Summary of Material Modifications

Important Benefits Information

The BellSouth Retiree Medical Assistance Plan

The BellSouth Retiree Dental Assistance Plan

The BellSouth Group Life Plan

This is a summary of material modifications (SMM) and is an update to the summary plan description (SPD) and any previously issued SMMs for the following programs: The BellSouth Retiree Medical Assistance Plan, The BellSouth Retiree Dental Assistance Plan and The BellSouth Group Life Plan, all component programs under the AT&T Umbrella Benefit Plan No. 1 effective Jan. 1, 2008.

Please keep this SMM with your program SPDs and previously issued SMMs.

DISTRIBUTION

Distributed to management retirees (including former employees who are Pre-92 management LTD recipients) of BellSouth Corporation and its subsidiaries, former represented employees (including former represented employees who are LTD recipients), all retirees of Stevens Graphics, Inc., L.M. Berry and Company and Berry Network, Inc., eligible dependents of retirees (including surviving dependents) and any qualified beneficiaries under COBRA who are receiving benefits under any of the Affected Plans subject to COBRA.

NIN 78-13078

IMPORTANT INFORMATION:

In all cases, the official documents for the Plan govern and are the final authority on the terms of the Plan and, if there are any discrepancies between the information in this SMM and the Plan, the Plan documents will control. AT&T reserves the right to terminate or amend any and all of its employee benefit plans or programs, subject to any applicable collective bargaining obligation. Participation in the plans and programs is neither a contract nor a guarantee of future employment.

This SMM is provided for your information and review.

TABLE OF CONTENTS

INTRODUCTION

Health and Insurance Plans SPD Amended by This SMM

This summary of material modifications (SMM) is an update to the Retiree Health and Insurance Plans for Retirees Summary Plan Descriptions (SPD), applies to the following health and insurance plans (hereafter referred to as the "Affected Plans") and shall be effective Jan. 1, 2008, unless otherwise specified:

- The BellSouth Retiree Medical Assistance Plan
- The BellSouth Retiree Dental Assistance Plan
- The BellSouth Group Life Plan

You should keep this document with your SPD for future reference.

Participants Affected by This SMM

The changes described in this SMM apply to the following individuals (hereafter referred to as the "Affected Participants"):

- Management retirees participating in one or more of the Affected Plans
- Former represented employees participating in one or more of the Affected Plans
- All retirees of Stevens Graphics, Inc., participating in one or more of the Affected Plans
- All retirees of L.M. Berry and Company and Berry Network, Inc., participating in one or more of the Affected Plans
- Eligible dependents of retirees (including surviving dependents) covered under any of the Affected Plans
- Qualified beneficiaries under COBRA who are receiving benefits under any of the Affected Plans subject to COBRA and who, prior to the applicable COBRA qualifying event, were participating in an Affected Plan
- Former represented employees who are receiving benefits under the BellSouth Long-Term Disability Plan for Non-Salaried Employees
- Any other former employees of BellSouth Corporation and its subsidiaries (and their dependents) who were eligible for benefits under any of the Affected Plans

GLOBAL SPD CHANGES

The following changes shall be made throughout the SPD:

- Everywhere that "**Benefits@Your Fingertips**" OR "**https://www.bellsouthbenefits.com**" appears, replace such language with "**http://resources.hewitt.com/att**."
- Remove all references to "STAP" or "The BellSouth Supplemental Transplant Assistance Plan" (since such plan was terminated effective Dec. 31, 2006) and specifically delete the

section entitled "Supplemental Transplant Assistance Plan (STAP)" on pages 114 through 118.1 in its entirety.

- Everywhere that "BellSouth Benefits Service Center" appears, replace such language with "AT&T Benefits Center."
- Delete the following statements from Pages 47, 48, 50, 52, 53, 59, 60, 61, 62, 65, 66, 118.1, 147 and 149 of the SPD:
  - "To access this information, from the home page of **Benefits@Your Fingertips** select 'Healthcare,' then select 'Medical' and on the medical page, under 'Learn About Your Medical Benefits' select 'View and Print Your Summary Plan Description."
  - "To find a participating pharmacy, go to the Medco Health Web site which can be accessed from the home page of **Benefits@Your Fingertips** by selecting 'Health Care' then selecting 'Medical' and on the medical page selecting the link under 'Prescription Drug Benefits.'"
  - "To view these SPDs, go to the home page of **Benefits@Your Fingertips.** From there, select 'Health Care,' then 'Medical' and then 'Access Your Medical Option's Summary Plan Description.'"

CESSATION OF PARTICIPATION FOR CERTAIN RETIREES

The following section "Cessation of Participation for Certain Retirees" shall be added to the end of Page 2 of the SPD after the "Who Is Eligible for Retiree Coverage" section:

"Cessation of Participation for Certain Retirees

Medical Coverage. Effective Jan. 1, 2008, no management retirees (including their eligible dependents and any surviving dependents) who retired on or after Jan. 1, 1992, shall be eligible to participate in the BellSouth Retiree Medical Assistance Plan. In addition, and also effective Jan. 1, 2008, all retirees from L.M. Berry and Company, Berry Network, Inc., and Stevens Graphics, Inc., (including their eligible dependents and any surviving dependents) shall not be eligible to participate in the BellSouth Retiree Medical Assistance Plan. For these affected participants, no medical claims incurred on or after Jan. 1, 2008, shall be payable under this plan.

Dental Coverage. Effective Jan. 1, 2008, no management retirees (including their eligible dependents and any surviving dependents) shall be eligible to participate in the BellSouth Retiree Dental Assistance Plan. In addition, and also effective Jan. 1, 2008, all retirees of L.M. Berry and Company, Berry Network, Inc., and Stevens Graphics, Inc., (including their eligible dependents and any surviving dependents) shall not be eligible to participate in the BellSouth Retiree Dental Assistance Plan. For these affected participants, no dental claims incurred on or after Jan. 1, 2008, shall be payable under this plan.

Group Life Coverage. Effective Jan. 1, 2008, no management retirees who retire on or after Jan. 1, 2008, shall be eligible to participate in the BellSouth Group Life Plan. In addition and also effective Jan. 1, 2008, all retirees of L.M. Berry and Company, Berry Network, Inc., and Stevens Graphics, Inc., who retire on or after Jan. 1, 2008, shall not be eligible to participate in the BellSouth Group Life Plan. For these affected participants, no benefits shall be paid under this plan for deaths occurring on or after Jan. 1, 2008."

CHILD ELIGIBILITY RULES

Change the heading "Age Requirements" on Page 16 of the SPD to "Age Requirements (excluding Pre-92 Management Retirees)."

Add the following new section to the end of Page 16 of the SPD after the "Age Requirements (excluding Pre-92 Management Retirees)" section:

"Age Requirements (For Pre-92 Management Retirees)

You can cover your unmarried children under the BellSouth Retiree Medical Assistance Plan until the end of the year in which they reach age 23. You can cover your unmarried children beyond the age of 23 in the following situations:

- You can cover a child through the end of the month in which he or she turns age 25 provided he or she:
  - Was enrolled as a full-time student as of Dec. 31, 2007.
  - Continues to meet the eligibility requirements as a full-time student.
  - Was born on or after Jan. 1, 1983, but before Jan. 1, 1985.
  - Remains continuously covered under the BellSouth Retiree Medical Assistance Plan as a full-time student.
- You can cover a disabled child for as long as he or she remains eligible for coverage.

Note: *The preceding rules will apply to all Pre-92 management retirees, and any other requirements to the contrary will no longer apply to this group. For example, effective Jan. 1, 2008, rules for disabled children begin for children aged 23 or older."*

LIMITED SURVIVING SPOUSE TRIAL

Add the following "Limited Surviving Spouse Trial" section to Page 26 of the SPD after the section entitled "Coverage Your Survivors Can Continue":

"**Limited Surviving Spouse Trial**

Surviving spouses/domestic partners — along with their eligible dependents — who drop medical coverage in connection with a solicitation on behalf of the Company and enroll in other medical coverage not sponsored by the Company or an affiliate may re-enroll in medical coverage hereunder during a subsequent enrollment effective Jan. 1, but only if:

- They continue to be eligible for medical coverage (dependents of a surviving spouse/domestic partner are not eligible after initial surviving dependent eligibility unless the surviving spouse/domestic partner remains eligible)
- They were enrolled in medical coverage sponsored by the Company or an affiliate immediately prior to becoming covered under a medical program not sponsored by the Company or an affiliate
- They establish to the satisfaction of the Plan Administrator (or its designee) that they had continuous medical coverage throughout the entire period they were not covered under a medical program sponsored by the Company or an affiliate"

PAYING FOR COVERAGE

Delete the section entitled "How Retirees Pay for Coverage" on Page 42 of the SPD and replace it with the following:

"**How Retirees Pay for Coverage**

Any contributions for plan coverage are deducted from your annuity pension check (if you are receiving a pension annuity from a company- or affiliate-sponsored pension plan AND if the gross amount of that check prior to deductions is greater than or equal to $400 a month). If you do not receive an annuity pension check (for example, if you received a lump sum distribution of your pension) or if the gross amount of your annuity pension check is less than $400 a month, then you must make direct payment of your contributions. You may also elect to be direct-billed rather than having the deduction come from your annuity pension check. If applicable, you will be direct-billed, and payments can be made for up to one year in advance. In addition, you can choose to pay your contributions through direct debit. To sign up for automatic withdrawal from your savings or checking account or to set up direct billing or for more information, contact the AT&T Benefits Center at **877-722-0020**."

MEDICARE PART B REIMBURSEMENT

Add the following language to the end of the "Reimbursement of Medicare Part B Premiums" section on Page 43 of the SPD:

"***Note**: Medicare Part B premium reimbursement is **not** automatic and will not be applied retroactively. You must contact the AT&T Benefits Center at **877-722-0020** to enroll in the Medicare Part B premium reimbursement program. If you are eligible, premium reimbursement will generally begin on the first day of the month following enrollment through the AT&T Benefits Center (but no earlier than your Medicare eligibility date). However, the AT&T Benefits Center may request verification of your Medicare Part B enrollment (e.g., a copy of your Medicare card) to complete your enrollment. In this event, your enrollment will not become effective until the required information is received and processed by the AT&T Benefits Center.*

There is no reimbursement for any Medicare Part A or D premiums that you or your dependents pay."

MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

Replace the chart in the "Mental Health and Substance Abuse Treatment" section on pages 74, 75 and 76 of the SPD with the following:

"Here's how mental health and substance abuse treatment is covered:

Service	In Network (MHMC)	Out of Network (Non-MHMC)
Inpatient mental health treatment (Services must be precertified before benefits can be paid.) Each inpatient admission for a mental health diagnosis must be separated by 60 days to be considered a separate admission and not part of the previous admission.	The plan pays 100% of covered charges for days 1 - 29 after you pay the deductible. The plan pays 95% of covered charges for days 30 - 59 after you pay the deductible. The plan pays 85% of covered charges for more than 90 days after you pay the deductible.	The plan pays 90% of the payment allowance for days 1 - 29 after you pay the deductible. The plan pays 85% of the payment allowance for days 30 - 59 after you pay the deductible. The plan pays 80% of the payment allowance for days 60 - 89 after you pay the deductible. The plan pays 75% of the payment allowance for more than 90 days after you pay the deductible.
Inpatient psychiatric physicians	The plan pays 90% of covered charges after you pay the deductible.	If a participant is admitted to an out of network facility by an out of network physician, the plan pays 90% of R&C charges after the deductible, up to $85 per visit. If a participant is admitted to an out of network facility by an in network physician, the plan pays 90% of covered charges per physician visit after the deductible is met. Maximum of 52 visits per year (limited to two visits a week).
Outpatient mental health treatment	You pay a $15 copayment per visit. No deductible is required.	The plan pays 90% of R&C charges after the deductible, up to $60 or $70 per visit (based on the type of provider). Maximum of 52 visits per year (limited to two visits a week).

Table continued on next page.

Service	In Network (MHMC)	Out of Network (Non-MHMC)
Inpatient detoxification (no more than two in a five-year period). (Services must be precertified before benefits can be paid.) The second admission must start at least 180 days after the first one ended to be considered separate and not part of the previous admission.	The plan pays 100% of covered charges after you pay the deductible. Any fees other than physician fees that are billed separately from the facility program charges will not be covered.	The plan pays 90% of the payment allowance after you pay the deductible. Physician fees must be included in the facility charge. Any fees billed separately from the facility program charges will not be covered.
Inpatient substance abuse rehabilitation (limit three per lifetime for up to 30 days each).* Each inpatient admission for a substance abuse diagnosis must be separated by 180 days to be considered a separate admission and not part of the previous admission.* (Services must be precertified before benefits can be paid.) **Note:** Class II and sponsored dependents are **not** eligible.	The plan pays 100% of covered charges after you pay the deductible. Any fees other than physician fees that are billed separately from the facility program charges will not be covered.	The plan pays 90% of the payment allowance after you pay the deductible. Physician fees must be included in the facility charge. Any fees billed separately from the facility program charges will not be covered.
Alternate benefits (mental health and substance abuse) If for substance abuse, limited to two benefits per lifetime for up to 30 days each. Includes partial hospitalization, residential treatment and intensive structured outpatient treatment. (Services must be precertified before benefits can be paid.) **Note:** Class II and sponsored dependents are **not** eligible.	The plan pays 100% of covered charges after you pay the deductible. Any fees, other than physician fees, that are billed separately from the facility program charges will not be covered.	The plan pays 90% of the payment allowance after you pay the deductible. Physician fees must be included in the facility charge. Any fees, including physician fees, that are billed separately from the facility program charges will not be covered.
**The mental health and substance abuse benefit pays for three substance treatments per lifetime for up to 30 days each. The three admissions can be inpatient, alternative levels of care or any combination if appropriate and precertified.*		

For more specific details on your mental health and substance abuse benefits, contact Magellan Health Services."

PRESCRIPTION DRUG CHANGES

Change the heading "Prescription Drug Program" on Page 66 of the SPD to "Prescription Drug Program (excluding Pre-92 Management Retirees)."

Add the following sentence to the end of the section entitled "Eligibility for Coverage" on Page 66 of the SPD:

"If you are a management retiree (who retired before Jan. 1, 1992) or an eligible dependent or survivor of such retiree, your prescription drug program is described starting on Page 73 of the SPD and you are not eligible for benefits under this section."

Add the following new section at the end of Page 73 of the SPD:

"**Prescription Drug Program (For Pre-92 Management Retirees)**

Eligibility for Coverage

Your prescription drug coverage is described in this section if you enroll in the:

- Preferred Provider Organization (PPO).
- Point of Service (POS) Plan.
- Indemnity Basic Plan or Indemnity Basic Plan when Medicare is primary.

The Prescription Drug Program (for pre-92 management retirees) covers drugs and medicines prescribed by your or your covered dependent's doctor on an outpatient basis. Some drugs and medicines aren't covered by the program. Contact Medco Health directly to get a list of covered drugs.

In addition, some medications are covered by the plan only for certain uses or in certain quantities. For example, a medication may not be covered when it is used for cosmetic purposes. Also, the quantity covered may be limited to certain amounts over certain time periods.

If you enroll in an HMO or EPO, prescription drug coverage is provided through the HMO or EPO and you are not eligible for prescription drug coverage under this program. Contact your plan administrator for details.

How the Program Works

You are eligible to receive coverage for short-term and long-term prescription drug benefits, subject to the Annual Deductible as later described. The prescription drug benefit consists of the following two programs:

Retail Prescription Drug Program — provides up to a 30-day supply and is used for short-term, immediate-use medications

Mail Order Prescription Drug Program — provides up to a 90-day supply and is used for long-term maintenance medications

Prescription drug copayments vary, depending on where you purchase your prescription drug (i.e., Network or Non-Network Retail Pharmacy or Medco's mail order program) and the type of prescription drug you receive (i.e., generic drug, Preferred Brand Drug or Nonpreferred Brand Drug).

A Preferred Brand Drug is a brand name prescription drug that is identified as **P** on the prescription drug Claims Administrator's Preferred Drug Guide. A Nonpreferred Brand Drug is one

that is identified as **NP** on the prescription drug Claims Administrator's Preferred Drug Guide. The Preferred Drug Guide identifies U.S. Food and Drug Administration-approved drugs identified as **P** that Medco's panel of doctors and pharmacists has determined to be as therapeutically effective as the Nonpreferred Brand Name Drugs and that are generally more cost-effective. The Preferred Drug Guide is generally revised on a quarterly basis and may change throughout the Plan Year. Different copayments apply to Preferred Brand Drugs than apply to Nonpreferred Brand Drugs (see the "Prescription Drug Copayment Chart" in this section for more information).

Important: Covered prescription drugs (1) include only medically necessary Food and Drug Administration (FDA)-approved medicine required by federal law to be dispensed only with a doctor's prescription; and (2) are dispensed subject to the professional judgment of the dispensing pharmacist, applicable laws and regulations, limitations imposed on controlled substances and the manufacturer's recommendations.

Retail Prescription Drug Program

You will receive a prescription drug identification card for use at a Network Retail Pharmacy. You can only receive benefits for up to a 30-day supply of your prescription when purchased at a participating Network Retail or Non-Network Retail Pharmacy. The retail prescription program is used for short-term prescriptions or those that are for immediate use in the event of an acute condition.

Limitations apply to coverage for Maintenance Drugs* and Specialty Prescription Drugs when purchased at a retail Pharmacy. A Maintenance Drug is a drug generally prescribed for chronic or long-term medical conditions, including but not limited to, diabetes or high cholesterol. A Specialty Prescription Drug is a drug used in the management of certain chronic diseases, such as hemophilia, growth hormone deficiency, multiple sclerosis, immune disorders and hepatitis C, and requires complex Pharmacy management. Special requirements apply to the purchase of Specialty Prescription Drugs.

If your doctor prescribes a Maintenance Drug, the prescription drug program will cover only the first two times you purchase that Maintenance Drug in a *rolling* 12-month period at a retail Pharmacy. For example, after you fill a prescription for a Maintenance Drug at a retail Pharmacy and use all of the drug, the prescription drug program will cover one additional refill of the drug (or another fill if you have received a new prescription) at a retail Pharmacy. This constitutes two fills. After the first two fills, all Maintenance Drugs must be filled through the Mail Order Prescription Drug Program in order to be covered under the prescription drug program. Any drugs that are not covered because they were not purchased through Mail Order will not be covered under the prescription drug program or otherwise covered under the plan.

Important: Prescription Drugs purchased at a retail Pharmacy cannot be canceled or returned. Federal and state laws require that returned medication must be destroyed and cannot be restocked. As a result, once the Pharmacist has dispensed the drug, the order cannot be canceled, and you are responsible for the full copayment. If you are uncertain of your copayment amount, contact the prescription drug Claims Administrator by either logging in to its Web site or by contacting customer service before you place your order.

**Participants submitting claims for Maintenance Drugs from a licensed Long Term Care facility with a National Association of Board Pharmacies (NABP) number will not be required to use the Mail Order Prescription Drug Program for their Maintenance Drugs.*

For Specialty Prescription Drugs, except for the initial fill of a particular Specialty Prescription Drug, purchases of the drug are covered only if purchased through Medco's Specialty Prescription Drug Pharmacy.

Your Benefits are paid based on whether you use a participating Network Retail Pharmacy or a Non-Network Retail Pharmacy, as described below:

- If your prescription is filled at a participating Network Retail Pharmacy, then you pay a copayment for up to a 30-day supply of the medication. The amount of the copayment depends on whether the prescription is for a generic, Preferred Brand or Nonpreferred Brand Drug. You generally will not be required to file a claim form when you use your prescription drug identification card at a participating Network Retail Pharmacy. The pharmacist will generally provide you with the prescribed medication, subject to the anticipated copayment, and file your claim for benefits for you. If your pharmacist cannot confirm your eligibility, or if there is a question concerning the coverage of the prescribed medication, the pharmacist may require you to pay the full Retail price for the prescription at the time of purchase. In this case, you must submit a claim for benefits to Medco for reimbursement.

  Note: To locate a participating Network Retail Pharmacy, contact Medco directly. If you go to a Network Retail Pharmacy and do not present your prescription drug identification card, you will not receive the benefit of discounted pricing and may be required to pay full price for the prescription and submit a claim for benefits in order to be reimbursed.

- If your prescription is filled at a Non-Network Retail Pharmacy, including prescriptions filled outside of the United States, you must pay for the prescription in full at the time of purchase and file a claim for benefits with Medco to be reimbursed. If you use a Non-Network Retail Pharmacy, the prescription drug program will pay the lesser of (1) the amount the prescription drug program would have paid if you used a Network Pharmacy, or (2) 75 percent of the Network cost of the prescription.

Mail Order Program

Medco's Mail Order program is used for long-term prescriptions (up to a maximum of 90 days) for the treatment of a chronic condition. Through Mail Order, you can receive up to the maximum each time you fill or refill a prescription. The Mail Order prescription is sent directly to your home at no additional cost to you.

You can fill your mail order prescriptions three ways:

- **By mail** — send in the completed order form with your prescription and copayment.
- **By phone** — ask your doctor to call Medco at **888-327-9791.** Give your doctor your member ID number, printed on your prescription ID card. You will be billed by Medco for your copayment later.
- **Online** — visit the Medco Web site.

Important: Mail Orders for prescription drugs cannot be canceled or returned. Federal and state laws require that returned medication must be destroyed and cannot be restocked or reshipped to you. As a result, once Medco has begun processing your Mail Order, the order cannot be canceled and you are responsible for the full copayment. Additionally, if you refuse the shipment or return the medication, you are still responsible for the full copayment. If you are uncertain of your copayment amount, contact Medco by either logging in to its Web site or by contacting customer service before you place your order.

Prescription Medication in the Hospital

If you are hospitalized, the medications you receive while confined are not covered by the prescription drug benefit described here but are covered under general medical plan provisions.

Birth Control Drugs

The prescription drug program provides coverage for the following birth control drugs:

- Oral contraceptives
- Depo-Provera and other similar injections for birth control
- Alternative birth control drug delivery mediums (such as a dermal patch) when the alternative medium may be delivered with the same efficacy as oral contraceptives and in a cost-effective manner

Generic Drugs

A generic drug uses its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand name drugs must meet the same standards for safety, purity, strength and effectiveness. When authorized by your physician and permitted by applicable law, a pharmacy is able to dispense a generic drug. You will find that using generic drugs will save you money.

To maximize your benefits, you should always purchase generics when permitted by your physician. Medco may fill your prescription with a generic drug if the prescription is not marked "Dispense as Written." Even if the prescription contains this stipulation, a change to a generic drug equivalent may be made if Medco's pharmacist contacts your physician and obtains his or her consent, either written or verbal. If the physician does not approve the change, your prescription will be filled as originally written.

Brand Drugs Purchased When a Generic Drug Is Available

If a generic drug is available and you purchase a Preferred or Nonpreferred Brand Drug at a Network Pharmacy, you will pay the applicable generic drug copayment plus the difference between the charge to the plan to dispense that brand drug and the charge to the plan if the generic drug were purchased at a Network Pharmacy (mail or retail, as appropriate). This applies regardless of your reason for not using the generic drug, **including if your doctor indicates that it should not be substituted.**

If a generic drug is available and you purchase a Preferred or Nonpreferred Brand Drug at a Non-Network Pharmacy, you will be reimbursed as if you had purchased the generic drug from a Network Pharmacy.

Copayments

The Network retail and Mail Order prescription drug copayments shall be adjusted annually based on actual prescription drug trend experience within the plan subject to the limits imposed in order for the plan to maintain actuarial equivalence to the Medicare Part D prescription drugs benefit. These annual adjustments may be delayed one year from their calculation to accommodate administrative programming requirements.

If the cost of your prescription drug is less than the required copayment, you will only be responsible for the cost of your prescription drug for both retail and Mail Order prescriptions.

Diabetic Supplies

The plan includes the provision of treatment for insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, non-insulin diabetes and coverage for medically necessary equipment prescribed by a physician. Prescribed medically necessary lancets, test strips (blood or urine), insulin syringes and glucometers for all categories of diabetes are covered, subject to the applicable copayment and other provisions of the prescription drug program.

Guidelines for Purchasing Specialty Prescription Drugs

- With the exception of the first time you fill your prescription for a Specialty Prescription Drug, you must fill all prescriptions for Specialty Prescription Drugs through Medco's Specialty Pharmacy for the medication to be covered under the plan. Specialty Prescription Drugs are automatically processed through the Specialty Pharmacy when you use Mail Order.
- The ***first time*** you purchase each Specialty Prescription Drug at a retail Pharmacy, the medication will be covered as a retail Pharmacy purchase. Subsequent purchases of the drug at a retail Pharmacy, including a Network Retail Pharmacy, ***will not*** be covered. The one-time exception applies to ***each*** Specialty Prescription Drug you purchase. Any drugs that are not covered because they were not purchased through Medco's Specialty Pharmacy is not reimbursable through the Plan.
- This Specialty Prescription Drug reimbursement limitation will apply to all Specialty Prescription Drugs — including Specialty Prescription Drugs obtained through a doctor's office or inpatient/outpatient facility and administered in the doctor's office, inpatient/outpatient facility or the Covered Person's home.
- The Specialty Pharmacy copayment is based on the number of days covered by the fill as follows:
    - Supplies for 30 days or less — one-third of the applicable Mail Order copayment
    - Supplies for 31 to 60 days — two-thirds of the applicable Mail Order copayment
    - Supplies for 61 to 90 days — 100 percent of the applicable Mail Order copayment

Prescription Drug Exclusions

The following prescription drugs are not covered under the prescription drug program:

- Charges for over-the-counter medication and pharmaceutical purchases, whether prescribed by a physician or otherwise, except for insulin and diabetic supplies, such as blood-testing

aids, diagnostic urine tests, hypodermic needles and syringes prescribed by a physician for use with covered injectables, as set forth in the "Diabetic Supplies" section

- Allergy serums
- Anti-wrinkle injections*
- Digestive aids, vitamins, minerals or other dietary supplements used solely as dietary supplements, regardless of whether such items are ordered or prescribed by a physician
- Erectile dysfunction agents*
- Hair-loss medications, hair-removal agents* and hair-growth agents*
- Maintenance Drugs not purchased through Medco, except for the first two fills of a prescription for the Maintenance Drug as described in the "Retail Prescription Drug Program" section
- Reproduction/Infertility drugs
- Topical retinoids, such as Retin A, Tretinoin, Accutane, Differin (for individuals who are 26 or older) Exception: Medco may approve if determined to be medically necessary through the appeals process.
- Specialty Drugs not purchased through Medco's Specialty Pharmacy, except for the initial purchase of a Specialty Drug, as described in the "Guidelines for Purchasing Specialty Prescription Drugs" section
- Topical anti-aging*
- Treatment for nail fungal infections, with the exception of participants who are immunocompromised or diabetic
- Weight-loss medications, unless covered through the Weight-Management Program
- Any prescriptions greater than a 30-day supply at retail or a 90-day supply at Mail Order, including any prepackaged prescriptions

*Refer to the "Personal Choice Drug" section in the "*Medco Health Solutions*" table on Page 16.

Medco Health Solutions	
To Contact Member Services or Access the Interactive Voice Response Unit (IVRU)	**877-797-7472** **800-759-1089** (TTY) Member Services is available 24 hours a day, 7 days a week (except Thanksgiving and Christmas).

Table continued on next page.

Medco Health Solutions	
Internet Access	Visit **www.medco.com,** your Internet prescription service, to verify Benefits or prescription costs, order prescription refills or inquire about the status of your order. When you register for the first time, be ready to provide: • The Member Number/Subscriber ID. • The date of birth (mmddyyyy) of the person registering. **Locate a pharmacy**: Find a Network Retail Pharmacy in your area. **Personalized Options.** Once registered on the site, you will be able to view detailed information about personal prescription Benefits and prescription information for minor dependents. If you already have registered, you will need the e-mail address you used when you first registered and your password to successfully log in each time you use the Web site. This process provides the appropriate security, consistent with proposed HIPAA regulations. **Check Drug Coverage, Costs and Preferred Prescriptions Member Guide.** You can price a medication and determine whether it is a Generic, Preferred or Nonpreferred drug. If there are money-saving alternatives available for you, you'll find a list of the drugs you're taking on an ongoing basis, your current out-of-pocket costs and lower-cost alternatives, such as lower-cost brand and generic drugs. **Benefits Summary.** View your or your covered minor dependent's Benefits Summary. **Refill Request.** Order mail service prescriptions from a list of ready-to-refill prescriptions for you and your covered minor dependents. **Order Status.** Recent orders are displayed with drug names and prescription numbers for a quick and easy check on order status. If an order is sent using a method other than U.S. mail, a tracking number is provided that ties directly to the carrier's Web site. **Prescription History.** View your and your covered dependent's prescription history for up to 18 months, including mail service, retail Pharmacy and processed paper Claims. **Print Forms.** Print Claim and Mail Order forms from the Web site.
Medicare Part B Opt-Out Program	If you are eligible for Medicare Part B coverage, your eligible Medicare Part B claims will be submitted for processing under your Medicare B coverage first. Medco will then process your claim as if your AT&T coverage was secondary. This will mean that your out-of-pocket expenses should be minimal for these eligible Medicare Part B drugs. If you wish to OPT OUT of this program, please contact a Medco Customer Service representative at **877-797-7472.**

Table continued on next page.

Medco Health Solutions	
Retail Prescription Drug Program — for Short-Term and Immediate Medications up to 30 Days	Claim forms are available through: • **www.medco.com** (Medco's Web site) • Medco at **877-797-7472** Mail Claims to: Medco Health Solutions Inc. P.O. Box 14711 Lexington, KY 40512 **Important:** Claims must be submitted no later than one year from the date the prescription drugs were purchased. Claims submitted past the filing date will not be considered for reimbursement. Remember to keep a copy for your records.
Personal Choice Drugs	Anti-wrinkle injections, topical anti-aging, hair-removal agents, hair-growth agents and erectile dysfunction agents are not covered under the prescription drug program. However, these personal choice drugs are available for purchase at 100% of AT&T's negotiated discount plus the fee for dispensing the medication when the drug is purchased at a Medco Network Retail Pharmacy and you present your prescription drug identification card. **Note:** Personal choice drugs are not subject to or counted toward your Annual Deductible and are not available through the Mail Order program.
Mail Service Prescription Drug Program — for Long-Term Medications up to 90 Days	**New Prescriptions**. For all new prescriptions, you must send in the original prescription with a Medco By Mail Order Form. Forms may be printed from the Medco Web site at **www.medco.com** or may be requested by calling Medco. Enclose a check or money order for the required payment, or write your credit card number (with expiration date*) on the order form. Mail the order form to Medco: Medco P.O. Box 650322 Dallas, TX 75265-0322 **Mail Service Refills**. You can request refills on maintenance medications by mail, phone or the Internet. Order three weeks in advance of the date your current prescription will run out. Suggested refill dates will be included on the prescription label you receive from Medco. • **Mail**. To refill a prescription by mail, attach the refill label and your prescription order to a completed Medco By Mail Order Form. Enclose a check or money order for the required payment or write your credit card number (with expiration date)* on the order form. Mail the order form to Medco: Medco P.O. Box 650322 Dallas, TX 75265-0322

Table continued on next page.

Medco Health Solutions	
Mail Service Prescription Drug Program — for Long-Term Medications up to 90 Days	• **Telephone**. To order refills over the telephone 24 hours a day, use a touch-tone telephone and call toll-free at **877-797-7472.** • **Internet**. Access the Online Pharmacy on **www.medco.com**. To order refills, access the Medco Web site and select the Order Prescriptions option. To check the status of your order, access the Medco Web site and select the Order Status option. Remember to keep an order copy for your records. **If your credit card has expired, it must be updated with Medco either online or on the Medco By Mail Order Form. When entering the credit card information on the Mail Order form, a signature is required for processing the credit card payment.*
Where to File an Appeal	Medco Health Solutions Attn: Appeals Department 8111 Royal Ridge Parkway Irving, TX 75063 Telephone: **800-946-3979**
Specialty Prescription Drug Program — for Prescription Drugs Used in the Management of Chronic Diseases	Medco's specialty care pharmacy, Accredo Health Group, is available 24 hours a day, seven days a week (except Thanksgiving and Christmas) by calling **877-797-7472.** Your Medco pharmacist will be available to answer your questions or concerns about your specialty medications and provide personalized counseling. You will have the same payment options as you do when using the Medco By Mail drug program. Contact Medco at **877-797-7472** for a current list of Specialty Prescription Drugs. This list changes frequently.

Prescription Drug Copayments* (Benefit Levels for Plan Year 2008)			
	Network Retail Pharmacy	**Non-Network Retail Pharmacy**	**Prescription Drug Claims Administrator's Mail Order Program**
Maximum Purchase for Each Prescription	Up to a 30-day supply	Up to a 30-day supply	Up to a 90-day supply
Generic Drug Copayment	$10	Greater of the applicable Network retail copayment, or the balance remaining after the Plan pays 75% of the Network Retail Cost of the prescription drug.	$20
Preferred Brand Drug Copayment	$25		$51
Nonpreferred Brand Drug Copayment	$47		$101
**Please review the applicable provisions of the prescription drug program for more specific information and limitations.*			

Secondary Benefits

If you have other medical coverage that is primary and BellSouth medical coverage is secondary for you or your eligible dependents, you may be eligible to receive secondary benefits for your prescription drug expenses. You may submit your covered secondary prescription expenses to Medco Health for reimbursement.

When this plan is secondary, Benefits will be reduced by the total amount of Benefits paid or provided by the primary plan. Benefits will be determined as follows:

- Determine benefits that would have been paid if the BellSouth retiree medical coverage was primary
- Subtract the amount that the primary plan paid

If there is a difference, the BellSouth retiree medical coverage will pay that amount.

To receive secondary benefits, call Medco Health at the number on the back of your prescription drug ID card for more information.

Claim Review/Appeal Process

The claim and appeal provisions set forth starting on Page 69 of the SPD shall continue to apply.

Weight-Management Program

The Medco weight-management program is a program tailored to support each participant's weight-management goals. Enrollment in the program is necessary in order to obtain and maintain coverage of any prescription weight-loss medication(s).

The weight-management program includes the following benefits:

- Support and consultation
- Unlimited toll-free access to Medco's weight-loss clinical pharmacists, who will provide consultation and support during the program
- Ongoing educational mailings to fit individual needs that focus on health and lifestyle issues
- A simple precertification process for obtaining weight-loss medication(s). For more information on the process, see the "Weight-Loss Medication Precertification Process" chart on Page 21.

In order to receive initial and continued coverage for prescription weight-loss medication(s), you must:

- Be under the care of a doctor who feels therapy is appropriate.
- Have tried to lose weight through diet and exercise for six months.
- Meet U.S. Food and Drug Administration prescribing guidelines of either:
  - Having a Body Mass Index (BMI) of equal to or greater than 30kg/m^2.
  - Having a BMI between 27 and 29.9 kg/m^2 when you also have an existing condition such as high blood pressure, diabetes or high cholesterol.

BMI is calculated by using the following formula (using your weight in pounds and your height in inches):

$$\frac{\text{Your weight x 703}}{\text{Your height x your height}}$$

- Meet the minimum age requirement for the prescribed medication (for most drugs the minimum is 17 years of age).
- Demonstrate continued weight management. A loss of 4 percent of initial weight should occur during the first three months of therapy. A loss of 8 percent of initial weight should occur during the first six months of therapy.
- Take your medication(s) as prescribed.
- Precertify all prescriptions for weight-loss medication(s) at least seven business days in advance through Medco (includes new and refill orders).

Enroll in the Medco weight-management program by visiting your doctor for an evaluation. If you receive a written prescription for weight-loss medication(s), call Medco. Medco will contact your doctor to verify that you meet the program requirements. Medco will also contact you regarding the status of your enrollment.

You stay enrolled in the weight-management program by:

- Continuing to lose weight.
- Taking your medication as prescribed. This is a key step in helping to manage your weight.
- Visiting your doctor for weight checks on a regular basis. Program guidelines require that you have a weight check every 90 days. (To obtain the greatest benefit from your weight-loss program, however, it is recommended that you have weight checks each month for the first three months.)
- Calling Medco to precertify your new and refill prescription(s) for weight-loss medication(s). Coverage in the weight-management program can be denied if:
    - You do not meet the prescribing guidelines for weight-loss medication(s).
    - You do not take your medication(s) as prescribed.
    - You do not continue to lose weight.
    - You fail to precertify before each 90-day fill of your prescription weight-loss medication(s).
    - You do not visit your doctor for weight checks as required by the program.

If you become disqualified from participating in the weight-management program, you will become eligible to re-enroll in the program on the next anniversary of your original start date in the program provided that you meet all the program requirements at the time you re-enroll.

Weight-Loss Medication Precertification Process
• Medco will approve or deny the medication based on U.S. Food and Drug Administration guidelines for the prescribed weight-loss medication. • When using a retail Pharmacy, you will be responsible for contacting Medco at **800-753-2851** before the weight-loss prescription is filled. Continued weight-management program eligibility requires weight loss or maintenance of weight, and your physician must complete the weight-management precertification questionnaire each time you request that a prescription be filled. The weight-management precertification questionnaire will be faxed to your physician by Medco. • If you fill the prescription for weight-loss medication at a retail Pharmacy without obtaining precertification, you are not eligible for benefits under the weight-management program. • If you submit the prescription to the Mail Order Program, Medco will contact the prescribing physician, when necessary, to obtain the required precertification information. You will receive either the filled prescription in the normal time frame or a denial letter from Medco. ***Note**: Precertification must be obtained before filling all weight-loss prescriptions.*

TIMING OF COVERAGE CHANGE REQUESTS

The "Timing of Coverage Change Requests" section on Page 128 of the SPD is replaced with the following:

"**Timing of Medical Coverage Change Requests**

If you have a qualified change in status and need to change your coverage during the year, the change should be reported within 31 days. Changes reported within 31 days of the event will be effective the date of the event.

In addition, changes in medical coverage can be made at any time, but if a change is not made within 31 days of a qualified change in status, (a nonqualified change), such change will be effective the first of the month following notification."

PLAN IDENTIFICATION CHANGES

Effective Jan. 1, 2008, the following plans shall become component programs under the AT&T Umbrella Benefit Plan No. 1:

- The BellSouth Retiree Medical Assistance Plan
- The BellSouth Retiree Dental Assistance Plan
- The BellSouth Group Life Plan

The Plan identification information for the AT&T Umbrella Benefit Plan No. 1 is set forth below:

Plan Information	
Plan Number	600
Plan Sponsor and Administrator	AT&T Inc. P.O. Box 29690 San Antonio, TX 78229 **210-351-3333**
Name and Address of Employer	Affiliates of AT&T Inc. P.O. Box 29690 San Antonio, TX 78229 **210-351-3333**
Plan Sponsor's Identification Number	43-1301883
Agent for Service of Legal Process	Process in legal actions concerning the provision of benefits under the component programs should be served on the Plan Administrator (the agent for service of legal process) at: AT&T Inc. P.O. Box 29690 San Antonio, TX 78229

CONTINUED APPLICABILITY

Except as amended herein, the provisions of the Affected Plans will remain in effect.