appeals. You will be provided written or electronic notification of the decision on your Appeal(s) as follows:

- For Appeals of Pre-Service Claims (as defined in the **"Benefit Determinations"** subsection), the first-level Appeal will be conducted and you will be notified by the Benefits Administrator of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days from receipt of a request for Appeal of a denied Claim. If you are not satisfied with the first-level Appeal decision, you have the right to request a second-level Appeal. Your second-level Appeal request must be submitted to the Benefits Administrator in writing within 180 days from receipt of the first-level Appeal decision. The second-level Appeal will be conducted and you will be notified by the Benefits Administrator of the decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days from receipt of a request for review of the first-level Appeal decision.

- For Appeals of Post-Service Claims (as defined in the **"Benefit Determinations"** subsection), the first-level Appeal will be conducted and you will be notified by the Benefits Administrator of the decision within a reasonable period of time, but not later than 30 days from receipt of a request for Appeal of a denied Claim. If you are not satisfied with the first-level Appeal decision, you have the right to request a second-level Appeal. Your second-level Appeal request must be submitted to the Benefits Administrator in writing within 180 days from receipt of the first-level Appeal decision. The second-level Appeal will be conducted and you will be notified by the Benefits Administrator of the decision within a reasonable period of time, but not later than 30 days from receipt of a request for review of the first-level Appeal decision.

- For Pre-Service and Post-Service Claim Appeals, the Company has delegated to the Benefits Administrator the exclusive right to interpret and administer the provisions of the Program. The Benefits Administrator's decisions are conclusive and binding, subject to the external review process below, if applicable.

NOTE: The Benefits Administrator's decision is based only on whether or not Benefits are available and the amount of Benefits under the Program for the proposed treatment or procedure. The determination as to whether the pending health Service is appropriate to treat your condition, any medical decision or what health Service you actually receive is between you and your Physician.

Urgent Care Appeals That Require Immediate Action

An Urgent Care Appeal does not need to be submitted in writing. You or your Provider should call the applicable Benefits Administrator as soon as possible. The Benefits Administrator will provide you with a written or electronic determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours from receipt of your request to Appeal a denied Urgent Care Claim. All necessary information, including the Benefits Administrator's determination of your Appeal, shall be transmitted between you or your authorized representative and the Benefits Administrator by telephone, facsimile, or other available similarly expeditious method.

For Urgent Care Appeals, the Plan Administrator has delegated the applicable Benefits Administrator the exclusive right to interpret and administer the provisions of the Program. The Benefits Administrator's decisions are conclusive and binding, subject to the external review process below.

If your internal Appeal is denied, in whole or in part, the Benefits Administrator will provide you with written or electronic notification of the Adverse Benefit Determination that will include:

- Information sufficient to identify the Claim (including the date of Service, the health care Provider, the Claim amount (if applicable), a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.
- Specific reasons for the denial.
- Specific references to the Program provisions upon which the denial is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your Claim.
- If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination and that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request.

- If applicable, an explanation of the scientific or clinical judgment for the determination, applying the Program's terms to your medical circumstances or a statement that this explanation will be provided free of charge upon request.
- A statement of your right to file a civil action under ERISA after you have exhausted all opportunities to appeal under the Program.

IMPORTANT: You may have additional rights available to you under ERISA, including the right to file a lawsuit in federal court. See the **"ERISA Rights of Participants and Beneficiaries"** section for more information.

External Review

If your Appeal is denied, in whole or in part, you may file a request for external review of your denied Claim for Eligibility or a denied Claim for Benefits if your Appeal involves:

- Medical judgment (including, but not limited to, a determination based on the Program's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered Benefit; or a determination that a treatment is Experimental or Investigational).
- Rescission of coverage (whether or not the rescission has any effect on any particular Benefit at that time).

A denied Claim for Eligibility based on an individual's failure to meet the requirements for eligibility (e.g. worker classification and similar issues) cannot be the subject of an external review.

If an external review is available, you will receive a notice from the Benefits Administrator. The notice will include instructions for requesting the review. You may request an external review by completing the request for external review that may be obtained from the Benefits Administrator.

Except for approved expedited external review regarding Urgent Care Claims, this external review is available only after you have exhausted the internal Appeals process.

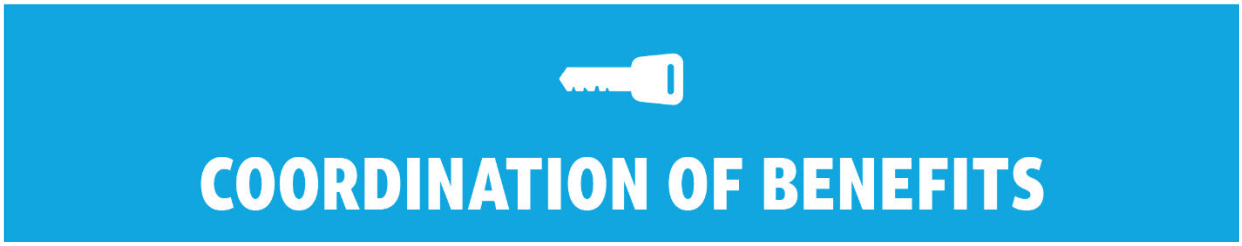
The external review will be made by an Independent Review Organization (IRO) using health care professionals who are not related to the Company and had no involvement with the decision on the Claim for Benefits or your Appeal. If the Benefits Administrator approves your request for external review, the Benefits Administrator will provide you notice of the identity of the external review organization.

Expedited

You can request an expedited external review of a denied Urgent Care Claim or a denied Appeal of an Urgent Care Claim if the time frame for completion of a standard external review would seriously jeopardize your life or health or your ability to regain maximum function. It is also

available if the denial involves an inpatient Admission, availability of care, continued stay, a health care item or discharge from a health care facility.

An external review decision is binding on the Program and the Claimant, except to the extent other remedies are available under law. The Program will provide Benefits as determined pursuant to the external review decision without delay, regardless of whether the Program intends to seek judicial review of the external review decision unless and until there is a judicial decision otherwise.



COORDINATION OF BENEFITS

KEY POINTS

- *Coordination of Benefits (COB) applies when you have health coverage under more than one plan.*
- *The COB rules describe how Program Benefits are determined and which Coverage Plan will pay first.*
- *Special COB rules apply if you are Medicare Eligible.*

Generally, the Program provides Benefits only for services not covered under another Company-sponsored or third party plan (for example, certain Experimental procedures, preventive care, etc.). As a result, this Program does not coordinate CarePlus Benefits with any other plan. If, however, the Program specifically permits an Expanded Covered Service (for example, hearing aids), to be covered under another program or third party plan and CarePlus, then the following Coordination of Benefits rules apply.

Determining Which Plan or Program Pays First

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

- A Coverage Plan may consider the Benefits paid or provided by another Coverage Plan in determining its Benefits only when it is secondary to the other Coverage Plan. The primary Coverage Plan pays Benefits as if the secondary Coverage Plan(s) does not exist.
- The primary Coverage Plan pays first without regard to what another Coverage Plan may cover. A secondary Coverage Plan pays after the primary Coverage Plan and as a result, may reduce the Benefits it pays.
- A Coverage Plan that does not contain a Coordination of Benefits (COB) provision pays first unless the Coverage Plan is group coverage provided to an organization's members that supplements a basic Benefits package and provides coverage in addition to that basic

Benefits package. Examples may include major medical coverages that apply after a base Coverage Plan's Hospital and surgical Benefits, and insurance coverages with a closed panel Coverage Plan that provides Non-Network Benefits.

- The following rules describe which Coverage Plan pays Benefits before another Coverage Plan — the first applicable rule is the rule that is used:
  - **Non-dependent or dependent.** The Coverage Plan that covers you as a non-dependent (for example, as an Employee, member, subscriber or Eligible Former Employee) is primary, and the Coverage Plan that covers you as a dependent is secondary. However, if you are Medicare Eligible and Medicare is your primary Coverage Plan, then the Coverage Plan covering you as a member, subscriber, retiree or Eligible Former Employee is secondary and the Coverage Plan that covers you as a dependent is third. If Medicare is your secondary Coverage Plan, then Medicare is secondary and the Coverage Plan that covers you as a dependent is third, unless Medicare is also secondary to that Coverage Plan.
  - **Active or inactive Employee.** The Coverage Plan that covers you as an Active Employee (not laid off or retired) is primary. This also applies if you are covered under separate plans as a dependent of an Eligible Former Employee and an Employee. If the other Coverage Plan does not have this rule and the Coverage Plans do not agree on the order of Benefits, this rule does not apply. If you are covered under separate plans as an Eligible Former Employee or retiree and as a dependent of an actively employed Spouse, the non-dependent or dependent rule described above applies.
  - **Continuation coverage.** If you are covered under any federal or state provided right of continuation coverage and also covered under another Coverage Plan, the Coverage Plan covering you as an Employee, member, subscriber, retiree or Eligible Former Employee (or as that person's dependent) is primary and the continuation coverage is secondary. If the other Coverage Plan does not have this rule and the Coverage Plans do not agree on the order of Benefits, this rule does not apply.
  - **Longer or shorter length of coverage.** The Coverage Plan that covers you as an Employee, member, subscriber or Eligible Former Employee longest is primary.

If the preceding rules do not determine the primary Coverage Plan, the Coverage Plans (as defined in this section) share the Allowable Charges equally. The sum of all Benefits payable from this Program and the primary Coverage Plan will not exceed actual Allowable Charges incurred.

COB for Eligible Dependent Child(ren)

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

- The Coverage Plan of the parent whose birthday is earlier in the year (birthday rule) is primary if:
  - The parents are married;
  - The parents are not separated (whether or not they ever have been married); or
  - A court decree awards joint custody without specifying who has responsibility to provide health care coverage.

- The Coverage Plan that covers either of the parents longer is primary if both parents have the same birthday.
- The Coverage Plan of the parent who is responsible for a Child's health care expenses or coverage, as specified by the terms of a court decree, is primary if the parent has knowledge of the terms. This rule applies to Claim determination periods or Plan Years beginning after the Coverage Plan receives notice of the court decree.

How COB Works

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

- Determine the Benefits the Program would pay if it were primary, however, if a negotiated rate applies to the Service, special rules apply to determine the Allowable Charge for the Service under the Program. Contact the Benefits Administrator if you have questions.
- Determine if total Benefits payable (before applying COB rules) under this Program and other Coverage Plans is more than 100 percent of actual Allowable Charges. If so, this Program reduces its Benefits so that the sum of all Benefits payable from this Program and the primary Coverage Plan do not exceed Allowable Charges incurred.
- COB rules do not apply if you enroll in two or more closed panel Coverage Plans and Benefits are not payable by a closed panel Coverage Plan. For example, COB does not apply if the closed panel Coverage Plan does not pay Benefits because you went to a non-panel provider.
- If you are eligible for Medicare as your primary coverage, this Program reduces its Benefits by the amount Medicare would pay for Medicare enrolled participants. COB with Medicare conforms to all applicable federal statutes and regulations. To the extent allowed by law, if you are Medicare Eligible, this Program assumes you have full Medicare Parts A and B coverage (i.e., Part A hospital insurance, Part B voluntary medical insurance) even if you have not enrolled for Medicare. See the **"If You, Your Spouse/Partner or Your Dependent Is Eligible for Medicare"** section for detailed information on Medicare coverage and its impact on Program Benefits.
- If you are enrolled in Medicare and Medicare is your primary Coverage, Program Benefits are secondary. Medicare pays first and Program Benefits are reduced by the amount Medicare pays. If you or your dependent is eligible for Medicare as your primary Coverage, but not enrolled in Medicare, Program Benefits are reduced by the amount Medicare would have paid.
- As an Active Employee or the dependent of an Active Employee, generally this Program pays primary to Medicare, even if you are eligible for and enrolled in Medicare.
- Payment made under another Coverage Plan may include an amount this Program should have paid. If this occurs, this Program may pay that amount to the organization that made the payment. This Program treats this amount as if it were a Benefit paid, and this Program will not have to pay that amount again. The term payment made includes

providing Services, in which case payment made means reasonable cash value of the Services provided.

- If the amount of the payments the Program made is more than it should have paid under this COB provision, the Program may recover the excess. The Program may recover this amount from one or more of the persons paid, from one or more of the persons for whom the Program paid or any other person or organization that may be responsible for the Benefits or Services provided. The amount of payments made includes the reasonable cash value of any Benefits provided in the form of Services.

IF YOU, YOUR SPOUSE OR YOUR DEPENDENT IS ELIGIBLE FOR MEDICARE

IF YOU, YOUR SPOUSE/PARTNER OR YOUR DEPENDENT IS ELIGIBLE FOR MEDICARE

KEY POINTS

- *Eligibility for Medicare can affect your Benefits under the Program.*
- *Once you are Medicare Eligible you must enroll in Medicare Parts A and B or your Medical Benefits may be substantially reduced.*

Your Program Benefits are affected when you or your dependent becomes Medicare Eligible. Program Benefits become secondary to Medicare and you must enroll in Medicare Parts A and B to receive the maximum coverage for your Medicare-Eligible expenses. While generally expenses covered under the Program are not covered under Medicare, it is possible that Medicare covers all or a portion of expenses that could be covered under the Program. For the impact on Program Benefits and the steps you must take if you are Medicare Eligible, see the **"Medicare Parts A and B"** section.

Medicare Parts A and B

Impact of Medicare Parts A and B on Program Benefits

Medicare Parts A and B provide coverage for many of the same expenses as the Program. When an individual is enrolled in both Medicare and a group health plan, federal law determines when Medicare or the Program provides primary coverage. When Medicare coverage is primary, Medicare pays first for these expenses before the Program calculates Benefits. Your Benefits under the Program will be secondary to Medicare for these expenses.

The chart below indicates when Medicare coverage or the Program generally is primary. To verify what coverage will be primary under your circumstances, contact the Centers for Medicare and Medicaid Services. See the **"More Information on Medicare"** section for contact information.

Circumstances	Additional Conditions	Primary Payer	Secondary Payer
Age-based Medicare entitlement for you or your Spouse or dependent + coverage under the Program due to current active employment status	Employer has 20 or more Employees	Program	Medicare
Age-based Medicare entitlement + coverage under the Program due to former employment status or COBRA	N/A	Medicare	Program
Disability-based Medicare entitlement for you or your Partner or dependent + coverage under the Program due to current active employment status of a family member	Employer has 100 or more Employees	Program	Medicare
Disability-based Medicare entitlement + coverage under the Program due to former employment status or COBRA	N/A	Medicare	Program
End-Stage Renal Disease (ESRD)-based Medicare eligibility or entitlement + coverage under the Program (including coverage due to current active employment status, Eligible Former Employee status or COBRA)	First 30 months of Medicare eligibility or entitlement	Program	Medicare
	After 30 months of Medicare eligibility or entitlement	Medicare	Program

To receive maximum coverage for services that could be covered under Medicare Parts A or B, you must enroll in Medicare Parts A and B when you first become Medicare Eligible. Once you or your covered dependent become eligible for Medicare as your primary coverage, Benefits payable under the Program will automatically be calculated and paid as secondary to Medicare. The Program will not pay any portion of your expenses that would be payable by Medicare Parts A or B as your primary coverage if you were enrolled. Once you become eligible for Medicare as your primary coverage, Benefits payable under the Program will automatically be reduced by Benefits that would be payable for the same services under Medicare Parts A and B. This applies whether or not you enroll in Medicare Parts A and B. As a result, to receive maximum coverage for medical services, you must enroll in both Medicare Parts A and B once you are Medicare Eligible, and remain enrolled.

While in some cases the Eligibility and Enrollment Vendor, the Company or a Benefits Administrator may be aware of your pending eligibility for Medicare and the Eligibility and Enrollment Vendor may send you materials regarding enrolling, it is your responsibility to enroll in Medicare when you first become eligible for Medicare as your primary coverage and notify the Eligibility and Enrollment Vendor of your enrollment. This includes eligibility based on disability as well as age. See the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section for contact information.

What are the consequences of not enrolling in Medicare when you are eligible? Here's an example.

Mike is a Medicare Eligible Former Employee who is enrolled in a Program that has a $400 individual Annual Deductible and a $2,000 Annual Out-of-Pocket Maximum, and pays a Benefit of 90 percent once the Annual Deductible is met. The Medicare Part B deductible for the Service is $162, which counts toward his Program Annual Deductible.

Assume Mike has a covered emergency room visit and receives a bill for $5,000. He has not yet accumulated any expenses toward the Program Annual Deductible. Since Mike is enrolled in Medicare, here's what happens:

	Mike Pays	Medicare Pays	Program Pays
Medicare Part B deductible	$162		
Medicare Part B Coinsurance		$3,870.40 (80% of $4,838 = $3,870.40) ($5,000 expense – $162 deductible = $4,838)	
Difference between Program deductible and Medicare deductible	$238 ($400 Program deductible less $162 Medicare deductible)		
Program Coinsurance			$269.60 ($4,140 - $3,870.40 = $269.60) 90% of $4,600 = $4,140 ($5,000 – $162 – $238 = $4,600)
Participant balance	$460 ($5,000 – $162 – $3,870.40 – $238 – $269.60 = $460)		
TOTAL	$860.00	$3,870.40	$269.60

The Program calculates Benefits as if Mike enrolled in Medicare — even if he didn't do so. If, in fact, Mike didn't enroll, his out-of-pocket costs would be much higher:

	Mike Pays	Medicare Pays	Program Pays
Assumed Medicare Part B Coinsurance		$3,870.40 (80% of $4,838 = $3,870.40) ($5,000 expense – $162 deductible = $4,838)	
Program deductible	$400		

	Mike Pays	Medicare Pays	Program Pays
Program Coinsurance			$269.60 90% of $4,600 = $4,140 ($5,000 – $400 = $4,600) $4,140 - $3,870.40 = $269.60
Participant balance	$4,330.40 ($5,000 – $400 – $269.60 = $4,330.40)		
TOTAL	$4,730.40	$0	$269.60

Mike will pay $4,730.40, and the Program will pay $269.60. Note that the $3,870.40 that Medicare would have paid does not count toward meeting the Program Annual Out-of-Pocket Maximum.

Becoming Eligible for Medicare

If within the next six months you or a covered dependent will become Medicare Eligible, either due to age or disability, or are planning to leave your employment, call your medical benefits administrator at the toll-free number on your Program identification card and ask how Medicare eligibility will affect payment of your Program Benefits.

For information regarding your eligibility for Program coverage after you leave employment, call the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section for contact information.

Other Consequences of Not Enrolling in Medicare Part A and Part B

In addition to the impact on Program Benefits, failing to enroll in Medicare Parts A and B when eligible for Medicare as your primary coverage can also impact the cost of your Medicare coverage.

When your Program coverage becomes secondary to Medicare, it is important that you enroll in Medicare Part A and Part B or you could be required to pay more for your monthly Medicare Part B coverage in the future due to Medicare's late enrollment penalties.

For some people, enrollment in Medicare Parts A and B is automatic, but this is not always the case.

There generally is no monthly charge for Medicare Part A coverage; however, the federal government charges a monthly premium for Medicare Part B coverage. While you will have the option to opt out of Medicare Part B and avoid the premium, you should first determine the impact on your Program Benefits as well as your future Medicare Part B premium, when you do decide to enroll in Medicare.

If you are not automatically enrolled for Part A or Part B, you must enroll when you are first eligible or during a Medicare enrollment period. If you do not enroll during your initial Medicare enrollment period or you opt out of coverage, you may be subject to Medicare late enrollment

penalties. These late enrollment penalties do not apply if you are eligible for enrollment during a Medicare special enrollment period. See the **"Medicare Enrollment Periods and Late Enrollment Penalties"** section for more information about these penalties and periods.

Medicare Enrollment Periods and Late Enrollment Penalties

When you first become eligible for Medicare Part A, you have an initial enrollment period in which to take action regarding Medicare Part B. Unless you have coverage under a group health plan available through your or your Spouse's current active employment (or any family member's active employment if you are eligible for Medicare due to disability), a delay on your part in Medicare Part B enrollment may delay Medicare coverage and result in higher Medicare premiums when you do enroll. This late enrollment penalty is in addition to a reduction in coverage of Medicare Eligible expenses described in the **"Impact of Medicare Parts A and B on Program Benefits"** section. The timing and length of the initial enrollment period vary, depending on the basis of Medicare eligibility. See the **"More Information on Medicare"** section for assistance with Medicare questions.

If You Work Past the Age of 65

If you remain Actively at Work with the Company after age 65 and are eligible for Medicare Part A, the Program will provide your primary coverage, and Medicare coverage will be secondary for you and your covered dependents. You may elect Medicare as your primary coverage while you are still working. If you elect Medicare as your primary coverage while you are still working, you and your Eligible Dependents will not receive any Benefits from the Program.

If you are Medicare Eligible when you terminate employment and you are enrolled in both the Program and Medicare, Medicare will become your primary Medical coverage. If you were not enrolled in Medicare while you were an Active Employee, if you are Medicare Eligible when you terminate employment, Program coverage ceases to be your primary Medical coverage on the first day of the month following your Termination Date. If you were not enrolled in Medicare while you were an Active Employee, you must enroll in Medicare to have Medicare coverage. You may enroll in Medicare after your Termination Date during a Medicare special enrollment period. If your Medicare enrollment is not effective as of the first day of the month following your Termination Date, you will have a gap in coverage of the medical expenses that could have been covered by Medicare. See the **"Medicare Enrollment Periods and Late Enrollment Penalties"** section for effective dates of Medicare coverage. You and/or your Spouse should enroll in Medicare Parts A and B before terminating employment to ensure you have the maximum coverage of your Medicare Eligible expenses.

If You Become Disabled Before the Age of 65

If you are disabled before age 65 and become eligible for Social Security for 24 months based on that disability, you also become eligible for Medicare. If your Company-sponsored coverage is not based on your current employment, to obtain maximum coverage for your Medical expenses that could be covered by Medicare, you must enroll in Medicare Parts A and B as soon as you are eligible. See the **"Impact of Medicare Parts A and B on Program Benefits"** section for more information.

If Your Dependent Becomes Eligible for Medicare While You Are Actively at Work

If your covered Spouse/Partner or dependent becomes eligible for Medicare while you are receiving medical coverage from a Company-sponsored plan due to your current employment, the Program will provide your covered Spouse/Partner's or dependent's primary coverage.

If you are planning to retire or terminate employment and you will be eligible for continued coverage under the Program, your covered dependent should enroll in Medicare before you terminate employment to receive the maximum coverage for your Medicare-eligible expenses. When you have terminated employment but are receiving coverage under the Program for any reason, Medicare will become primary for any covered dependent who is eligible for Medicare. This will affect their Program coverage. See the **"Impact of Medicare Parts A and B on Program Benefits"** and **"Medicare Enrollment Periods and Late Enrollment Penalties"** sections for information. You must also notify the Eligibility and Enrollment Vendor of your covered dependent's Medicare eligibility to ensure that your contributions reflect your covered dependent's Medicare status.

If end-stage renal disease is the cause of Medicare eligibility for your covered dependent, see the **"If You Have End-Stage Renal Disease (ESRD)"** section for more information.

If You Have End-Stage Renal Disease (ESRD)

If you or your dependent has ESRD you may be eligible for Medicare before age 65 even if you are not disabled; for example, if you are receiving dialysis or require a kidney transplant.

If you are eligible for Medicare solely on the basis of ESRD and are enrolled in Program coverage, your Program coverage will be primary to Medicare for a period of 30 months, after which Medicare will provide primary coverage, even if you are Actively at Work. This is known as the coordination period.

Enrollment in Medicare Parts A and B is not automatic. You must actively enroll to have coverage. If you or your dependent do not enroll when eligible for Medicare as your primary coverage due to ESRD, Program Benefits will be affected in the same manner as if you became Medicare Primary due to age. See the **"Impact of Medicare Parts A and B on Program Benefits"** section for information.

If you have questions regarding Program coverage, contact the Benefits Administrator. If you have questions concerning Medicare coverage, refer to the *Medicare & You* handbook. If you or your dependent is eligible for Medicare, you will receive a copy of this handbook in the mail every year from Medicare.

If You Have Other Health Insurance

If you or your dependent is enrolled in Medicare and you have other health insurance (not individual insurance), it is important to determine whether Medicare is primary to either or both coverages. If Medicare is primary to both, Medicare will pay benefits first. After Medicare pays, the Program and the other health insurance plan will coordinate payment of benefits between them, based on the Coordination of Benefits (COB) rules. See the **"Coordination of Benefits"** and **"Impact of Medicare Parts A and B on Program Benefits"** sections for more information. If Medicare is primary to the Program (for example, you are a former Employee) but secondary to the other health coverage (for example, the coverage is through your current employer), the other coverage is primary and pays first, Medicare pays second and the Program third.

Be sure to notify your health care Providers about your other coverage to ensure that your bills are paid correctly and without delay.

Medicare Crossover Program

The Medicare crossover program is an electronic claim filing service set up by Medicare. This program electronically transmits Medicare Parts A and B Claims processed by Medicare to other group health insurance plans for processing. This eliminates the need for you to send a copy of the Provider's bill and the Explanation of Medicare Benefits (EOB) to your Benefits Administrator when filing a Claim for Benefits.

Once you elect Medicare crossover, you should allow 30-60 days from the set-up date for the crossover to start. Your EOB will indicate whether the Claim was electronically sent to the Benefits Administrator. Until this message appears, you must continue to file secondary Claims with the Benefits Administrator. Once the crossover starts, when Medicare processes a Claim, it is automatically forwarded electronically via the crossover program to the Benefits Administrator for processing. You should allow 30 days for Medicare to process the Claim and to electronically transmit the Claim to the Benefits Administrator for processing.

The Medicare crossover program links Medicare (all states; Washington, D.C.; Guam; Puerto Rico and U.S. Virgin Islands) to the Benefits Administrator.

IMPORTANT: If you do not want to participate in the Medicare crossover program, contact the Benefits Administrator to make your request. Changes in the Medicare crossover program are sent to Medicare, but may take 4-6 weeks before the change becomes effective. Retroactive requests are not available.

More Information on Medicare

If you have questions on how Medicare affects your Program Benefits, contact your Benefits Administrator at the toll-free number on your Program identification card. The Benefits Administrator is available to help you understand how your Medicare and Program Benefits are coordinated and how that affects your Program Benefits as a whole.

Assistance with Medicare Questions

If you need assistance in understanding Medicare's rules and regulations, you may contact Medicare toll-free at **800-MEDICARE** (**800-633-4227**) or at **medicare.gov**. You can refer to the *Medicare & You* handbook, which is available from Medicare. This handbook will help you understand Medicare.

You may also contact the Social Security Administration toll-free at **800-772-1213** or call your local Social Security Administration office. To find your local Social Security office, call **800-772-1213.** If you have access to the Internet, you may go to **ssa.gov**.

Qualified Status Changes Associated with Medicare

A gain or loss of Medicare Eligibility may affect your ability to change your Program coverage during the Plan Year.

To determine what your coverage options are due to a change in eligibility under Medicare:

- See the **"Contributions"** section for information on your ability to change your contribution election.
- See the **"Change-in-Status Events"** section for information on your ability to change your coverage election.

If you have further questions about a change in status associated with Medicare, please contact the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section for contact information.

Additional Medicare Contact Information

For More Information About Medicare Part D and This Program

If you have questions about how the Program coordinates Prescription Drug coverage with Medicare Part D, you may contact your Prescription Drug Benefits Administrator at the toll-free number on your identification card.

For More Information About Your Options Under Medicare Part D Prescription Drug Coverage

More detailed information about Medicare Part D Prescription Drug plans is available in the *Medicare & You* handbook. If you or your dependent is eligible for Medicare, you will receive a copy of this handbook in the mail every year from Medicare. You also may be contacted directly by Medicare Part D Prescription Drug plans.

For more information about Medicare Part D Prescription Drug coverage:

- Visit Medicare on the Internet at **medicare.gov**.
- Call your State Health Insurance Assistance Program (refer to the Helpful Resources & Tools section of your copy of the *Medicare & You* handbook for the telephone number) for personalized help.
- Call Medicare at **800-MEDICARE** (**800-633-4227**). TTY users should call **877-486-2048.**

WHEN COVERAGE ENDS

KEY POINTS

- *Coverage under the Program generally terminates on the last day of the month in which your employment with the Company ends.*
- *Coverage for an eligible Spouse/Partner or Child will end as of the last day of the month when the Spouse/Partner or Child no longer meets the requirements to be eligible under the Program.*
- *Under certain circumstances, coverage will be continued for a disabled Former Employee and a Disabled Child(ren).*
- *You and your eligible Spouse/Partner and Child(ren) may be able to continue coverage under COBRA in certain circumstances. In some circumstances, continued coverage will be provided after your death for some period of time.*

For Employees

Coverage under the Program will stop on the earliest of the following:

- The last day of the month in which your employment with the Company stops.
- The last day of the month in which you stop being an Eligible Employee of the Company.
- Your company is no longer a Participating Company in a Base Medical Program.
- The last day of a period for which contributions for the Cost of Coverage have been made in full, if the contributions for the next period are not made in full when due.
- The day the Program ends.

See the **"Extension of Coverage - COBRA"** section for information about what rights you may have to continue coverage.

The remainder of this section describes certain other situations where continued coverage may be available for your and/or your covered dependents.

For Covered Spouse/Partner and Child(ren)

Coverage for your Spouse/Partner and/or your Child(ren) stops when one of the following occurs:

- Your coverage stops.
- The last day of a period for which contributions for the Cost of Coverage have been made in full if the contributions for the next period are not made in full when due.

Coverage for a Spouse/Partner or Child will stop sooner if one of the following occurs:

- The individual becomes covered as an Employee of the Company under this Program.
- The individual is no longer eligible as defined in the section called **"Eligible Dependents."** (Coverage stops on the last day of the month in which the individual is no longer eligible.) Coverage ends for your Child(ren) at the end of the month in which they turn age 26.

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

A mentally or physically incapacitated Child's coverage under the Program will not stop due to age. It will continue as long as your dependent's coverage under the Program continues and the Child continues to meet the conditions described in the sections entitled **"Eligible Dependents"** and **"Certification of Disabled Dependents."**

If You Are Laid Off from Active Employment

If you terminate employment due to a force adjustment or layoff, extended coverage may be available for a limited period (as long as you continue to pay any applicable contribution) in accordance with the provisions of your severance program. If you are a Bargained Employee, you should refer to your collective bargaining agreement to determine the layoff benefits and what options are available for extended coverage. You may also contact the Eligibility and Enrollment Vendor for assistance with questions. See the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section for contact information.

If You Are Retiring from the Company

If you are retiring from the Company, you are eligible for Post-Employment Benefits under this Program if you are eligible to participate in your Base Medical Program. The eligibility requirements for Post-Employment Benefits are set forth in the SPD of your Base Medical Program. Refer to the **"Eligibility and Participation"** section of your Base Medical Program SPD for information on these eligibility requirements. You will receive a copy of the relevant Base Medical Program SPD after retiring from the Company if Post-Employment Benefits are not included in your Active Employee Base Medical Program SPD. If you do not receive your Base Medical Program SPD, contact the Eligibility and Enrollment Vendor to request a copy. See the **"Contact Information"** section for contact information. You also may be eligible to elect continuation coverage under COBRA in lieu of the Benefits available for Eligible Former Employees.

If Your Active Employment Ends by Reason of Disability

If you are disabled, you may be eligible to continue your (and your Eligible Dependents') coverage under the Program. See the section entitled **"Eligible Former Disabled Employees"** for a

description of the eligibility requirements applicable to totally disabled former Employees. You also may be eligible to elect continuation coverage under COBRA in lieu of the benefits available for Eligible Former Employees.

If Your Active Employment Ends by Reason of Your Death

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

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

Rescission of Coverage

A rescission of your coverage occurs if the coverage is cancelled retroactively except when the termination is for nonpayment. Your coverage can be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice or omission that constitutes fraud; or if you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact.

You will be provided with 30 calendar days' advance notice before your coverage is rescinded. You have the right to request an internal Appeal of a rescission of your coverage. Once the internal Appeal process is exhausted, you may have the additional right to request an independent external review. If you appeal a rescission in coverage, coverage will be maintained pending a resolution of the Appeal to the extent required by law. See the **"External Review"** section for information.

Dependent Coverage Upon Your Death

If you are enrolled in the Program as of your date of death, coverage for your enrolled dependent(s) will continue through the month in which your death occurs. Following your death, your Eligible Dependents who are enrolled as of your date of death will continue to be eligible for coverage under the Program under the same provisions that apply to their eligibility for survivor coverage under the Base Medical Program for which the surviving dependent is eligible. For more information regarding survivor coverage, refer to the SPD for your Base Medical Program. The election to continue coverage under this Program will be separate from any election made under your Base Medical Program. In addition, your surviving dependent(s) covered as of the date of your death will have the option to continue Program coverage through COBRA, as provided by federal law.

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

WHAT HAPPENS WHEN YOU LEAVE THE COMPANY

Active Program Coverage

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

Post-Employment Coverage

The Eligibility and Enrollment Vendor will send you information regarding Post-Employment Benefits and required monthly contributions. Contact the Eligibility and Enrollment Vendor if you do not receive this statement within two weeks of your employment Termination Date or if you would like to make any changes to your coverage. See the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section for more information.

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

Information concerning your post-employment eligibility, enrollment, benefits and contributions is included in this document. See the "Contents" to identify sections of this document containing this information.

Steps You Must Take to Ensure Coverage Continuation	
Within two weeks of your termination of employment	Look for information from the Eligibility and Enrollment Vendor
Within 31 days of receipt of information from the Eligibility and Enrollment Vendor	Enroll for Post-Employment Benefits available to Eligible Former Employees, if applicable
Within 31 days of enrollment for Post-Employment Benefits available to Eligible Former Employees	Submit payment for any required contributions
Within 65 days of your active Program coverage end date or receipt of COBRA Enrollment Notice, whichever is later	Elect COBRA coverage, if applicable
Within 45 days of receipt of a bill for COBRA coverage from the Eligibility and Enrollment Vendor	Submit payment for COBRA coverage
Ongoing	• Submit payments to the Eligibility and Enrollment Vendor by the payment due date • Promptly report your address change by calling the Pension Service Center. If you are not eligible to receive a pension plan benefit or have already received your entire pension plan benefit in a lump sum and are not eligible for a retiree death benefit from your pension plan, report your address change to the Eligibility and Enrollment Vendor. • Promptly report any Change-in-Status Events to the Eligibility and Enrollment Vendor. • See the **"Contact Information"** section for contact information.

Dependent Coverage

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

Annual Deductible Credit

When you terminate employment and begin your Post-Employment Benefits, you will receive credit for any amounts applied to your Annual Deductible as an Active Employee for the remainder of the calendar year in which you retire. Your Annual Deductible will begin anew on Jan. 1 of the following year.

Enrollment in Medicare

Eligibility for Medicare may affect your Benefits under the Program. Once you or your covered dependent is Medicare Eligible or will become eligible soon, it is important to understand how the Program works with Medicare and to notify the Eligibility and Enrollment Vendor. See the **"If You, Your Spouse/Partner or Your Dependent is Eligible For Medicare"** section for details.

COBRA Coverage in Lieu of Post-Employment Benefits

Upon your termination of employment from the Company, you will receive a COBRA enrollment notice from the Eligibility and Enrollment Vendor. As an alternative to Post-Employment Benefits for Eligible Former Employees, you may choose to continue your active Program coverage by electing COBRA coverage, as provided by federal law. Eligibility for COBRA coverage does not affect your eligibility for Post-Employment Benefits for Eligible Former Employees. However, if you elect COBRA coverage, you may not commence your Post-Employment Benefits for Eligible Former Employees until such time as COBRA coverage ends. Once COBRA coverage ends, you may enroll in Post-Employment Benefits for Eligible Former Employees. See the "Extension of Coverage – COBRA" section for more information.

EXTENSION OF COVERAGE - COBRA

KEY POINTS

- *COBRA continuation coverage is a temporary extension of group coverage that allows Program participants who have lost coverage due to a Qualifying Event to continue coverage for a period of time.*
- *Continuation coverage is the same coverage that the Program offers similarly situated Covered Persons who are currently receiving coverage under this Program.*
- *If you experience a Qualifying Event, you must notify the Eligibility and Enrollment Vendor no later than 60 days after the date the event occurs.*
- *If you experience a termination of employment or reduction in hours, the Company will notify the vendor on your behalf.*
- *Once the vendor is notified, you and your Spouse/Partner and Child(ren) will receive an election form and notice. If you or your Spouse/Partner and Child(ren) do not elect your COBRA continuation coverage within the 65-day election period, you will lose your right to elect continuation coverage.*

- *Generally, you will be required to pay the entire cost of COBRA continuation coverage. This cost is equal to 102 percent of the Company's cost of providing coverage to similarly situated Covered Persons under the Program.*
- *If you fail to pay the COBRA premium by the due date, your COBRA coverage will end and you will not be able to re-enroll.*

COBRA Continuation Coverage

Federal law requires most employers sponsoring group health plans to offer a temporary extension of coverage (called continuation coverage or COBRA coverage) in certain instances when coverage under the Program would otherwise end. This coverage is available to Employees/Eligible Former Employees and their families who are covered by the Program. **This section contains important information about your right to continue your health coverage through COBRA, as well as other health coverage options that may be available to you through (a) the Health Insurance Marketplace at HealthCare.gov or by calling 800-318-2596; (b) Medicaid; or (c) other group health plan coverage options (such as a spouse's plan) through what is called a special enrollment period.**

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, you may be able to get coverage that costs less than COBRA continuation coverage through the Health Insurance Marketplace. Please read the information contained in this section very carefully and keep it for your records. In this section, "you" is defined as the person or persons who lost coverage due to a Qualifying Event (the Qualified Beneficiary).

The Program is a group health plan subject to this law. You do not have to show that you are insurable to elect COBRA continuation coverage during the election period. However, you will have to pay the entire premium for your COBRA continuation coverage. At the end of the maximum coverage period (described below in this section), you may be allowed to enroll in an individual conversion health plan if it is available under the Program. You will be responsible for paying the premiums for this coverage as required by the individual conversion health plan.

This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive this coverage. This section provides only a summary of your COBRA continuation coverage rights. See the **"Your ERISA Rights"** section for contact information.

The COBRA Administrator is the Eligibility and Enrollment Vendor. See the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section for contact information.

In the Health Insurance Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

For more information about health insurance options available through the Health Insurance Marketplace, visit **HealthCare.gov**.

What Is COBRA Continuation Coverage?

COBRA continuation coverage provides a temporary extension of group health coverage. It is available when coverage would otherwise end because of a life event known as a Qualifying Event. Specific Qualifying Events are listed later in this section.

After a Qualifying Event occurs and any required notice is provided to the COBRA Administrator, COBRA continuation coverage must be offered to each person who is a Qualified Beneficiary. A Qualified Beneficiary is someone who will lose coverage under the Program because of a Qualifying Event. Only Qualified Beneficiaries may elect to continue their group health coverage under COBRA. Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Depending on the type of Qualifying Event, the following may be considered Qualifying Beneficiaries if they are covered under the Program on the day before the Qualifying Event occurs:

- Employees/Eligible Former Employees.
- Spouses/Partners of Employees/Eligible Former Employees.
- Dependent Child(ren) of Employees/Eligible Former Employees.

Certain newborns, newly adopted Child(ren) and alternate recipients under Qualified Medical Child Support Orders (QMCSOs) may also be Qualified Beneficiaries. This is discussed in more detail in the **"Child(ren) Born to or Placed for Adoption With the Covered Employee/Eligible Former Employee During COBRA Period"** section and the **"Alternate Recipients Under Qualified Medical Child Support Orders"** section.

COBRA continuation coverage is the same coverage that the Program gives to Covered Persons or beneficiaries who are currently participating in the Program and not receiving COBRA continuation coverage. Ordinarily, the COBRA continuation coverage will be the same coverage that you had on the day before the Qualifying Event occurred. But if coverage is changed for similarly situated Active Employees or Eligible Former Employees covered by the Program, or their Spouses/Partners or Child(ren), the COBRA continuation coverage generally will be changed in the same way for the Qualified Beneficiaries on COBRA at the same time.

IMPORTANT: If a COBRA Continuation Coverage participant is eligible for Medicare, Medicare coverage becomes primary to COBRA Continuation Coverage. See the **"If You, Your Spouse/Partner or Your Dependent Is Eligible for Medicare"** section for information.

As a COBRA continuation coverage participant, you will have the same rights under the Program during your COBRA continuation coverage period as other Covered Persons or beneficiaries covered under the Program, including Annual Enrollment and special enrollment rights.

You can find specific information describing the coverage to be continued under the Program elsewhere in this document and in the Plan document. For more information about your rights and obligations under the Program, you can get a copy of the Plan document by requesting it from the Plan Administrator as described in the **"Your ERISA Rights"** section.

Qualifying Events: When Is COBRA Continuation Coverage Available?

Employee

If you are an Employee of a Participating Company and are covered by the Program, you become a Qualified Beneficiary and have the right to elect COBRA continuation coverage if you lose your coverage under the Program due to one of the following Qualifying Events:

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

Spouse or Partner

If you are the Spouse/Partner of an Employee/Eligible Former Employee covered under the Program, you will become a Qualified Beneficiary and have the right to elect COBRA continuation coverage if you lose your coverage under the Program because of any of the following Qualifying Events:

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

IMPORTANT: If you are an Employee/Eligible Former Employee and you eliminate coverage for your Spouse/Partner in anticipation of a divorce or partnership dissolution, and the divorce or partnership dissolution occurs, then the actual divorce or partnership dissolution will be considered a Qualifying Event even though the ex-Spouse/Partner lost coverage earlier. If the ex-Spouse/Partner notifies the Eligibility and Enrollment Vendor within 60 days after the later of the divorce or partnership dissolution or the date coverage terminates under the Program and can establish that the coverage was eliminated earlier in anticipation of the divorce or partnership dissolution, then COBRA continuation coverage may be available for the period after the divorce or partnership dissolution.

Child(ren)

Your Child who is covered by the Program will become a Qualified Beneficiary and have the right to elect COBRA continuation coverage if he or she loses group health coverage under the Program because of any of the following Qualifying Events, or he or she is born to or placed with you for adoption during a period of COBRA continuation coverage and is enrolled in the Program:

- The Employee/Eligible Former Employee-parent dies.
- The Employee/Eligible Former Employee-parent's employment ends for reasons other than gross misconduct, or the Employee/Eligible Former Employee-parent's hours of employment with the Company are reduced.
- The parents' divorce or legal separation or the parents' partnership dissolves.
- The Employee/Eligible Former Employee-parent becomes entitled to Medicare Part A, Part B or both.
- The Child ceases to be eligible as a Child under the Program.

FMLA (Active Employee Only)

Special COBRA rules apply if you take FMLA leave and do not return to work at the end of the leave. Failure to return to work at the end of an FMLA leave may constitute a Qualifying Event (i.e., an Employee and the Employee's Spouse/Partner and Child(ren) may elect COBRA continuation coverage). In this case, you and your Spouse/Partner and Child(ren), if any, will be entitled to elect COBRA if both of the following conditions are met:

- They were covered under the Program on the day before the FMLA leave began (or became covered during the FMLA leave).
- They will lose coverage under the Program because you do not return to work at the end of the FMLA leave.

This means that you may be entitled to elect COBRA continuation coverage at the end of an FMLA leave for yourself and your dependents even if coverage under the Program ended during the leave.

If you are on a non-FMLA leave that provides coverage as if you were still an Active Employee, and your employment is terminated during the leave or your coverage ends at the end of the maximum coverage period specified for your leave, you (and your Spouse/Partner and Child(ren)) may elect COBRA continuation coverage to be effective as of the date your coverage would end if you are both:

- Covered under the Program on the day before beginning the leave of absence (LOA).
- Terminated from employment for any reason except gross misconduct or lost your coverage due to the expiration of the maximum coverage period.

If COBRA continuation coverage is elected, the maximum coverage period will begin with the date your coverage would otherwise have ended. See the **"How Long Does COBRA Continuation Coverage Last?"** section for more information.

Important Notice Obligations

You will only receive notification that COBRA continuation coverage is available to you if you notify the COBRA Administrator in a timely manner that a Qualifying Event has occurred.

Your Employer's Notice Obligations

When the Qualifying Event is one of the following, your Employer will notify the Eligibility and Enrollment Vendor within 30 days of the Qualifying Event:

- The end of your employment.
- The reduction of your hours of employment.
- AT&T Inc.'s or your Participating Company's commencement of a Chapter 11 proceeding in bankruptcy.

If your employment ends due to a termination that your Employer determines to have been a result of your gross misconduct, you will receive a notice indicating that you have been determined **not** to be eligible for continuation coverage and why. You may appeal this determination by filing an Appeal with the Eligibility and Enrollment Vendor within 60 days after your receipt of this determination. See the **"How to File a Claim for Eligibility"** section for more information on your right to appeal an adverse eligibility determination under this Program.

Your Notice Obligations

You are responsible for notifying the Eligibility and Enrollment Vendor if your Spouse/Partner or Child loses coverage under the Program as a result of divorce, legal separation, partnership dissolution, or your entitlement for Medicare (Part A or Part B or both), or the Child's loss of eligible status under the Program. Your Spouse/Partner or Child is responsible for notifying the Eligibility and Enrollment Vendor if your Spouse/Partner or Child loses coverage under the Program as a result of your death. You, your Spouse/Partner or Child *must* provide this notice, using the procedures specified in the **"COBRA Notice and Election Procedures"** section, no later than 60 days after the later of the date the event occurs or the date the Qualified Beneficiary loses or would lose coverage under the Program's terms. This is generally at the end of the month

in which the date on which the Qualifying Event occurs (see the **"When Coverage Ends"** section for more details).

If you, your Spouse/Partner or Child fails to provide this notice to the COBRA Administrator during this 60-day notice period (using the procedures specified), any Spouse/Partner or Child who loses coverage will not be offered the option to elect continuation coverage. If you, your Spouse/Partner or Child fails to provide this notice to the Eligibility and Enrollment Vendor and if any Claims are mistakenly paid for expenses incurred after the date coverage should have terminated, then you, your Spouse/Partner and Child will be required to reimburse the Program for any Claims paid.

If the COBRA Administrator is provided with timely notice of a Qualifying Event that has caused a loss of coverage for a Spouse/Partner or Child, then the COBRA Administrator will send a COBRA enrollment notice to the last known address of the individual who has lost coverage. The COBRA Administrator will also notify you (the Employee/Eligible Former Employee), your Spouse/Partner and Child of the right to elect continuation coverage after the administrator receives notice of either of the following events that results in a loss of coverage:

- Employee's termination of employment for any reason (other than for gross misconduct)
- Reduction in the Employee's hours

COBRA Notice and Election Procedures

All COBRA notices must be provided to the Eligibility and Enrollment Vendor within the time frames and methods specified in this section.

Important COBRA Notice and Election Procedures

You must provide all required notices (or make your COBRA election) no later than the last day of the required notice period (or election period). You can do this by placing a telephone call to the COBRA Administrator at the telephone number in the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section of this SPD or subsequent summaries of material modifications. You must speak to a service associate at the time of the call. Written or electronic communications or calls to other telephone numbers will not meet your obligation to provide this notice. (If you are unable to use a telephone because of deafness, the COBRA Administrator has TTY telephone service available.)

When you call to provide notice or elect coverage, you must provide the name and address of the Employee/Eligible Former Employee covered under the Program and the name(s) and address(es) of the Qualified Beneficiary(ies) affected. If your notice concerns a Qualifying Event, you also must include the name of the Qualifying Event or second Qualifying Event, if applicable, as well as the date the event(s) happened. If your notice concerns the disability of a Qualified Beneficiary, you also must include the name of the disabled Qualified Beneficiary, the date when the Qualified Beneficiary became disabled and the date the Social Security Administration made its determination. You may be required to provide documentation to support eligibility.

Electing COBRA Continuation Coverage

Once you inform the Eligibility and Enrollment Vendor that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each Qualified Beneficiary. If you elect COBRA continuation coverage in a timely fashion, COBRA continuation coverage will begin on the date that the Program coverage would otherwise have been lost.

In order to elect COBRA continuation coverage (if you are entitled to do so), you and/or your Spouse/Partner and Child(ren) must complete and return the form within 65 days after the later of:

- The date you and/or your dependents lose coverage; or
- The date you and/or your covered dependents are notified of your right to continue coverage (the date on the COBRA enrollment notice).

If you or your Spouse/Partner and Child(ren) do not elect continuation coverage within this 65-day election period using the procedure described in the "COBRA Notice and Election Procedures" section above, you will lose your right to elect continuation coverage.
However, as described in the **"Surviving Dependent Coverage"** section, when you or a Child is eligible for extended coverage during a leave of absence or after termination of employment and the extended coverage runs concurrently with COBRA continuation coverage, you will automatically be enrolled in COBRA continuation coverage for the duration of your eligibility for extended coverage. At the end of your extended coverage, you may continue COBRA

continuation coverage for the remainder of your eligible period (if any), by paying the required COBRA premiums. See the **"Surviving Dependent Coverage"** section for more information.

If you reject COBRA continuation coverage during the election period, you may change that decision and enroll anytime until the end of the election period, using the required election procedure.

In most cases, a single COBRA election form and notice will be provided to the Employee/Eligible Former Employee and any eligible Spouse/Partner and Child(ren) or, in the case of an election provided only to the Spouse/Partner and Child(ren), a single election form and notice will be provided to the Spouse/Partner. However, each Qualified Beneficiary has an independent right to elect continuation coverage. For example, both you and your Spouse/Partner may elect continuation coverage, or only one of you may choose to elect continuation coverage. In addition, each eligible Child may elect coverage, even if one or both of you do not. Parents may elect to continue coverage on behalf of their Child(ren).

Even if you have other health coverage or are enrolled in Medicare benefits on or before the date COBRA is elected, you are entitled to elect COBRA continuation coverage. However, as discussed below, a Qualified Beneficiary's eligibility for COBRA continuation coverage will end if, **after** electing COBRA, he or she becomes covered under another employer-sponsored group health plan or program (after any pre-existing condition exclusion in that other plan ends) or becomes enrolled in Medicare. If this occurs, the other Qualified Beneficiaries may still elect COBRA continuation coverage.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Also, in certain circumstances, the Program provides Company Extended Coverage (CEC) and may share in the cost of that coverage as described in the **"When Coverage Ends"** section.

Paying for COBRA Continuation Coverage

Generally, each Qualified Beneficiary may be required to pay the entire cost of COBRA continuation coverage. The amount may not exceed 102 percent of the cost to the group health plan (including both Employee/Eligible Former Employee and Employer contributions) for coverage of a similarly situated Covered Person or beneficiary who is not receiving COBRA continuation coverage (or, in the case of an extension of COBRA continuation coverage due to a disability, 150 percent). Your election notice from the Eligibility and Enrollment Vendor will include the cost of COBRA continuation coverage. In some circumstances, when you or your dependents are receiving Company Extended Coverage, the Company will make contributions toward the applicable COBRA premium. See the **"Surviving Dependent Coverage"** section for more information. The amount of your COBRA premium may change from time to time during your period of COBRA coverage, for example, upon annual changes in the cost of group health plan coverage or if you elect changes in your coverage. You will be notified of any COBRA premium changes.

When you elect COBRA, you will receive an initial bill from the Eligibility and Enrollment Vendor. You must make your first payment for COBRA continuation coverage no later than 60 days after the date of your election. The amount of your required first payment will be stated on your initial bill. It will include the cost of COBRA continuation coverage from the date coverage begins through the end of the month following the month in which the bill is issued. Claims for payment of Benefits under the Program may not be processed and paid until you have elected COBRA continuation coverage and made the first payment. **Any Benefits paid during this period will be retroactively canceled if you do not elect COBRA or if coverage is canceled because you do not make timely payments.** Bills for subsequent coverage will be issued monthly.

How Long Does COBRA Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. The maximum duration for COBRA continuation coverage is described in this section. COBRA continuation coverage can end before the end of the maximum coverage period for several reasons that are described in the **"Termination of COBRA Continuation Coverage Before the End of the Maximum Coverage Period"** section.

COBRA Events	
Event	**Length of Coverage**
If you leave the Company (for reasons other than gross misconduct)	Coverage for you and your dependents may last for up to 18 months*
If coverage stops because you no longer meet the eligibility requirements	Coverage for you and your dependents may last for up to 18 months*
If coverage stops because you are on a military leave	Coverage for you and your dependents may last for up to 24 months
If you die	Coverage for your dependents may last for up to 36 months
If you and your Spouse divorce or become legally separated or Partner requirements are no longer met	Coverage for your Spouse, Partner and/or Eligible Dependent Child(ren) may last for up to 36 months**
If a Child loses dependent status	Coverage for that dependent Child may last for up to 36 months**
If you are laid off	Coverage for you and your dependents may last for up to 18 months*
If you fail to return to work at the end of your family medical leave	Coverage for you and your dependents may last for up to 18 months*

An 18-month continuation period may be extended. For more information, see the **"18 Months (Extended Under Certain Circumstances)" section below.*

***If you do not call or provide written notice within 60 days after the event, COBRA or insurance continuation rights will be lost for that event.*

18 Months (Extended Under Certain Circumstances)

When the Qualifying Event is the end of employment or reduction in hours, COBRA continuation coverage for you, your Spouse/Partner or Child, as applicable, can last for up to 18 months from

the date of termination of employment or reduction in hours. There are three ways this 18-month period of COBRA continuation coverage can be extended:

- **Disability Extension.** An 11-month extension of coverage may be available if any of the Qualified Beneficiaries in your family become disabled. All of the Qualified Beneficiaries who have elected COBRA continuation coverage will be entitled to the 11-month disability extension if one of them is qualified under this rule. The Social Security Administration (SSA) must formally determine under Title II (Old Age, Survivors and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the Qualified Beneficiary was disabled at some time prior to or during the first 60 days of COBRA continuation coverage. You must notify the Eligibility and Enrollment Vendor of this fact, using the notification procedure identified in the **"COBRA Notice and Election Procedures"** section. **You must provide this notification within 60 days after the later of the SSA's determination or the beginning of COBRA continuation coverage and before the end of the first 18 months of COBRA continuation coverage.** The disabled individual does not need to enroll for coverage in order for the other Qualified Beneficiary family members to be covered. In the event the disabled party does not continue COBRA, only 102 percent of the premium may be charged for months 19 through 29. If the disabled party does continue COBRA, 150 percent of the premium will be charged for months 19 through 29. **If notice of the disability is not provided within the required period using the required procedure, there will be no disability extension of COBRA continuation coverage for any Qualified Beneficiary.** If the Qualified Beneficiary is determined by the SSA to no longer be disabled, you must notify the COBRA Administrator within 30 days after the SSA's determination. This is accomplished by using the notice procedure identified in the **"COBRA Notice and Election Procedures"** section. COBRA continuation coverage for all Qualified Beneficiaries will terminate as of the first day of the month that is more than 30 days after the SSA's determination that the Qualified Beneficiary is no longer disabled, provided it is after the initial 18-month period. The Program reserves the right to retroactively cancel COBRA coverage and will require reimbursement of all Benefits paid after the first day of the month that is more than 30 days after the SSA's determination.

- **Second Qualifying Event.** An extension of up to 18 months of COBRA continuation coverage will be available to Spouses/Partners and Child(ren) who elect COBRA continuation coverage if a second Qualifying Event occurs during the 18-month or 29-month coverage period following an Employee's termination of employment or reduction in hours. The maximum amount of continuation coverage available when a second Qualifying Event occurs is 36 months. The second Qualifying Event must be an event that would provide a 36-month continuation coverage period, such as the death of a covered Employee/Eligible Former Employee or a Child ceasing to be eligible for coverage. For the extension period to apply, notice of the second Qualifying Event must be provided to the Eligibility and Enrollment Vendor no later than the 60th day after the later of the date of the second Qualifying Event or the date coverage would otherwise end, using the notification procedure specified in the **"COBRA Notice and Election Procedures"** section.

If the notice procedure is not followed or notice is not given within the required period, then there will be no extension of COBRA continuation coverage due to a second Qualifying Event.

- **Medicare extension for Spouse/Partner and Child(ren).** If a Qualifying Event that is a termination of employment or a reduction of hours occurs within 18 months after the Employee becomes entitled to Medicare, then the maximum coverage period for the Spouse/Partner and eligible Child(ren) will end three years after the date the Employee became entitled to Medicare (but the covered Employee's maximum coverage period will remain 18 months).

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

COBRA continuation coverage for the Employee/Eligible Former Employee, Spouse/Partner and/or Child(ren) will automatically terminate when any one of the following six events occurs before the end of the maximum coverage period:

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

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

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

A Child born to, adopted by or placed for adoption with you during a period of COBRA continuation coverage is considered to be a Qualified Beneficiary if you are a Qualified Beneficiary and have elected continuation coverage for yourself. The Child's COBRA continuation coverage begins when the Child is enrolled in the Program, whether through special enrollment, Prospective Enrollment or Annual Enrollment. It lasts for as long as COBRA continuation coverage lasts for your other family members. To be enrolled in the Program, the Child must satisfy the otherwise-applicable eligibility requirements (for example, age).

Annual Enrollment Rights and HIPAA Special Enrollment Rights

If you elect COBRA, you will be given the same opportunity available to similarly situated Active Employees to change your coverage options or to add or eliminate coverage for dependents at Annual Enrollment. In addition, the special enrollment rights provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA continuation coverage certain rights to add coverage for Eligible Dependents if that person acquires a new dependent (through marriage, birth, adoption or placement for adoption) or if an Eligible Dependent declines coverage because of other coverage and later loses that coverage as a result of certain qualifying reasons. Except for certain Child(ren) described in the **"Child(ren) Born to or Placed for Adoption With the Covered Employee/Eligible Former Employee During COBRA Period"** section above, dependents who are enrolled in a special enrollment or Annual Enrollment do not become Qualified Beneficiaries. Their coverage will end at the same time that coverage ends for the person who elected COBRA and later added them as dependents.

Alternate Recipients Under Qualified Medical Child Support Orders

If you have a Child that is receiving Benefits under the Program pursuant to a Qualified Medical Child Support Order received by the Eligibility and Enrollment Vendor during your (the Employee's/Eligible Former Employee's) period of employment with the Company, he or she is entitled to the same rights under COBRA as an eligible Child of yours, regardless of whether that Child would otherwise be considered eligible (other than on account of age).

When You Must Notify Us 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. See the *Active Employee Address and Telephone Number Changes* table in the **"Information Changes and Other Common Resources"** section for information on how to keep your address current while you are an Active Employee. For former Employees, if your address changes, you must promptly report your address change. See the *Pension Service Center* table in the **"Information Changes and Other Common Resources"** section for information on whom to contact to report your address change. If you are not eligible to receive a pension plan benefit, or have already received your entire pension plan benefit in a lump sum and are not eligible for an Eligible Former Employee death benefit from your pension plan, contact the Eligibility and Enrollment Vendor to update

your home address. See the *Pension Service Center* table in the **"Contact Information"** section for contact information.

Also, for all participants, if your marital status changes or if a covered Child ceases to be eligible for coverage under the Program terms, you, your Spouse/Partner or Child must promptly notify the Eligibility and Enrollment Vendor to remove that person from your coverage. You also must provide the appropriate mailing address for mailing your Spouse's/Partner's or Child's COBRA notice. Such notification is necessary to protect COBRA rights for your Spouse/Partner and Child(ren). In addition, you must notify us if a disabled Employee or family member is determined to no longer be disabled. Once your dependent is enrolled in COBRA, he or she must promptly report any address changes. See the **"Information Changes and Other Common Resources"** section for information on whom to contact to report your address change.

For More Information on COBRA

Contact the Eligibility and Enrollment Vendor if you, your Spouse/ Partner or Child(ren) have any questions about this section or COBRA. You also may contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and telephone numbers of regional and district EBSA offices are available online at **dol.gov/ebsa** (EBSA's website).

For contact information for the COBRA Administrator, see the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section. For contact information for the Plan Administrator, see the *Other Plan Information* table in the **"Plan Information"** section.

PLAN ADMINISTRATION

KEY POINTS

- *This section contains important information about how the Plan, including this component Program, is administered.*
- *The Plan is administered by the Plan Administrator, who has full authority and discretion to administer, interpret and enforce the terms of the Plan, and who may delegate that authority and discretion to other entities or individuals.*
- *General information about the Plan and its administrators can be found here.*
- *The Plan Sponsor has the right to amend or terminate the Plan at any time.*
- *You must exhaust your Claim and Appeal rights under the Program before bringing a court action for Benefits.*

- *There are time limits for filing an action for Benefits under the Program.*
- *It is very important that you keep the Plan informed of any changes in your mailing address, contact information and family status changes.*

Plan Administrator

The Plan Administrator is the named fiduciary of the Plan, including all component programs, and has the power and duty to do all things necessary to carry out the terms of the Plan. The Plan Administrator has the sole and absolute discretion to interpret the provisions of the Plan, to resolve any ambiguity in the terms of the Plan, to make findings of fact, to determine the rights and status of you and others under the Plan, to decide and resolve disputes under the Plan and to delegate all or a part of this discretion to third parties. To the extent permitted by law, such interpretations, findings, determinations and decisions are final, conclusive and binding on all persons for all purposes of the Plan.

If the Plan Administrator fails to strictly enforce any provision of the Plan in a given instance, it will not be construed as a waiver of that provision in any later case. The Plan Administrator reserves the right to strictly enforce each and every Plan provision at any time without regard to its prior actions and decisions, the similarity of the circumstances or the number of occurrences.

The Plan Administrator has the authority and discretion to settle or compromise any Claim against the Plan based on the likelihood of a successful outcome as compared with the cost of contesting such Claim. The Plan Administrator also has the authority and discretion to pursue, relinquish or settle any Claim of the Plan against any person. No person may rely on the actions of the Plan Administrator regarding Claims by or against the Plan in connection with any subsequent matter.

Coverage under the Program will be determined solely according to the terms of the Program and the applicable facts. Only the duly authorized acts of the Plan Administrator are valid under the Program. You may not rely on any oral statement of any person regarding the Program and may not rely on any written statement of any person unless that person is authorized to provide the statement by the Plan Administrator and **one** of the following applies:

- The statement is an official decision of the Plan Administrator to an individual whose eligibility for enrollment, participation or payment of Benefits under the Program is in dispute.
- The statement constitutes a duly authorized interpretation of an ambiguous or doubtful term of the Program.
- The statement constitutes the issuance of a rule, regulation or policy under the Program and applies to all participants.
- The statement communicates an amendment to the Program and applies to all participants.

Administration

The Plan Administrator has contracted with third parties for certain functions including, but not limited to, the processing of Benefits and Claims. In carrying out these functions, these third-party

administrators have been delegated responsibility and discretion for interpreting the provisions of the Program, making findings of fact, determining the rights and status of you and others under the Program and deciding disputes under the Program. The *Other Plan Information* table indicates the functions performed by a third-party contractor, as well as the name, address and telephone number of each contractor.

Nondiscrimination in Benefits

The federal tax and other laws prohibit discrimination in favor of highly compensated participants or key Employees with regard to some of the Benefits offered under the Program. The Plan Administrator may restrict the amount of nontaxable Benefits provided to key Employees or highly compensated participants and their covered dependents so that these nondiscrimination requirements are satisfied.

Benefits provided under the Program will not discriminate in any of the following ways:

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

Amendment or Termination of the Plan or Program

AT&T Inc. intends to continue the Program described within this SPD, but reserves the right to amend or terminate the Program and eliminate Benefits under the Program at any time.

In addition, your Participating Company (or the Participating Company from which you terminated employment) reserves the right to terminate its participation in the Program. In any such event, you and other Program participants may not be eligible to receive Benefits as described in this SPD and you may lose Benefits coverage. However, no amendment or termination of the Program will diminish or eliminate any Claim for any Benefits to which you may have become entitled prior to the termination or amendment, unless the termination or amendment is necessary for the Program to comply with the law.

Although no Program amendment or termination will affect your right to any Benefits to which you are already entitled, this does not mean that you or any other Active or Eligible Former Employee will acquire a lifetime right to any Benefits under the Program, or to eligibility for coverage under the Program or to the continuation of the Program merely by reason of the fact that the Program was in effect during your employment or at the time you received Benefits under the Program or at any time thereafter.

Limitation of Rights

Participation in the Program does not give you a right to remain employed with your Participating Company or any other AT&T-affiliated Company.

Legal Action Against the Plan

If you wish to bring any legal action concerning your right to participate in the Plan or your right to receive any Benefits under the Plan, you must first go through the claims and appeal process described in this SPD. You may not bring any legal action against the Plan for any denied Claim until you have completed the claims and appeal process, except as provided in the **"Claims and**

Appeal Procedures" section of this SPD. Legal action involving a denied Claim for Benefits under the Plan must be filed directly against the Plan. The Plan Administrator is the Plan's agent for receipt of legal process in legal actions for Benefits under the Plan, as provided in the *Other Plan Information* table below. In order to bring an action against the Plan for Benefits, you must bring the action no later than five years following the date your Claim was denied.

You Must Notify Us of Address Changes, Dependent Status Changes and Disability Status Changes

In order to protect your rights under the Program and those of your family members, it is vitally important that you keep the Plan Administrator informed of any changes in your mailing address and those of any covered family members who do not live with you. While you are an Active Employee, your address in the system of the Eligibility and Enrollment Vendor will be used to send important Program information to you and your covered dependents, including COBRA notices, should your coverage end because of a Qualifying Event such as termination of employment or reduction of hours. See the *Active Employee Address and Telephone Number Changes* table in the **"Information Changes and Other Common Resources"** section for information on how to keep your address current while you are an Active Employee.

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

Where eligibility of a dependent is lost through death, divorce or other loss of eligibility, you, your Spouse/Partner or your dependent must promptly notify the Eligibility and Enrollment Vendor to remove that dependent from your coverage and, if applicable, provide the appropriate mailing address for mailing the affected dependent's COBRA notice. Such notification is necessary to reflect the change in the applicable premiums as well as to protect COBRA rights for your Spouse/Partner or dependent Child who is affected by the loss of coverage. Failure to keep the Eligibility and Enrollment Vendor advised of changes in your marital status, dependents, mailing address and contact information may result in the permanent loss of significant Benefits rights. Also review and update your beneficiary designations on file as necessary. See the Pension Service Center table in the **"Contact Information"** section for more information.

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

Plan Information

This section provides you with important information about the Plan. The following *Other Plan Information* table provides you important administrative details including:

- **Plan Administrative Information.** The Plan can be identified by a specific name and identification number that is on file with the U.S. Department of Labor. The *Other Plan Information* table provides this official Plan name, the name of the Program addressed in this SPD, the Plan identification number, Plan Year and certain details on Plan records.
- **Important Entities and Addresses.** Situations may occur that require you to contact (in writing or by telephone) a specific administrative entity related to the Plan. Details throughout this SPD explain instances when the entities identified in the *Other Plan Information* table are important to a process related to the Plan.
- **Plan Funding.** The *Other Plan Information* table provides details on how the Plan funds the Cost of Coverage.
- **Collective Bargaining Procedures (if applicable).** Certain Programs contain provisions maintained pursuant to a collective bargaining agreement. The *Other Plan Information* table provides information on how to obtain copies of the collective bargaining agreement.

The text immediately after the table provides information regarding the arrangements by the Plan Administrator with various third parties to provide Services to the Plan, including Benefits Administration and eligibility and enrollment functions. Please see the applicable *Benefits Administrator* table in the **"Contact Information"** section for contact information for these third parties.

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

Other Plan Information	
Program Name	AT&T CarePlus - A Supplemental Benefit Program
Plan Number	603
Plan Sponsor/Employer Identification Number (EIN)	AT&T Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333** EIN 43-1301883
Plan Administrator	AT&T Services, Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333**
Name and Address of Employer	Affiliates of AT&T Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333**
Type of Administration	Plan administration is retained by the Plan Administrator. However, the Plan Administrator has contracted with third parties for certain functions associated with the Program as follows • The Plan Administrator administers Claims and Appeals for Benefits under the Program on a contract basis with the Benefits Administrator, see the **"Contact Information"** section for more information. The Benefits Administrator has full discretionary authority to interpret Plan provisions as they apply to entitlement for benefit. • The Plan Administrator administers enrollment, eligibility, monthly contribution and COBRA under the Program provisions, including the determination of initial Claims for eligibility, on a contract basis with the Eligibility and Enrollment Vendor, see the **"Contact Information"** section for more information. • The AT&T Eligibility and Enrollment Appeals Committee (EEAC) determines final Appeals from the denial of eligibility. The EEAC has full discretionary authority to interpret Plan provisions as they apply to eligibility for benefits. See the **"Contact Information"** section for the address to write to.
Agent for Service of Legal Process	Process in legal actions in which the Plan is a party should be served on the Plan at the following Address CT Corporation System 1999 Bryan Street, Suite 900 Dallas, TX 75201-3136 Service of legal process also may be made upon a Trustee.

Other Plan Information	
Type of Plan	The Plan is a supplemental benefit plan.
Plan Year	Jan. 1 through Dec. 31
Trustee	AT&T Voluntary Employee Beneficiary Association Trust Frost National Bank 100 W. Houston Street San Antonio, TX 78299
Plan Funding and Contributions	Covered Employees pay the cost of providing coverage under the Program. Certain costs of the Program may be paid through the AT&T Voluntary Employee Beneficiary Association Trust, established exclusively for purposes of providing Benefits through the Program. Program Benefits are not paid for by insurance.
Plan Records	All Program records are kept on a calendar year basis beginning on Jan. 1 and ending on Dec. 31.
Collectively Bargained Plan	With respect to certain Eligible Employees, the Program is maintained pursuant to one or more collective bargaining agreements. A copy of the collective bargaining agreement may be obtained by participants and beneficiaries whose rights are governed by such collective bargaining agreement upon written request to the Plan Administrator and also is available for examination by participants and beneficiaries as specified under Department of Labor Regulations Section 2520.104b-30.

Type of Administration and Payment of Benefits

Plan administration is retained by the Plan Administrator. However, the Plan Administrator has contracted with third parties for certain functions associated with the Program, as described below. Benefits under the Program are paid through funds made available for this purpose through the trust listed in the Plan Funding row in the *Other Plan Information* table above. The Benefits Administrator below does not insure Benefits provided under the Program.

Benefits Administrator

The Plan Administrator administers claims and appeals for Benefits under this Program on a contract basis with UnitedHealthcare. The Plan Administrator has discretionary authority to interpret the provisions of the Program and to determine entitlement to Benefits. The Benefits Administrator has full discretionary authority to interpret the provisions of the Program and to determine Benefits available under the Program.

Eligibility and Enrollment Vendor

The Plan Administrator manages enrollment, eligibility, monthly contributions and COBRA under the Program provisions, including the determination of initial Claims for Eligibility, on a contract basis with Alight Solutions (AT&T Benefits Center). The AT&T Eligibility and Enrollment Appeals Committee (EEAC) determines final Appeals from the denial of Claims for Eligibility. The EEAC has full discretionary authority to interpret the provisions of the Program and to determine, eligibility for Program Benefits and monthly contribution amounts.

NOTE: Contact information for the above Benefits Administrators and the Eligibility and Enrollment Vendor is located in the **"Contact Information"** section.

Unclaimed Benefits

If any amount becomes payable under the Program and that amount is not claimed or any check issued pursuant to the Program remains uncashed for one year from the date the check is issued, the amount is forfeited and ceases to be a liability of the Program; provided that the Plan Administrator exercised reasonable efforts in attempting to make such payments.

Non-alienation of Benefits

No benefit, right, or interest of any Participant or any Beneficiary under the Plan or any Program shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law or as otherwise provided in a Program.

No Participant or Beneficiary shall have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, commute, or anticipate any benefit payment under the Plan to a third party, and such payment shall not be subject to any legal process to levy, execution upon, or attachment or garnishment proceedings against for the payment of any claims. Benefit payments under the Plan may not be assigned, transferred, or in any way made over to another party by a Participant or Beneficiary. Nothing contained in this Plan shall be construed to make the Plan or the Plan Sponsor liable to any third party to whom a Participant or Beneficiary may be liable for health care, treatment, or services. The Plan Administrator may pay a benefit directly to a provider of health care, treatment, or services instead of the Participant or Beneficiary when this is done, such payment shall not be construed as an assignment or to make the Plan or the Plan Sponsor liable to any third party to whom a Participant or Beneficiary may be liable for health care, treatment, or services. However, the Plan reserves the right to not honor any assignment to any third party, including but not limited to, any Provider. The foregoing does not preclude any assignment of payment to Medicaid or to the extent required by law. The Plan will not honor claims for benefits brought by a third-party; such third-party shall not have standing to bring any such claim either independently, as a Participant or Beneficiary.

YOUR ERISA RIGHTS

ERISA RIGHTS OF PARTICIPANTS AND BENEFICIARIES

KEY POINTS

- *ERISA is a federal law that provides certain rights and protections to all participants.*
- *The persons who are responsible for the operation of the Plan have a duty to act prudently and in the interest of the Plan and their beneficiaries.*
- *No one may fire or discriminate against you for exercising your rights under ERISA.*

Your ERISA Rights

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

Receive information about your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including collective bargaining agreements, insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the EBSA.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies. Your written request must be directed to:

AT&T Services, Inc.
Attn: Plan Documents
P.O. Box 132160
Dallas, TX 75313-2160

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report (SAR).

Continue Group Health Plan Coverage

- You may have the right to continue health care coverage for yourself, Spouse/Partner or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event (see the **"Extension of Coverage - COBRA"** section). You, your Spouse/Partner or your

covered dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

- If you had creditable coverage from another group health plan or health insurance issuer before you became a participant in this Plan, you should be provided a certificate of creditable coverage, free of charge, from the other plan when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage or when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage under this Plan.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a Claim for Benefits that is denied or ignored, in whole or in part, and you have exhausted all applicable administrative remedies under the Plan, you may file suit in state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your Claim is frivolous.

Assistance With Your Questions

If you have questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in

obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or at

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

WHAT HAPPENS WHEN BENEFITS ADMINISTRATORS CHANGE

Certain administrative procedures and medical policies may change when a Benefits Administrator for the Company Self-Insured Option changes. If a new Benefits Administrator denies coverage for a Service that was determined to be eligible for coverage under the Company Self-Insured Option by the former Benefits Administrator, unless the decision by the prior Benefits Administrator is determined to have been a mistake, the Company Self-Insured Option will cover such Service for such Covered Person for a period of 12 months from the date the new Benefits Administrator assumed its responsibilities. However, this is the case only as long as the facts applicable to the Covered Person or relevant Program provisions have not materially changed since the prior Benefits Administrator made its determination. For purposes of this provision, *materially changed* means a change in the Service or supply, or terms of the Company Self-Insured Option such that the new Benefits Administrator determines, in its sole discretion, that as a result of the change, the Service would not be covered under the Company Self-Insured Option.

If you believe you have been denied coverage for a Service by a new Benefits Administrator that was approved by the prior Benefits Administrator and there has not been a material change as described above, contact the new Benefits Administrator and let them know that you may have a situation that is covered by this transition provision and ask them to please review your Claim accordingly.

RIGHT OF RECOVERY AND SUBROGATION

RIGHT OF RECOVERY AND SUBROGATION

KEY POINTS

- *In this section, the term you includes your covered family members or dependents and also includes any trust or special needs trust established to receive monies recovered on account of your Injury.*
- *The Program will pay Benefits for you, but will have the right to recover those Benefit payments from the party who caused the Injury or from an insurance policy.*
- *You have an obligation to cooperate with the Program's exercise of its rights under this section.*
- *If the Program pays Benefits that should have been paid by another or pays excessive Benefits, the Program will have a right to recover the excess payment.*

This section applies if you or your covered family members are injured, suffer an Illness or are disabled as a result of the negligent or wrongful act or omission of another.

Summary of the Program's Right of Recovery

If you recover any amount for your Injury, Illness or disability by way of a settlement or a judgment in or out of a court of law, the Program must be reimbursed out of the recovery for the amounts paid by the Program, up to the full amount you have recovered, without any reduction for legal fees or costs and without regard to whether you have been made whole by the recovery. The Program's right of reimbursement shall have the status of an equitable lien against your recovery.

It is the intent of this Program that you should recover only one payment for any cost that is covered under the Program. If you suffer an Injury, Illness or disability for which another may be responsible or may have a financial or insurance obligation, the Program will be reimbursed from any recovery you may obtain, to the extent of the Benefits paid by the Program. For example, if you are injured by another person and obtain a recovery from the other person's insurance or from your own uninsured or underinsured motorist coverage, then you must reimburse the Program for the medical expenses the Program paid for that Injury.

Under this section, the term recovery means any and all sums of money and/or any promise to pay money in the future, received by you from the person who caused the Injury or Illness, or from any other source (such as your or their other insurance coverage, uninsured, underinsured, homeowners or umbrella insurance policies). Recovery includes payments no matter how characterized, including but not limited to sums paid or promised as compensation for actual medical expenses, pain and suffering, aggravation, wrongful death, loss of consortium, punitive or

exemplary damages, attorneys' fees, costs, expenses or any other compensatory damages. Recovery may be obtained by way of judgment, settlement, arbitration, mediation or otherwise. The Program shall have an equitable lien on any recovery, and the Program's right to recovery shall not be reduced, even if you receive less in recovery than the full amount of damages claimed or suffered by you, unless the Program agrees to a reduction. The amount of money to be recovered by the Program shall not be reduced by any legal fees or costs that you incur in connection with obtaining a recovery unless the Program agrees to such reduction.

If you decline to pursue a recovery, the Program is subrogated to your rights and shall succeed to all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any Services and Benefits the Plan pays on your behalf relating to any Illness, Injury or disability caused by any third party. This means the Program can step into your shoes and possess your right to pursue a recovery to the extent of the Benefits paid (and to be paid) for the Injury. The Program has the option to bring suit against or otherwise make a claim to collect directly from the person or entity that may be responsible for the Injury or Illness, with or without your consent. If the Program exercises this option, you must cooperate in pursuing such recovery, including assisting the Program's attorneys in preparing or pursuing the case, including attendance at hearings, depositions and trial. In the event the Program obtains any recovery, the Program will apply the monies received first to the Program as reimbursement for Benefits, second to the Program or its attorneys for costs, expenses and attorneys' fees incurred in connection with the recovery, and third, any remaining balances to you. The Plan Administrator, however, may, in its sole discretion, apportion the recovery in some other manner if it chooses to do so.

You are required to cooperate fully with the Program, the Benefits Administrator or their agents in the exercise of these rights of subrogation and recovery, including:

- You must sign all necessary forms requested by the Program or the Benefits Administrator, including, without limitation, an acknowledgement of the Program's rights to reimbursement or subrogation and an assignment of your Claims or causes of action against the other party.
- You must provide the Program or the Benefits Administrator with all reasonably necessary information as requested.
- You may not take any action after your Illness, Injury or disability that could prejudice the Program's rights as described in this section, or the Program's ability to obtain reimbursement or subrogation.
- You must promptly notify the Program of any recovery obtained from the responsible person or entity, or their or your insurer, whether by judgment, settlement, arbitration or otherwise.

Right of Recovery of Overpayments

The Program or the Benefits Administrator may pay Benefits that should have been paid by another plan or program, organization or person, or may pay Benefits in excess of what should have been paid under this Program. In such event, the Program may recover the excess amount from the other plan, organization or person, or from you, including by reducing future Benefits otherwise payable under this Program, if necessary.

IMPORTANT NOTICES ABOUT YOUR BENEFITS

IMPORTANT NOTICES ABOUT YOUR BENEFITS

KEY POINTS

- *This section describes various laws that may impact your right to Program Benefits.*
- *Some laws provide specific Program eligibility rights.*
- *Other laws provide specific Program coverage rights, such as coverage for mastectomy, childbirth and Mental Health/Substance Use Disorder Services.*
- *Certain laws protect the privacy and security of your protected health information.*

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act (MHPAEA) is a federal law that requires a group health benefits plan to provide parity between Mental Health/Substance Use Disorder (MH/SUD) benefits and medical and surgical benefits.

Wherever the Program provides MH/SUD Services, coverage will generally be provided to the same extent as medical and surgical Services.

This means the Program:

- May not apply more restrictive financial or treatment limitations on Benefits for MH/SUD Services when compared to Benefits for medical and surgical Services.
- May not apply more restrictive annual or lifetime maximum dollar limits on MH/SUD Services than are applied to medical and surgical Services.
- Must cover Non-Network Benefits for MH/SUD Services to the same extent as Non-Network Benefits for medical and surgical Services.
- Prior authorization requirements for MH/SUD Services must be comparable to or less restrictive than those for medical and surgical Services.

However, the Program may apply cost-containment methods as long as those methods are consistent with parity requirements under federal law. Common cost-containment methods for MH/SUD Services may include the following:

- Cost sharing: Co-payments, Coinsurance and Annual Deductibles
- Limitations on the number of office visits or inpatient/outpatient days

- The terms and conditions of the amount, duration or scope of Benefits
- Need for Prior Authorization and proof of Medical Necessity

Federal guidelines for MH/SUD Services as required under the MHPAEA are continually evolving, however, the Program and its Benefits Administrators are making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to MHPAEA or MH/SUD Services, please see the applicable *Benefits Administrator* table in the **"Contact Information"** section for contact information.

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA), as amended, is a federal law intended to extend health care benefits and coverage to most Americans by 2014.

The PPACA, sometimes referred to as Health Care Reform or the Affordable Care Act (ACA), imposes mandates on both insurers and employers who provide group health benefits to their employees and their dependents.

Federal guidelines for certain health care benefits and coverage as required under the PPACA are continually evolving, however, the Program and its Benefits Administrators are making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to PPACA or mandated health care benefits and coverage, please see the applicable *Benefits Administrator* table in the **"Contact Information"** section for contact information.

Qualified Medical Child Support Orders

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

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

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

A medical child support order has to satisfy certain specific conditions to be qualified. The Eligibility and Enrollment Vendor will notify you if the Company receives a medical child support order that applies to you and will provide you a copy of the Program's procedures used for determining whether the medical child support order is qualified. A medical child support order will generally not be considered to be qualified if it requires the Program to provide certain benefits or options that are not otherwise provided by the Program. Participants and beneficiaries can obtain, free of charge, a copy of such procedures from the Eligibility and Enrollment Vendor.

If the Eligibility and Enrollment Vendor determines the order to be qualified, your Child named in the order will be eligible for coverage as required by the order. You must then enroll the Child in the Program and pay any applicable contributions for coverage of the Child. If a QMCSO is issued

for your Child and you are eligible but not participating in the Program at that time, you must enroll yourself and your Child in the Program and pay any applicable contributions.

Federal guidelines for medical child support orders as required under ERISA are continually evolving, however, the Program and its Eligibility and Enrollment Vendor are making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to a QMCSO, please see the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section for contact information.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act (GINA) is a federal law prohibiting discrimination against an Employee, dependent or Spouse on the basis of an individual's genetic information. Genetic information is defined as information about an individual's genetics based on genetic tests of an individual's family members or information about the manifestation of a disease or disorder within an individual's family. Genetic information includes any request for or receipt of genetic services (including genetic testing, counseling or education), or participation in clinical research that includes such services, by the individual or family member.

Federal guidelines related to GINA are constantly evolving, however, the Program is making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to the use of your genetic information or GINA, please see the *Benefits Administrator* table in the **"Contact Information"** section for contact information.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

An individual who has had or is receiving mastectomy-related Benefits under this Program and who elects breast reconstruction in connection with the mastectomy will receive coverage in a manner determined in consultation with the attending physician and patient for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to give a symmetrical appearance, any needed prostheses and coverage for treatment of physical complications of all stages of the mastectomy, including lymphedema. This coverage is subject to any annual deductible, co-payment or coinsurance percentage levels applicable to other medical and surgical Benefits provided under the Program.

If you have any questions with respect to WHCRA or mastectomy-related Benefits, please see the *Benefits Administrator* table in the **"Contact Information"** section for contact information.

You may view or print a copy of the Women's Health and Cancer Rights Act of 1998 annual notice here:

http://directpath.dcatalog.com/v/WHCRA-Notice/

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage under the Program, but are unable to afford the premiums, some states have premium-assistance programs that can help pay for coverage. These states use

funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

- If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state that participates in CHIP, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.
- If you or your dependents are **not** currently enrolled in Medicaid or CHIP and you think you or any of your dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial **877-KIDS NOW (877-543-7669)** or **insurekidsnow.gov** to find out how to apply.
- If you qualify, you can ask the state if it has a Medicaid or CHIP program that might help you pay the contributions for health coverage under the Program.
- If you or your dependents are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **healthcare.gov**.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, the Program is required to permit you and your dependents to enroll in the Program — as long as you and your dependents are eligible, but not already enrolled in the Program. This is called a special enrollment opportunity in the Program, but you must request coverage within 60 days of being determined eligible for premium assistance.

Alternatively, if you and your dependents are eligible, but not enrolled in the Program, and you lose your eligibility for premium assistance under Medicaid or CHIP, you are entitled to a special enrollment opportunity in the Program, but you must request coverage within 60 days of losing eligibility for premium assistance.

Federal guidelines related to premium assistance are constantly evolving; however, the Program is making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to premium assistance, please see the *Eligibility and Enrollment Vendor* table in the **"Contact Information"** section for contact information.

For information on which states have a premium assistance program or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor Employee Benefits Security Administration **dol.gov/ebsa** **866-444-EBSA (866-444-3272)**	U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services **cms.hhs.gov** **877-267-2323 (choose option 4), ext. 61565**

You may view or print a copy of the Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) annual notice here:

https://directpath.dcatalog.com/v/CHIP-Notice

Protecting the Privacy of Your Protected Health Information – Notice of HIPAA Privacy Rights

The privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) went into effect April 14, 2003, and require that we send you updated notices regarding the privacy of your health information. You have received a summary of those rights from the Plan. HIPAA provides you with certain rights in connection with the privacy of your health information. The Program will not use or disclose your protected health information (PHI) for purposes other than treatment, payment or Program administrative functions without your written authorization or as otherwise required or permitted by federal law.

You have the right to inspect and copy, request amendment or correction, request a restriction on the use or disclosure, and request an accounting of certain uses and disclosures of your PHI. The Plan maintains a Notice of Privacy Practices that provides information to individuals whose PHI will be used or maintained by the Plan.

You may request a free copy of this information at any time upon request by contacting the AT&T Benefits Center as identified in the **"Contact Information"** section.

You may also view or print a copy of this notice here:

https://directpath.dcatalog.com/v/HIPAA-Notice

Newborns' and Mothers' Health Protection Act

To the extent this Program provides Benefits for Hospital lengths of stay in connection with childbirth, the Program will cover the minimum length of stay required for deliveries (i.e., a 48-hour Hospital stay after a vaginal delivery or a 96-hour stay following a delivery by caesarean section). The mother's or newborn's attending physician, after consulting with the mother, may discharge the mother or her newborn earlier than the minimum length of stay otherwise required by federal law. No Provider authorization is required from the Program or any Benefits Administrator for prescribing a length of stay less than 48 or 96 hours. This coverage is subject to any applicable annual deductible, co-payment or coinsurance percentage levels.

Federal guidelines for minimum Hospital stays related to childbirth as required under Newborns' and Mothers' Health Protection Act (NMHPA) are continually evolving, however, the Program and its Benefits Administrators are making a good faith effort to comply with current guidelines as we understand them.

If you have any questions with respect to NMHPA or Hospital stays related to childbirth, please see the *Benefits Administrator* table in the **"Contact Information"** section for contact information.

CONTACT INFORMATION

CONTACT INFORMATION

Contact Information	
Benefits Administrator	
Name	UnitedHealthcare
Type	Supplemental Medical Benefits
Services Provided	Supplemental Benefits - Benefits Administration
Benefits Administrator Contact Numbers	
Contact Numbers Information	To reach a Customer Care Professional (to confirm whether a specific procedure is covered or to obtain Prior Approval for a Covered Procedure)
Domestic Telephone Number	**877-261-3340**
International Telephone Number	**877-246-8173**
Hearing Impaired Telephone Number	**711** from a TTY phone
Benefits Administrator Hours of Operation	
Hours of Operation	**Service Center:** Available Monday through Friday from 7 a.m. to 7 p.m. Central time.
Benefits Administrator Microsite	
Microsite	**https://careplus.att.com/**

Contact Information	
Benefits Administrator Mailing Address	
General Mailing Address	
Domestic	UnitedHealthcare P.O. Box 30886 Salt Lake City, UT 84130-0886
International	UnitedHealthcare P.O. Box 30886 Salt Lake City, UT 84130-0886
Claims	
Claims Regular	AT&T CarePlus - A Supplemental Benefit Program P.O. Box 30886 Salt Lake City, UT 84130-0886
Claims Overnight	AT&T CarePlus - A Supplemental Benefit Program P.O. Box 30886 Salt Lake City, UT 84130-0886
Claims International	UnitedHealthcare International Claims AT&T CarePlus - A Supplemental Benefit Program P.O. Box 740817 Atlanta, GA 30374
Appeals	
Appeals Regular	UnitedHealthcare Attn: Appeals - AT&T CarePlus - A Supplemental Benefit Program P.O. Box 740816 Atlanta, GA 30374-0816
Appeals Overnight	UnitedHealthcare Attn: Appeals - AT&T CarePlus - A Supplemental Benefit Program P.O. Box 740816 Atlanta, GA 30374-0816
Appeals International	UnitedHealthcare Attn: Appeals - AT&T CarePlus - A Supplemental Benefit Program P.O. Box 740816 Atlanta, GA 30374-0816

Contact Information	
Vendor	
Name	Bright Horizons
Type	Dependent Back-Up Care
Services Provided	Provides Dependent Back-Up Care
Vendor Contact Numbers	
Domestic Telephone Number	**855-591-9857**
Vendor Hours of Operation	
Hours of Operation	Available 24/7, 7 days a week
Vendor Website	
Website	**clients.brighthorizons.com/att**

Contact Information	
Vendor	
Name	AT&T Benefits Center
Type	Eligibility and Enrollment Vendor
Services Provided	Eligibility, enrollment, contributions, billing and COBRA processing
Vendor Contact Numbers	
Contact Numbers Information	To speak to the AT&T Benefits Center by phone, you will need to provide the last four digits of your Social Security number, your date of birth and your AT&T Benefits Center password. Contact the AT&T Benefits Center at:
Domestic Telephone Number	**877-722-0020**
International Telephone Number	**847-883-0866**
Vendor Hours of Operation	
Hours of Operation	**Service Center:** Monday through Friday from 7 a.m. to 7 p.m. Central time. **IVR System:** An interactive voice response (IVR) system is available 24 hours a day (except Sunday from 1 a.m. to noon Central time and periodically during the week for one hour between midnight and 5 a.m. for maintenance and updates).

Contact Information	
Vendor Website	
Website Access Information	To access the website, you will need your AT&T Benefits Center user ID and password.
Website	**att.com/benefitscenter**
Vendor Mailing Address	
General Mailing Address	
Mailing Address Information	General questions about eligibility or enrollment in the Program may be sent to:
Domestic	AT&T Benefits Center P.O. Box 7105 Rantoul, IL 61866-7105
Claims	
Claims Information	Written Claims for Eligibility under the Program **must** be sent to:
Claims Regular	AT&T Benefits Center Claims and Appeals Management P.O. Box 7105 Rantoul, IL 61866-7105
Claims Overnight	AT&T Benefits Center Claims and Appeals Management P.O. Box 7105 Rantoul, IL 61866-7105 **847-554-1397** (Fax number)
Appeals	
Appeals Information	Written Appeals for eligibility under the Program **must** be sent to:
Appeals Regular	AT&T Benefits Center Eligibility and Enrollment Appeals Committee P.O. Box 7105 Rantoul, IL 61866-7105
Appeals Overnight	AT&T Benefits Center Eligibility and Enrollment Appeals Committee P.O. Box 7105 Rantoul, IL 61866-7105 **847-554-1397** (Fax number)

Contact Information	
Vendor Fax Number	
Domestic	**847-883-8217** for general information **847-554-1397** for Claims and Appeals only

Contact Information	
Vendor	
Name	Fidelity Service Center
Type	Pension Service Center
Services Provided	Term of Employment (also known as Net Credited Service), Address Updates for Former Employees and Beneficiaries; Beneficiary Designation, Death and Survivor Benefits Administration
Vendor Contact Numbers	
Contact Numbers Information	Call the Fidelity Service Center to report the death of an employee, an Eligible Former Employee and/or an Eligible Dependent, or ask questions about beneficiary designations. (If you have submitted an AT&T Beneficiary Designation Form to the Fidelity Service Center, service associates will be able to answer questions regarding the designation that you have on file.) You may manage your beneficiary designations via the AT&T Online Beneficiary tool. (Note: Some Eligible Former Employees and former vested employees may need to call the Fidelity Service Center for further assistance.) You may also request an AT&T Beneficiary Designation Form by calling the Fidelity Service Center. An AT&T Beneficiary Designation Form will be mailed to you within three business days. Return completed AT&T Beneficiary Designation Forms to the mailing address below.
Domestic Telephone Number	**800-416-2363**
International Telephone Number	Dial your country's toll-free AT&T Direct Access Number, then enter **800-416-2363.**
Hearing Impaired Telephone Number	**888-343-0860**
Vendor Mobile Application	
Mobile App	Fidelity NetBenefits
Instructions	Access the Mobile App in the App Store on your mobile device

Contact Information	
Vendor Hours of Operation	
Hours of Operation	**Service Center:** Available every business day that the New York Stock Exchange (NYSE) is open from 7:30 a.m. to 11 p.m. Central time. **Interactive voice response (IVR) system:** The IVR is available 24 hours a day, seven days a week.
Vendor Website	
Website Access Information	**IMPORTANT:** Call the Fidelity Service Center to update your address, update beneficiary information, report the death of an Employee, an Eligible Former Employee and/or an Eligible Dependent. You do not need a Fidelity Service Center PIN or Social Security number/customer ID to report a death.
Website	**netbenefits.com/att**
Vendor Mailing Address	
General Mailing Address	
Domestic	Fidelity Service Center P.O. Box 770003 Cincinnati, OH 45277-0065
Claims	
Claims Information	Written claims about a denied Beneficiary designation **must** be sent to:
Claims Regular	Fidelity Service Center Beneficiary Designation Administrator P.O. Box 770003 Cincinnati, OH 45277-0065
Claims Overnight	Fidelity Service Center Beneficiary Designation Administrator 100 Crosby Parkway, KC1F-D Covington, KY 41015
Appeals	
Appeals Information	Written Appeals about a denied beneficiary designation **must** be sent to:

Contact Information	
Appeals Regular	Fidelity Service Center Beneficiary Designation Administrator P.O. Box 770003 Cincinnati, OH 45277-0072
Appeals Overnight	Fidelity Service Center Beneficiary Designation Administrator 100 Crosby Parkway, KC1F-D Covington, KY 41015
Vendor Special Instructions	
Instructions	**IMPORTANT:** You will need your Fidelity Service Center PIN and Social Security number/customer ID when you access the Fidelity NetBenefits website or automated voice response system, or call to speak to a service associate. You do not need a Fidelity Service Center PIN or Social Security number/customer ID to report a death. All Beneficiary designations made using the Online Beneficiary tool will be available for future viewing and updating at your convenience. Please note that you in some cases you may have to print your AT&T Beneficiary Designation, gather additional signatures, and then return the Form before your AT&T Beneficiary Designation is valid (for example, in cases for which spousal consent is required by the applicable benefit plan). Please follow the prompts for when a printed Form must be returned to the Fidelity Service Center.

COMMON RESOURCES

INFORMATION CHANGES AND OTHER COMMON RESOURCES

It's important to keep your work and home addresses current because the majority of your benefits, payroll or similar information is sent to them. Please include any room, cubicle, apartment, or suite number that will help make mail routing more efficient.

Active Employee Address and Telephone Number Changes

Go to **https://hraccess.att.com** and log in using your Global Logon > Locate Update Personal Information

- Click on Update Permanent Residence
- Update Office / Cubicle Information or
- Update Emergency Contact
- Make any necessary changes and click Save.

Employees on a Leave of Absence or Eligible Former Employee Home Address Changes

Call the Fidelity Service Center to change your address or phone number.

Telephone numbers and dialing instructions:

800-416-2363

888-343-0860 (hearing-impaired)

Dial your country's toll-free AT&T Direct Access Number and then enter **800-416-2363** (international)

Hours of operation:

Monday through Friday from 7:30 a.m. to 11 p.m. Central Time

You will need to establish a user name and password, if you haven't already, and you will need it when you call to speak to a service associate.

IMPORTANT: These instructions are for Eligible Former Employees, recipients of long-term disability benefits, Employees on a leave of absence (LOA), as well as COBRA participants, alternate payees and survivors who have a pension benefit (including a retiree death benefit) or savings plan benefit that has yet to be paid to you.

If you are not eligible to receive a pension or savings plan benefit or have already received your entire pension and savings plan benefits in a lump sum and are not eligible for a retiree death benefit from your pension plan, call the AT&T Benefits Center at **877-722-0020** to update your home address.

AT&T Benefits Intranet and Internet Access

Active Employees - HROneStop

Go to **https://hraccess.att.com** (AT&T's secure Internet site) by logging in using your Global Logon. Click HROneStop > Learn More >

- For health information, click Health (from menu)
- For money/retirement information, click Money (from menu)

DEFINITIONS

DEFINITIONS

Active Employee. An Employee who is on a Participating Company's active payroll, regardless of whether such Employee is currently receiving pay.

Actively at Work. A time when an Employee is actually working for the Company on a regular basis at the Employee's customary place of employment, receiving short-term disability benefits under a Company-sponsored disability plan, or is on a leave of absence (LOA) that provides for continued coverage, but only for the period of continued coverage while on the LOA.

Adverse Benefit Determination. A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a Program Benefit, including any such denial, reduction, termination of, or failure to provide or make a payment that is based on a determination of a Covered Person's eligibility to participate in the Program.

Allowed Charge. The payment for a Preventive Care Service, agreed upon by the Benefits Administrator and the Approved Preventive Care Provider. If there is no agreed-upon payment in place between the Benefits Administrator and a Provider, the Allowed Charge is the billed charge. For purposes of the Dental Services Provided in a Medical Care Facility Expanded CarePlus Benefit, the payment for approved inpatient or outpatient services when receiving Dental Services Provided in a Medical Care Facility, agreed upon by the Benefits Administrator and the Approved Medical Care Facility. If there is no agreed-upon payment in place between the Benefits Administrator and a Provider, the Allowed Charge is the billed charge.

Annual Deductible. The amount of money you must first pay out of pocket each calendar year for Covered Health Services before the Program begins to pay Benefits that are subject to a Deductible. See the Cost Sharing subsections of the Medical Benefits and Prescription Drug Coverage sections of your Base Medical Program for more information.

Annual Enrollment. The period specified by the Company during which Eligible Employees, Eligible Former Employees and COBRA participants may make changes to their coverage (including coverage options and enrolled dependents) under the Program. See the **"Annual Enrollment"** section for additional information.

Appeal. A written request for the review of an Adverse Benefit Determination or a denial of a Claim for Eligibility under the formal process outlined in the Program for a Claim for Eligibility or Claim for Benefits, as applicable. See the **"Claims and Appeal Procedures"** section for more information.

Approved Medical Care Facility. For Dental Services Provided in a Medical Care Facility, an Approved Medical Care Facility is a Medical Care Facility that has contracted to participate in a Network the Benefits Administrator makes available for use by the Program.

Approved Preventive Care Provider. For Preventive Care Services, except Preventive Care Drugs, an Approved Preventive Care Provider is a Provider who has contracted to participate in a Network the Benefits Administrator makes available for use by the Program. For Preventive Care Drugs, an Approved Preventive Care Provider includes any duly licensed pharmacy.

Approved Provider. A Physician, Hospital and/or other healthcare providers approved by the Benefits Administrator to perform a Covered Service at a cost (Negotiated Rate) agreed to by the Benefits Administrator and the Approved Provider.

AT&T Controlled Group. AT&T Controlled Group includes any of the following:

- Corporation that is a member of a controlled group of corporations within the meaning of section 414(b) of the Code of which the Company is a member.
- Trade or business (whether or not incorporated) that the Company is under common control (as defined in section 414(c) of the Code.
- Organization (whether or not incorporated) that is a member of an affiliated service group (as defined by section 414(m) of the Code) that includes the Company.
- Other entity required to be aggregated with the Company and treated as a single employer under section 414(o) of the Code.

AT&T Controlled Group Member. Each entity in the AT&T Controlled Group.

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

Audiologist. An individual who, by virtue of academic degree, clinical training, and license to practice and/or professional credential, is uniquely qualified to provide a comprehensive array of professional services related to the prevention of hearing loss and the audiologic identification, assessment, diagnosis, and treatment of persons with impairment of auditory and vestibular function, and to the prevention of impairments associated with them.

Bargained Employee. Either: (1) an Employee whose job title and classification is included in a collective bargaining agreement between a Participating Company and a union, or (2) an Employee whose job title and classification have been excluded from a collective bargaining agreement but for whom the Company provides the same Benefits provided to Employees included in a collective bargaining agreement between the union and the Participating Company.

Base Medical Program. The medical benefits program sponsored by your Company for which you are eligible to enroll for comprehensive medical benefits. Effective Jan. 1, 2022, the WarnerMedia Medical Program and The CW Network, LLC Health and Welfare Programs are no longer Base Medical Programs.

Benefits. Payments for Covered Services that are available under the Program. The availability of Benefits is subject to the terms, conditions, limitations and exclusions of the Program.

Benefits Administrator. Any third party, insurance company or other organization or individual to which the Company or the Plan Administrator has delegated the duty to process and/or review Claims for Benefits under the Program.

Care Event. A single day of in-center care for your child(ren) at a Network Center or one caregiver for one day of in-home care for your child(ren) or an eligible adult dependent.

Change-in-Status Event. Certain life events such as marriage, birth of a Child, loss of benefits under another employer's medical plan, or going on an LOA that under the terms of the Program trigger the ability to change your enrollment under the Program. See the **"Enrollment and Changes to Your Coverage"** section for information.

Child(ren). See the **"Eligible Dependents"** section for the definition of Child(ren).

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

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

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

Claims Administrator. See the definition of Benefits Administrator.

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted April 7, 1986, and as subsequently amended from time to time. Any reference to COBRA shall be deemed to include any applicable regulations and rulings. See the **"Extension of Coverage - COBRA"** section for information.

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

Coinsurance. The percentage of the Allowable Charge that you pay for covered services. Other cost sharing requirements may apply.

Common Law Marriage. A marriage occurring in a state recognizing common-law marriages and satisfying the specific minimum state requirements to be considered married under common law.

Company. Company means any or all of AT&T Inc., AT&T Services, Inc., or a Participating Company as indicated by the context, or the successor(s) to such entity(ies), or any successor or successors thereof.

Company Extended Coverage or CEC. Continued coverage under the Program that may be available to you or your dependents in limited circumstances. For more information, see the **"Surviving Dependent Coverage"** section.

Company Sponsored High Deductible Health Plan. A medical option that is designed to have Annual Out of Pocket Maximum and Annual Deductible amounts that qualify the option to be combined with a health savings account (HSA).

Coordination of Benefits (COB). The method of determining which health plan pays a plan participant's Claims first (primary), which pays second (secondary) and, in some cases, which pays third (tertiary), when the participant has coverage under more than one health plan. See the **"Coordination of Benefits"** section and the **"If You Have Other Health Insurance"** subsection of

the **"If You, Your Spouse/Partner or Your Dependent is Eligible for Medicare"** section for more information.

Co-pay (Co-payment). The specific fixed dollar amount (for example $15) you pay for certain covered services.

Course of Treatment. The continuous treatment of a person for a condition.

Coverage Plan. See the **"Coordination of Benefits"** section.

Covered Expenses. Incurred charges or expenses or a portion of such for treatments, services or supplies, for the specified list of Covered Services, to the extent that the charges or expenses meet the terms of the Program.

Covered Health Services. As used in regard to coverage for transportation expenses associated with treatment for cancer, Services, supplies and Prescription Drugs provided for the purpose of preventing, diagnosing or treating an Illness or Injury, Mental Illness, substance use disorder or their symptoms that are determined by the medical Benefits Administrator of the Base Medical Program to be Medically Necessary and included in the *What Is Covered* section and not excluded under the *Exclusions and Limitations* section of the Base Medical Program.

Covered Person. Either the Eligible Employee, Eligible Former Employee or an Eligible Dependent if, and only if, the individual is enrolled under the Program. References to you and your throughout this SPD, except with to respect to eligibility and enrollment, are references to a Covered Person. See the **"Eligibility and Participation"** section for eligibility provisions.

Covered Service. A service specifically identified in the treatment protocol in connection with the list of designated medical services.

Custodial Care. Services that:

- Are non-health related Services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating).
- Are health-related Services that do not seek to cure or that are provided during periods when the medical condition of the patient who requires the Service is not changing.
- Do not require continued administration by trained medical personnel to be delivered safely and effectively.

Dental Services Provided in a Medical Care Facility. Services, other than the dental procedure itself, that are determined by the Benefits Administrator to be necessary to perform required dental care where the performance of the dental services in a Medical Care Facility is necessary to safeguard the life or health of the patient.

Disabled Child(ren). Your Child who is over the age of 26 and meets the requirements to be eligible for Program coverage due to disability. See the **"Eligible Dependents"** section for more information.

Domestic Partner. Your partner of the same gender:

- Who resides in the same household as you;

- Who is at least 18 years old, mentally competent to enter into a valid contract, unrelated to you and not legally married to anyone;
- With whom you have a close and committed personal relationship and there is no other such relationship with any other person; and
- With whom you share responsibility for each other's welfare and financial obligations.

Dual Enrollment. See the **"Dual Enrollment"** section for more information.

East Region. The states of Connecticut, Massachusetts and Rhode Island.

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

Eligibility and Enrollment Vendor. The Eligibility and Enrollment Vendor, referred to as the AT&T Benefits Center, is the third-party vendor to which the Plan Administrator has delegated responsibility under the Program for initial eligibility determinations, enrollment administration, Cost of Coverage information, billing, COBRA administration and Change-in-Status Event administration.

Eligible Dependent. An individual who is eligible to participate in the Program as described in the **"Eligible Dependents"** section.

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

Eligible Expenses. The expenses for Covered Health Services that are eligible for consideration for payment of Benefits under the Program. Benefits paid under the Program are based on the Allowable Amount of Eligible Expenses determined by the Benefits Administrator.

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

Eligible Former Employee. An Employee who has terminated employment with a Participating Company or former Participating Company and who meets the eligibility requirements for Program coverage described in the Eligible Former Employees section of your base medical program SPD.

Employee. Any individual, other than a leased employee or Nonresident Alien Employed Outside the United States, who is carried on the payroll records of a Participating Company as a common law employee and who receives a regular and stated compensation, other than a pension or retainer, from that Participating Company, in exchange for services rendered to that AT&T Participating Company.

- For purposes of the preceding sentence, the term leased employee refers to any individual who is a leased employee within the meaning of Section 414(n)(2) of the Code; and

- The term Employee does not include any individual:
  - Who is rendering services to an AT&T Participating Company pursuant to a contract, arrangement or understanding either purportedly (i) as an independent contractor, or (ii) as an employee of an agency, leasing organization or any other such company that is outside of the AT&T Controlled Group and is providing services to an AT&T Participating Company; or
  - Who is treated by an agency, leasing organization or any other such company that is outside of the AT&T Controlled Group as an employee of such agency, leasing organization or other such company while rendering services to an AT&T Participating Company, even if such individual is later determined (by judicial action or otherwise) to have been a common-law employee of an AT&T Participating Company rather than an independent contractor or an employee of such agency, leasing organization or other such company.
- For purposes of this definition, a Nonresident Alien Employed Outside the United States is any individual who receives no earned income (within the meaning of Section 11(d)(2) of the Code) from any AT&T Participating Company that constitutes income from sources within the United States (within the meaning of Section 861(a)(3) of the Code). Notwithstanding the preceding sentence, any individual who is classified by an AT&T Participating Company as a global manager will not be considered a Nonresident Alien Employed Outside the United States.

Employer. The AT&T Controlled Group Member that issues your paycheck/that pays you.

ERISA. The Employee Retirement Income Security Act of 1974, as amended from time to time. Any reference to any section of ERISA shall be deemed to include any applicable regulations and rulings.

Expatriate Employee. An Employee (including a Global Manager) who is assigned by a Participating Company to work outside the United States of America for a period originally intended to be six or more consecutive months.

Experimental or Investigational Services. Medical, surgical, diagnostic, psychiatric, substance use disorder or other health care Services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time a determination is made regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.

- Subject to review and approval by any institutional review board for the proposed use. (Devices that are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

If you have a life-threatening Illness or condition (one that is likely to cause death within one year of the request for treatment), the Benefits Administrator may, in its discretion, determine that an Experimental or Investigational Service meets the definition of a Covered Health Service for that Illness or condition. For this to take place, the Benefits Administrator must determine that the procedure or treatment is promising, but unproven, and that the Service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

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

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

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

Foster Child(ren). A child placed with you or your Spouse/Partner for foster care in accordance with applicable state or local law, for whom you or your Spouse/Partner provide support.

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

Hospital. A facility that is:

- Licensed as a general acute care hospital by the state in which it is located, accredited by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) and Medicare-certified.
- Provides 24-hour nursing Services by registered nurses (RNs) on duty or on call.
- Provides Services under the supervision of a staff of one or more Physicians to diagnose and treat ill or injured patients hospitalized for surgical, medical, or MH/SUD conditions. A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

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

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

Legacy AT&T Corp. Company. A company that was a former Controlled Group Member of AT&T Corp. prior to the Nov. 18, 2005, change in control.

Legally Recognized Partner (LRP). Any individual:

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

Management Employee. An Employee who is classified as management on the records of the Company.

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

Medical Care Facility. A Hospital or other duly licensed or accredited facility providing out-patient surgical services.

Medically Necessary. As used in regard to Covered Health Services and coverage for transportation expenses associated with treatment for cancer, see the *Medically Necessary* section of your Base Medical Program for a definition and details regarding how the medical Benefits Administrator determines Medically Necessary Covered Health Services, including examples of what is Medically Necessary and what is not considered Medically Necessary.

Medicare. The health insurance program for the aged and disabled established by Title XVIII, United States Social Security Act, and as later amended.

Medicare Advantage. Coverage under Medicare Part C.

Medicare Allowable (MA). The amount Medicare will consider eligible for determining Medicare benefits.

Medicare Eligible. When you are eligible for Medicare as your primary coverage over the Program if you were to enroll in Medicare. See the **"If You, Your Spouse/Partner or Your Dependent Is Eligible for Medicare"** section for information.

Medicare Part D. The Part D (Voluntary Prescription Drug Benefit) of the insurance program established by Title XVIII of the United States Social Security Act, as amended, 42 U.S.C. Sections 1394, et seq.

Mental Illness. As used in regard to Covered Health Services and coverage for transportation expenses associated with treatment for cancer, a condition that meets either of the following two requirements:

- It is classified as a mental illness in the latest edition of the International Classification of Disease of the United States Department of Health and Human Services; or
- It is a condition generally accepted by the health care professionals in the United States as one that requires psychiatric treatment and responds to such treatment.

MH/SA or MH/SUD. The abbreviation for Mental Health/Substance Abuse or Mental Health Substance Use Disorder.

MHPAEA. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Midwest Region. The states of Illinois, Indiana, Michigan, Ohio and Wisconsin.

Necessary Treatment. Treatment (including any resulting expenses) of a Participant for one of the specific Covered Services, which is determined by the treating physician to be integral to the treatment protocol, and which has been communicated to and confirmed in writing by the Benefits Administrator.

Negotiated Rate. The agreed-upon payment for a Covered Service between the applicable Benefits Administrator and the Provider.

Network Center. A network of eligible childcare centers as determined by the Dependent Care Administrator.

Network Provider. As used in regard to coverage for transportation expenses associated with treatment for cancer, a Provider who has contracted to participate in the applicable Benefits Administrator's Network available under the Base Medical Program.

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

Notification. A written or oral notice provided by you, your Provider or your representative to the applicable Benefits Administrator using the procedure specified by the Benefits Administrator. See the **"Prior Approval and Notification Requirements"** section for information and a list of Covered Services that require Notification.

Out-of-Pocket Maximum. See the definition of Annual Out-of-Pocket Maximum in your Base Medical Program SPD.

Participating Company. Any AT&T Company that has elected to participate in the Base Medical Program subject to approval by the Plan Sponsor. Participating Companies are listed in the Summary Plan Description for the Base Medical Programs.

Partner.

- Bargained Employees and those that do not follow Management Employee Benefits:
  - Your Legally Recognized Partner (LRP) or, if eligible and enrolled in the Program, your Domestic Partner. See the definitions of Legally Recognized Partner and Domestic Partner for information.
- Management Employees and those that follow Management Employee Benefits:
  - The Registered Domestic Partner (RDP) of an Eligible Employee or Eligible Former Employee, or
  - Any individual with whom an Eligible Employee or Eligible Former Employee has entered into a same or opposite gender relationship pursuant to and in accordance

with state or local law, such as a civil union or other legally recognized arrangement that provides similar legal benefits, protections and responsibilities under state law to those afforded to a Spouse, or

- Any adult in an exclusive and committed relationship with an Eligible Employee or Eligible Former Employee that is intended to be permanent. The Eligible Employee and partner must:
  - have been in the relationship for at least six months,
  - have shared a primary residence for at least six months,
  - be responsible for each other's welfare on a continuing basis,
  - both be at least 18 years old and may not be related by blood to a degree of closeness that would prohibit marriage under applicable law,
  - not be legally married to or in a legal civil union with another person, and
  - be willing to file an Affidavit of Domestic Partnership and/or Declaration of Tax Status with the Program's Eligibility and Enrollment Vendor or your employer, if requested.

Pharmacist. A person licensed to dispense Prescription Drugs under the laws of the state in which he or she practices.

Physician. A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) licensed to practice medicine in all its branches, prescribe and dispense all drugs and perform all surgery under applicable laws of the place where treatment is rendered.

Plan. The AT&T Umbrella Benefit Plan No. 3.

Plan Administrator. AT&T Services, Inc.

Plan Year. The calendar year beginning Jan. 1 and ending Dec. 31.

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

PPACA. The Patient Protection and Affordable Care Act, as amended, including any applicable regulations and rulings. See the **"Patient Protection and Affordable Care Act"** section for information.

Pregnancy. The condition of and complications arising from a woman having a fertilized ovum, embryo or fetus in her body, usually, but not always in the uterus, and lasting from the time of conception to the time of childbirth, abortion, miscarriage or other termination.

Prescription Drug. A drug or medicine approved by the United States Food and Drug Administration for general use by the public, requiring a prescription by a Physician.

Preventive Care. Services that are intended to prevent diseases or to identify disease while it is more easily treatable.

Preventive Care Drugs. Medications that are required under the Patient Protection and Affordable Care Act (PPACA) and associated regulations and guidance to be covered as Preventive Care as determined by the Prescription Drug Benefits Administrator. See the **"Preventive Care Drugs"** section for more information.

Preventive Care Services. Services that are determined by the Benefits Administrator to provide Preventive Care and are identified as Preventive Care in the Benefits Administrator's preventive care policy, including at a minimum services required to be covered as Preventive Care under the Patient Protection and Affordable Care Act (PPACA) and associated regulations and guidance. These services will change from time to time, as new medical evidence emerges and evidence-based recommendations change. See the **"Preventive Care Services"** section for more information.

Prior Approval. Written approval of an Experimental Service or an Expanded Service received from the Benefits Administrator before the Covered Service is delivered.

Program. The component part of the Plan providing Benefits for Covered Services to enrolled eligible individuals under the specified terms and conditions. See the **"Using this Summary Plan Description"** section for information.

Provider. Any health care institution or Physician or Practitioner licensed to render health care Services and practicing within the scope of that license.

Qualified Beneficiary. A Covered Person losing coverage under the Program who is eligible to elect COBRA continuation coverage. See the **"Extension of Coverage - COBRA"** section for more information.

Qualified Medical Child Support Order (QMCSO). See the **"Qualified Medical Child Support Orders"** section for a definition and requirements.

Qualifying Event. An event such as loss of your job, reduction of your hours, death of a covered Employee or former Employee, divorce, or loss of eligibility as a Dependent, that results in the loss of coverage under the Program and gives rise to a right to elect COBRA continuation coverage. See the **"Extension of Coverage - COBRA"** section for more information.

Registered Domestic Partner (RDP). Any individual with whom an Employee or Eligible Former Employee has entered into a domestic partnership that has been registered with a governmental body pursuant to state or local law authorizing such registration and such relationship has not terminated. You may be asked to provide a copy of the domestic partner registration and other evidence that you continue to meet the requirements of the applicable registry and that the registered domestic partnership has not ended. See the **"Dependent Eligibility Verification"** section for information for dependent enrollment and verification of dependent eligibility.

Regular Employee. An individual who is classified as a Regular Employee by a Participating Company.

Southeast Region. The states in which BellSouth Corporation and its affiliates operated prior to the Dec. 31, 2006, change in control.

Southwest Region. The states of Arkansas, Kansas, Missouri, Oklahoma and Texas.

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

Substance Use Disorder Services. Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association.

Summary Plan Description (SPD). Each of the Program descriptions that are required by Section 102 of ERISA that provide a summary of the medical and prescription drug Benefits under the Program.

Temporary Employee. An individual who is classified as a Temporary Employee by a Participating Company.

Term Employee. An individual who is classified as a Term Employee by a Participating Company.

Term of Employment. A period of employment of an Employee in the service of one or more members of the AT&T Controlled Group, as determined in accordance with the pension benefit plan the Employee participates in as of termination of employment.

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

Urgent Care Claim. Claim for treatment where a delay could seriously jeopardize the life or health of the patient or the ability to regain maximum function. Such a Claim is also one involving a condition that would, in the opinion of a Physician, Provider or Practitioner with knowledge of the condition subject the patient to severe pain that cannot be adequately managed without the care or treatment that is related to the Claim.

West Region. The states of California and Nevada.

APPENDIX

APPENDIX A

Change-in-Status Events

The following provides further clarification on the Change-in-Status Events and actions you are able to take during those Change-in-Status Events.

Status Change Codes:

E	Enroll yourself and/or your Eligible Dependent under the Program
AS	Add your Spouse/Partner to medical coverage under the Program
DS	Drop medical coverage for your Spouse/Partner under the Program
AD	Add your Eligible Dependent(s) to medical coverage under the Program
DD	Drop medical coverage for your dependent under the Program
W	Waive or terminate your medical coverage enrollment under the Program

Change in Legal Marital or Partnership Status

You may change your enrollment if you experience a marriage, partnership, divorce, death of Spouse/Partner, termination of partnership, legal separation or legal annulment. Marriage will generally trigger a HIPAA special enrollment right in addition to your right to a change in enrollment.

For specific information about dependent eligibility, see the **"Eligible Dependents"** subsection in the **"Eligibility and Participation"** section.

Change in Legal Marital or Partnership Status	Changes Permitted	Notes
Marriage or Partnership	AD, AS, DD, E, W	E, AD, AS: For newly eligible Spouse/Partner and any dependent Child(ren) of Employee or new Spouse/Partner. DD, W: Only if coverage is effective under new Spouse/Partner's medical plan.

Change in Legal Marital or Partnership Status	Changes Permitted	Notes
Death of Spouse/Partner*	AD, DD, DS, E	E, AD: Only if you lose coverage under your Spouse/Partner's medical plan. DD: Only if other dependent loses coverage under your Spouse/Partner's medical plan.
Divorce, Legal Separation, Legal Annulment or Dissolution of Partnership	AD, DD, DS, E	E, AD: Only if you or your dependent loses coverage under your Spouse/Partner's medical plan. DD: Only if dependent loses coverage under your Spouse/Partner's medical plan.

Change in Number of Dependents or Dependent Eligibility

You may change your enrollment if your dependent experiences a gain or loss of dependent status including birth, adoption, placement for adoption and death. Gaining a dependent will also trigger HIPAA special enrollment rights in addition to a change in enrollment.

Change in Number of Child Dependent(s)	Changes Permitted	Notes
Birth, Adoption or Placement for Adoption	AD, AS, E, W, DD, DS	W: Only if medical coverage is effective under your Spouse/Partner's medical plan.
Death of Child Dependent*	DD	You may only drop the deceased dependent.

If a Dependent Dies

If your dependent dies, you must notify the Fidelity Service Center at **800-416-2363.** Although you are not required to notify the Fidelity Service Center within a specified period of time after the death of your dependent, please contact the Center as soon as possible to initiate the appropriate changes to your Program coverage.

Dependent Satisfies or Ceases to Satisfy Dependent Eligibility Requirements

In addition to birth and adoption, there are other Change-in-Status Events that may affect your dependent's eligibility under the Program and permit you to enroll the dependent. This applies to both your Spouse and Child dependents. There are many events that affect a dependent's eligibility under the Program including circumstances where a dependent:

- Reaches the maximum age for adult dependent Child coverage under the Program.
- Loses eligibility as a Spouse or dependent Child under the terms of the Program.
- Becomes your legal dependent.
- Becomes your certified disabled dependent Child.

Change in Dependent Status	Changes Permitted	Notes
Gain of Dependent Status	AD, AS, E, W	E, AD, AS: For the dependent only. W: Only if there is a gain of coverage under another health plan.
Loss of Dependent Status	DD, DS	May only drop coverage for the newly ineligible dependent.

Change in Employee's Employment Status

You may change your enrollment if you experience a change in employment that affects your eligibility under the Program including: termination of employment, commencement of employment, strike or lockout, commencement of an unpaid LOA, termination of an unpaid LOA and change in worksite that constitutes a change in employment status.

IMPORTANT:

(1) A change in employment status generally does not apply unless Benefit eligibility under the Program is affected as a result of the event.

(2) A change in financial circumstance (for example, a pay reduction) is not considered a change in employment status unless it affects eligibility under the Program.

Change in Employee's Employment Status	Changes Permitted	Notes
Gain of Eligibility Due to a Change in Employee's Work Schedule or Employment Status	AD, AS, E	Only if eligibility for medical coverage option is gained.
Loss of Eligibility Due to a Change in Employee's Work Schedule or Employment Status	W	
Employee Commences Strike or Lockout Resulting in a Change in Benefit Eligibility	W	Participants must lose eligibility and coverage.
Employee Returns From Strike or Lockout Resulting in a Change in Benefit Eligibility	AD, AS, E, W	

Change in Employee's Employment Status	Changes Permitted	Notes
Employee Rehires Within 30 Days of Termination	Reinstate prior enrollment	No change permitted unless there is another permissible status change within that 30 day period.
Employee Rehires After 30 Days Following Termination	AD, AS, E	You may enroll and make new enrollment choices.

Change in Spouse's/Partner's or Dependent's Employment Status

You may change your enrollment if your Spouse/Partner or dependent experiences a gain or loss of eligibility for medical coverage under another employer's plan as a result of a change in their employment status. Your change in enrollment for that individual under the Program must correspond with their specific Change-in-Status Event.

For example, if your dependent loses eligibility under his employer's medical plan due to a reduction of hours, you could change your enrollment to add him to your Program coverage. However, you could not change your election to drop all coverage under the Program.

Change in Spouse's/Partner's or Dependent's Employment Status	Changes Permitted	Notes
Gain of Employment	DD, DS, W	Enrollment changes under the Program are only permitted for you, your Spouse/Partner or dependent who gain coverage under another employer's medical plan.
Loss of Employment Spouse	AD, AS, E	AD, AS, E: Only with respect to you, your Spouse/Partner or dependent who lose coverage under another employer's medical plan.
Change in Work Schedule that Triggers a Loss of Eligibility Under their Employer's Medical Plan	AD, AS, E	AD, AS, E: Only with respect to the individual who lost coverage under another employer's plan.
Change in Work Schedule that Triggers a Gain of Eligibility under their Employer's Medical Plan	DD, DS, W	Only with respect to the individual who gains coverage under another employer's plan.
Spouse/Partner or Dependent Commences a Strike or Lockout	AD, AS, E	
Spouse/Partner or Dependent Returns from a Strike or Lockout	DD, DS, W	

Change in Residence

If you experience a change of residence that affects eligibility under the Program, you are permitted to make an enrollment change. For example, you may change your option enrollment if, as a result of a move, you are no longer eligible for the Benefits under the Program.

Change in Residence	Changes Permitted	Notes
Relocation Triggers Gain in Eligibility	AD, AS, E	
Relocation Triggers Gain in Medical Benefit Option Availability	AD, AS, E	Only if eligibility for coverage option is gained.
Relocation Triggers Loss in Eligibility	W, DD, DS	
Relocation Triggers a Loss of Medical Benefit Option Availability	W, DD, DS	Only if eligibility for coverage option is lost.

Change in Benefit Coverage Under Another Employer's Plan

You may change your enrollment to add or drop medical coverage for you, your Spouse/Partner or dependent if any of you gain or lose coverage under another employer's medical plan.

Change in Benefit Coverage	Changes Permitted	Notes
Gain of Medical Coverage under Another Employer's Plan	DD, DS, W	
Loss of Medical Coverage under Another Employer's Medical Plan	AD, AS, E	AD, AS: Only with respect to the Spouse/Partner or dependent who lost coverage under another employer's medical plan.
Spouse/Partner or Dependent's Annual Enrollment Does Not Correspond with the Program's Annual Enrollment Period	AD, AS, DD, DS, E, W	AD, AS, DD, DS, E, W: Changes are permitted that reflect corresponding changes in non-AT&T Spouse/Partner or dependent's medical plan.
You Gain Eligibility Under Another Employer's Medical Benefit Plan(s)	DD, DS, W	If Employee, Spouse/Partner and/or dependent coverage under other employer's medical plan is effective.
You Lose Eligibility Under Another Employer's Medical Benefit Plan(s)	AD, AS, C, E	

Loss of Coverage Under a Government or Educational Institution

You may change your enrollment if you experience a loss of group health coverage sponsored by an educational or governmental institution (for example: student health coverage provided by a university, coverage due to military service or certain Indian tribal programs, etc.).

IMPORTANT: There is no change in enrollment permitted for a gain of coverage from a government or educational institution. However, there are special rules for a gain or loss of Medicaid or state sponsored Children's Health Insurance Program (CHIP) coverage. See the **"Gain or Loss of Medicaid Coverage and CHIP Premium Assistance"** section below.

Loss of Educational or Governmental Institutional Coverage	Changes Permitted	Notes
Your Loss of Other Government or Educational Institution Coverage (for example state risk pool coverage, student coverage under a university health plan, tribal coverage, etc.)	AD, AS, E	Note: Loss of coverage under state Medicaid or CHIP programs will permit you a 60 day enrollment period.
Spouse/Partner or Dependent's Loss of Other Government or Educational Institution Coverage (for example state risk pool coverage, student coverage under a university health plan, tribal coverage, etc.)	AD, AS, E	Note: Loss of coverage under state Medicaid or CHIP programs will permit you a 60 day enrollment period.

Gain or Loss of Medicaid Coverage and CHIP Premium Assistance

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

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

Gain or Loss of Medicaid Coverage and CHIP Premium Assistance	Changes Permitted	Notes
Your Gain of Medicaid Coverage or CHIP Premium Assistance	W, E, AD, AS	
Your Spouse/Partner or Dependent's Gain of Medicaid Coverage or CHIP Premium Assistance	DD, DS, W	
Your Loss of Medicaid Coverage or CHIP Premium Assistance	AD, AS, E, W, DD, DS	
Your Spouse/Partner or Dependent's Loss of Medicaid Coverage or CHIP Premium Assistance	AD, AS, E, W, DD, DS	

Change in Cost

You may change your enrollment if you experience a significant increase or decrease in your portion of the cost of your medical option under the Program during a period of coverage.

You may also change your enrollment if your Spouse/Partner or dependent experiences a significant increase or decrease in the cost of another employer's medical plan.

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

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

The Eligibility and Enrollment Vendor generally will notify you of increases or decreases in the cost of medical coverage.

If there is an insignificant increase or decrease in the cost of your current medical option, the Eligibility and Enrollment Vendor may automatically adjust your enrollment contributions to reflect the minor change in cost and you will not be permitted to change your medical coverage.

Change in Cost	Changes Permitted	Notes
Significant Increase in Cost of Your Medical Benefit Option	AS, AD, DD, DS, E, W	May change enrollment to match cost increase OR W and AD, AS, E: Another medical benefit option providing similar coverage OR W, DD, DS: If no other medical benefit option provides similar coverage
Significant Decrease in Cost of Your Medical Benefit Option	AS, AD, DD, DS, E, W	May change enrollment to match the cost decrease OR W, DD, DS: Current option and AD, AS, E: Drop other medical benefit option and add the medical benefit option with decreased cost
Increase in Cost Under Spouse/Partner or Dependent's Employer's Benefit Plan	AD, AS, E	
Decrease in Cost Under Spouse/Partner or Dependent's Employer's Benefit Plan	DD, DS, W	
You, your Spouse/Partner or Dependent Experience a Complete Loss of Medical Plan Subsidy from Another Employer	E, AD, AS	

Change in Coverage Under Another Employer's Plan

You may make an enrollment change if you experience a change under another employer's plan (including a plan of your Spouse's/Partner's or Dependent's employer) if the enrollment change is on account of and corresponds with the change and the other plan permits its participants to make an enrollment change.

Change in Enrollment Under Another Employer's Plan	Changes Permitted	Notes
Increase in Coverage Under Spouse/Partner or Dependent's Employer's Benefit Plan	DD, DS, W	If coverage under other employer's plan is effective.
Decrease in Coverage Under Spouse/Partner or Dependent's Employer's Benefit Plan	AD, AS, E	AD, AS, E: If coverage under another employer's plan is decreased or dropped.

Addition or Significant Improvement of Benefit Plan Option

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

If a medical option is added or significantly improves, eligible individuals who have not enrolled in the Program may enroll.

If an addition or significant improvement is made under your Spouse's/Partner's or dependent's medical plan, you may change your enrollment under the Program consistent with those changes.

Addition or Significant Improvement of Benefit Plan Option	Changes Permitted	Notes
Addition or Significant Improvement of a Program Medical Benefit Option	AD, AS, DD, DS, E, W	DD, DS, W then AD, AS, E: May drop current medical benefit option and elect the new or significantly improved medical benefit option. AD, AS: If previously enrolled in a medical benefit option, you may elect the new or significantly improved medical benefit option.
Addition or Significant Improvement of Medical Benefit Option to Spouse/Partner or Dependent's Employer's Benefit Plan	DD, DS, W	Only if coverage under another employer's plan is effective.

Significant Curtailment of Coverage (With or Without Loss of Coverage)

You may change your enrollment if you experience a significant curtailment of coverage under the Program during a period of coverage. In this case, you may change your enrollment for an existing medical benefit option even if there is no loss of coverage. An enrollment may be changed to a different medical benefit option or, in some cases, drop coverage if no similar coverage option is available under the Program.

Coverage is significantly curtailed only if there is an overall reduction in coverage provided under the Program that reduces coverage generally.

Significant Curtailment of Coverage	Changes Permitted	Notes
Significant Curtailment or Termination of Coverage With or Without a Loss of Coverage	DD, DS, W	
Significant Curtailment or Termination of Spouse/Partner or Dependent Coverage under Another Employer's Medical Benefit Plan	AD, AS, E	You may only change your election if there is a loss of coverage and no similar coverage is available under another employer's plan.

Medicare or Medicaid

If you, your Spouse/Partner, or dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Program. Similarly, if you, your Spouse/Partner or your dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to enroll or increase that person's coverage under the Program.

Change Due to Medicare or Medicaid	Changes Permitted	Notes
You Gain Medicare or Medicaid Coverage	W	
You Lose Medicare or Medicaid Coverage	AD, AS, E	
Spouse/Partner Gains Medicare or Medicaid Coverage	DD, DS	If Spouse/Partner or dependent enrolls in Medicare or Medicaid coverage.
Spouse/Partner Loses Medicare or Medicaid Coverage	E, AD, AS	AD, AS, E: If Spouse/Partner or dependent loses Medicare or Medicaid coverage.

Public Marketplace Exchange

You may change your enrollment if you enroll or return from participation in the Public Marketplace Exchange.

Change Due to Public Marketplace Exchange	Changes Permitted	Notes
Employee gains eligibility in Public Marketplace Exchange due to reduction in expected hours of service from more than 30 hours per week to less than 30 hours per week	W	W – only if Employee enrolls self and individuals losing coverage in minimum essential coverage under another plan by the first day of the second month following the month in which coverage is revoked
Employee gains eligibility in Public Marketplace Exchange due to Special or Annual Enrollment period	W	W – only if Employee enrolls self and individuals losing coverage in Public Marketplace Exchange effective no later than the day immediately following the last day of the prior coverage that was revoked

Leave of Absence (LOA)

You may make certain changes to your enrollment if you, your Spouse/Partner or dependent begin or return from an LOA.

Common LOAs that trigger the right to a change in enrollment are: federal Family and Medical Leave Act (FMLA), state family and medical leave, federal military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA), unpaid personal leave, etc.

Change Due to LOA	Changes Permitted	Notes
You begin an LOA	DD, DS, W	Whether paid or unpaid whether FMLA or non-FMLA.
You return from an LOA	AD, AS, E	Whether paid or unpaid whether FMLA or non-FMLA.
Spouse/Partner or Dependent Begin an Unpaid LOA (including a FMLA leave) Resulting in a Loss of Eligibility under Another Employer's Medical benefit plan	AD, AS, E	AD, AS, E: Only with respect to Employee, Spouse/Partner who lost coverage under another employer's plan.
Spouse/Partner or Dependent Returns from an Unpaid LOA (including a FMLA leave) Resulting in a Gain of Eligibility Under Another Employer's Medical Benefit Plan	DD, DS, W	Only with respect to you, your Spouse/Partner who gains coverage under another employer's plan.
Spouse/Partner or Dependent Starts an Unpaid LOA (Non-FMLA) Without a Change in Eligibility under Another Employer's Plan	AD, AS, E	Only with respect to you, your Spouse/Partner who loses coverage under another employer's plan.
Spouse/Partner or Dependent Returns from an Unpaid LOA (Non-FMLA) Without Change in Eligibility Under Another Employer's Plan	DD, DS, W	Only with respect to you, your Spouse/Partner who gain you, your Spouse/Partner's coverage under another employer's plan.

Judgments, Orders and Decrees

If a judgment, court order or judicial decree resulting from a divorce, legal separation, annulment or change in legal custody requires medical coverage for your Spouse/Partner or dependent, you (or in some cases, the Program) may make a change to your enrollment to meet the legal obligation. While the judgment order or decree will cause you to be able to make the change in enrollment, it will not cause a Spouse/Partner or dependent to be eligible for coverage.

In addition, coverage may be dropped for the dependent if another person (e.g. your former Spouse) is required to cover the dependent.

NOTE: This enrollment change does not apply to voluntary changes in responsibility for medical coverage of a dependent between ex-Spouses.

Change in Coverage Under a Judgment, Order or Decree	Changes Permitted	Notes
QMCSO or Court Order Requiring You to Cover a Dependent	AD	
QMCSO or Court Order Requiring Another Individual to Cover Your Dependent	DD	
Expiration or Termination of a QMCSO or Court Order	W, DD	

Change in COBRA Continuation Coverage

Change in COBRA Continuation Coverage	Changes Permitted	Notes
Mid-Year Expiration of Maximum Coverage Period of COBRA Continuation Coverage Under Another Employer's Group Health Plan	AD, AS	You must exhaust the maximum COBRA coverage period available to you in order to make this change in enrollment. In general, you will not be permitted to make this change if your COBRA continuation coverage is terminated by you or your COBRA continuation coverage Provider before the maximum period of coverage.