The Retiree Medical Assistance Plan for BellSouth Employees

Basic Plan,
Basic Plan When Medicare is Primary,
And Basic Indemnity Plan

Effective January 1, 2008

NIN: 78-13904

Customer Service Center:

Blue Cross and Blue Shield of Illinois
3405 Liberty Drive
Springfield, IL 62704

Customer Service:

1 800 621-7336 toll-free

Preadmission Certification, Blue Care Connection (BCC):

1 800 621-0965 toll-free

web site:

www.bcbsil.com/att

WELCOME

All of us at Blue Cross and Blue Shield of Illinois pledge to you we will provide the best service we can in the administration of your group health plan. The following information summarizes your group's benefits. It also summarizes conditions, limitations, and exclusions to those benefits. There is a Section defining certain words. Please be sure to read this information in its entirety. This information is a "Summary Plan Description" or "plan" as defined by ERISA, the **E**mployee **R**etirement **I**ncome **S**ecurity **A**ct of 1974 as amended.

Blue Cross and Blue Shield of Illinois is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of **independent** Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield Association permits us to use the Blue Cross and Blue Shield service marks in the state of Illinois. Blue Cross and Blue Shield of Illinois is not acting as an agent of the Association. No representation is made that any organization other than Blue Cross and Blue Shield of Illinois and your employer will be responsible for honoring this contract. The purpose of this paragraph is for legal clarification; it does not add additional obligations on the part of Blue Cross and Blue Shield of Illinois not created under the original agreement.

If you have any questions, please contact the Customer Service Unit.

This booklet contains a summary in English of your plan rights and benefits. If you require assistance in understanding your benefits and speak Spanish, please contact the Customer Service Unit at 1 800 621-7336. Simply request a Spanish translator and one will be provided to assist you in understanding your benefits.

INTRODUCTION

The Retiree Medical Assistance Plan for BellSouth Employees has special features that require you and your covered dependents to make certain choices about how and where to seek medical care. These features include the Blue Care Connection (BCC) and the PPO Network of Participating Facilities and Providers. By using these special features, you can receive maximum plan benefits. As you read this booklet, keep in mind that you and your physician must make all decisions regarding appropriate medical treatment for you and your covered dependents. AT&T Inc. reserves the right, at its discretion to amend, reduce, or terminate the plan and coverage at any time for active, retired, or former employees and all dependents, subject to applicable collective bargaining agreements.

AT&T Inc. will update this booklet periodically to describe changes in the plan, but there may be a delay between the effective date of a change and the date you receive the information. If you have any questions regarding coverage before you incur expenses for any non-emergency treatment, contact Blue Cross and Blue Shield of Illinois or BCC as appropriate.

NIN: 78-13904

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Retiree Medical Assistance Plan for BellSouth Employees benefit information is listed below. For the Retiree Medical Assistance Plan for BellSouth Employees When Medicare is Primary, please refer to page 17 for benefit information. For Basic Indemnity for Retirees refer to page 30.

SUMMARY OF HEALTH BENEFITS – RETIREE MEDICAL ASSISTANCE BASIC PLAN FOR BELLSOUTH EMPLOYEES

This table is a summary of benefits and is subject to all other terms and conditions of the Retiree Medical Assistance Plan for BellSouth Employees:

To maximize your benefits, seek medical services from a Preferred Provider who participates in the BlueCard Preferred Provider Organization (PPO) Program. Please call 1 800 810-BLUE (2583) or access our web site at www.bcbsil.com/att to find out if your provider is a PPO member. When using Non-Preferred providers you can incur significant out-of-pocket expenses in addition to higher deductibles, copays and coinsurance as the provider may bill you for charges in excess of the Allowed Amount (see Allowed Amount in the Definitions section of this booklet).

Please be aware that not all providers participating in the BlueCard PPO Program will be recognized by us as approved providers for the type of service or supply being furnished as explained more fully in paragraph 4 of "Benefit Conditions."

ALL RETIREES INPATIENT HOSPITAL		
Benefit	**PPO**	**Non-PPO**
Coverage	No limit on the number of days for inpatient hospital care; covered inpatient expenses paid at 100% of the PPO Allowance, subject to the calendar year deductible	No limit on the number of days for inpatient hospital care; covered inpatient expenses paid at 80% of the Allowed Amount, subject to the calendar year deductible
Preadmission Certification	Required for all admissions including maternity over 48 hours for a normal delivery and over 96 hours for a C-Section; emergency admissions require notification within 48 hours of admission; **for precertification call BCC 1 800 621-0965 toll-free;** if no preadmission certification is obtained, there will be a $250 penalty	

MANAGEMENT AND CRAFT PRE 1992 RETIREES OUTPATIENT HOSPITAL *		
Benefit	**PPO**	**Non-PPO**
Accidental Injury and Medical Emergencies No benefits are available if not a True Emergency	100% of the PPO Allowance, subject to a $20 copay, when services are rendered within 72 hours of an accident or the sudden onset of symptoms; the copay is waived if admitted	100% of the Allowed Amount, subject to a $50 copay, when services are rendered within 72 hours of an accident or the sudden onset of symptoms; the copay is waived if admitted

CRAFT POST 1991 RETIREES OUTPATIENT HOSPITAL *		
Benefit	**PPO**	**Non-PPO**
Accidental Injury and Medical Emergencies **No benefits are available if not a True Emergency**	100% of the PPO Allowance, subject to a $75 copay, when services are rendered within 72 hours of an accident or the sudden onset of symptoms; the copay is waived if admitted	100% of the Allowed Amount, subject to a $75 copay, when services are rendered within 72 hours of an accident or the sudden onset of symptoms; the copay is waived if admitted

ALL RETIREES OUTPATIENT HOSPITAL*		
Benefit	**PPO**	**Non-PPO**
Surgery**	100% of the PPO Allowance, subject to the calendar year deductible	80% of the Allowed Amount, subject to the Calendar year deductible
Diagnostic Lab and X-ray, IV Therapy, Hemodialysis, Radiation Therapy and Chemotherapy (Includes Diagnosed Mammograms and Preadmission Testing) **Routine Labs and X-rays in an outpatient facility are not covered (except routine Mammograms, routine Pap smears and routine Colorectal Screenings)**	100% of the PPO Allowance, subject to the calendar year deductible	80% of the Allowed Amount, subject to the Calendar year deductible
Routine Mammograms One Baseline Mammogram between the ages of 35 and 39; one annually beginning at age 40 **Note: The first mammogram received that was either routine or for a diagnosed condition will be paid at the higher benefit level**	100% of the PPO Allowance, no copayment or deductible	80% of the Allowed Amount, subject to the calendar year deductible
Routine Pap Smear Limited to one each year For females	100% of the PPO Allowance, no deductible or copayment for the Pap smear only	100% of the Allowed Amount, no deductible or copayment for the Pap smear only

ALL RETIREES OUTPATIENT HOSPITAL* - Continued		
Benefit	**PPO**	**Non-PPO**
Routine Colorectal Screenings Annually beginning at age 50 See Colorectal Cancer Screenings (later in this booklet) for additional information	100% of the PPO Allowance, subject to the calendar year deductible	Not covered
Physical, Occupational and Speech Therapy Precertification is required; if precertification is not obtained, no benefits are available; if precertification is obtained retroactively, a $250 penalty will apply	100% of the PPO Allowance, subject to the calendar year deductible	80% of the Allowed amount, subject to the calendar year deductible

* Outpatient hospital services will be processed as Other Covered Services rather than as Outpatient Hospital Benefits if:

(1) the facility bills for an emergency room visit but the patient's condition does not meet the definition of a medical emergency (this includes any lab and x-ray exams, diagnostic tests and other services or supplies associated with the emergency room fee)

(2) the services or supplies you receive are not listed in the table above

** Outpatient hospital coverage includes services at an Ambulatory Surgical Care Center.

MANAGEMENT AND CRAFT PRE 1992 RETIREES PHYSICIAN SERVICES – HOSPITAL BASED		
Benefit	**PPO**	**Non-PPO**
Surgery, Inpatient Hospital Visits, Inpatient or Outpatient Consultations, Hemodialysis, and Chemotherapy **Inpatient visits are limited to one per day for the attending physician and one per day per specialist per admission; consultations are limited to one consult per specialty per admission**	90% of the PPO Allowance, no deductible	80% of the Allowed Amount, subject to the calendar year deductible

MANAGEMENT AND CRAFT PRE 1992 RETIREES PHYSICIAN SERVICES – HOSPITAL BASED – continued		
Benefit	**PPO**	**Non-PPO**
Assistant Surgeon – Note: Covered when medically necessary	90% of the PPO Allowance, no deductible	80% of the Allowed Amount, subject to the calendar year deductible
Hospital Based Physicians including Certified Registered Nurse Anesthetist, Anesthesiologist, Pathologist, Radiologist, Neonatologist and the Physician Charges for the Professional Reading of EKG 's	90% of the PPO Allowance, no deductible	90% of the Allowed Amount, no deductible
Diagnosed Mammograms	90% of the PPO Allowance, no deductible	80% of the Allowed Amount, subject to the calendar year deductible
Emergency Room Physician Services Note: Not covered if not a True Emergency	100% of the PPO Allowance, no deductible or copayment	100% of the Allowed Amount, no deductible
Maternity	100% of the PPO Allowance, after a $15 copayment, no deductible	80% of the Allowed Amount, subject to the calendar year deductible

MANAGEMENT AND CRAFT PRE 1992 RETIREES PHYSICIAN SERVICES – OFFICE BASED		
Benefit	**PPO**	**Non-PPO**
Surgery, Anesthesia, Chemotherapy and Radiation Therapy **Anesthesia in the office is considered part of the total reimbursement for surgery**	100% of the PPO Allowance, after a $15 office visit copayment	80% of the Allowed Amount, subject to the calendar year deductible
Office Visits and Office Consultations Emergency and Accidental Injury	100% of the PPO Allowance, after a $15 office visit copayment	80% of the Allowed Amount, subject to the calendar year deductible
Office Visits for a Medical Condition by an Optometrist and not Related to the Initial Eye Exam following Intraocular Surgery	100% of the PPO Allowance, after a $15 office visit copayment	80% of the Allowed Amount, subject to the calendar year deductible

MANAGEMENT AND CRAFT PRE 1992 RETIREES PHYSICIAN SERVICES – OFFICE BASED – continued		
Benefit	**PPO**	**Non-PPO**
Office Visits by a Nurse Practitioner or Physician Assistant when Operating within the Scope of their License	100% of the PPO Allowance, after a $15 copayment	80% of the Allowed Amount, subject to the calendar year deductible
Diagnostic X-Rays and Lab Exams (Includes Diagnosed Mammograms and Diagnosed Pap smears)	100% of the PPO Allowance, after a $15 copayment	80% of the Allowed Amount, subject to the calendar year deductible
Allergy Testing and Treatment	100% of the PPO Allowance, after a $15 office visit copayment; a separate copayment will be applied on a visit for the injection only	80% of the Allowed Amount, subject to the calendar year deductible
Second Opinions (Not Required)	100% of the PPO Allowance, after a $15 office visit copayment	80% of the Allowed Amount, subject to the calendar year deductible
Pneumococcal Vaccine - No age limit. See Physician Benefits Section for additional information	100% of the PPO Allowance, after a $15 office visit copayment	80% of the Allowed Amount, subject to the calendar year deductible

MANAGEMENT AND CRAFT PRE 1992 RETIREES PREVENTIVE CARE SERVICES		
Benefit	**PPO**	**Non-PPO**
In-Hospital Routine Newborn Care Limited to one Well Baby pediatric examination during the mother's hospital stay	90% of the PPO Allowance, no deductible or copayment	80% of the Allowed, subject to the calendar year deductible
Routine Well Child Care *	100% of the PPO Allowance, subject to the $15 copayment; birth to age five, no visit limit; age six to 12 limited to one exam per year	Not covered

MANAGEMENT AND CRAFT PRE 1992 RETIREES **PREVENTIVE CARE SERVICES** – Continued		
Benefit	**PPO**	**Non-PPO**
Routine Physical Exams* No benefits are available for routine physicals performed in an inpatient or outpatient setting	100% of the PPO Allowance, subject to the $15 copayment; limited to one each calendar year for ages 13 and older	Not covered
Venipuncture, Urinalysis, Lipid Panel, Cholesterol, Lipoprotein, and Triglycerides*	100% of the PPO Allowance, subject to the $15 copayment; limited to one each calendar year, no age limit	Not covered
TB Skin Test when provided in conjunction with an office visit *	100% of the PPO Allowance, subject to the $15 copayment; limited to one each year, no age limit	Not covered
Hematocrit or Hemoglobin (HCT or HGB)*	100% of the PPO Allowance, subject to the $15 copayment, one each year for member to age 17	Not covered
Routine Immunizations See the Section for Preventive Care for Covered Immunizations	100% of the PPO Allowance, no deductible or copayment	Not covered
Tetanus	100% of the PPO Allowance, no deductible or copayment, limited to one every 10 calendar years, no age limit	Not covered
Pneumococcal Vaccine	100% of the PPO Allowance, no deductible or copayment; limited to one in a lifetime for members age 65 and older	Not covered
Influenza Vaccine	100% of the PPO Allowance, no deductible or copayment; limited to one each calendar year with no age limit	Not covered
HPV Vaccine	100% of the PPO Allowance, no deductible or copayment for females ages 9 through 26	Not covered
Zoster (Shingles) Vaccine	100% of the PPO Allowance, no deductible or copayment for members age 60 and over	Not covered

MANAGEMENT AND CRAFT PRE 1992 RETIREES **PREVENTIVE CARE SERVICES** – Continued		
Benefit	**PPO**	**Non-PPO**
Routine Pap Smears**	100% of the PPO Allowance with no deductible; limited to one per year for females	100% of the Allowed Amount, no deductible; limited to one each year for females
Routine Mammogram* **Note: The first mammogram received that was either routine or for a diagnosed condition will be considered at the higher benefit level** **See Mastectomy and Mammograms (later in this booklet) for additional information**	Office Based: 100% of the PPO Allowance subject to the $15 copayment Facility Based: 100% of the PPO Allowance, no deductible or copayment for the physician's fee Benefits are limited to one exam for women between the ages of 35 and 39 and one per year for women ages 40 and over	80% of the Allowance, subject to the calendar year deductible Benefits are limited to one exam for women between the ages of 35 and 39 and one per year for women ages 40 and over
Routine Prostate Specific Antigen (PSA)*	100% of the PPO Allowance, subject to the $15 copayment; limited to one exam per year for males ages 40 and over	Not covered
CBC and SMA20/Chemistry Profile*	100% of the PPO Allowance, subject to the $15 copayment; limited to one each year for members age 18 and older	Not covered
EKG, Basic Metabolic Panel, General Health Panel, Comprehensive Metabolic Panel, Renal Function Panel*	100% of the PPO Allowance, subject to the $15 copayment; limited to one each per member ages 50 and older	Not covered
Colorectal Cancer Screening – Ages 50 and Over Fecal occult blood test (FOBT) once per calendar year; Flexible sigmoidoscopy once per calendar year; Double-contrast barium enema once every five calendar years; Colonoscopy once every 10 calendar years **See Colorectal Cancer Screenings (later in this booklet) for additional information**	100% of the PPO Allowance, no deductible	Not covered

MANAGEMENT AND CRAFT PRE 1992 RETIREES **PREVENTIVE CARE SERVICES** – Continued		
Benefit	**PPO**	**Non-PPO**
Contraceptive Coverage for Females* Oral contraceptives are only available through Medco Health Solutions, Inc.	100% of the PPO Allowance, subject to the $15 copayment	80% of the Allowed Amount, subject to the calendar year deductible

* One $15 copayment will be applied per specialty per day.

** Physician services by a PPO physician for the office visit associated with a Pap smear are provided at 100% of the PPO Allowance, subject to the $15 copayment; limited to one per person each calendar year. Pap smears provided by an independent laboratory are provided at 100% of the PPO Allowance, no deductible or copayment. When a Pap smear is provided by a Non-PPO provider, benefits are not available for the associated office visit.

CRAFT POST 1991 RETIREES **PHYSICIAN SERVICES – HOSPITAL BASED**		
Benefit	**PPO**	**Non-PPO**
Surgery, Inpatient Hospital Visits, Inpatient or Outpatient Consultations, Hemodialysis, and Chemotherapy **Inpatient visits are limited to one per day for the attending physician and one per day per specialist per admission; consultations are limited to one consult per specialty per admission**	90% of the PPO Allowance, no deductible	80% of the Allowed Amount, subject to the calendar year deductible
Assistant Surgeon – Note: Covered when medically necessary	90% of the PPO Allowance, no deductible	80% of the Allowed Amount, subject to the calendar year deductible
Hospital Based Physicians including Certified Registered Nurse Anesthetist, Anesthesiologist, Pathologist, Radiologist, Neonatologist and the Physician Charges for the Professional Reading of EKG 's	90% of the PPO Allowance, no deductible	90% of the Allowed Amount, no deductible

CRAFT POST 1991 RETIREES PHYSICIAN SERVICES – HOSPITAL BASED – continued		
Benefit	**PPO**	**Non-PPO**
Diagnosed Mammograms	90% of the PPO Allowance, no deductible	80% of the Allowed Amount, subject to the calendar year deductible
Emergency Room Physician Services Note: Not covered if not a True Emergency	100% of the PPO Allowance, no deductible or copayment	100% of the Allowed Amount, no deductible
Maternity	100% of the PPO Allowance, after a $20 copayment, no deductible	80% of the Allowed Amount, subject to the calendar year deductible

CRAFT POST 1991 RETIREES PHYSICIAN SERVICES – OFFICE BASED		
Benefit	**PPO**	**Non-PPO**
Surgery, Anesthesia, Chemotherapy and Radiation Therapy. Anesthesia in the office is considered part of the total Reimbursement for surgery	100% of the PPO Allowance, after a $20 office visit copayment	80% of the Allowed Amount, subject to the calendar year deductible
Office Visits and Office Consultations Emergency and Accidental Injury	100% of the PPO Allowance, after a $20 office visit copayment	80% of the Allowed Amount, subject to the calendar year deductible
Office Visits for a Medical Condition by an Optometrist and not Related to the Initial Eye Exam following Intraocular Surgery	100% of the PPO Allowance, after a $20 office visit copayment	80% of the Allowed Amount, subject to the calendar year deductible
Office Visits by a Nurse Practitioner or Physician Assistant when Operating within the Scope of their License	100% of the PPO Allowance, after a $20 copayment	80% of the Allowed Amount, subject to the calendar year deductible
Diagnostic X-Rays and Lab Exams (Includes Diagnosed Mammograms and Diagnosed Pap smears)	100% of the PPO Allowance, after a $20 copayment	80% of the Allowed Amount, subject to the calendar year deductible

CRAFT POST 1991 RETIREES PHYSICIAN SERVICES – OFFICE BASED – Continued		
Benefit	**PPO**	**Non-PPO**
Allergy Testing and Treatment	100% of the PPO Allowance, after a $20 office visit copayment; a separate copayment will be applied on a visit for the injection only	80% of the Allowed Amount, subject to the calendar year deductible
Second Opinions (Not Required)	100% of the PPO Allowance, after a $20 office visit copayment	80% of the Allowed Amount, subject to the calendar year deductible
Pneumococcal Vaccine - No age limit. See Physician Benefits Section for additional information	100% of the PPO Allowance, after a $20 office visit copayment	80% of the Allowed Amount, subject to the calendar year deductible

CRAFT POST 1991 RETIREES PREVENTIVE CARE SERVICES		
Benefit	**PPO**	**Non-PPO**
In-Hospital Routine Newborn Care Limited to one Well Baby pediatric examination during the mother's hospital stay	90% of the PPO Allowance, no deductible or copayment	80% of the Allowed, subject to the calendar year deductible
Routine Well Child Care*	100% of the PPO Allowance, subject to the $20 copayment; birth to age five, no visit limit; age six to 12 limited to one exam per year	Not covered
Routine Physical Exams* - No benefits are available for routine physicals performed in an inpatient or outpatient setting	100% of the PPO Allowance, subject to the $20 copayment; limited to one each calendar year for ages 13 and older	Not covered
Venipuncture, Urinalysis, Lipid Panel, Cholesterol, Lipoprotein, and Triglycerides*	100% of the PPO Allowance, subject to the $20 copayment; limited to one each calendar year, no age limit	Not covered
TB Skin Test when provided in conjunction with an office visit*	100% of the PPO Allowance, subject to the $20 copayment; limited to one each year, no age limit	Not covered

CRAFT POST 1991 RETIREES **PREVENTIVE CARE SERVICES** – Continued		
Benefit	**PPO**	**Non-PPO**
Hematocrit or Hemoglobin (HCT or HGB)*	100% of the PPO Allowance, subject to the $20 copayment, one each year for member to age 17	Not covered
Routine Immunizations - See the Section for Preventive Care for Covered Immunizations	100% of the PPO Allowance, no deductible or copayment	Not covered
Tetanus	100% of the PPO Allowance, no deductible or copayment, limited to one every 10 calendar years, no age limit	Not covered
Pneumococcal Vaccine	100% of the PPO Allowance, no deductible or copayment; limited to one in a lifetime for members age 65 and older	Not covered
Influenza Vaccine	100% of the PPO Allowance, no deductible or copayment; limited to one each calendar year with no age limit	Not covered
HPV Vaccine	100% of the PPO Allowance, no deductible or copayment for females ages 9 through 26	Not covered
Zoster (Shingles) Vaccine	100% of the PPO Allowance, no deductible or copayment for members age 60 and over	Not covered
Routine Pap Smears**	100% of the PPO Allowance with no deductible; limited to one per year for females	100% of the Allowed Amount, no deductible; limited to one each year for females
Routine Mammogram* Note: The first mammogram received that was either routine or for a diagnosed condition will be considered at the higher benefit level **See Mastectomy and Mammograms (later in this booklet) for additional information**	Allowance subject to the $20 copayment Facility Based: 100% of the PPO Allowance, no deductible or copayment for the physician's fee Benefits are limited to one exam for women between the ages of 35 and 39 and one per year for women ages 40 and over	80% of the Allowance, subject to the calendar year deductible Benefits are limited to one exam for women between the ages of 35 and 39 and one per year for women ages 40 and over

CRAFT POST 1991 RETIREES PREVENTIVE CARE SERVICES – Continued		
Benefit	**PPO**	**Non-PPO**
Routine Prostate Specific Antigen (PSA)*	100% of the PPO Allowance, subject to the $20 copayment; limited to one exam per year for males ages 40 and over	Not covered
CBC and SMA20/Chemistry Profile*	100% of the PPO Allowance, subject to the $20 copayment; limited to one each year for members age 18 and older	Not covered
EKG, Basic Metabolic Panel, General Health Panel, Comprehensive Metabolic Panel, Renal Function Panel*	100% of the PPO Allowance, subject to the $20 copayment; limited to one each per member ages 50 and older	Not covered
Colorectal Cancer Screening – Ages 50 and Over Fecal occult blood test (FOBT) once per calendar year; Flexible sigmoidoscopy once per calendar year; Double-contrast barium enema once every five calendar years; Colonoscopy once every 10 calendar years See Colorectal Cancer Screenings (later in this booklet) for additional information	100% of the PPO Allowance, no deductible	Not covered
Contraceptive Coverage for Females* Oral contraceptives are only available through Medco Health Solutions, Inc.	100% of the PPO Allowance, subject to the $20 copayment	80% of the Allowed Amount, subject to the calendar year deductible

* One $20 copayment will be applied per specialty per day.

** Physician services by a PPO physician for the office visit associated with a Pap smear are provided at 100% of the PPO Allowance, subject to the $20 copayment; limited to one per person each calendar year. Pap smears provided by an independent laboratory are provided at 100% of the PPO Allowance, no deductible or copayment. When a Pap smear is provided by a Non-PPO provider, benefits are not available for the associated office visit.

MANAGEMENT AND CRAFT PRE 1992 RETIREES GENERAL PROVISIONS		
Benefit	**PPO**	**Non-PPO**
Calendar Year Deductible	$200 per person per calendar year; two deductibles per family or $450 family aggregate deductible*	$300 per person per calendar year; two deductibles per family or $600 family aggregate deductible*
Annual Out-of-Pocket Maximum	$1,300 per person; $2,600 per family plus the calendar year deductible; covered expenses paid at 100% of the Allowed Amount thereafter for the remainder of the calendar year**	$1,750 per person; $3,500 per family plus the calendar year deductible; covered expenses paid at 100% of the Allowed Amount thereafter for the remainder of the calendar year**
Lifetime Maximum	Unlimited	

CRAFT POST 1991 RETIREES GENERAL PROVISIONS		
Benefit	**PPO**	**Non-PPO**
Calendar Year Deductible	$300 per person per calendar year; two deductibles per family or $600 family aggregate deductible*	$400 per person per calendar year; two deductibles per family or $800 family aggregate deductible*
Annual Out-of-Pocket Maximum	$1,300 per person; $2,600 per family plus the calendar year deductible; covered expenses paid at 100% of the Allowed Amount thereafter for the remainder of the calendar year**	$1,750 per person; $3,500 per family plus the calendar year deductible; covered expenses paid at 100% of the Allowed Amount thereafter for the remainder of the calendar year**
Lifetime Maximum	Unlimited	

* The calendar year deductible will be applied to claims in the order in which they are processed regardless of the order in which they are received. Once the maximum number of family members specified above has met the full deductible, no additional covered expenses will be applied toward any family member's individual deductible for the rest of the calendar year; however, all charges applied toward individual deductibles until that point are non-refundable.

** Fixed copayments, the calendar year deductible, the $250 precertification penalty, the amount above the allowable charge, amounts over the maximum allowed for chiropractic visits, and non-covered expenses do not apply toward the Annual Out-of-Pocket Maximum.

MANAGEMENT AND CRAFT PRE 1992 RETIREES OTHER COVERED SERVICES*		
Benefit	**PPO**	**Non-PPO**
Physical Therapy, Occupational Therapy, and Speech Therapy Precertification is required; if precertification is not obtained, no benefits are available; if precertification is obtained retroactively, a $250 penalty will apply	100% of the PPO Allowance, subject to a $15 copay, no deductible	80% of the Allowed Amount, subject to the PPO calendar year deductible
Surgical Management of Temporomandibular Joint (TMJ) Disorders Office Based Services Non-surgical or dental treatment of TMJ is not covered	100% of the PPO Allowance, subject to the $15 office visit copay	80% of the Allowed Amount, subject to the calendar year deductible
Durable Medical Equipment (DME)	90% of the Allowed Amount, subject to the in-network calendar year deductible	

CRAFT POST 1991 RETIREES OTHER COVERED SERVICES*		
Benefit	**PPO**	**Non-PPO**
Physical Therapy, Occupational Therapy, and Speech Therapy Precertification is required; if precertification is not obtained, no benefits are available; if precertification is obtained retroactively, a $250 penalty will apply	100% of the PPO Allowance, subject to a $20 copay, no deductible	80% of the Allowed Amount, subject to the calendar year deductible

CRAFT POST 1991 RETIREES OTHER COVERED SERVICES* - continued		
Benefit	**PPO**	**Non-PPO**
Surgical Management of Temporomandibular Joint (TMJ) Disorders Office Based Services Non-surgical or dental treatment of TMJ is not covered	100% of the PPO Allowance, subject to the $20 office visit copay	80% of the Allowed Amount, subject to the calendar year deductible
Equipment (DME)	90% of the Allowed Amount, subject to the in-network calendar year deductible	
Ambulance Service	90% of the Allowed Amount; subject to the in-network calendar year deductible; ambulance service from a Non-PPO hospital to a PPO hospital when approved by BCC is covered at 100% of the Allowed Amount after the in-network calendar year deductible	
Chiropractic Services	90% of the Allowed Amount, subject to the in-network calendar year deductible; limited to $100 for the first visit, limited to once in a lifetime; all other visits are limited to a maximum of $50 per visit and limited to two visits per week and 20 visits each calendar year per member	
Prescription Drugs Provided for Members Residing in a Skilled Nursing Facility (SNF)	100% of the Allowed Amount, subject to the in-network calendar year deductible	
Eyeglasses and Contact Lenses	90% of the Allowed Amount, subject to the in-network calendar year deductible limited to the initial pair following intraocular surgery, this includes the related examination and prescription for the glasses or contact lenses	
Hearing Aids	90% of the Allowed Amount, subject to the in-network calendar year deductible; limited once after ear surgery	

* See Other Covered Services in the Health Benefits section for additional services.

ALL RETIREES OTHER COVERED SERVICES – ALTERNATE CARE		
Benefit	**PPO**	**Non-PPO**
Home Health Care/Home IV Therapy	100% of the Allowed Amount, subject to the in-network calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available	
Hospice Care	100% of the Allowed Amount, subject to the in-network calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available	

ALL RETIREES OTHER COVERED SERVICES – ALTERNATE CARE – continued		
Benefit	**PPO**	**Non-PPO**
Skilled Nursing Facilities (SNF)	100% of the Allowed Amount, subject to the in-network calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available	
Private Duty Nursing	90% of the Allowed Amount, subject to the in-network calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available	
Birthing Centers	100% of the Allowed Amount, subject to the in-network calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available	
Nurse Midwives	100% of the Allowed Amount; subject to the in-network calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available	

ALL RETIREES BABY YOURSELF PROGRAM	
Benefit	
Baby Yourself	A prenatal wellness program with high-risk pregnancy early intervention that is provided by BCC at 1 800 621-0965; a $55 maximum reimbursement will be provided to the Participant from Blue Cross and Blue Shield of Illinois for the purchase of a car seat, stroller or breast feeding pump; for multiple births, the reimbursement is per child. Members may enroll into the Program at any time during their pregnancy; in order to receive the incentive reimbursement, the member must be enrolled into the Program by the 28th week of their pregnancy.

ALL RETIREES INDIVIDUAL CASE MANAGEMENT	
Benefit	
Individual Case Management	A program to assist Participants and their families in coordinating care in the event of a lengthy illness. Services available through BCC; see the Individual Case Management section for details; call BCC at 1 800 621-0965

SUMMARY OF HEALTH BENEFITS – RETIREE MEDICAL ASSISTANCE BASIC PLAN FOR BELLSOUTH EMPLOYEES WHEN MEDICARE IS PRIMARY

This table is a summary of benefits and is subject to all other terms and conditions of the Retiree Medical Assistance Plan for BellSouth Employees When Medicare is Primary:

To maximize your benefits, seek medical services from a Preferred Provider who participates in the BlueCard Preferred Provider Organization (PPO) Program. Please call 1 800 810-BLUE (2583) or access our web site at www.bcbsil.com/att to find out if your provider is a PPO member.

Please be aware that not all providers participating in the BlueCard PPO Program will be recognized by us as approved providers for the type of service or supply being furnished as explained more fully in paragraph 4 of "Benefit Conditions."

- All services must be first submitted to Medicare for reimbursement and the amount allowed under the Retiree Medical Assistance Plan for BellSouth Employees When Medicare is Primary will be reduced by the amount that is paid by Medicare. For a Medicare assigned claim, the Allowable charge is the Medicare Allowed Amount. You may not be billed for any differences between the provider's billed charge and the Medicare Allowed Amount.
- For a Medicare non-assigned claim you may be billed for any difference in the amount paid by the plan and what the provider actually bills for the service.

ALL RETIREES INPATIENT HOSPITAL	
Benefit	
Coverage	No limit on the number of days for inpatient hospital care; covered inpatient expenses are paid at 100% of the Allowed Amount, subject to the calendar year deductible
Preadmission Certification	When Medicare is primary, precertification is not required for inpatient hospital admissions unless Medicare benefits are exhausted
MANAGEMENT AND CRAFT PRE 1992 RETIREES OUTPATIENT HOSPITAL *	
Benefit	
Accidental Injury and Medical Emergencies	100% of the Allowed Amount, subject to a $35 copay, when services are rendered within 72 hours of an accident or the sudden onset of symptoms; the copay is waived if admitted No benefits are available if not a True Emergency
CRAFT POST 1991 RETIREES OUTPATIENT HOSPITAL*	
Benefit	
Accidental Injury and Medical Emergencies	100% of the Allowed Amount, subject to a $75 copay, when services are rendered within 72 hours of an accident or the sudden onset of symptoms; the copay is waived if admitted No benefits are available if not a True Emergency

ALL RETIREES OUTPATIENT HOSPITAL*	
Benefit	
Surgery**	100% of the Allowed Amount, subject to the calendar year deductible
Diagnostic Lab and X-ray, IV Therapy, Hemodialysis, Radiation Therapy and Chemotherapy (including Diagnosed Mammograms and Preadmission Testing) **Routine Labs and X-rays in an outpatient facility are not covered (except for routine Mammograms, routine Pap smears and Routine Colorectal Screenings)**	100% of the Allowed Amount, subject to the calendar year deductible
Routine Mammogram One Baseline Mammogram between the ages of 35 and 39; one annually beginning at age 40 **Note: The first mammogram received that was either routine or for a diagnosed condition will be paid at the higher benefit level**	100% of the Allowed Amount, no deductible
Routine Pap Smear Limited to one per year for Females	100% of the Allowed Amount, no deductible for the Pap smear only
Routine Colorectal Screenings Annually beginning at age 50 **See Colorectal Cancer Screenings (later in this booklet) for additional information**	100% of the Allowed Amount, subject to the calendar year deductible

ALL RETIREES OUTPATIENT HOSPITAL* - continued	
Benefit	
Physical, Occupational and Speech Therapy	100% of the Allowed Amount, subject to the calendar year deductible Note: No Precertification is required when Medicare is primary unless Medicare benefits are exhausted

*Outpatient hospital services will be processed as Other Covered Services rather than as Outpatient Hospital Benefits if:

(1) the facility bills for an emergency room visit but the patient's condition does not meet the definition of a medical emergency (this includes any lab and x-ray exams, diagnostic tests and other services or supplies associated with the emergency room fee)

(2) the services or supplies you receive are not listed in the table above.

**Outpatient Facility coverage includes services provided in an Ambulatory Surgical Center.

ALL RETIREES PHYSICIAN SERVICES - HOSPITAL BASED	
Benefit	
Surgery, Inpatient Hospital Medical Visits, Inpatient or Outpatient Consultations, Hemodialysis and Chemotherapy	90% of the Allowed Amount, subject to the calendar year deductible Note: Inpatient visits are limited to one per day for the attending physician and one per day per specialist per admission; consultations are limited to one consult per specialty per Admission Multiple surgical procedures performed on the same day by the same provider at the same operative session are paid at 100% of Medicare's Allowance
Assistant Surgeon Note: Covered when Medically Necessary	90% of the Allowed Amount, subject to the calendar year deductible
Hospital Based Physicians including CRNA (Certified Registered Nurse Anesthetist), Anesthesiologist, Pathologist, Radiologist, Neonatologist and the Physician Charges for the Professional Reading of EKG's	90% of the Allowed Amount, subject to the calendar year deductible
Diagnosed Mammograms	90% of the Allowed Amount, no deductible
Emergency Room Physician Services when a True Emergency	100% of the Allowed Amount, no deductible or copay

ALL RETIREES PHYSICIAN SERVICES – HOSPITAL BASED - continued	
Benefit	
Emergency Room Physician Services not a True Emergency	90% of the Allowed Amount, subject to the calendar year deductible
Maternity	100% of the Allowed Amount, no deductible or copay

ALL RETIREES PHYSICIAN SERVICES -OFFICE BASED	
Benefit	
Surgery, Anesthesia , Chemotherapy and Radiation Therapy	90% of the Allowed Amount, subject to the calendar year deductible. Note: Anesthesia in the office is considered part of the total reimbursement for surgery
Office Visits and Office Consultations for Non-Accidental Injuries	90% of the Allowed Amount, subject to the calendar year deductible
Office Visits for a Medical Condition by an Optometrist and not Related to the Initial Eye Exam following Intraocular Surgery	90% of the Allowed Amount, subject to the calendar year deductible
Office Visits for Emergency and Accidental Injury	90% of the Allowed Amount, no deductible
Office Visits by a Nurse Practitioner or Physician Assistant When Operating within the Scope of their license	90% of the Allowed Amount, subject to the calendar year deductible
Diagnostic X-rays and Lab (Includes Diagnosed Mammograms and Diagnosed Pap smears)	90% of the Allowed Amount, subject to the calendar year deductible
Allergy Testing and Treatment	90% of the Allowed Amount, subject to the calendar year deductible
Second Surgical Opinions (Not Required)	90% of the Allowed Amount, subject to the calendar year deductible

ALL RETIREES PHYSICIAN SERVICES -OFFICE BASED – continued	
Benefit	
Pneumococcal Vaccine - No age limit See the Physician Benefits Section for additional information	90% of the Allowed Amount, subject to the calendar year deductible

ALL RETIREES PREVENTIVE CARE SERVICES – WELL CHILD	
Benefit	
In-Hospital Routine Newborn Care	90% of the Allowed Amount, subject to the calendar year deductible; limited to one Well Baby pediatric examination during the mother's hospital stay
Routine Well Child Care*	90% of the Allowed Amount, to age five, no visit limit 90% of Allowed Amount subject to a $5 copay, limited to one exam per year for members ages six to 12
Lipid Panel, Cholesterol, Lipoprotein, and Triglycerides	90% of the Allowed Amount, no deductible or copayment to age 12
TB Skin Test when provided in conjunction with an office visit*	90% of the Allowed Amount, no deductible or copayment to age 12
Routine Immunizations - See the Section for Preventive Care for Covered Immunizations	90% of the Allowed Amount, no deductible or copayment
Hepatitis B*	90% of the Allowed Amount, no deductible or copayment for members to age six
Tetanus*	90% of the Allowed Amount, no deductible or copayment; limited to one each 10 calendar years, to age 12
Influenza Vaccine	90% of the Allowed Amount, no deductible or copayment, limited to one per year with no age limit
HPV Vaccine	90% of the Allowed Amount, no deducible or copayment; for females ages 9 through 26

*Well child care including examinations, immunizations and lab test is limited to $250 maximum per child or $400 per family each calendar year.

MANAGEMENT AND CRAFT PRE 1992 RETIREES PREVENTIVE CARE SERVICES – AGES 13 AND OLDER	
Benefit	
Routine Physical Exams*	100% of the PPO Allowance, subject to the $15 copayment; limited to one each calendar year for ages 13 and older. Note: No benefits are available for routine physicals performed in an inpatient or outpatient setting
Lipid Panel, Cholesterol, Lipoprotein, Triglycerides*	100% of the Allowed Amount, subject to a $15 copayment; limited to one each per year; ages 13 and older
TB Skin Test when provided in conjunction with an office visit*	100% of the PPO Allowance, subject to a $15 copayment; limited to one each per year; ages 13 and older limit
Venipuncture and Urinalysis*	100% of the Allowed Amount, subject to a $15 copayment; limited to one each per year; ages 13 and older
Hematocrit or Hemoglobin (HCT or HGB)*	100% of the Allowed Amount, subject to a $15 copayment; one per year for members ages 13 through 17
Routine Immunizations* See the Section for Preventive Care for Covered Immunizations	100% of the Allowed Amount, subject to a $15 copayment
Tetanus*	100% of the Allowed Amount, subject to a $15 copayment; limited to one each 10 calendar years, ages 13 and older
Pneumococcal Vaccine*	100% of the Allowed Amount, subject to a $15 copayment; limited one in a lifetime for members ages 65 and older
Influenza Vaccine*	100% of the Allowed Amount, subject to a $15 copayment; limited to one per year with no age limit
Zoster (Shingles) Vaccine	100% of the Allowed Amount, subject to a $15 copayment for females ages 9 through 26
HPV Vaccine*	100% of the Allowed Amount, subject to a $15 copayment for females ages 9 through 26
Routine Pap Smears**	100% of the Allowed Amount, no deductible; limited to one per year for females

MANAGEMENT AND CRAFT PRE 1992 RETIREES PREVENTIVE CARE SERVICES – AGES 13 AND OLDER – continued	
Benefit	
Routine Mammogram Note: The first mammogram received that was either routine or for a diagnosed condition will be considered at the higher benefit level. See Mastectomy and Mammograms (later in this booklet) for additional information	100% of the Allowed Amount with no deductible or copayment; limited to one baseline mammogram between the age of 35 and 39, and one annually beginning at age 40
Routine Prostate Specific Antigen (PSA)*	100% of the Allowed Amount subject to a $15 copayment; limited to one per year for males ages 40 and over
CBC and SMA20/Chemistry Profile*	100% of the Allowed Amount, subject to a $15 copayment; limited to one each per year for members ages 18 and older
EKG, Basic Metabolic Panel, General Health Panel, Comprehensive Metabolic Panel; Renal Function Panel*	100% of the Allowed Amount, subject to a $15 copayment; limited to one each per member ages 50 and older
Colorectal Cancer Screening – Ages 50 and Over Fecal occult blood test (FOBT) once per calendar year; Flexible sigmoidoscopy once per calendar year; Double-contrast barium enema once every five calendar years; Colonoscopy once every 10 calendar years See Colorectal Cancer Screenings (later in this booklet) for additional information	100% of the PPO Allowance, no deductible

MANAGEMENT AND CRAFT PRE 1992 RETIREES PREVENTIVE CARE SERVICES – AGES 13 AND OLDER – continued	
Benefit	
Contraceptive Coverage for Females * Oral contraceptives are only available through Medco Health Solutions, Inc.	100% of the Allowed Amount, subject to a $15 copayment

* One $15 copayment will be applied per specialty per day.

** Physician services for the office visit associated with a Pap smear are provided at 100% of the Allowed Amount, subject to the $15 copayment; limited to one per person each calendar year. Pap smears provided by an independent laboratory are provided at 100% of the Allowed Amount, no deductible or copayment.

CRAFT POST 1991 RETIREES PREVENTIVE CARE SERVICES – AGES 13 AND OLDER	
Benefit	
Routine Physical Exams*	100% of the PPO Allowance, subject to the $20 copayment; limited to one each calendar year for ages 13 and older. Note: No benefits are available for routine physicals performed in an inpatient or outpatient setting
Lipid Panel, Cholesterol, Lipoprotein, Triglycerides*	100% of the Allowed Amount, subject to a $20 copayment; limited to one each per year; ages 13 and older
TB Skin Test when provided in conjunction with an office visit*	100% of the PPO Allowance, subject to a $20 copayment; limited to one each per year; ages 13 and older limit
Venipuncture and Urinalysis*	100% of the Allowed Amount, subject to a $20 copayment; limited to one each per year; ages 13 and older
Hematocrit or Hemoglobin (HCT or HGB)*	100% of the Allowed Amount, subject to a $20 copayment; one per year for members ages 13 through 17
Routine Immunizations* See the Section for Preventive Care for Covered Immunizations	100% of the Allowed Amount, subject to a $20 copayment
Tetanus*	100% of the Allowed Amount, subject to a $20 copayment; limited to one each 10 calendar years, ages 13 and older
Pneumococcal Vaccine*	100% of the Allowed Amount, subject to a $20 copayment; limited one in a lifetime for members ages 65 and older

CRAFT POST 1991 RETIREES PREVENTIVE CARE SERVICES – AGES 13 AND OLDER – continued	
Benefit	
Influenza Vaccine*	100% of the Allowed Amount, subject to a $20 copayment; limited to one per year with no age limit
Zoster (Shingles) Vaccine	100% of the Allowed Amount, subject to a $20 copayment for females ages 9 through 26
HPV Vaccine*	100% of the Allowed Amount, subject to a $20 copayment for females ages 9 through 26
Routine Pap Smears**	100% of the Allowed Amount, no deductible; limited to one per year for females
Routine Mammogram **Note: The first mammogram received that was either routine or for a diagnosed condition will be considered at the higher benefit level.** **See Mastectomy and Mammograms (later in this booklet) for additional information**	100% of the Allowed Amount with no deductible or copayment; limited to one baseline mammogram between the age of 35 and 39, and one annually beginning at age 40
Routine Prostate Specific Antigen (PSA)*	100% of the Allowed Amount subject to a $20 copayment; limited to one per year for males ages 40 and over
CBC and SMA20/Chemistry Profile*	100% of the Allowed Amount, subject to a $20 copayment; limited to one each per year for members ages 18 and older
EKG, Basic Metabolic Panel, General Health Panel, Comprehensive Metabolic Panel; Renal Function Panel*	100% of the Allowed Amount, subject to a $20 copayment; limited to one each per member ages 50 and older

CRAFT POST 1991 RETIREES PREVENTIVE CARE SERVICES – AGES 13 AND OLDER – continued	
Benefit	
Colorectal Cancer Screening – Ages 50 and Over Fecal occult blood test (FOBT) once per calendar year; Flexible sigmoidoscopy once per calendar year; Double-contrast barium enema once every five calendar years; Colonoscopy once every 10 calendar years See Colorectal Cancer Screenings (later in this booklet) for additional information	100% of the PPO Allowance, no deductible
Contraceptive Coverage for Females * Oral contraceptives are only available through Medco Health Solutions, Inc.	100% of the Allowed Amount, subject to a $20 copayment

* One $20 copayment will be applied per specialty per day.

** Physician services for the office visit associated with a Pap smear are provided at 100% of the Allowed Amount, subject to the $20 copayment; limited to one per person each calendar year. Pap smears provided by an independent laboratory are provided at 100% of the Allowed Amount, no deductible or copayment.

MANAGEMENT AND CRAFT PRE 1992 RETIREES GENERAL PROVISIONS	
Benefit	
Calendar Year Deductible	$200 per person per calendar year; two deductibles per family or $450 family aggregate Deductible*
Annual Out-of-Pocket Maximum	$1,300 per person; $2,600 per family plus the calendar year deductible; covered expenses paid at 100% of the Allowed Amount thereafter for the remainder of the calendar year**
Lifetime Maximum	Unlimited

CRAFT POST 1991 RETIREES GENERAL PROVISIONS	
Benefit	
Calendar Year Deductible	$300 per person per Calendar year; two deductibles per family or $600 family aggregate Deductible*
Annual Out-of-Pocket Maximum	$1,300 per person; $2,600 per family plus the calendar year deductible; covered expenses paid at 100% of the Allowed Amount thereafter for the remainder of the calendar year**
Lifetime Maximum	Unlimited

* The calendar year deductible will be applied to claims in the order in which they are processed regardless of the order in which they are received. Once the maximum number of family members specified above has met the full deductible, no additional covered expenses will be applied toward any family member's individual deductible for the rest of the calendar year; however, all charges applied toward individual deductibles until that point are non-refundable.

** Fixed copayments, the calendar year deductible, the $250 precertification penalty, amounts over the Allowed Amount, amounts over the maximum allowed for chiropractic visits, amounts over the maximum for Well Child Care, and non-covered expenses do not apply toward the Annual Out-of-Pocket Maximum.

ALL RETIREES OTHER COVERED SERVICES	
Benefit*	
Physical Therapy, Occupational Therapy, and Speech Therapy	90% of the Allowed Amount, subject to the calendar year deductible; precertification is not required when Medicare is primary unless Medicare benefits are exhausted
Surgical Management of Temporomandibular Joint (TMJ) Disorders Office Based Services	90% of the Allowed Amount, subject to the calendar year deductible Non-surgical and dental treatment of TMJ is excluded
Durable Medical Equipment (DME)	90% of the Allowed Amount, subject to the calendar year deductible
Ambulance Service	90% of the Allowed Amount, subject to the calendar year deductible
Chiropractic Services	90% of the Allowed Amount; subject to the calendar year deductible limited to $100 for the first visit, limited to once in a lifetime; all other visits are limited to a maximum of $50 per visit, two visits per week and 20 visits each calendar year per member
Prescription Drugs Provided to Members Residing in a Skilled Nursing Facility (SNF)	100% of the Allowed Amount, subject to the calendar year deductible
Eyeglasses and Contact Lenses	90% of the Allowed Amount, subject to the calendar year deductible limited to the initial pair following intraocular surgery; includes the related examination and prescription for eyeglasses or contact lenses

ALL RETIREES OTHER COVERED SERVICES – continued	
Benefit*	
Hearing Aids	90% of the Allowed Amount, subject to the calendar year deductible; limited to once after ear surgery

* See Other Covered Services in the Health Benefits section for additional services. Most Other Covered Services are paid at 90% of the Allowed Amount after the calendar year deductible is met.

OTHER COVERED SERVICES – ALTERNATE CARE	
Benefit	
Home Health Care/ Home IV Therapy	100% of the Allowed Amount, subject to the calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available
Hospice Care	100% of the Allowed Amount, subject to the calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available
Skilled Nursing Facilities (SNF)	100% of the Allowed Amount, subject to the calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available
Private Duty Nursing	90% of the Allowed Amount, subject to the calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available
Birthing Centers	100% of the Allowed Amount, subject to the calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available
Nurse Midwives	100% of the Allowed Amount; subject to the calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available

BABY YOURSELF PROGRAM	
Benefit	
Baby Yourself	A prenatal wellness program with high-risk pregnancy early intervention that is provided by BCC at 1 800 621-0965; a $55 maximum reimbursement will be provided to the Participant from Blue Cross and Blue Shield of Illinois for the purchase of a car seat, stroller or breast feeding pump; for multiple births, the reimbursement is per child. Members may enroll into the Program at any time during their pregnancy; in order to receive the incentive reimbursement, the member must be enrolled into the Program by the 28th week of their pregnancy.

INDIVIDUAL CASE MANAGEMENT	
Benefit	
Individual Case Management	A program to assist Participants and their families in coordinating care in the event of a lengthy illness. Services are available through BCC; see the Individual Case Management section for details; call BCC at 1 800 621-0965.

SUMMARY OF HEALTH BENEFITS – BASIC INDEMNITY PLAN FOR RETIREES

This table is a summary of benefits and is subject to all other terms and conditions of the Basic Indemnity Plan for BellSouth Retirees:

To maximize your benefits, seek medical services from a Preferred Provider who participates in the BlueCard Preferred Provider Organization (PPO) Program. Please call 1 800 810-BLUE (2583) or access our web site at www.bcbsil.com/att to find out if your provider is a PPO member.

Please be aware that not all providers participating in the BlueCard PPO Program will be recognized by us as approved providers for the type of service or supply being furnished as explained more fully in paragraph 4 of "Benefit Conditions."

ALL RETIREES INPATIENT HOSPITAL	
Benefit	
Coverage	No limit on the number of days for inpatient hospital care; covered inpatient expenses are paid at 100% of the Allowed Amount, subject to the calendar year deductible
Preadmission Certification	Required for all admissions including maternity over 48 hours for a normal delivery and over 96 hours for a C-Section; emergency admissions require precertification within 48 hours of admission; **for precertification call BCC at 1 800 621-0965 Toll-Free;** if no preadmission certification is obtained, there will be a $250 penalty
MANAGEMENT AND CRAFT PRE 1992 RETIREES OUTPATIENT HOSPITAL	
Benefit	
Accidental Injury and Medical Emergencies	100% of the Allowed Amount, subject to a $35 copay, when services are rendered within 72 hours of an accident or sudden onset of symptoms; the copay is waived if admitted No benefits are available if not a True Emergency
CRAFT POST 1991 RETIREES OUTPATIENT HOSPITAL *	
Benefit	
Accidental Injury and Medical Emergencies	100% of the Allowed Amount, subject to a $75 copay, when services are rendered within 72 hours of an accident or the sudden onset of symptoms; the copay is waived if admitted No benefits are available if not a True Emergency
ALL RETIREES OUTPATIENT HOSPITAL*	
Benefit	
Surgery**	90% of the Allowed Amount, subject to the calendar year deductible

ALL RETIREES OUTPATIENT HOSPITAL* - Continued	
Benefit	
Diagnostic Lab and X-ray, IV Therapy, Hemodialysis, Radiation Therapy and Chemotherapy (including Diagnosed Mammograms and Preadmission Testing) Routine Labs and X-rays in an Outpatient Facility are not covered (except for routine Mammogram, routine Pap smear and routine Colorectal Screenings)	90% of the Allowed Amount, subject to the calendar year deductible
Routine Mammogram One Baseline Mammogram between ages 35 and 39; annually beginning at age 40 Note: The first Mammogram received either as routine or for a diagnosed condition is paid at the higher benefit level	100% of the Allowed Amount, no deductible
Routine Pap Smears Limited to one per year for females	100% of the Allowed Amount, no deductible for the Pap Smear only
Routine Colorectal Screening Annually beginning at age 50 See Colorectal Screening (later in this booklet) for additional information	90% of the Allowed Amount, subject to the calendar year deductible
Physical, Occupational and Speech Therapy	90% of the Allowed Amount, subject to the calendar year deductible. Note: Precertification is required. If precertification is not obtained, no benefits are available. If precertification is obtained retroactively, a $250 penalty will apply

* Outpatient hospital services will be processed as Other Covered Services rather than as Outpatient Hospital Benefits if:

(1) the facility bills for an emergency room visit but the patient's condition does not meet the definition of a medical emergency (this includes any lab and x-ray exams, diagnostic tests

and other services or supplies associated with the emergency room fee)

(2) the services or supplies you receive are not listed in the table above.

** Outpatient Facility coverage includes services provided in an Ambulatory Surgical Center.

ALL RETIREES PHYSICIAN SERVICES - HOSPITAL BASED	
Benefit	
Surgery, Inpatient Hospital Visits, Inpatient or Outpatient Consultations, Hemodialysis, and Chemotherapy	90% of the Allowed Amount, subject to the calendar year deductible. Note: Inpatient visits are limited to one per day for the attending physician and one per day per specialist per admission. Consultations are limited to one consult per specialty per admission
Hospital Based Physicians including Certified Registered Nurse Anesthetist, Anesthesiologist, Pathologist, Radiologist, Neonatologist and the Physician Charges for the Professional Reading of EKG's	90% of the Allowed Amount, subject to the calendar year deductible
Assistant Surgeon Note: Covered when Medically Necessary	90% of the Allowed Amount, subject to the calendar year deductible
Diagnosed Mammograms	90% of the Allowed Amount, no deductible
Emergency Room Physician Services when a True Emergency	100% of the Allowed Amount, no deductible or copay
Emergency Room Physician Services not a True Emergency	90% of the Allowed Amount, subject to the calendar year deductible
Maternity	100% of the Allowed Amount, no deductible or copay

ALL RETIREES PHYSICIAN SERVICES –OFFICE BASED	
Benefit	
Surgery, Anesthesia, Chemotherapy and Radiation Therapy	90% of the Allowed Amount, subject to the calendar year deductible Note: Anesthesia in the office is considered part of the global reimbursement for the surgery
Office Visits and Office Consultations for Non-Accidental Injury and not a True Emergency	90% of the Allowed Amount, subject to the calendar year deductible
Office Visits for a Medical Condition by an Optometrist and not Related to the Initial Eye Exam following Intraocular Surgery	90% of the Allowed Amount, subject to the calendar year deductible
Office Visits by a Nurse Practitioner or Physician Assistant When Operating within the Scope of their License	90% of the Allowed Amount, subject to the calendar year deductible
Office Visit for Emergency and Accidental Injury Office Visit when a True Emergency	90% of the Allowed Amount, no deductible or copay
Diagnostic X-rays and Lab (Includes Diagnosed Mammograms and Diagnosed Pap smears)	90% of the Allowed Amount, subject to the calendar year deductible
Allergy Testing and Treatment	90% of the Allowed Amount, subject to the calendar year deductible
Second Surgical Opinions (Not Required)	90% of the Allowed Amount, subject to the calendar year deductible
Pneumococcal Vaccine - No age limit See Physician Benefits Section for additional information	90% of the Allowed Amount, subject to the calendar year deductible

ALL RETIREES PREVENTIVE CARE SERVICES – WELL CHILD	
Benefit	
In-Hospital Routine Newborn Care	90% of the Allowed Amount, subject to the calendar year deductible; limited to one Well Baby pediatric examination during the mother's hospital stay
Routine Well Child Care*	90% of the Allowed Amount, to age five, no visit limit 90% of Allowed Amount subject to a $5 copay, for members ages six to 12 limited to one exam per year
Lipid Panel, Cholesterol, Lipoprotein, and Triglycerides	90% of the Allowed Amount, no deductible or copayment to age 12
TB Skin Test when provided in conjunction with an office visit*	90% of the Allowed Amount, no deductible or copayment to age 12
Routine Immunizations* See the Section for Preventive Care for Covered Immunizations	90% of the Allowed Amount, no deductible or copayment to age six
Tetanus *	90% of the Allowed Amount, no deductible or copayment; limited to one each 10 calendar years, to age 12
Influenza Vaccine*	90% of the Allowed Amount, no deductible or copayment, limited to one per year with no age limit
HPV Vaccine*	90% of the Allowed amount, no deductible or copayment; for females ages 9 through 26

* Well child care including examinations, immunizations and lab test are limited to $250 maximum per child or $400 per family each calendar year.

MANAGEMENT AND CRAFT PRE 1992 RETIREES PREVENTIVE CARE SERVICES – AGES 13 AND OLDER	
Benefit	
Routine Physical Exams*	100% of the PPO Allowance, subject to the $15 copayment; limited to one each calendar year for ages 13 and older. Note: No benefits are available for routine physicals performed in an inpatient or outpatient setting
Lipid Panel, Cholesterol, Lipoprotein, Triglycerides *	100% of the Allowed Amount, subject to a $15 copayment; limited to one each per year; ages 13 and older

MANAGEMENT AND CRAFT PRE 1992 RETIREES PREVENTIVE CARE SERVICES – AGES 13 AND OLDER – Continued	
Benefit	
TB Skin Test when provided in conjunction with an office visit*	100% of the PPO Allowance, subject to a $15 copayment; limited to one each per year; ages 13 and older limit
Venipuncture and Urinalysis *	100% of the Allowed Amount, subject to a $15 copayment; limited to one each per year; ages 13 and older
Hematocrit or Hemoglobin (HCT or HGB) *	100% of the Allowed Amount, subject to a $15 copayment; one per year for members ages 13 through 17
Routine Immunizations* See the Section for Preventive Care for Covered Immunizations	100% of the Allowed Amount, subject to a $15 copayment
Tetanus *	100% of the Allowed Amount, subject to a $15 copayment; limited to one each 10 calendar years, ages 13 and older
Pneumococcal Vaccine*	100% of the Allowed Amount, subject to a $15 copayment; limited one in a lifetime for members ages 65 and older
Influenza Vaccine*	100% of the Allowed Amount, subject to a $15 copayment; limited to one per year with no age limit
HPV Vaccine*	100% of the Allowed Amount, subject to a $15 copayment; for females ages 9 through 26
Zoster (Shingles) Vaccine	100% of the Allowed Amount, subject to a $15 copayment for members ages 60 and over
Routine Pap Smears**	100% of the Allowed Amount, no deductible; limited to one per year for females
Routine Mammogram Note: The first mammogram received that was either routine or for a diagnosed condition will be considered at the higher benefit level See Mastectomy and Mammograms (later in this booklet) for additional information	100% of the Allowed Amount with no deductible or copayment; limited to one baseline mammogram between the age of 35 and 39, and one annually beginning at age 40
Routine Prostate Specific Antigen (PSA)*	100% of the Allowed Amount subject to a $15 copayment; limited to one per year for males ages 40 and over
CBC and SMA20/Chemistry Profile*	100% of the Allowed Amount, subject to a $15 copayment; limited to one each per year for members ages 18 and older

MANAGEMENT AND CRAFT PRE 1992 RETIREES PREVENTIVE CARE SERVICES – AGES 13 AND OLDER -Continued	
Benefit	
EKG, Basic Metabolic Panel, General Health Panel, Comprehensive Metabolic Panel; Renal Function Panel*	100% of the Allowed Amount, subject to a $15 copayment; limited to one each per member ages 50 and older
Colorectal Cancer Screening – Ages 50 and Over Fecal occult blood test (FOBT) once per calendar year; Flexible sigmoidoscopy once per calendar year; Double-contrast barium enema once every five calendar years; Colonoscopy once every 10 calendar years See Colorectal Cancer Screenings (later in this booklet) for additional information	100% of the PPO Allowance, no deductible
Contraceptive Coverage for Females.* Oral contraceptives are only available through Medco Health Solutions, Inc.	100% of the Allowed Amount, subject to a $15 copayment

* One $15 copayment will be applied per specialty per day.

** Physician services for the office visit associated with a Pap smear are provided at 100% of the Allowed Amount, subject to the $15 copayment; limited to one per person each calendar year. Pap smears provided by an independent laboratory are provided at 100% of the Allowed Amount, no deductible or copayment.

CRAFT POST 1991 RETIREES PREVENTIVE CARE SERVICES – AGES 13 AND OLDER	
Benefit	
Routine Physical Exams*	100% of the PPO Allowance, subject to the $20 copayment; limited to one each calendar year for ages 13 and older. Note: No benefits are available for routine physicals performed in an inpatient or outpatient setting
Lipid Panel, Cholesterol, Lipoprotein, Triglycerides *	100% of the Allowed Amount, subject to a $20 copayment; limited to one each per year; ages 13 and older

CRAFT POST 1991 RETIREES PREVENTIVE CARE SERVICES – AGES 13 AND OLDER – Continued	
Benefit	
TB Skin Test when provided in conjunction with an office visit*	100% of the PPO Allowance, subject to a $20 copayment; limited to one each per year; ages 13 and older limit
Venipuncture and Urinalysis *	100% of the Allowed Amount, subject to a $20 copayment; limited to one each per year; ages 13 and older
Hematocrit or Hemoglobin (HCT or HGB) *	100% of the Allowed Amount, subject to a $20 copayment; one per year for members ages 13 through 17
Routine Immunizations* See the Section for Preventive Care for Covered Immunizations	100% of the Allowed Amount, subject to a $20 copayment
Tetanus *	100% of the Allowed Amount, subject to a $20 copayment; limited to one each 10 calendar years, ages 13 and older
Pneumococcal Vaccine*	100% of the Allowed Amount, subject to a $20 copayment; limited one in a lifetime for members ages 65 and older
Influenza Vaccine*	100% of the Allowed Amount, subject to a $20 copayment; limited to one per year with no age limit
HPV Vaccine*	100% of the Allowed Amount, subject to a $20 copayment; for females ages 9 through 26
Zoster (Shingles) Vaccine	100% of the Allowed Amount, subject to a $20 copayment for members ages 60 and over
Routine Pap Smears**	100% of the Allowed Amount, no deductible; limited to one per year for females
Routine Mammogram Note: The first mammogram received that was either routine or for a diagnosed condition will be considered at the higher benefit level See Mastectomy and Mammograms (later in this booklet) for additional information	100% of the Allowed Amount with no deductible or copayment; limited to one baseline mammogram between the age of 35 and 39, and one annually beginning at age 40
Routine Prostate Specific Antigen (PSA)*	100% of the Allowed Amount subject to a $20 copayment; limited to one per year for males ages 40 and over
CBC and SMA20/Chemistry Profile*	100% of the Allowed Amount, subject to a $20 copayment; limited to one each per year for members ages 18 and older

CRAFT POST 1991 RETIREES PREVENTIVE CARE SERVICES – AGES 13 AND OLDER -Continued	
Benefit	
EKG, Basic Metabolic Panel, General Health Panel, Comprehensive Metabolic Panel; Renal Function Panel*	100% of the Allowed Amount, subject to a $20 copayment; limited to one each per member ages 50 and older
Colorectal Cancer Screening – Ages 50 and Over Fecal occult blood test (FOBT) once per calendar year; Flexible sigmoidoscopy once per calendar year; Double-contrast barium enema once every five calendar years; Colonoscopy once every 10 calendar years See Colorectal Cancer Screenings (later in this booklet) for additional information	100% of the PPO Allowance, no deductible
Contraceptive Coverage for Females.* Oral contraceptives are only available through Medco Health Solutions, Inc.	100% of the Allowed Amount, subject to a $20 copayment

* One $20 copayment will be applied per specialty per day.

** Physician services for the office visit associated with a Pap smear are provided at 100% of the Allowed Amount, subject to the $20 copayment; limited to one per person each calendar year. Pap smears provided by an independent laboratory are provided at 100% of the Allowed Amount, no deductible or copayment.

MANAGEMENT AND CRAFT PRE 1992 RETIREES GENERAL PROVISIONS	
Benefit	
Calendar Year Deductible	$200 per person per calendar year; two deductibles per family or $450 family aggregate deductible*
Annual Out-of-Pocket Maximum	$1,300 per person; $2,600 per family plus the calendar year deductible; covered expenses paid at 100% of the Allowed Amount thereafter for the remainder of the calendar year**
Lifetime Maximum	Unlimited

CRAFT POST 1991 RETIREES GENERAL PROVISIONS	
Benefit	
Calendar Year Deductible	$300 per person per calendar year; two deductibles per family or $600 family aggregate Deductible*
Annual Out-of-Pocket Maximum	$1,300 per person; $2,600 per family plus the calendar year deductible; covered expenses paid at 100% of the Allowed Amount thereafter for the remainder of the calendar year**
Lifetime Maximum	Unlimited

* The calendar year deductible will be applied to claims in the order in which they are processed regardless of the order in which they are received. Once the maximum number of family members specified above has met the full deductible, no additional covered expenses will be applied toward any family member's individual deductible for the rest of the calendar year; however, all charges applied toward individual deductibles until that point are non-refundable.

** Fixed copayments, the calendar year deductible, the $250 precertification penalty, amounts over the Allowed Amount, amounts over the maximum allowed for chiropractic visits, amounts over the maximum for Well Child Care, and non-covered expenses do not apply toward the Annual Out-of-Pocket Maximum.

ALL RETIREES OTHER COVERED SERVICES	
Benefit*	
Physical Therapy, Occupational Therapy, and Speech Therapy	90% of the Allowed Amount, subject to the calendar year deductible. Note: Precertification is required. If precertification is not obtained, no benefits are available. If precertification is obtained retroactively, a $250 penalty will apply
Surgical Management of Temporomandibular Joint (TMJ) Disorders Office Based Services	90% of the Allowed Amount, subject to the calendar year deductible. Non-surgical and dental treatment of TMJ is excluded
Durable Medical Equipment (DME)	90% of the Allowed Amount, subject to the calendar year deductible
Ambulance Service	90% of the Allowed Amount, subject to the calendar year deductible
Chiropractic Services	90% of the Allowed Amount; subject to the calendar year deductible limited to $100 for the first visit, limited to once in a lifetime; all other visits are limited to a maximum of $50 per visit, two visits per week, and 20 visits each calendar year per member
Prescription Drugs Provided to Members Residing in a Skilled Nursing Facility (SNF)	100% of the Allowed Amount, subject to the calendar year deductible

ALL RETIREES OTHER COVERED SERVICES – continued	
Benefit*	
Eyeglasses and Contact Lenses	90% of the Allowed Amount, subject to the calendar year deductible limited to the initial pair following intraocular surgery; Includes the related examination and prescription for eyeglasses or contact lenses
Hearing Aids	90% of the Allowed Amount, subject to the calendar year deductible; limited once after ear surgery

* See Other Covered Services in the Health Benefits section for additional services. Most Other Covered Services are paid at 90% of the Allowed Amount after the calendar year deductible is met.

ALL RETIREES OTHER COVERED SERVICES – ALTERNATE CARE	
Benefit	
Home Health Care/ Home IV Therapy	100% of the Allowed Amount, subject to the calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available
Hospice Care	100% of the Allowed Amount, subject to the calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available
Skilled Nursing Facilities (SNF)	100% of the Allowed Amount, subject to the calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available
Private Duty Nursing	90% of the Allowed Amount, subject to the calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available
Birthing Centers	100% of the Allowed Amount, subject to the calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available
Nurse Midwives	100% of the Allowed Amount; subject to the calendar year deductible. Precertification is required; if precertification is not obtained, no benefits are available; retroactive certification is not available

ALL RETIREES BABY YOURSELF PROGRAM	
Benefit	
Baby Yourself	A prenatal wellness program with high-risk pregnancy early intervention that is provided by BCC at 1 800 621-0965. A $55 maximum reimbursement will be provided to the participant from Blue Cross and Blue Shield of Illinois for the purchase of a car seat, stroller or breast feeding pump; for multiple births, the reimbursement is per child. Members may enroll into the Program at any time during their pregnancy; in order to receive the incentive reimbursement, the member must be enrolled into the Program by the 28th week of their pregnancy.

ALL RETIREES INDIVIDUAL CASE MANAGEMENT	
Benefit	
Individual Case Management	A program to assist Participants and their families in coordinating care in the event of a lengthy illness. Services are available through BCC; see the Individual Case Management section for details; call BCC at 1 800 621-0965.

BENEFIT CONDITIONS

To qualify as plan benefits, medical services and supplies must meet the following:

1. They must be furnished after your coverage becomes effective;

2. We must determine before, during or after services and supplies are furnished that they are medically necessary;

3. PPO benefits must be furnished while you are covered by this plan and the provider must be a PPO Provider when the services or supplies are furnished to you;

4. Separate and apart from the requirement in paragraph 3. above, services and supplies must be furnished by a provider (whether a Preferred Provider or not) who is recognized by us as an approved provider for the type of service or supply being furnished. For example, we reserve the right not to pay for some or all services or supplies furnished by certain persons who are not Medical Doctors (M.D.'s), even if the services or supplies are within the scope of the provider's license. Call the Customer Service Unit if you have any question whether your provider is recognized by us as an approved provider for the services or supplies you plan on receiving;

5. Services and supplies must be furnished when the plan and your coverage both are in effect. No benefits will be provided for services you receive after the plan or your coverage ends, even if they are for a condition which began before the plan or your coverage ends.

HEALTH BENEFITS

All benefits are subject to all deductibles, conditions, limitations and exclusions of the plan.

BEFORE YOUR HOSPITAL ADMISSION--CAUTION: One of several requirements for hospital benefits is that we certify the medical necessity of your hospital stay in advance; this includes all hospital stays including maternity over 48 hours for normal delivery and more than 96 hours for C Section. Emergency admissions require notice to BCC within 48 hours and must also be certified by us as both medically necessary and as an emergency admission. You may appeal these decisions. **Failure to obtain our certification of medical necessity will result in penalties as described in the Summary of Health Benefits.** Just because we certify a hospital admission as medically necessary does NOT mean we have decided to pay benefits for it. For example, the admission may be for an excluded condition.

Inpatient Hospital Benefits

1. Bed and board and general nursing care in a semiprivate room; **or**
2. Private room in a Private Room only hospital; or
3. Use of special hospital units such as intensive care or burn care and the hospital nurses who staff them; **and**
4. Use of operating, delivery, recovery, and treatment rooms and the equipment in them;
5. Administration of anesthetics by hospital employees and all necessary equipment and supplies;
6. Casts and splints, surgical dressings, treatment and dressing trays;
7. Diagnostic tests, including laboratory exams, metabolism tests, cardiographic exams, encephalographic exams, and x-rays;
8. Physical therapy, occupational therapy, speech therapy, hydrotherapy, radiation therapy and chemotherapy;
9. Oxygen and equipment to administer it;
10. All drugs and medicines used by you and administered in the hospital;
11. Regular nursery care and diaper service for a newborn baby while the mother is confined;
12. Special diets;
13. Blood transfusions administered by a hospital employee.

- Inpatient hospital admissions that are primarily rehabilitative or custodial in nature are not covered. You should contact BCC prior to all inpatient hospital admissions. You should also contact BCC if your therapy continues after the hospital stay.
- Hospitalization for dental care is covered when confinement results from an accidental bodily injury or a physician, other than a dentist, certifies through BCC that the hospitalization is necessary due to a non-dental organic impairment to safeguard the health or life of the patient.

- Weekend admissions for hospitalization, admissions primarily for diagnostic x-rays, laboratory tests, surgery, physical therapy or any other service that could have been provided on an outpatient basis or are solely for the convenience of the patient or the patient's family are not covered. BCC will certify all inpatient hospital admissions on the basis of medical necessity.

Inpatient Hospital Benefits for Maternity

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

Note: Newborns who remain hospitalized after the mother is discharged will require certification of medical necessity.

Outpatient Facility Benefits

1. Emergency treatment of an accidental injury within 72 hours;
2. Chemotherapy and radiation therapy;
3. IV therapy;
4. Hemodialysis;
5. X-rays, lab and pathology services;
6. Medical emergency (subject to copay);
7. Surgery;
8. Physical, occupational, and speech therapy.

- Care provided in the emergency room that is not a True Emergency is not covered.
- Physical, occupational, and speech therapy requires precertification by BCC, unless Medicare is primary. Precertification is required when Medicare benefits are exhausted.
- Routine Lab and x-ray services provided in an Outpatient Hospital setting are not covered (except routine Mammograms and routine Pap smears and routine Colorectal Screenings).

Physician Benefits

Covered Physician Benefits are:

1. Surgery, which includes preoperative and postoperative care, reduction of fractures and endoscopic procedures;
2. Anesthesia for a covered service;

3. Elective second surgical opinion services;

4. Obstetrical care for childbirth, pregnancy, and the usual care before and after those services;

5. Inpatient visits while you're a hospital patient for other than surgery, obstetrical care, or radiation therapy except for an unrelated condition;

6. Amniocentesis for women who will be 35 on the estimated date of delivery;

7. Consultation for a medical, surgical or maternity condition by a specialty physician but only one for each hospital stay;

8. Diagnostic lab, x-ray and pathology services in a physician's office when related to covered services;

9. Radiation therapy and chemotherapy;

10. Care in the emergency room of a hospital for other than surgery or maternity when a True Emergency;

11. Preventive care services;

12. Examination, diagnosis, and treatment for an illness or injury;

13. Pneumococcal Vaccine when medically necessary. You may access the medical policy for the pneumococcal vaccine through the Blue Cross and Blue Shield of Illinois web site, http://www.bcbsil.com/att.

In order to maximize your benefits, you should select a PPO physician for all services.

There may be times when a PPO physician is not available or when a non-PPO specialist may be called into an emergency room without your knowledge or consent. While it is your responsibility to use a PPO physician when possible, you may submit a request for an appeal when you are unable to do so.

There are no waivers in effect for the Plan for failing to use a PPO provider solely due to the fact that one is not available within a specific area. Availability of a PPO physician is dependent on the information furnished to us by the local Plan in which the services are provided.

Your PPO physician or other Preferred or Participating Provider may bill another group health plan for any difference between the amount we pay and their charge for any service that is a benefit of this plan. You are responsible for any amounts over the allowed amount for services provided by a Non-PPO Provider.

Preventive Care Services

1. Routine immunizations are covered for the Retiree Medical Assistance Basic Plan, the Basic Plan When Medicare is Primary and the Basic Indemnity Plan for Retirees as follows:

    - Prevnar for ages two months to five years;
    - Polio and Chicken Pox to age six;
    - Meningococcal vaccine, no age limit
    - Tetanus vaccine, no age limit; limited to one every 10 calendar years

- Influenza vaccine, no age limit; limited to one each calendar year
- Hepatitis A, no age limit
- Rotavirus, no age limit
- Human Papilloma Virus (HPV) vaccine for members age 9 to 26; HPV is given in a series of three doses; if the member turns 27 before the third dose is given, we will extend coverage for the remaining doses.
- Zoster (Shingles) Vaccine for members age 60 and over
- Pneumococcal vaccine for member ages 65 and older; limited to a lifetime maximum of one

2. Additional Routine immunizations are covered for the Retiree Basic Plan as follows:

   - Diphtheria, pertussis, rubella, mumps, measles, and HIB to age 12;
   - Hepatitis B vaccine to age 17.

3. Additional Routine immunizations are covered for the Retiree Basic Plan When Medicare is Primary and the Basic Indemnity Plan for Retirees members as follows:

   - Diphtheria, pertussis, rubella, mumps, measles, and HIB to age six;
   - Hepatitis B vaccine to age six and from age 13 through 17.

4. One inpatient pediatric visit for routine newborn care during the mother's hospital stay;

5. One routine Pap smear a year for females provided in either an office or Outpatient hospital setting;

6. One baseline mammogram for females ages 35-39; one mammogram a year for ages 40 and over provided in either an office or Outpatient hospital setting; see Mastectomy and Mammograms (later in this booklet) for additional information;

7. One routine prostate specific antigen test (PSA) each year for males ages 40 and over;

8. One Venipuncture each year for the Retiree Basic Plan with no age limit and one Venipuncture each year beginning at age 13 for the Retiree Basic Plan When Medicare is Primary and the Basic Indemnity Plan for Retirees;

9. One urinalysis each year under the Retiree Basic Plan with no age limit and one urinalysis each year beginning at age 13 for the Retiree Basic Plan When Medicare is Primary and the Basic Indemnity Plan for Retirees;

10. One CBC and one SMA20, chemistry profile each year for members ages 18 and older;

11. One HCT or HGB each year for members through age 17 for the Retiree Basic Plan. For the Retiree Basic Plan When Medicare is Primary and the Basic Indemnity Plan for Retirees, one HCT or HGB each year for members age 13 through17.

12. One lipid panel, one cholesterol, one lipoprotein and one triglycerides each year with no age limit;

13. One EKG, basic metabolic panel, general health panel, comprehensive metabolic panel, and renal function panel each year for members ages 50 and older;

14. One office visit a year for members ages 13 and older (subject to copay);

15. Well child office visits for the first five years of a child's life; annual exams for ages six through twelve (subject to the copay).

16. Colorectal Cancer Screening for ages 50 and over including:
    - Fecal occult blood test (FOBT) once per calendar year;
    - Flexible sigmoidoscopy once per calendar year;
    - Double-contrast barium enema once every five calendar years;
    - Colonoscopy once every 10 calendar years;
    - Benefits for the Sigmoidoscopy, Double-contrast barium enema and Colonoscopy are available in either an office or Outpatient hospital setting.

See Colorectal Cancer Screenings (later in this booklet) for additional information.

Any routine laboratory tests, routine x-rays or routine physician visits that are not specified in the Preventive Care Sections are not covered. All routine laboratory, routine x-rays, and routine examinations in an inpatient hospital setting are not covered. In an outpatient hospital setting, routine tests other than a routine Mammogram, routine Pap smear and routine Colorectal Screenings as specified are not covered.

If you are covered under the Retiree Basic Plan, you must use a PPO provider in order to receive benefits for preventive care except routine mammograms and routine Pap smears. Retiree Basic Plan When Medicare is Primary Participants and Basic Indemnity Plan for Retirees Participants may use any physician for preventive care.

Baby Yourself Program

If you or your spouse is pregnant, Baby Yourself offers individual care by a registered nurse. Please call BCC at 1 800 621-0965 as soon as you find out that you are pregnant. Begin care for you and your baby as early as possible and continue throughout your pregnancy. Your baby has the best chance for a healthy start by early, thorough care while you are pregnant. If you fall into one of the following risk categories, please tell your doctor and your Baby Yourself nurse:

- Ages 35 or older
- High blood pressure
- Diabetes
- History of previous premature births
- Multiple births (twins, triplets, etc.)

Other Covered Services

1. Outpatient hospital services, not listed elsewhere in this document.

2. Anesthesia for surgery or obstetrical care when given by a covered provider who is not the surgeon or obstetrician or hospital employee.

3. Physical therapy and hydrotherapy given by a licensed physical therapist. It is the responsibility of the Participant to be sure that the required precertification is in place before the service begins. If precertification is denied, you will have the right to appeal the denial. Precertification is not required when Medicare is primary unless Medicare benefits are exhausted. Physical therapy must be prescribed by a physician and performed by a physical therapist such as a Registered Physical Therapist (RPT) or a Licensed Physical Therapy Assistant (LPTA) when supervised and billed by an RPT.
    - Charges for therapies that are determined to be maintenance treatment, except for certain diagnosed conditions of minor children, are not covered.
    - Children under age eighteen who have reached the maintenance level of therapy can continue to have therapy certified by BCC for the following diagnoses:

- Cerebral palsy
- Developmental delay
- Spina bifida
- Down's syndrome
- Speech dysarthia
- Maintenance therapy is not to exceed two sessions per month up to 24 sessions per year with a maximum benefit of $40 per session. The patient is allowed two sessions of each type of therapy (physical, speech, occupational). BCC will certify maintenance therapy every six months.

4. Radiation and Chemotherapy.

5. Laboratory and x-ray exams and other diagnostic tests.

6. Allergy testing and treatment.

7. Artificial arms and other prosthetics; leg braces and other orthopedic devices.

8. Medical supplies such as oxygen, crutches, casts, splints, catheters, colostomy bags, diabetic supplies and urinary supplies.

9. Treatment of natural teeth injured by a force outside your mouth or body, if service is received within 90 days of the injury.

10. Professional ambulance service is only available as Emergency transport to the closest hospital that could treat the patient for an acute or serious medical condition; Professional ambulance service is not covered for non-emergency transport.

11. The less expensive for rental or purchase of durable medical equipment such as wheelchairs and hospital beds.

12. Hemodialysis services of a Participating Renal Dialysis Facility.

13. Physician Assistants and Nurse Practitioners are covered providers under the plan when operating within the scope of their license. Physician Assistants who are licensed as Surgical Assistants are covered providers when medically necessary.

14. Optometrists are covered providers when operating within the scope of their license and when treating medical conditions that are not related to routine vision and for the initial examination and fitting of the initial pair of eyeglasses or contact lens following intraocular surgery.

15. Occupational therapy services when medically necessary and performed by a licensed occupational therapist. Precertification is required under the Retiree Basic Plan and Basic Indemnity Plan for Retirees. Retiree Basic Plan When Medicare is Primary Participants are not required to obtain precertification unless Medicare benefits are exhausted.

16. Surgical management of TMJ.

17. Chiropractic services.

18. Private duty nursing services by a licensed registered nurse (RN) or a licensed practical nurse (LPN) only when precertified by BCC as medically necessary. No benefits are available unless precertified.

19. Home Health Care is covered when it is precertified by BCC and is performed by or

under the direct supervision of a licensed, registered or practical nurse and reviewed by a physician. No benefits are available unless precertified. Covered services include:

- Nursing service by either an RN or LPN;
- Physical, occupational, speech and respiratory therapy;
- Medical social service;
- Home health aid service;
- Nutritional guidance;
- Diagnostic services;
- Oxygen and its administration;
- Hemodialysis.

20. Hospice care is covered when precertified by BCC and performed by a hospice program to a person who, based on a physician's determination, is expected to live no more than six months. No benefits are available unless precertified. Covered services include:

- Room and board and general nursing care;
- Services of hospice employed physicians;
- Physical therapy, occupational therapy, respiratory therapy and speech language pathology services provided by licensed providers;
  Medical social services provided by licensed social workers;
- Home health and visits by hospice employees;
- Medical appliances and drug and biologicals to relieve pain and control symptoms of the member related to their terminal illness;
- Skilled nursing visits by a licensed registered nurse (RN) or licensed practical nurse (LPN).

21. Skilled nursing facility benefits are available when precertified by BCC and are covered when the patient is recovering from a serious illness or injury, confined to a bed with a long term illness or injury, or has a terminal condition. The benefit includes the facility charges for room, board, and routine nursing care. No benefits are available unless precertified. **Custodial Care is not covered.**

22. Speech therapy given by a qualified speech therapist or physician when precertified by BCC. Medicare Primary Participants are not required to obtain precertification unless Medicare benefits are exhausted.

23. Medical services by a Nurse Midwife acting within the scope of their license when precertified by BCC. No benefits are available unless precertified.

24. Birthing center when precertified by BCC. No benefits are available unless precertified.

25. The initial pair of eyeglasses and contact lenses following intraocular surgery. The intraocular surgery must have been performed while the member was covered under the Plan.

26. Hearing aids one time only following ear surgery. The ear surgery must have been performed while the member was covered under the Plan.

Mandatory Outpatient Surgical Procedures

The following surgeries must be performed on an outpatient basis unless precertified by BCC:

- Dilation and curettage
- Excisions of lesions of skin
- Eye muscle operations

- Hammertoe repair
- Hemorrhoidectomy
- Herniorrhaphy
- Mastoidectomy
- Neuroplasty
- Submuccous resection
- Tendon (sheath) release/repair
- Varicose vein ligation

Individual Case Management

Unfortunately, some people suffer from catastrophic, long-term, and chronic illness or injury. If you have a catastrophic, long-term or chronic illness or injury, a Blue Cross Registered Nurse may assist you in accessing the most appropriate health care for your condition. The nurse case manager will work with you, your physician, and other health care professionals to design a treatment plan to best meet your health care needs. In order to implement the plan, you, your physician, and Blue Cross must agree to the terms of the plan. The program is voluntary to you and your physician. Under no circumstances are you required to work with a Blue Cross case management nurse. Benefits provided to you through Individual Case Management are subject to your benefit contract maximums. If you think that you may benefit from Individual Case Management, please call the Blue Care Connection (BCC) at 1 800 621-0965.

The Managed Care Program

When the Retiree Medical Assistance Plan for BellSouth Employees is the primary plan, there are certain times you should contact BCC. BCC will assist you and your covered dependents in securing quality medical care. BCC will provide you with information that allows you, in consultation with your physician, to evaluate medically appropriate alternatives to surgery and hospitalization. In addition, BCC monitors any certified hospital confinement and keeps you informed as to whether or not the stay remains certified under the Plan.

Remember that all decisions regarding your medical care are between you and your physician. It is however your responsibility to be sure BCC is contacted when required by the plan for the following services:

Inpatient hospital admissions [1, 2]

Outpatient therapy (physical, occupational and speech)[1]

Alternate care (Precertification is always required)

- Home Care/Home IV Therapy
- Hospice Care
- Skilled Nursing Facilities (SNF)
- Private Duty Nursing
- Birthing Centers
- Nurse Midwives
- Individual Case Management (which may include human organ transplants)

1 - Precertification is not required when Medicare is primary unless Medicare benefits have been exhausted. Precertification is not required for out-of-country inpatient admissions.
2 - Inpatient admissions are evaluated on the medical necessity of the admission and would include review of any service such as surgery or therapy that could be performed on an outpatient

basis.

Organ, Tissue and Bone Marrow/Stem Cell Transplants

The Retiree Medical Assistance Plan for BellSouth Employees covers medical expenses for the treatment associated with the following human organ and tissue transplants:

- Heart
- Heart/Lung combined procedure
- Lung
- Liver
- Kidney
- Cornea
- Pancreas
- Heart-valve
- Skin
- Small bowel
- Bone marrow transplants that include stem cells and bone marrow to restore stronger bone marrow function
- Any human organ transplant approved by Blue Cross and Blue Shield of Illinois

Bone Marrow transplants that include stem cells and marrow to restore stronger bone marrow function are also included.

When BCC approves a transplant, it is limited to the specific types of transplants stated. Donor organ costs are limited to search, removal, storage and transporting the organ and removal team.

There are no transplant benefits for: (1) any artificial or mechanical devices; (2) organ or bone marrow transplants from animals; (3) donor costs available through other group coverage; (4) if any government funding is provided; (5) the recipient if not covered by this plan; (6) a condition or disease for which a transplant is considered investigational; (7) transplants performed in a facility not on our approved list for that type or for which we have not given written approval in advance.

Benefits for services and expenses of organ and tissue transplants covered under the Retiree Medical Assistance Plan for BellSouth Employees are subject to the following limitations:

- Must be performed in a hospital or facility that Blue Cross approves in advance in writing for the particular transplant services.
- Must be performed in a hospital or facility which is on a list (available upon request) of approved hospitals or facilities for the particular transplant services that Blue Cross maintains.
- Must be precertified through BCC.

The Retiree Medical Assistance Plan for BellSouth Employees will only reimburse you for medically necessary expenses incurred for the care and treatment associated with covered transplants. Any charges for care, treatment, services or supplies that are determined not to be medically necessary, or which are provided solely for your convenience, are considered exclusions of the plan.

Transplant travel benefits are available as follows:

a. $5,000.00 combined lifetime maximum for air ambulance or airfare; benefits are available to the transplant patient and a family member **and** for a living donor and a family member, and

b. $10,000.00 combined lifetime maximum for other travel expenses, meals and lodging for the transplant patient and a family member and for a living donor and a family member; benefits are available for up to $100.00 per day up to $2,500.00 per month for the transplant patient and a family member **and** $100.00 per day up to $2,500.00 per month for a living donor and a family member.

In order to qualify for travel benefits, the distance traveled must be at least 50 miles from the transplant patient's or living donor's home to the Center of Excellence. Receipts are required to support travel expenses.

Mastectomy and Mammograms

Women's Health and Cancer Rights Act Information

A member who is receiving benefits in connection with a mastectomy will also receive coverage for reconstruction of the breast on which a mastectomy was performed and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications at all stages of the mastectomy, including lymphedema.

Treatment decisions are made by the attending physician and patient. Benefits for this treatment will be subject to the same calendar year deductibles and coinsurance provisions that apply for other medical and surgical benefits.

Benefit for Mammograms

Benefits for mammograms vary depending upon the reason the procedure is performed and the way in which the provider files the claim:

- If the mammogram is performed in connection with the diagnosis or treatment of a medical condition, and if the provider properly files the claim with this information, we will process the claim as a diagnostic procedure according to the benefit provisions of the plan dealing with diagnostic x-rays. Diagnosed mammograms are not limited to specific age bands.
- If you are at high risk of developing breast cancer or you have a family history of breast cancer – within the meaning of our medical guidelines – and if the provider properly files the claim with this information, we will process the claim as a diagnostic procedure according to the benefit provisions of the plan dealing with diagnostic x-rays.
- In all other cases the claim will be subject to the routine mammogram benefit provisions and limits described elsewhere in this booklet.

Colorectal Cancer Screenings

Benefits for colorectal cancer screenings vary depending upon the reason the procedure is performed and the way in which the provider files the claim:

- If the colorectal cancer screening is performed in connection with the diagnosis or treatment of a medical condition, and if the provider properly files the claim with this information, we will process the claim as a diagnostic or surgical procedure according to the benefit provisions of the plan dealing with diagnostic or surgical procedures.
- If you have family history of colon cancer – within the meaning of our medical guidelines – and if the provider properly files the claim with this information, we will process the

claim as a diagnostic or surgical procedure according to the benefit provisions of the plan dealing with diagnostic or surgical procedures.

- In all other cases the claim will be subject to the routine colorectal cancer screening benefit provisions with the age and frequency limitations described elsewhere in this booklet.

COORDINATION OF BENEFITS (COB)

Coordination of Benefits (COB) is a provision designed to help manage the cost of health care by avoiding duplication of benefits when a person is covered by two or more benefit plans. COB provisions determine which plan is primary and which is secondary.

A primary plan is one whose benefits for a person's health care coverage must be determined first without taking the existence of any other plan into consideration.

A secondary plan is one which takes into consideration the benefits of the primary plan before determining benefits available under its plan.

Which plan is primary is decided by the first rule below that applies (note, however, that if the other plan is Medicare, the order of benefit determination is determined by the applicable Medicare secondary payer laws):

1. If the other plan has no COB provision, it is primary.

2. Employee/Dependent: The plan covering a patient as an employee, member, or subscriber (that is other than as a dependent) is primary over the plan covering the patient as a dependent. In some cases, depending upon the size of the employer, Medicare secondary payer rules may require us to reverse this order of payment. This can occur when the patient is covered as an inactive or retired employee, is also covered as a dependent of an active employee, and is also covered by Medicare. In this case, the order of benefit determination will be as follows: first, the plan covering the patient as a dependent; second, Medicare; and third, the plan covering the patient as an inactive or retired employee.

3. Dependent Child/Parents Not Separated or Divorced: If both plans cover the patient as a dependent child, the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the plan covering the patient longer is primary. If the other plan does not use this "birthday rule" the other plan's rule will be used.

4. Dependent Child/Separated or Divorced Parents: If two or more plans cover the patient as a dependent child of divorced or separated parents, benefits are determined in this order:
    a. first, the plan of the parent with custody;
    b. second, the plan of the spouse of the parent with custody;
    c. third, the plan of the parent without custody; and
    d. last, the plan of the spouse of the parent without custody.

    If the divorced or separated parents have joint legal custody, benefits are determined as if the parents are not separated or divorced (see paragraph 3 above).

    If there is a court order that specifically states that one parent must provide for the child's health expenses or provide health insurance coverage for the child, benefits are determined in this order:

    a. first, the plan of the court-ordered parent;
    b. second, the plan of the spouse of the court-ordered parent;
    c. third, the plan of the non-court-ordered parent; and,
    d. last, the plan of the spouse of the non-court-ordered parent.

5. Active/Inactive Employee: When a patient is covered under one plan as an active employee and under another plan as a retired or inactive employee (e.g., a former employee receiving COBRA benefits), the plan which covers the patient as an active employee is primary over a plan which covers the patient as a laid-off or retired employee. This applies to the

employee's dependents as well unless the dependents have other coverage due to their own current or former employment status.

6. Longer/Shorter Length of Coverage: If none of the above rules determine the order of payment, the plan covering the patient the longer time is primary.

If our records indicate this plan is secondary, we will not process your claims until you have filed them with the primary plan and the primary plan has made its benefit determination.

Non-Duplication of Benefits

If this plan is secondary according to the above rules, it will calculate benefits as if it were the primary plan, applying all applicable cost-sharing provisions. This plan will then reduce, on a dollar for dollar basis, any benefits that it would have paid by the benefits paid pursuant to the primary plan. In many cases, this will result in no payment of benefits under this plan.

Special Language for Spousal Carve Out

If a covered dependent is entitled to purchase group health care coverage at his or her place of employment (regardless of whether the employer pays for some or all of the cost of such health care coverage) we will process benefits for that dependent as if the dependent were enrolled in the plan of his or her employer. In order for AT&T Inc. to pay secondary on medical claims, the eligible dependent must have primary coverage, applied for benefits from his primary carrier, and provided proof that primary benefits have been paid (i.e., via an Explanation of Benefits).

MEDICARE

There are two parts of Medicare: Part A provides benefits for inpatient hospital care and for skilled nursing facilities. Part B provides benefits for physician's fees, outpatient hospital fees and certain other covered expenses. The Plan will coordinate with Medicare Parts A and B.

Based on current federal law, you and your dependents may become eligible for both parts of Medicare upon reaching age 65, or before age 65 if you are disabled and have received 24 months of disability payments from Social Security. Medicare is also available if the Participant has End Stage Renal Disease.

You should contact your local Social Security Office for information on how to enroll in Medicare. There are no premiums for Medicare Part A. For Medicare Part B, the Federal Government charges a monthly premium.

Once you or your dependents meet the eligibility requirements for Medicare, if you enroll in Medicare Part A but fail to elect coverage for Medicare Part B, your Part A eligible charges will process secondary to Medicare and there is no coverage under the Plan for Medicare Part B eligible charges. If you elect not to enroll in Medicare Part A and Medicare Part B, you have no benefits under the Plan for any A or B Medicare eligible service.

SUBROGATION

Right of Subrogation

If we pay or provide any benefits for you under this plan, we are subrogated to all rights of recovery which you have in contract, tort, or otherwise against any person or organization for the amount of benefits we have paid or provided. That means that we may use your right to recover money from that other person or organization.

Right of Reimbursement

Besides the right of subrogation, we have a separate right to be reimbursed or repaid from any money you, including your family members, recover for an injury or condition for which we've paid plan benefits. This means that you promise to repay us from any money you recover the amount we've paid or provided in plan benefits. It also means that if you recover money as a result of a claim or a lawsuit, whether by settlement or otherwise, you must repay us. And, if you are paid by any person or company besides us, including the person who injured you, that person's insurer, or your own insurer, you must repay us. In these and all other cases, you must repay us.

We have the right to be reimbursed or repaid first from any money you recover, even if you are not paid for all of your claim for damages and you aren't made whole for your loss. This means that you promise to repay us first even if the money you recover is for (or said to be for) a loss besides plan benefits, such as pain and suffering. It also means that you promise to repay us first even if another person or company has paid for part of your loss. And it means that you promise to repay us first even if the person who recovers the money is a minor. In these and all other cases, we still have the right to first reimbursement or repayment out of any recovery you receive from any source.

Right to Recovery

You agree to furnish us promptly all information which you have concerning your rights of recovery or recoveries from other persons or organizations and to fully assist and cooperate with us in protecting and obtaining our reimbursement and subrogation rights in accordance with this section.

You or your attorney will notify us before filing any suit or settling any claim so as to enable us to participate in the suit or settlement to protect and enforce our rights under this section. If you do notify us so that we are able to and do recover the amount of our benefit payments for you, we will share proportionately with you in any attorney's fees charged you by your attorney for obtaining the recovery. If you do not give us that notice, our reimbursement or subrogation recovery under this section will not be decreased by any attorney's fee for your attorney.

You further agree not to allow our reimbursement and subrogation rights under this plan to be limited or harmed by any other acts or failures to act on your part. It is understood and agreed that if you do, we may suspend or terminate payment or provision of any further benefits for you under the plan.

CLAIMS AND APPEALS

The following explains the rules under your Plan for filing claims and appeals.

Remember that you may always call the Customer Service Unit for help if you have a question or problem that you would like Blue Cross and Blue Shield of Illinois to review without an appeal. The phone number to reach the Customer Service Unit is 1 800 621-7336 and is on the back of your Blue Cross and Blue Shield identification card.

In General

Claims for benefits under the plan can be post-service (i.e. after the service has been provided or supplies purchased), pre-service (such as requests for precertification of inpatient admissions, physical therapy, occupational therapy, speech therapy, Alternate Benefits, etc.), or concurrent (services that require periodic medical necessity review and recertification such as an ongoing hospitalization or services such as physical, speech or occupational therapy, etc.). This summary explains how Blue Cross and Blue Shield of Illinois processes these different types of claims and how you can appeal a partial or complete denial of a claim.

The claims and appeal procedures are designed to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Even if your plan is not covered by ERISA, we will process your claim according to ERISA's standards and provide you with the ERISA appeal rights that are discussed in this section of your booklet.

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this section of your booklet. An authorized representative is someone you designate in writing to act on your behalf. We have developed a form that you must use if you wish to designate an authorized representative. You can get the form by calling the Customer Service Unit. You can also go to our Internet web site at **www.bcbsil.com/att** and ask us to mail you a copy of the form. If a person is not properly designated as your authorized representative, we will not be able to deal with him or her in connection with the exercise of your rights under this section of your booklet.

For urgent pre-service claims, we will presume that your provider is your authorized representative unless you tell us otherwise in writing.

Post-Service Claims

What Constitutes a Claim: For you to obtain benefits after medical services have been rendered or supplies purchased (a post-service claim), we must receive a properly completed and filed claim from you or your provider.

In order for us to treat a submission by you or your provider as a post-service claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, must provide us with the data elements that we specify in advance. **Most providers are aware of our claim filing requirements and will file claims for you**. If your provider does not file your claim for you, you should call our AT&T Customer Service Department and ask for a claim form. Tell us the type of service or supply for which you wish to file a claim (for example, hospital, physician, or pharmacy), (Note: The Pharmacy form applies only to prescription drugs purchased for persons residing in a Skilled Nursing Facility) and we will send you the proper type of claim form. When you receive the form, complete it, attach an itemized bill, and send it to us at:

Blue Cross and Blue Shield of Illinois
P.O. Box 1364
Chicago, Illinois 60690-1364

Claims must be submitted and received by us within 12 months after the service takes place to be eligible for benefits.

If we receive a submission that does not qualify as a claim, we will notify you or your provider of the additional information we need. Once we receive that information, we will process the submission as a claim.

Processing of Claims: Even if we have received all of the information that we need in order to treat a submission as a claim, from time to time we might need additional information in order to determine whether the claim is payable. The most common example of this is medical records that we may need in order to determine whether services or supplies were medically necessary. If we need this sort of additional information, we will ask you to furnish it to us, and we will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to us. In order to expedite our receipt of the information, we may request it directly from your provider. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information on time.

Ordinarily, we will notify you of our decision within 30 days of the date on which your claim is filed. If it is necessary for us to ask for additional information, we will notify you of our decision within 15 days after we receive the requested information. If we do not receive the information, your claim will be considered denied at the expiration of the 90-day period we gave you for furnishing the information to us.

In some cases, we may ask for additional time to process your claim. If you do not wish to give us additional time, we will go ahead and process your claim based on the information we have. This may result in a denial of your claim.

Who Gets Paid: Some of the contracts we have with providers of services, such as hospitals, require us to pay benefits directly to the providers. With other claims we may choose whether to pay you or the provider. If you or the provider owes us money we may deduct the amount owed from the benefit paid. When we pay or deduct the amount owed from you or the provider, this completes our obligation to you under the plan. We need not honor an assignment of your claim to anyone. Upon your death or incompetence, or if you are a minor, we may pay your estate, your guardian or any relative we believe is due to be paid. This, too, completes our plan obligation to you.

Pre-Service Claims

A pre-service claim is one in which you are required to obtain approval from the Blue Care Connection (BCC) before services or supplies are rendered. As examples, you may be required to obtain precertification of inpatient hospital benefits, physical therapy, occupational therapy, speech therapy, or Alternate Benefits. Or you may be required to obtain a pre-procedure review of other medical services or supplies in order to obtain coverage under the plan. Pre-service claims pertain only to the medical necessity of a service or supply. If we grant a pre-service claim, we are not telling you that the service or supply is, or will be, covered; we are only telling you that the service or supply meets our medical necessity guidelines. For example, we might precertify your inpatient hospital admission but later deny your claim because the service or supply is excluded under the plan.

In order to file a pre-service claim you or your provider must call BCC 1 800 621-0965. You must tell BCC your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person BCC can call back, and a phone number to reach that person. You may also, if you wish, submit pre-service claims in writing. Written pre-service claims should be sent to us at BCBS of Illinois, P.O. Box 1364, Chicago, Illinois 60690-1364.

Non-urgent pre-service claims (for example, those relating to elective services and supplies) must be submitted to us during our regular business hours. Urgent pre-service claims can be submitted at any time. Emergency admissions to a hospital do not require you to file a pre-service claim so long as you provide notice to BCC within 48 hours of the admission and we certify the admission as both medically necessary and as an emergency admission.

If you attempt to file a pre-service claim but fail to follow our procedures for doing so, we will notify you of the failure within 24 hours (for urgent pre-service claims) or five days (for non-urgent pre-service claims). Our notification may be oral, unless you ask for it in writing. We will provide this notification to you only if (i) your attempt to submit a pre-service claim was received by a person or organizational unit of our company that is customarily responsible for handling benefit matters, and (ii), your submission contains the name of a member, a specific medical condition or symptom, and a specific treatment or service for which approval is being requested.

Urgent Pre-Service Claims: We will treat your claim as urgent if a delay in processing your claim could seriously jeopardize your life, health, or ability to regain maximum function or, in the opinion of your treating physician, a delay would subject you to severe pain that cannot be managed without the care or treatment that is the subject of your claim. If your treating physician tells us that your claim is urgent, we will treat it as such.

If your claim is urgent, we will notify you of our decision within 72 hours. If we need more information, we will let you know within 24 hours of your claim. We will tell you what further information we need. You will then have 48 hours to provide this information to us. We will notify you of our decision within 48 hours after we receive the requested information. Our response may be oral; if it is, we will follow it up in writing within three days. If we do not receive the information, your claim will be considered denied at the expiration of the 48-hour period we gave you for furnishing the information to us.

Non-Urgent Pre-Service Claims: If your claim is not urgent, we will notify you of our decision within 15 days. If we need more information, we will let you know before the 15-day period expires. We will tell you what further information we need. You will then have 90 days to provide this information to us. In order to expedite our receipt of the information, we may request it directly from your provider. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information on time. We will notify you of our decision within 15 days after we receive the requested information. If we do not receive the information, your claim will be considered denied at the expiration of the 90-day period we gave you for furnishing the information to us.

Courtesy Pre-Determinations: For some procedures we encourage, but do not require, you to contact us before you have the procedure. For example, if you or your physician thinks a procedure might be excluded as cosmetic, you can ask us to determine beforehand whether the procedure is cosmetic or reconstructive. We call this type of review a courtesy pre-determination. If you ask for a courtesy pre-determination, we will do our best to provide you with a timely response. If we decide that we cannot provide you with a courtesy pre-determination (for example, we cannot get the information we need to make an informed decision), we will let you know. In either case, courtesy pre-determinations are not pre-service claims under the plan. When we process requests for courtesy pre-determinations, we are not bound by the time frames and standards that apply to pre-service claims. In order to request a courtesy pre-

determination, you or your provider should call the Customer Service Unit.

Concurrent Care Determinations

Determinations by us to Limit or Reduce Previously Approved Care: If we have previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and we later decide to limit or reduce the previously approved stay or course of treatment, we will give you enough advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow any reasonable rules we establish for the filing of your appeal, such as time limits within which the appeal must be filed.

Requests by You to Extend Previously Approved Care: If a previously approved hospital stay or course of treatment is about to expire, you may submit a request to extend your approved care. You may make this request in writing or orally either directly to us or through your treating physician or a hospital representative. The Blue Care Connection (BCC) phone number to call in order to request an extension of care is 1 800 621-0965 (toll-free).

If your request for additional care is urgent, and if you submit it no later than 24 hours before the end of your pre-approved stay or course of treatment, we will give you our decision within 24 hours of when your request is submitted. If your request is not made before this 24-hour time frame, and your request is urgent, we will give you our determination within 72 hours. If your request is not urgent, we will treat it as a new claim for benefits, and will make a determination on your claim within the pre-service or post-service time frames discussed above, as appropriate.

Your Right To Information

You have the right, upon request, to receive copies of any documents that we relied on in reaching our decision and any documents that were submitted, considered, or generated by us in the course of reaching our decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If our decision was based on a medical or scientific determination (such as medical necessity), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a health care professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Any request that you make for information under this paragraph must be in writing. We will not charge you for any information that you request under this paragraph.

Member Satisfaction

If you are dissatisfied with our handling of a claim or have any questions or complaints, you may do one or more of the following:

- You may call or write the Customer Service Unit. We will help you with questions about your coverage and benefits or investigate any adverse benefit determination you might have received.
- You may file an appeal if you have received an adverse benefit determination.

Your satisfaction is important to us. We will do our utmost to maintain it.

Appeals

In General: The rules in this section of the booklet allow you or your authorized representative to appeal any adverse benefit determination. An adverse benefit determination includes any one

or more of the following:

- Any determination we make with respect to a post-service claim that results in your owing any money to your provider other than copayments, coinsurance and deductible amounts that you make, or are required to make, to your provider;
- Our denial of a pre-service claim; or,
- An adverse concurrent care determination (for example, we deny your request to extend previously approved care).

In all cases other than determinations by us to limit or reduce previously approved care, you have 180 days following our adverse benefit determination within which to submit an appeal.

How to Appeal Post-Service Adverse Benefit Determinations: If you wish to file an appeal of an adverse benefit determination relating to a post-service claim we recommend that you send us a letter. Your letter must contain at least the following information:

- The patient's name;
- The patient's contract number;
- Sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure (if known), and claim number (if available) (the best way to satisfy this requirement is to include a copy of your Claims Report with your appeal); and,
- A statement that you are filing an appeal.

You must send your appeal to the following address:

Blue Cross and Blue Shield of Illinois
Attn: Appeals Coordinator
3405 Liberty Drive
Springfield, Illinois 62704

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to resolve your questions or concerns.

How to Appeal Pre-Service Adverse Benefit Determinations: You may appeal an adverse benefit determination relating to a pre-service claim in writing or over the phone.

If over the phone, you should call the AT&T Customer Service Department at 1 800 621-7336 (toll-free).

If in writing, you should send your letter to the address listed below:

Blue Cross and Blue Shield of Illinois
Attention: Appeal Coordinator
3405 Liberty Drive
Chicago, Illinois 62704

Your written appeal should provide us with your name, contract number, the name of the facility or provider involved, and the date or dates of service.

Please note that if you call or write us without following the rules just described for filing an appeal, we will not treat your inquiry as an appeal. We will, of course, do everything we can to

resolve your questions or concerns.

Conduct Of The Appeal: We will assign your appeal to one or more persons within our organization who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires us to make a medical judgment (such as whether services or supplies are medically necessary), we will consult a health care professional who has appropriate expertise. If we consulted a health care professional during our initial decision, we will not consult that same person or a subordinate of that person during our consideration of your appeal.

If we need more information, we will ask you to provide it to us. In some cases we may ask your provider to furnish that information directly to us. If we do this, we will send you a copy of our request. However, you will remain responsible for seeing that we get the information. If we do not get the information, it may be necessary for us to deny your appeal.

We will consider your appeal fully and fairly.

Time Limits For Our Consideration Of Your Appeal: If your appeal arises from our denial of a post-service claim, we will notify you of our decision within 60 days of the date on which you filed your appeal.

If your appeal arises from our denial of a pre-service claim, and if your claim is urgent, we will consider your appeal and notify you of our decision within 72 hours. If your pre-service claim is not urgent, we will give you a response within 30 days.

If your appeal arises out of a determination by us to limit or reduce a hospital stay or course of treatment that we previously approved for a period of time or number of treatments, (see Concurrent Care Determinations above), we will make a decision on your appeal as soon as possible, but in any event before we impose the limit or reduction.

If your appeal relates to our decision not to extend a previously approved length of stay or course of treatment (see Concurrent Care Determinations above), we will make a decision on your appeal within 72 hours (in urgent pre-service cases), 30 days (in non-urgent pre-service cases), or 60 days (in post-service cases).

In some cases, we may ask for additional time to process your appeal. If you do not wish to give us additional time, we will go ahead and decide your appeal based on the information we have. This may result in a denial of your appeal.

If You Are Dissatisfied After Exhausting Your Mandatory Plan Administrative Remedies: If you have filed an appeal and are dissatisfied with our response, you may do one or more of the following:

- You may ask the Customer Service Unit for further help;
- You may file a voluntary appeal (discussed below); or,
- You may file a lawsuit in federal court under Section 502(a) of ERISA or in the forum specified in your plan if your claim is not a claim for benefits under Section 502(a) of ERISA.

Voluntary Appeals: If we have given you our appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). If your voluntary appeal relates to a pre-service adverse benefit determination, you may file your appeal in writing or over the phone. If over the phone, you should call the AT&T Customer Service Department at 1 800 621-7336 (toll-free). If in writing, you should send your letter to the following address:

Blue Cross and Blue Shield of Illinois
Attention: Appeals Coordinator
3405 Liberty Drive
Springfield, IL 62704

If your voluntary appeal relates to a post-service adverse benefit determination, it must be submitted in writing to the following address:

Blue Cross and Blue Shield of Illinois
Attention: Appeals Coordinator
3405 Liberty Drive
Springfield, IL 62704

Your written appeal must state that you are filing a voluntary appeal.

If you file a voluntary appeal (whether oral or written), we will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. We will also agree that any defense based upon timeliness or statutes of limitations will be tolled during the time that your voluntary appeal is pending. In addition, we will not impose any fees or costs on you as part of your voluntary appeal.

You may ask us to provide you with more information about voluntary appeals. This additional information will allow you to make an informed judgment about whether to request a voluntary appeal.

GENERAL INFORMATION

Delegation of Discretionary Authority to Blue Cross

The employer has delegated to us the discretionary responsibility and authority to determine claims under the plan, to construe, interpret, and administer the plan, and to perform every other act necessary or appropriate in connection with our provision of administrative services under the plan. Whenever we make reasonable determinations that are neither arbitrary nor capricious in our administration of the plan, those determinations will be final and binding on you, subject only to your right of review under the plan and thereafter to judicial review to determine whether our determination was arbitrary or capricious.

Notice

We give you notice when we mail it or send it electronically to you or your group at the latest address we have. You and your group are assumed to receive notice three days after we mail it. Your group is your agent to receive notices from us about the plan. The group is responsible for giving you all notices from us. We are not responsible if your group fails to do so. Mail notices to us at 300 East Randolph Street, Chicago, Illinois 60601-5099, with your full name and contract number. We get notice when it arrives at this address.

Correcting Payments

While we try to pay all claims quickly and correctly, we do make mistakes. If we pay you or a provider in error, the payee must repay us. If he does not, we may deduct the amount paid in error from any future amount paid to you or the provider. If we deduct it from an amount paid to you, it will show in your Claim Report.

Responsibility for Providers

We are not responsible for what providers do or fail to do. If they refuse to treat you or give you poor or dangerous care, we cannot be responsible. We need not do anything to enable them to treat you.

Misrepresentation

If you make any material misrepresentation in applying for coverage, when we learn of this we may terminate your coverage back to your effective date. We need not even refund any payment for your coverage. If your group materially misrepresents its application it will be as though the plan never took effect, and we need not even refund any payment for any member.

PRIVACY AND SECURITY OF YOUR PROTECTED HEALTH INFORMATION

The confidentiality of your personal health information is important to us. Under a new federal law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), plans such

as this one are generally required to limit the use and disclosure of your protected health information to treatment, payment, and health care operations and to put in place appropriate safeguards to protect your protected health information. This section of the booklet explains some of the HIPAA requirements. Additional information is contained in the plan's notice of privacy practices. You may request a copy of this notice by contacting the AT&T Customer Service Department at 1-800-621-7336. You may also view or print a copy of the notice through the AT&T secured internet site at http://Access.att.com.

Disclosures of Protected Health Information to the Plan Sponsor: In order for your benefits to be properly administered, the plan needs to share your protected health information with the plan sponsor (your employer). Here are the circumstances under which the plan may disclose your protected health information to the plan sponsor:

- The plan may inform the plan sponsor whether you are enrolled in the plan.
- The plan may disclose summary health information to the plan sponsor. The plan sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.
- The plan may disclose your protected health information to the plan sponsor for plan administrative purposes. This is because employees of the plan sponsor perform some of the administrative functions necessary for the management and operation of the plan.

Here are the restrictions that apply to the plan sponsor's use and disclosure of your protected health information:

- The plan sponsor will only use or disclose your protected health information for plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the plan sponsor discloses any of your protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.
- The plan sponsor will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the plan sponsor.
- The plan sponsor will promptly report to the plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of the booklet.
- The plan sponsor will allow you or the plan to inspect and copy any protected health information about you that is in the plan sponsor's custody and control. The HIPAA regulations set forth the rules that you and the plan must follow in this regard. There are some exceptions.
- The plan sponsor will amend, or allow the plan to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.
- With respect to some types of disclosures, the plan sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). You have a right to see the disclosure log. The plan sponsor does not have to maintain the log if disclosures are for certain plan related purposes, such as payment of benefits or health care operations.
- The plan sponsor will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the plan and to the U.S. Department of Health and Human Services, or its designee.
- The plan sponsor will, if feasible, return or destroy all of your protected health information in the plan sponsor's custody or control that the plan sponsor has received from the plan

or from any business associate when the plan sponsor no longer needs your protected health information to administer the plan. If it is not feasible for the plan sponsor to return or destroy your protected health information, the plan sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

For a list of approved AT&T Inc. members who may disclose your protected health information, please refer to the Health and Insurance Plans for Retirees Summary Plan Description.

If any employee or workforce member of the plan sponsor use or disclose your protected health information in violation of the rules that are explained above, the employees or workforce members will be subject to disciplinary action and sanctions -which may include termination of employment. If the plan sponsor becomes aware of any violation like this, the plan sponsor will promptly report the violation to the plan and will cooperate with the plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to you.

Security of Your Personal Health Information: Here are the restrictions that will apply to the plan sponsor's storage and transmission of your electronic protected health information on and after April 21, 2005:

- The plan sponsor will have in place appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your electronic protected health information, as well as to ensure that only those classes of employees or other workforce members of the plan sponsor described above have access to use or disclose your electronic protected health information in accordance with the HIPAA regulations.
- If the plan sponsor discloses any of your electronic protected health information to any of its agents or subcontractors, the plan sponsor will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations.
- The plan sponsor will report to the plan any security incident of which it becomes aware in accordance with the HIPAA regulations.

Our Use and Disclosure of Your Personal Health Information: As a business associate of the plan, we (Blue Cross and Blue Shield of Illinois) have an agreement with the plan that allows us to use your personal health information for treatment, payment, health care operations, and other purposes permitted or required by HIPAA. In addition, by applying for coverage and participating in the plan, you agree that we may obtain, use and release all records about you and your minor dependents that we need to administer the plan or to perform any function authorized or permitted by law. You further direct all persons to release all records to us about you and your minor dependents that we need in order to administer the plan.

Multiple Coverage

If you are covered both by this contract and by a non-group contract we issue, you will be entitled to benefits only under the one that provides the most coverage for you.

Applicable Law

The federal ERISA law governs this plan. If any state law applies, the law of Illinois governs.

Termination of Benefits and Termination of the Plan

1. Blue Cross's obligation to provide benefits under the Plan may be terminated at any time by either the employer or Blue Cross by giving 120 days notice in writing to the other.

2. If the employer fails to make payments to Blue Cross, then Blue Cross will provide written notice of payments due and the employer will have 90 days from receipt of notice in which to make such payments. Blue Cross may execute termination notice to be effective 30 days after the end of the default cure period.

3. The Plan Sponsor may terminate the Plan at any time through action by its authorized officers. In the event of termination of the Plan, all benefits payments will cease as of the effective date of termination, regardless of whether notice of the termination has been provided to you by the employer or Blue Cross.

Changes in Plan

1. Any or all of the provisions of this plan may be amended by the Plan Sponsor at any time and from time to time, by an instrument in writing.

2. No representative or employee of Blue Cross is authorized to amend or vary the terms and conditions of this plan or to make any agreement or promise not specifically contained herein or to waive any provision hereof.

Out-of-Area Copay and Coinsurance

When you obtain health care services through the BlueCard Program outside of the Illinois service area, the amount you pay for covered services is calculated on the **lower** of:

1. The billed charges for your covered services, or

2. The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Plan") passes on to us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Plan. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be adjusted in the future to correct for overestimation or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Plan to use a basis for calculating your payment for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate payment calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

OTHER PLAN MATTERS

AT&T Inc. has delegated the following services to the entities referenced below:

- Eligibility issues: AT&T Inc. Benefits Center: 1 877 722-0020
- Mental Health, Substance Abuse and Employee Assistance Program: Magellan Behavioral Health: 1 800 984-9135
- Prescription Drug Benefits: Medco Health Solutions, Inc.: 1 877 797-7472

HEALTH BENEFIT EXCLUSIONS

The following services are excluded under the Plan:

1. Services or expenses we determine are not medically necessary.

2. Services, care, or treatment you receive after the date your coverage ends. This exclusion will not apply if you are receiving inpatient hospital benefits on the date of cancellation; basic hospital benefits will continue until you are discharged. This Plan does not insure against any condition (such as pregnancy, disease, or injury) but only provides benefits for services or supplies furnished while the contract to provide Plan benefits is in effect.

3. Services or expenses for cosmetic surgery. "Cosmetic surgery" is any surgery done primarily to improve or change the way one appears. "Reconstructive surgery" is any surgery done primarily to restore or improve the way the body works or correct deformities that result from disease, trauma or birth defects. Reconstructive surgery is a covered benefit; cosmetic surgery is not. (See the section, Women's Health and Cancer Rights Act, for exceptions.) Complications or later surgery related in any way to cosmetic surgery is not covered, even if medically necessary, if caused by an accident, or if done for mental or emotional relief.

   a. Please contact us prior to surgery to find out whether a procedure will be reconstructive or cosmetic. You and your physician must prove to our satisfaction that surgery is reconstructive and not cosmetic. You must show us your history and physical exams, visual fields measures and photographs before and after surgery.

   b. Some surgery is always cosmetic such as ear piercing, neck tucks, face lifts, buttock and thigh lifts, implants to small but normal breasts (except as provided by the Women's Health and Cancer Rights Act), hair implants for male pattern baldness and correction of frown lines on the forehead. In other surgery, such as Blepharoplasty (eyelids), Rhinoplasty (nose), chemical peel and chin implants, it depends on why that procedure was done. For example, a person with a deviated septum may have trouble breathing and many sinus infections. To correct this they have a Septoplasty. During surgery the physician may remove a hump or shorten the nose (Rhinoplasty). The Septoplasty would be reconstructive surgery while the Rhinoplasty would be denied as cosmetic surgery. An additional example would be surgery to remove excess skin from the eyelids (Blepharoplasty) is cosmetic if done to improve your appearance but reconstructive if done because your eyelids kept you from seeing very well.

4. Services or expenses to care for, treat, fill, extract, remove or replace teeth or to increase the periodontium. The periodontium includes the gums, the membrane surrounding the root of a tooth, the layer of bone covering the root of a tooth and the upper and lower jaws and their borders, which contain the sockets for the teeth. Care to treat the periodontium, dental pulp or "dead" teeth, irregularities in the position of the teeth, artificial dental structures such as crowns, bridges or dentures, or any other type of dental procedure is excluded. Hydroxyapatite or any other material to make the gums rigid is excluded. It does not matter whether their purpose is to improve conditions inside or outside the mouth (oral cavity). These services, supplies or expenses are not covered even if they are used to prepare a patient for services or procedures that are plan benefits. Braces on the teeth are excluded for any purpose, even to prepare a person with a cleft palate for surgery on the bones of the jaw. With the exception of braces, which are never covered under the medical plan, this exclusion does not apply to those services by a physician to treat or replace natural teeth which are harmed by accidental injury covered under Other Covered Services.

5. Dental implants into, across, or just above the bone and related appliances. Services or

expenses to prepare the mouth for dental implants such as those to increase the upper and lower jaws or their borders, sinus lift process, guided tissue regrowth or any other surgery, bone grafts, hydroxyapatite and similar materials. These services, supplies or expenses, even if medically or dentally necessary, are not covered under the medical plan even if they are needed to treat conditions existing at birth, while growing, or resulting from an accident.

6. Services or expenses rendered for any disease, injury or condition arising out of and in the course of employment for which benefits and/or compensation are available in whole or in part under the provisions of any Workers' Compensation or employers' liability laws, state or federal. This applies whether you fail to file a claim under that law. It applies whether the law is enforced against or assumed by the employer. It applies whether the law provides for hospital or medical services as such. It applies whether the provider of those services was authorized as required by the law. Finally, it applies whether your employer has insurance coverage for benefits under the law.

7. Services or expenses covered in whole or in part under the laws of the United States, any state, county, city, town or other governmental agency that provides or pays for care, through insurance or any other means. This applies even if the law does not cover all your expenses.

8. Services or supplies to the extent that a member is, or would be, entitled to reimbursement under Medicare, regardless of whether the member properly and timely applied for, or submitted claims to Medicare, except as otherwise required by federal law.

9. Routine well child care and routine immunizations except as provided by the Plan.

10. Routine physical examinations except as provided by the Plan.

11. Services or expenses for custodial care. Care is "custodial" when its primary purpose is to provide room and board, routine nursing care, training in personal hygiene, and other forms of self-care or supervisory care by a physician for a person who is mentally or physically disabled.

12. Investigational treatment, procedures, facilities, drugs, drug usage, equipment, or supplies, including services that are part of a clinical trial.

13. Services or expenses for routine foot care such as removal of corns or calluses or the trimming of nails (except mycotic nails).

14. Hospital admissions in whole or in part when the patient primarily receives services to rehabilitate such as physical therapy, speech therapy, or occupational therapy.

15. Services and expenses provided to a hospital patient which could have been provided on an outpatient basis, given the patient's condition and the services provided. Benefits for those services will apply as though the services were provided on an outpatient basis. Examples are hospital stays primarily for diagnosis, diagnostic study, medical observation, rehabilitation, physical therapy and hydrotherapy.

16. Services or expenses for, or related to, sexual dysfunctions or inadequacies not related to organic disease or which are related to surgical sex transformations that are not determined to be medically necessary.

17. Services or expenses for an accident or illness resulting from war, or any act of war, declared or undeclared, or from riot or civil commotion.

18. Services or expenses for treatment of injury sustained in the commission of a crime or for treatment while confined in a prison, jail, or other penal institution.

19. Services or expenses for which a claim is not properly submitted to Blue Cross.

20. Services or expenses for treatment of any condition including, but not limited to, obesity, diabetes, or heart disease, which is based upon weight reduction or dietary control or services or expenses of any kind to treat obesity, weight reduction or dietary control. This exclusion does not apply to surgery for morbid obesity if medically necessary and in compliance with guidelines of the Claims Administrator.

21. Services or expenses which you are not legally obligated to pay, or for which no charge would be made if you had no health coverage.

22. Services or expenses for or related to organ, tissue or cell transplantations except specifically as allowed by this plan.

23. Dental treatment or non-surgical treatment for or related to temporomandibular joint (TMJ) disorders.

24. Services or expenses for or related to Assisted Reproductive Technology (ART). ART is any process of taking human eggs or sperm or both and putting them into a medium or the body to try to cause reproduction. Examples of ART are in vitro fertilization and gamete intrafallopian transfer.

25. Eyeglasses or contact lenses or related examination or fittings. The initial pair of eyeglasses, contact lenses or one pair of each will be covered under Other Covered Services if they replace the lens of the eye after eye surgery or injury or defect.

26. Services or expenses for eye exercises, eye refractions, visual training orthoptics, shaping the cornea with contact lenses, or any surgery on the eye to improve vision including radial keratotomy.

27. Services or expenses for personal hygiene, comfort or convenience items such as air-conditioners, humidifiers, whirlpool baths, and physical fitness or exercise apparel. Exercise equipment is also excluded. Some examples of exercise equipment are shoes, weights, exercise bicycles or tracks, weights or variable resistance machinery, and equipment producing isolated muscle evaluations and strengthening. Treatment programs, the use of equipment to strengthen muscles according to preset rules, and related services performed during the same therapy session are also excluded.

28. Services or expenses for speech, recreational, educational, or occupational (except as stated covered previously) therapy.

29. Speech therapy for self-correcting articulation problems.

30. Services or expenses for acupuncture, biofeedback and other forms of self-care or self-help training.

31. Hearing aids or examinations or fittings for them except as previously stated.

32. Services or expenses of a hospital stay if BCC determines that the admission was not medically necessary.

33. Services or expenses of private duty nurses unless previously stated as a covered service.

34. Services, care, treatment, or supplies furnished by a provider that is not recognized by us as an approved provider for the services rendered as explained more fully in paragraph 4. under

the section of this summary called "Benefit Conditions."

35. Services or expenses any provider rendered to a member who is related to the provider by blood or marriage or who regularly resides in the provider's household. Examples of a provider include a physician, a licensed registered nurse (RN), a licensed practical nurse (LPN) or a licensed physical therapist.

36. Services provided by Substance Abuse Facilities including Substance Abuse Residential Facilities.

37. Services or expenses of any kind for nicotine addiction such as smoking cessation treatment.

38. Travel, even if prescribed by your physician.

39. Services or expenses for a claim we have not received within 12 months after services were rendered or expenses incurred.

40. Services or expenses for physical therapy which does not require a licensed physical therapist, given the level of simplicity and the patient's condition, will not further restore or improve the patient's bodily functions, or is not reasonable as to number, frequency or duration.

41. Physical therapy by an athletic trainer or massage therapist.

42. Services or expenses in any federal hospital or facility except as provided by federal law.

43. Services or expenses for sanitarium care, convalescent care, or rest care.

44. Anesthesia services or supplies, or both, by local infiltration.

45. Services provided through teleconsultation.

46. Sales or use tax on prescription drugs.

47. Charges in excess of the allowed amount.

48. Hospitalization for dental care except those described in the Hospital Benefits Section.

49. Charge for hospital personal services, such as radios, televisions and guest meals.

50. Physician or prescription drug copayment amounts.

51. Amounts in excess of chiropractic visit limits.

52. Amounts exceeding the Well Child Care limits for the Retiree Plan When Medicare is Primary Plan and the Basic Indemnity Plan for Retirees.

53. Care in a nursing home or convalescent center unless precertified by BCC.

54. Secondary coverage for prescription drugs.

DEFINITIONS

Accidental Injury: A traumatic injury to you caused solely by an accident.

Allowed Amount: Benefit payments for covered services are based on the amount of the provider's charge that we recognize for payment of benefits. This amount is limited to the lesser of the provider's charge for care or the amount of that charge that is determined by us to be allowable depending on the type of provider utilized and the state in which services are rendered, as described below:

1) **Preferred Providers:** Blue Cross and Blue Shield plans contract with providers to furnish care for a negotiated price. This negotiated price is often a discounted rate, and the preferred provider normally accepts this rate (subject to any applicable copays, coinsurance, or deductibles that are the responsibility of the patient) as payment in full for covered services or care. The negotiated price applies only to services that are covered under the Plan and also covered under the contract that has been signed with the preferred provider. Please be aware that not all participating or contracting providers are preferred providers. Each local Blue Cross and/or Blue Shield plan determines which of its participating or contracting providers will be considered preferred providers.

2) **Non-Preferred Providers:** The Allowed Amount for care for non-preferred providers or for services or supplies not included in a preferred provider's contract is normally determined by the Blue Cross and/or Blue Shield plan where services are rendered. This amount may be based on the negotiated rate payable to preferred providers, or may be based on the average or anticipated charge or discount for care in the area or state, or for care from that particular type of provider. When the local Blue Cross and/or Blue Shield plan does not provide us with appropriate pricing data or when we are determining the Allowed Amount for services or supplies by a non-preferred provider (or for services and supplies not included in the contract with the provider), Blue Cross and Blue Shield of Illinois determines the Allowed Amount using historical data and information from various sources such as, but not limited to:

   - The charge for the same or a similar service;
   - The relative complexity of the service;
   - The preferred provider allowance for the same or a similar service;
   - The average expected or estimated provider discount for the type of provider in the service area, as reported by the Blue Cross and Blue Shield Association from time to time;
   - Applicable state health care factors;
   - The rate of inflation using a recognized measure; and,
   - Other reasonable limits, as required with respect to outpatient prescription drug costs.

   Non-preferred providers include providers that have not signed a contract with the Blue Cross and/or Blue Shield plan where services are rendered as well as participating or contracting providers who have not been designated by the local Blue Cross and/or Blue Shield plan as preferred providers.

   In this situation the provider may bill the member for charges in excess of the Allowed Amount. The Allowed Amount will not exceed the amount of the provider's charge.

Alternate Benefits: A benefit program that gives you and your family an alternative to lengthy hospitalizations. It is designed to provide the patient with the best environment for recovery and in the most cost-effective setting. Also known as "Comprehensive Managed Care," "Individual Case Management," and "Care Management."

Assisted Reproductive Technology (ART): Any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to, in vitro fertilization, gamete intrafallopian transfer, zygote intrafallopian transfer and pronuclear stage tubal transfer.

Blue Cross: Blue Cross and Blue Shield of Illinois.

BlueCard Program: An arrangement among Blue Cross Plans by which a member of one Blue Cross Plan receives benefits available through another Blue Cross Plan located in the area where services occur.

Certification of Medical Necessity: The written results of our review using recognized medical criteria to determine whether a member requires treatment in the hospital before he is admitted, or within 48 hours or the next business day after the admission in the case of emergency admissions. Certification of medical necessity means only that a hospital admission is medically necessary to treat your condition. Certification of medical necessity does not mean that your group has paid us all monies due for you. Certification of medical necessity does not consider whether your admission is excluded by this plan.

Coinsurance: The dollar amount that a Participant pays when using various programs such as the Retiree Basic Plan, the Retiree Basic Plan When Medicare is Primary and the Basic Indemnity Plan for Retirees.

Contract: The Group Health Benefits contract between your Employer and Blue Cross and Blue Shield of Illinois. The contract is made up of (1) your employer's Group Application for the contract; (2) this Summary Plan Description; and (3) any written change to this Summary Plan Description. Your contract number is listed on your ID card.

Contract Effective Date: The date the Group Health Benefits contract becomes effective.

Copayment: The dollar amount that a Participant pays when using various programs such as the Retiree Basic Plan, the Retiree Basic Plan When Medicare is Primary and the Basic Indemnity Plan for Retirees.

Cosmetic Surgery: Any surgery done primarily to improve or change the way one appears, cosmetic surgery does not primarily improve the way the body works or correct deformities resulting from disease, trauma or birth defect. For important information on cosmetic surgery, see the "Exclusions" section.

Custodial Care: Care primarily to provide room and board for a person who is mentally or physically disabled.

Deductible: The amount of covered expenses the Participant pays during the calendar year before the plan will begin paying benefits. The calendar year deductible is applied in the order that the Claims Administrator processes the claims regardless of the order in which they are received.

Dependent: A family member that qualifies for coverage under the Plan as either a Class I or Class II Dependent.

Durable Medical Equipment: Equipment we approve as medically necessary to diagnose or treat an illness or injury or to prevent a condition from becoming worse. To be durable medical equipment an item must be made to withstand repeated use, be for a medical purpose rather than for comfort or convenience, be useful only if you are sick or injured, and be related to your condition and prescribed by your physician to use in your home.

Effective Date: The date on which the coverage of each individual Participant and dependent begins as listed in Blue Cross's records.

Eligible Person: Any employee or member of the group or other person who meets the eligibility standards of their plan and is designated as eligible to us by the group.

Family Coverage: Coverage for a Participant and more than one dependent.

Group: The employer, association, or other entity which contracts with Blue Cross and through which you have coverage.

Hospice: A Participating or a Non-Participating Hospice. An institution or organization designed to provide care for the terminally ill.

Hospital: A Participating or a Non-Participating Hospital as defined in this plan. A legally instituted institution that provides 24 hour nursing services and maintains on the premises the equipment, space, and supplies to provide diagnosis and treatment of the ill or injured people by or under the supervision of a staff of physicians, which are accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAH) qualify as hospitals under the plan.

Individual Case Management: Benefits which are an alternative to more expensive covered benefits. They provide the patient with the best environment for recovery and in the most cost-effective setting. Also known as "Comprehensive Managed Care" and "Care Management."

Inpatient: A registered bed patient in a hospital.

Investigational: Any treatment, procedure, facility, equipment, drugs, drug usage, or supplies that either we have not recognized as having scientifically established medical value, or that does not meet generally accepted standards of medical practice. When possible, we develop written criteria (called medical criteria) concerning services or supplies that we consider to be investigational. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that we make available to the medical community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is considered investigational according to one of our published medical criteria policies, we will not pay for it. If the investigational nature of a service or supply is not addressed by one of our published medical criteria policies, we will consider it to be non-investigational only if the following requirements are met:

- The technology must have final approval from the appropriate government regulatory bodies;
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
- The technology must improve the net health outcome;
- The technology must be as beneficial as any established alternatives; and,
- The improvement must be attainable outside the investigational setting.

It is important for you to remember that when we make determinations about the

investigational nature of a service or supply we are making them solely for the purpose of determining whether to pay for the service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

Medical Emergency/True Emergency: A medical condition that occurs suddenly and without warning with symptoms which are so acute and severe as to require immediate medical attention to prevent permanent damage to the health, other serious medical results, serious impairment to bodily function, or serious and permanent lack of function of any bodily organ or part.

Medically Necessary or Medical Necessity: We use these terms to help us determine whether a particular service or supply will be covered. When possible, we develop written criteria (called medical criteria) that we use to determine medical necessity. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put these medical criteria in policies that we make available to the medical community and our members. We do this so that you and your providers will know in advance, when possible, what we will pay for. If a service or supply is not medically necessary according to one of our published medical criteria policies, we will not pay for it. If a service or supply is not addressed by one of our published medical criteria policies, we will consider it to be medically necessary only if we determine that it is:

- Appropriate and necessary for the symptoms, diagnosis, or treatment of your medical condition;
- Provided for the diagnosis or direct care and treatment of your medical condition;
- In accordance with standards of good medical practice accepted by the organized medical community;
- Not primarily for the convenience and/or comfort of you, your family, your physician, or another provider of services;
- Not "investigational;" and,
- Performed in the least costly setting, method, or manner, or with the least costly supplies, required by your medical condition. A "setting" may be your home, a physician's office, an ambulatory surgical facility, a hospital's outpatient department, a hospital when you are an inpatient, or another type of facility providing a lesser level of care. Only your medical condition is considered in deciding which setting is medically necessary. Your financial or family situation, the distance you live from a hospital or other facility, or any other non-medical factor is not considered. As your medical condition changes, the setting you need may also change. Ask your physician if any of your services can be performed on an outpatient basis or in a less costly setting.

It is important for you to remember that when we make medical necessity determinations, we are making them solely for the purpose of determining whether to pay for a medical service or supply. All decisions concerning your treatment must be made solely by your attending physician and other medical providers.

Member: A Participant or eligible dependent who has coverage under the contract. The term member also refers to a former dependent or Participant who was not terminated for gross misconduct and who is eligible for and covered under COBRA.

Mental and Nervous Disorders: These are mental disorders, mental illness, psychiatric illness, mental conditions and psychiatric conditions. These disorders, illnesses and conditions are considered mental and nervous disorders whether they are of organic, biological, chemical, or genetic origin. They are considered mental and nervous disorders however they are caused, based or brought on. Mental and nervous disorders include, but are not limited to, psychoses, neuroses, schizophrenic-affective disorders, personality disorders, and psychological or behavioral abnormalities associated with temporary or permanent dysfunction of the brain or

related system of hormones controlled by nerves. They are intended to include disorders, conditions, and illnesses listed in the current Diagnostic and Statistical Manual of Mental Disorders.

Non-Participating Home Health Care Agency: Any home health care agency which is not a Participating Home Health Care Agency, but which meets Medicare's definition.

Non-Participating Hospice: Any hospice which is not a Participating Hospice but which meets the conditions for participation in Medicare.

Non-Participating Hospital: Any hospital (other than a Participating Hospital) that has been approved by the American Hospital Association as a "general" hospital or meets the requirements of the American Hospital Association for registration or classification as a "general medical and surgical" hospital. "General" hospitals do not include those that are classified or could be classified under standards of the American Hospital Association as "special" hospitals. Examples of these "special" hospitals are those classified for psychiatric, alcoholism and other chemical dependency, rehabilitation, mental retardation, chronic disease or any other specialty. "General" hospitals also do not include facilities primarily for convalescent care or rest or for the aged, school or college infirmaries, sanatoria, or nursing homes. Each Blue Cross and Blue Shield Plan has separate requirements for Participating Hospitals.

Non-PPO Provider: Any provider which is not a PPO Provider with any Blue Cross and/or Blue Shield Plan.

PPO: Preferred Provider Organization.

PPO Allowance: The amount that any Blue Cross and/or Blue Shield Plan has agreed to pay its PPO Provider for plan benefits.

PPO Fee Schedule: The schedule of medical and surgical procedures and the fee amounts for those procedures under the other Preferred Provider programs as applicable.

PPO Hospital, PPO Physician, PPO Provider, or Preferred Provider: Any hospital, physician, or provider with which any Blue Cross and/or Blue Shield Plan has a PPO contract for the furnishing of health care services.

Participant: The employee whose application for coverage under the contract is made and accepted by Blue Cross.

Participating Ambulatory Surgical Facility: Any facility with which any Blue Cross and Blue Shield Plan has a Participating Ambulatory Surgical Facility contract for furnishing health care services.

Participating Home Health Care Agency: Any home health care agency with which any Blue Cross and Blue Shield Plan has a contract.

Participating Hospice: Any hospice with which any Blue Cross and Blue Shield Plan has a contract.

Participating Hospital: Any hospital with which Blue Cross and/or Blue Shield Plan has a contract for furnishing health care services.

Participating Nurse Practitioner: A nurse practitioner who has an agreement with Blue Cross to provide services within the scope of the license of a nurse practitioner, to members entitled to benefits under the PPO Program or another Preferred Care Program through a contract with Blue Cross.

Participating Nurse Practitioner Allowance: The amount that will be paid to a Participating Nurse Practitioner for services rendered. It is the fee for a procedure listed in the PPO Fee Schedule for Nurse Practitioners or the amount of the Participating Nurse Practitioner's actual charge, whichever is less.

Physician: One of the following when licensed and acting within the scope of that license at the time and place you are treated or receive services: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S), Doctor of Medical Dentistry (D.M.D.), Doctor of Chiropractic (D.C.), Doctor of Podiatry (D.P.M.), Doctor of Optometry (O.D.), Certified Registered Nurse Practitioners, and Certified Nurse Midwives, who are licensed by the state in which they practice.

All Physician Assistants (PA) and Nurse Practitioners (NP) are covered providers when performing services within the scope of their license; therefore, any Physician Assistant who is a licensed Surgical Assistant is considered a covered provider when medically necessary. The benefit for a Physician Assistant and/or Nurse Practitioner is the same level as any other covered provider.

Plan: This Summary Plan Description (SPD) describing the benefits of your BellSouth Retiree Medical Assistance Plan.

Preadmission Certification and Postadmission Review: The procedures used to determine whether a member requires treatment as a hospital inpatient prior to a member's admission, or within 48 hours or the next business day after the admission in the case of an emergency admission, based upon medically recognized criteria.

Preferred Care: A program whereby providers have agreements with any Blue Cross and Blue Shield Plan to furnish certain medically necessary services and supplies according to an agreed upon fee schedule for medical and surgical procedures, certain services and supplies to members entitled to benefits under the Preferred Care Program.

Preferred Medical Doctor or Preferred Physician: A physician who has an agreement any Blue Cross and Blue Shield Plan to provide surgical and medical services to members entitled to benefits under the PPO Program or another Preferred Care Program through a contract with Blue Cross.

Preferred Provider Organization (PPO): Hospitals, physicians, or other providers who have agreements with any Blue Cross and Blue Shield Plan to provide surgical and medical services to members entitled to plan benefits under the PPO Program.

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.

Private Duty Nursing: Nursing care provided in the patient's home by a licensed registered nurse (RN) or a licensed practical nurse (LPN) who does not reside in the patient's home and is not related to the patient by blood or marriage.

Semiprivate Room Accommodations: A hospital room containing 2, 3, or 4 beds.

Skilled Nursing Facility: Any Medicare participating skilled nursing facility which provides non-acute care for patients needing skilled nursing services 24 hours a day. This facility must be staffed and equipped to perform skilled nursing care and other related health services. A skilled nursing facility does not provide custodial or part-time care.

Special Care Unit: A specially equipped unit, set aside as a distinct patient care area, staffed and equipped to treat seriously ill patients requiring extraordinary care on a concentrated and continuous basis. Some examples are intensive care, coronary care, or burn care units.

Teleconsultation: Consultation, evaluation, and management services provided to patients via telecommunication systems without personal face-to-face interaction between the patient and healthcare provider.

Two-Person Coverage: Coverage for a Participant and one dependent.

Umbrella Plan: The AT&T Umbrella Benefit Plan No. 1 (as well as all programs, including the BellSouth Retiree Medical Assistance Plan, which are incorporated into the Umbrella Plan).

We, Us, Our: Blue Cross and Blue Shield of Illinois.

You, Your: The Participant or member as shown by context.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation, to the extent applicable to the plan.

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 plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description 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 your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan administrator and do not receive them within 30 days, you may file suit in a Federal court (unless your plan has a binding arbitration clause). In such a case, the court may require the plan administrator, which is not Blue Cross, to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after you have exhausted your administrative remedies under the plan. In addition, if you disagree with the plan administrator's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, 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.

Administrative Information

The following information is provided to complete the requirements for making this a Summary Plan Description as outlined in the Employee Retirement Income Security Act.

1. The Umbrella Plan's official name is: The AT&T Umbrella Benefit Plan No. 1

2. The Plan’s official name is: The BellSouth Retire Medical Assistance Plan

3. The Plan Sponsor and Plan Administrator is:

   AT&T Inc.
   P.O. Box 29690
   San Antonio, TX 78229
   (210) 351-3333

AT&T Inc. is responsible for discharging all obligations that ERISA and its regulations impose

upon Plan Sponsors and Plan Administrators, such as delivering Summary Plan Descriptions, annual reports, and COBRA notices when required by law. To the extent not delegated to Blue Cross, AT&T Inc., as Plan Sponsor, has the discretionary authority to interpret and construe the terms of the plan.

4. The Plan Number assigned by the Plan Sponsor is: 600

5. The IRS Employer Identification Number (EIN) of the Sponsor is: 43-1301883

6. The Plan provides hospital and medical benefits as administered under a contract by Blue Cross and Blue Shield of Illinois. Blue Cross has complete discretion to interpret and administer the provisions of the Plan. Its administrative functions include paying claims, determining medical necessity, etc. The address of Blue Cross and Blue Shield of Illinois is 300 East Randolph Street; Chicago, Illinois 60601. The plan benefits are self-insured.

7. The Agent for legal process is:

   AT&T Inc.
   P.O. Box 29690
   San Antonio, TX 78229

8. The records of the health plan are kept on the basis of a plan year which begins on January 1st and ends on the following December 31st.

9. AT&T Inc. currently intends to continue the Group Health Care Plan as described herein, but reserves the right, in its discretion, to amend, reduce or terminate the plan and coverage at any time for active employees, retirees, former employees, and all dependents, subject to applicable collective bargaining agreements.