Health and Insurance Plans For Retirees

Summary Plan Descriptions

BellSouth Corporation

April 1, 2006

Incorporating updates made by
an addendum dated July 2006 and a
Summary Material Modification
dated October 2006

This summary plan description (SPD) is being provided to you and it describes benefits provided to you by your plan, and your rights under the plan. The SPD is based on official plan documents. It is not, nor is it intended to be, the official plan document, or a contract between BellSouth and any retiree, or a guarantee of future retiree benefits. Every effort has been made to ensure the accuracy of this information. In the unlikely event that there is a discrepancy between the SPD and the official plan documents, the official plan documents will control. BellSouth reserves the right to amend, suspend, or terminate the plan(s) or program(s) at any time. BellSouth has the discretionary authority to interpret the terms of the plan(s) summarized in this document and determine your eligibility for benefits under its terms.

In addition, there may be situations where the plan(s) provides different benefits to different employee groups. This SPD provides only those benefits that are applicable to you based on your employee group.

This SPD may be available to you online through the ***Benefits@Your Fingertips*** Web site, **https://www.bellsouthbenefits.com**. You may have access and the ability to view the SPD on the Web site, and print pages of this SPD from the Web site. You also have the right to request and receive, free of charge, a printed copy of the electronically delivered document from the BellSouth Benefits Service Center. If there are any discrepancies between the information on the Web site and your printed copy, the Web site version will control.

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Health and Insurance Plans Overview

The Health and Insurance Plans are designed to assist you financially in case of illness, accident, or death. The Health and Insurance Plans include:

- Medical—The BellSouth Retiree Medical Assistance Plan
- Dental—The BellSouth Retiree Dental Assistance Plan
- STAP—The BellSouth Supplemental Transplant Assistance Plan
- Life Insurance—The BellSouth Group Life Plan

{The following paragraph and table were added to the printed booklet by an addendum dated 7/2006:}

Former represented employees who are receiving benefits through the BellSouth Long-Term Disability Plan for Non-Salaried Employees continue participation in the following Health and Insurance Plans, depending on their situation:

In this situation:	These benefits may continue:
You are: • Not eligible for a service or disability pension benefit, or • Eligible for a disability pension benefit, but waive it	• Medical—The BellSouth Retiree Medical Assistance Plan • Basic and Optional Life and AD&D Insurance—The BellSouth Group Life Plan for 3 years
You are: • Eligible for a service pension, or • Eligible for a disability pension and take it	Retiree benefits including: • Medical—The BellSouth Retiree Medical Assistance Plan • Dental—The BellSouth Retiree Dental Assistance Plan • Life Insurance—The BellSouth Group Life Plan

Enrolling for Coverage

When you retire, some retiree coverages begin without your having to enroll. You may choose to enroll and elect different coverage options other than what has been assigned to you and make changes to covered dependents.

If you have a qualified change in status, you can make midyear changes to your coverage that are consistent with your status change.

If You Have Other Healthcare Coverage Available

You may be eligible for coverage under more than 1 medical or dental plan—for example, your spouse/partner may be able to cover you under his or her employer's plans. In this case, you can waive coverage under the BellSouth plans.

If your spouse/partner has medical coverage available through his or her employer, you may be subject to working spouse primary coverage guidelines if you choose to carry your spouse/partner as primary on your BellSouth medical coverage.

Having coverage under more than 1 medical or dental plan doesn't necessarily mean you get more benefits. Most plans coordinate benefits. For example, your total benefit is limited to what you would receive under the plan with the highest coverage level.

Be sure to review the benefits offered by both plans carefully before making your enrollment choices.

Paying for Coverage

The company contributes to the cost of many of your benefits. Some plans are voluntary and require you to pay your share of the cost either through pension deductions, by direct billing, or by direct debit from a checking or savings account.

When you first retire, you'll be set up for direct billing. If you receive a monthly pension annuity payment, you can choose to have your payment for benefits deducted from your pension annuity. Call the BellSouth Benefits Service Center to initiate deductions from your pension annuity.

You can also call the BellSouth Benefits Service Center to initiate direct debit from a checking or savings account.

Eligibility for Coverage

Who Is Eligible for Retiree Coverage

If you retire on a service or disability pension, you and your eligible dependents will be eligible for retiree coverage, according to plan guidelines (some Stevens Graphics represented employees may not be eligible for retiree benefits—refer to your contract). Represented employees (excluding SGI-represented employees) on long-term disability benefits under the BellSouth Long-Term Disability Plan for Non-Salaried Employees but who are not receiving a service disability pension are also eligible for certain coverages.

Management employees: You qualify for a service pension when any combination of your net credited service (NCS) and your age (in whole years and whole months) equals or exceeds 75 years (this is called the Rule of 75). You must also have a minimum of 10 years of NCS.

For example, if you are 46½ years old and have 28½ years of NCS, you meet the Rule of 75 and are eligible for a service pension. However, if your final service is with an affiliate that is not a participating company, you must have completed a minimum of 10 years of vesting service credit (VSC) with participating companies to be eligible for a service pension.

Represented employees: A service pension is generally assumed to begin at age 65. However, you qualify for a service pension on any 1 of the following dates, when:

- You reach your normal retirement age (65 years old) with at least 10 years of seniority;
- You reach age 55 with at least 20 years of seniority;
- You reach age 50 with at least 25 years of seniority; or
- You reach any age with at least 30 years of seniority.

Note: If your last employment is not with a participating company, a service pension will only be granted if you have at least 10 years of seniority with a participating company.

National Directory Assistance Represented employees may be eligible for certain coverages in accordance with the memorandum of agreement.

Utility Operations employees are not eligible for retirement benefits other than the Supplemental Transplant Assistance Plan.

Service Pensions are payable as soon as you retire. However, you may defer payments until a future date, but not beyond the first month following your 65th birthday.

Eligibility Rules for Rehired Retirees

If you are rehired as an active employee after having retired from BellSouth, your eligibility for health and insurance benefits will generally be determined as follows:

If you are rehired:	You will be eligible for active benefits:
Within 6 months after your retirement effective date	Immediately upon rehire. Your service "bridges" so you do not have to satisfy the normal waiting periods to become eligible for active healthcare benefits.
More than 6 months after your retirement effective date	After satisfying the normal waiting periods for active healthcare benefits. During the waiting periods, your retiree benefits may continue at the same costs, if any, that you were paying prior to being rehired.

If you work long enough to become eligible to retire a second time, when you retire again, you may be subject to the benefits and provisions, including costs, in effect at the time of your second retirement.

If you do not work long enough to become eligible to retire a second time, once your BellSouth employment terminates, your previous retiree benefits will resume and they would be effective the first of the month following your termination date.

Note: There could be changes in the retiree plan design and costs consistent with plan changes.

Eligibility Rules for Survivors of Retirees

When you die, your surviving dependents may be eligible to continue their retiree medical coverage if **both** of these apply:

- You're enrolled in the Retiree Medical Plan on the date of your death.
- Your surviving dependents are enrolled under your Retiree Medical Plan coverage on the date of your death.

Competitor Rule and Benefit Forfeiture Provision

(This section only applies to retired, non-represented employees of BAPCO, Intelligent Media Ventures, IYP Employee Services, Stevens Graphics, and all employees of L.M. Berry and Company.)

All non-represented BAPCO employees who retire on or after April 1, 1996, and all non-represented employees of Stevens Graphics, Intelligent Media Ventures, IYP Employee Services, all employees of L.M. Berry and Company who retire on or after April 1, 2006 may forfeit their rights and their dependents' rights to post-retirement medical benefits if, during the 2 years following retirement from BellSouth, they provide services to or acquire an interest in a BellSouth competitor. **It is important to understand that once such coverage is terminated, it will not be reinstated.**

Definition

A “Competitor” of BellSouth or its affiliates is one who, in BellSouth's judgment, directly or through an affiliate, provides goods or services, represents for sale, refers, promotes, negotiates, or otherwise markets any goods or services that displace or are in competition with any line of business in which BellSouth or 1 or more of its affiliates is engaged, such as, but not limited to:

- The provision of wireline telecommunications services, systems, or products;
- The printing, sale, publication, or provision of print or electronic classified directories, or directory advertising;
- The provision of wireless (including without limitation cellular, personal communications service and mobile data telecommunications services, systems, or products); and
- The provision of paging goods or services.

A “Competitor” includes any agency that is not related to BellSouth by ownership and that sells advertising, directly or indirectly, for publications of BellSouth or its affiliates, such as a certified marketing representative (CMR) or other such provider.

Under the BellSouth Retiree Medical Assistance Plan, a former non-represented employee who last worked for one of the A&P companies identified above will forfeit his or her entitlement to post-retirement benefits if, during the 2-year period following the employee's retirement, the former employee:

- Acquires ownership of more than 5% of any class of stock of—or acquires beneficial ownership of more than 5% of the earnings or profits of a—competitor; or
- Becomes employed by, consults with, or renders service to a competitor, **unless** the employee's activities on behalf of the competitor make no use, directly or indirectly of: 1) BellSouth confidential information, or 2) the specialized skill the former employee developed or the training provided to the employee or 3) relationships established or maintained by the former employee whether directly or through the employee's subordinate(s), in each case during his or her last 2 years of employment with BellSouth or any of its affiliates; or
- Discloses to any competitor, or uses for him- or herself or another, confidential information relative to the business of BellSouth. “Confidential information” includes, without limitation, the following types of information: information, whether generated internally or externally, relating to BellSouth's business or to its affiliates' businesses that derives economic value, actual or potential, from not being generally known to other persons and is the subject of efforts that are reasonable under the circumstances to maintain its secrecy or confidentiality, including, but not limited to, studies and analyses, technical or nontechnical data, programs, patterns, compilations, devices, methods, models (including cost and/or pricing models and operating models), techniques, drawings, processes, employee compensation data, and financial data (including sales and marketing information and strategies, customer account records, billing information, and personnel data); or
- Whether for his own account or the account of a Competitor, solicits business from any person or entity known by the former employee to be a customer or actively sought prospective

customer of BellSouth or any of its affiliates, if 1) the former employee had direct or indirect contact with such person or entity during and by reason of the former employee's employment at BellSouth or any of its affiliates, and 2) the business or service solicited displaces or is in competition with any line of business in which BellSouth or any of its affiliates is engaged.

The activities prohibited under this paragraph include soliciting advertising business, for or through a CMR or similar business, that BellSouth is in the business of directly providing to customers, even if such sales by CMR or similar business provides a business benefit to BellSouth or its affiliates.

For purposes of the BellSouth Forfeiture Provision, the business activities of BellSouth and its affiliates at the point in time that a former employee retires from his or her employment at one of the A&P companies identified above will determine whether that entity is a competitor.

Health and welfare benefits are deemed terminated upon the date of occurrence of any of the above forfeiture events; for example, the date that more than a 5% ownership interest in a competitor is acquired, or the date that employment with a competitor is begun. Upon learning of a forfeiture event, BellSouth reserves the right to seek the reimbursement of any benefits that were paid following the occurrence of that event.

Request for Benefits Forfeiture Ruling

You may file a "Request for Benefits Forfeiture Ruling" with the Lead HR Generalist. In order to prevent a possible forfeiture, you are encouraged to obtain such a ruling before engaging in any of the activities described above. On the basis of the information included in the request, you will receive a binding determination, within 30 days, based on the activity described in the request, as to whether the entity is a competitor, and if applicable, if the activity in question is deemed to be a violation of the Benefits Forfeiture Provision.

The address of the Lead HR Generalist is listed below:

BellSouth Advertising & Publishing Corp.
Suite 7D24
2247 Northlake Parkway
Tucker, GA 30084

Forfeiture Appeals

If you do not seek a ruling prior to engaging in a prohibited activity and your benefits eligibility is terminated under the Benefits Forfeiture Provision, you may, on your own behalf, or through a representative, have that action reviewed by submitting a written request, within 60 days of receipt of the notification of termination of eligibility, to the Lead HR Generalist at the address shown above.

You will receive written notice of the Lead HR Generalist's decision, including the specific reasons for the decision and the procedures for appealing the decision, within 90 days of the date the Lead HR Generalist received the appeal.

In some cases, the Lead HR Generalist may need more than 30 days to make a decision on a Request for Benefits Forfeiture Ruling, and may need more than 90 days to make a decision on a request for review of the termination of benefits. In such cases, the Lead HR Generalist will

notify the employee in writing within the initial 30-or 90-day period, as applicable, that more time is needed. An additional 90 days may be taken to make the decision if the Lead HR Generalist sends this notice. The extension notice will show the date by which the Lead HR Generalist's decision will be sent. If the Lead HR Generalist does not provide a decision within the designated time span, the appeal is deemed to be denied.

If your request to the Lead HR Generalist for a ruling or review is denied (or deemed denied when no reply is received within 30 or 90 days, as applicable or within an additional 90 days if an extension was requested), you may challenge such a denial by submitting a written appeal to the Vice President—Human Resources at the following address:

BellSouth Advertising & Publishing Corp.
Suite 1043
2247 Northlake Parkway
Tucker, GA 30084

Such an appeal must be submitted in writing within 60 days after the receipt of the Lead HR Generalist' denial notification, or within 60 days of the date that the original request was deemed to be denied if no denial is received. The Vice President—Human Resources will conduct a review and issue a determination within 60 days after receipt of the appeal. In some cases, more than 60 days may be needed to make a decision. In such cases, the Vice President—Human Resources will notify the employee in writing within the initial 60-day period that more time is needed. The Vice President—Human Resources may then have 60 days more, or a total of 120 days, in which to make a decision.

The Vice President—Human Resources will issue a final written decision that will include specific reasons for the decision. If the Vice President—Human Resources does not issue a decision within the appropriate time span, the appeal is deemed to be denied.

In submitting a request to the Lead HR Generalist or an appeal to the Vice President–Human Resources, the employee is entitled to include a written statement of the issues and any other documents in support of the request or appeal. All material provided to either the Lead HR Generalist or the Vice President—Human Resources will be carefully considered in the determination.

BellSouth has delegated to the Lead HR Generalist and the Vice President–Human Resources the duty to administer the request and appeal procedures with respect to Requests for Benefits Forfeiture Rulings and benefit eligibility terminations under the Benefits Forfeiture Provision. The Lead HR Generalist and the Vice President—Human Resources have the discretion and authority to interpret and to enforce the Benefits Forfeiture Provision and their determinations and interpretations are final and conclusive.

As a participant in the various benefit plans subject to the Benefits Forfeiture Provision, you have further rights under the Employee Retirement Income Security Act of 1974 and the Consolidated Omnibus Budget Reconciliation Act of 1986. Those rights are described in detail elsewhere in the Summary Plan Descriptions for the affected plans.

Coverage Not Requiring Enrollment

Retiree Coverage

As a retiree who meets the eligibility requirements, you receive retiree life insurance without having to enroll for it.

Coverage You Need to Elect

Retiree Coverage

When you first retire, some coverages may be assigned to you. You may choose to waive coverage or change your coverage option or the dependents you cover in these plans:

- Retiree Medical Insurance
- Retiree Dental Insurance
- Optional Retiree Coverage under the BellSouth Group Life Plan (represented employees)
- Supplemental Transplant Assistance Plan (STAP)—If you are a retiring management employee, you will be assigned individual coverage under this plan.

If you are a retiring represented employee and you are currently enrolled for STAP coverage, your current coverage will continue. If you are not currently enrolled for STAP, you are not eligible to enroll for coverage at this time. During the year, you can change your coverage, except the Optional Retiree Coverage under the BellSouth Group Life Plan, if you have a qualified change in status. The coverage change must be consistent with your qualified status change.

When Coverage Begins

At Retirement

Your coverage takes effect retroactive to the 1st of the month following your last day of active employment:

- Retiree Medical Insurance
- Retiree Dental Insurance
- Supplemental Transplant Assistance Plan—If you are a retiring management employee, you will be assigned Individual coverage under this plan.

If you are a retiring represented employee and you are currently enrolled for STAP coverage, your current coverage will continue. If you are not currently enrolled for STAP, you are not eligible to enroll for coverage at this time. If you are a Utility Operations or ND/CA employee, you may have the opportunity to enroll in STAP.

If you initially waive coverage and then later choose to enroll, coverage will take effect on the first of the month after notification.

Your retiree life insurance coverage takes effect on the first day of the month after your last day of active employment.

Your Optional Retiree Coverage under the BellSouth Group Life Plan (represented employees) takes effect the later of your retirement date or the date your enrollment application is received. A 1 time opportunity to apply for this coverage must be made within 75 days of your retirement date to be eligible for this coverage.

At Annual Enrollment for Retiree Coverage

For current retirees making new coverage choices during annual enrollment, your new coverage begins the following January 1.

When Becoming Eligible for Medicare

When you or your covered spouse or same-sex domestic partner becomes eligible for Medicare, you may enroll in a different medical option. As a retiree, you must enroll in parts A and B of Medicare to have any coverage through BellSouth.

If you wish to participate in BellSouth's prescription drug coverage for retirees, you should not enroll in Medicare Part D. If you enroll in Medicare Part D, prescription drug coverage from the BellSouth Retiree Medical Assistance Plan will be secondary and your coverage under Medicare Part D will be primary.

For information on when coverage for Parts A, B, and D takes effect, visit the Medicare Web site at **www.medicare.gov** or contact the Social Security Administration.

Dependents You Can Cover

If 1 or more of your dependents are also eligible BellSouth employees, special rules apply.

If You're a Retiree

Your eligible dependents include:

- Class I dependents
- Class II dependents
- Sponsored child(ren)

Not all dependents are eligible for all plans. As an eligible retiree, if you are covered by the following plans, you can also enroll your eligible dependents for coverage:

- Retiree Medical Insurance
- Retiree Dental Insurance
- Supplemental Transplant Assistance Plan (STAP)

If You're Participating in COBRA

If you're an eligible COBRA participant, you can enroll your dependents who are covered the day before your COBRA qualifying event under your current coverage. During a qualified status change or at annual enrollment, you may add eligible dependents to your current plans.

Eligible Dependents

Class I Dependents

A Class I dependent is:

- Your eligible spouse (including common-law spouse) or domestic partner
- Your eligible children

Class II Dependents

You may enroll for medical coverage—as a Class II dependent—any of the following dependents if they satisfy the conditions listed below:

- Unmarried children who are not Class I dependents
- Unmarried grandchildren
- Unmarried brothers and sisters
- Your or your spouse's parents or grandparents

To qualify as a Class II dependent:

- The dependent must have lived with you or in a household owned, leased, or rented entirely by you in the "same vicinity" for at least 6 months before applying for coverage. For this purpose, "same vicinity" means the same town, city, or ZIP code area as your own residence, or within a distance where you can provide daily care and supervision of the dependent.

- The dependent's total annual income must be less than $8,800 during the calendar year in which he or she is covered. All sources of income, including Social Security but excluding any support you provide, count toward the annual limit.

To initiate the application process for a Class II dependent, call the BellSouth Benefits Service Center at 1-800-528-1232. You may not enroll a Class II dependent through the ***Benefits@Your Fingertips*** Web site.

{The following paragraph was added to the printed booklet by an addendum dated 7/2006:}

Your cost of coverage for Class II dependents enrolled on or before January 1, 1988, is 50 percent of the total cost of coverage for a Class II dependent. Your cost of coverage for Class II dependents enrolled after January 1, 1988, will be the total cost of coverage for a Class II dependent. Contact the BellSouth Benefits Service Center for the rates.

Note: Some HMO/EPO medical options do not cover Class II dependents. If you are interested in covering a Class II dependent, call Member Services at the HMO/EPO to confirm that it offers coverage for Class II dependents.

Sponsored Children

You may also enroll a sponsored child for medical coverage. Sponsored children include unmarried dependents age 19 up to 23 that are not full-time students or Class I or Class II dependents. You may sponsor a child until the end of the year the dependent reaches age 23.

To initiate the application process for a sponsored child, call the BellSouth Benefits Service Center at 1-800-528-1232. You may not enroll a sponsored child through the ***Benefits@Your Fingertips*** Web site.

{The following paragraph was added to the printed booklet by an addendum dated 7/2006:}

You pay the full cost of coverage for these dependents. Contact the BellSouth Benefits Service Center for the rates.

Note: Some HMO/EPO medical options do not cover sponsored children. If you are interested in covering a sponsored child, call Member Services at the HMO/EPO to confirm that it offers coverage.

Spouse Eligibility Rules

Definition of a Spouse

If you're eligible for coverage, you may be able to enroll your spouse for coverage under the company's plans. If your spouse is also an eligible BellSouth employee or retiree, special rules apply.

Your spouse is the person you're legally married to under the laws of the state in which you live and in accordance with the Federal Defense of Marriage Act of 1997.

Legal spouses with respect to state law include common-law spouses in states that recognize common-law marriages.

Working Spouse Primary Coverage

If your spouse works 30 hours or more per week and has access to medical coverage available through his or her employer, the following rules determine whether you can enroll him or her under your BellSouth medical coverage:

{The following table replaced the table in the printed booklet by an addendum dated 7/2006:}

If the premium for medical coverage offered by your spouse's employer is:	**Here's what you can do with your BellSouth medical coverage:**
100% paid by the employee	Enroll your spouse under your BellSouth medical coverage for primary coverage without having to pay the additional monthly Working Spouse Primary premium.
Paid partly by the employer and partly by your spouse	You may enroll your spouse for secondary coverage* without having to pay the additional Working Spouse Primary premium. However, you will have to pay the premium for your specific coverage level, i.e., you and your spouse. ***or*** You may enroll your spouse for working spouse primary coverage, paying the monthly working spouse primary premium in addition to any other amount you are required to pay for your specific coverage level, i.e., you and your spouse.
100% paid by the employer	Nothing. If your spouse's employer offers free coverage, you may not enroll your spouse for BellSouth primary medical coverage.

*This means your BellSouth medical option may pay additional benefits for your spouse after his or her employer's medical plan has paid its benefits. You can only be reimbursed for any difference between the amount the employer's medical plan pays and the amount that would be paid by the BellSouth medical option if your spouse had primary BellSouth coverage.

In order to enroll for Working Spouse Primary Coverage, your spouse must waive coverage under his or her employer's medical plan.

Payment is taken by direct billing, direct debit, or pension check deduction

If you change your spouse's coverage as a result of a qualified change in status, any changes to the working spouse primary premium are effective on the 1st of the month following your notice to the BellSouth Benefits Service Center.

Common-Law Marriage

Certain states currently recognize common-law marriages. Each state has different requirements for common-law marriages. Some of the more common requirements are:

- Living together for a specified period
- Having joint bank accounts
- Filing joint tax returns
- Introducing each other in public as your “husband” or “wife”

If you live in a state that doesn't recognize common-law marriages, you may be able to add your common-law spouse to your coverage if you previously lived in a state that recognizes such marriages and you met that state's requirements.

By adding a common-law spouse as a dependent, you certify that your relationship meets your state's requirements for common-law marriages.

Keep in mind that once you've entered into a valid common-law marriage, it can be ended only by death or formal, legal divorce.

To add a common-law spouse, you'll need to return documentation to the BellSouth Benefits Service Center. Information on the materials that need to be returned can be found in the “Request Materials” section of the ***Benefits@Your Fingertips*** Web site.

Domestic Partner Eligibility Rules

Definition of an Eligible Domestic Partner

If you're a retired employee and want to add your domestic partner, you had to retire on or after July 1, 2001 if you were a former management employee or January 1, 2002 if you were a former represented employee.

To be eligible for coverage, you and your partner must sign a Domestic Partnership Affidavit and Agreement declaring that all of the following criteria are met:

- Both partners are age 18 or older and are competent to enter into a contract;
- The partners are not related by blood or law;
- Partners are the same gender;
- Neither partner is legally married to, nor the common-law spouse or domestic partner of, another person; however, a domestic partner may be the spouse of the employee under applicable state law if the domestic partner and the employee are of the same gender;
- The couple reside in the same principal residence and intends to do so indefinitely;
- The couple is financially interdependent (examples include joint checking or joint title of home, lease, etc); and
- The relationship has been exclusive for at least 6 consecutive months

If your domestic partner is also an eligible company employee or retiree, special rules apply.

Coverage for Opposite-Sex Domestic Partners

You may cover an opposite-sex domestic partner (who meets all of the eligibility requirements listed above except the same gender requirement) under Long-Term Care Insurance.

Enrolling Your Domestic Partner

You can enroll for qualification of your domestic partner at any time during the year. If your Domestic Partner Affidavit and Agreement is received within 31 days from the date your domestic partner first becomes eligible to be a domestic partner, coverage will begin on the date your domestic partner first becomes eligible. Otherwise, coverage will generally begin on the first of the month after the completed Domestic Partnership Affidavit and Agreement is received by the BellSouth Benefits Service Center.

Note: If federal or state recognition of a domestic partner relationship becomes available, you and your domestic partner must apply with the appropriate governing body within 90 days of being able to do so; otherwise, coverage will be terminated for the domestic partner.

If the domestic partner relationship ends:

- You must complete a Notice of Termination of Domestic Partnership and send it to the BellSouth Benefits Service Center. You also must provide a copy of this notice to your former partner.

- You cannot enroll a new domestic partner for at least 6 months from the date of terminating coverage for a prior domestic partner.

Working Domestic Partner Primary Coverage

If your domestic partner works 30 hours or more per week and has medical coverage available through his or her employer, the following rules determine whether you can enroll him or her under your BellSouth medical coverage:

{The following table replaced the table in the print booklet by an addendum dated 7/2006:}

If the premium for medical coverage offered by your domestic partner's employer is:	**Here's what you can do with your BellSouth medical coverage:**
100% paid by the partner	Enroll your domestic partner under your BellSouth medical coverage for primary coverage without having to pay the additional monthly Working Domestic Partner Primary premium.
Paid partly by the employer and partly by your partner	You may enroll your domestic partner for secondary coverage* without having to pay the additional monthly Working Domestic Partner Primary premium. However, you will have to pay the premium for your specific coverage level, i.e., you and your partner. ***or*** You may enroll your domestic partner for Working Domestic Partner Primary coverage, paying a Working Domestic Partner Primary premium in addition to any other amount you are required to pay for your specific coverage level, i.e., you and your partner.
100% paid by the employer	Nothing. If your domestic partner's employer offers free coverage, you may not enroll your domestic partner for BellSouth primary medical coverage.

*This means your BellSouth medical option may pay additional benefits for your domestic partner after his or her employer's medical plan has paid its benefits. You can only be reimbursed for any difference between the amount the employer's medical plan pays and the amount that would be paid by the BellSouth medical option if your domestic partner had primary BellSouth coverage.

In order to enroll for Working Domestic Partner Primary Coverage, your domestic partner must waive coverage under his or her employer's medical plan.

Payment is taken by direct billing, direct debit, or pension check deduction.

If you change your domestic partner's coverage as a result of a qualified change in status, any changes to the Working Domestic Partner Primary premium are effective on the 1st of the month following your notice to the BellSouth Benefits Service Center.

Available Coverage

You can enroll your domestic partner for this coverage:

Plan	Same-Sex Domestic Partner	Opposite-Sex Domestic Partner
Medical	Yes (except in some fully-insured HMO/EPO medical options)	No
Dental	Yes	No
Supplemental Transplant Assistance Plan (STAP)	Yes	No
Long-Term Care Insurance	Yes	Yes

Enrolling Your Partner for Coverage

You should enroll your same-sex domestic partner for certain coverages within 31 days of the date he or she becomes eligible for coverage.

If you don't enroll your partner within 31 days, you can enroll him or her during the next annual enrollment or if you have a qualified change in status.

You'll be required to submit an affidavit of domestic partnership when you enroll your partner for coverage. You can get a copy of the affidavit and instructions on completing it on the "Request Materials" section of the ***Benefits@Your Fingertips*** Web site.

You'll be subject to taxes on imputed income for the coverage you choose for your same-sex domestic partner and his or her children. As a retiree, you'll be required to send a check to BellSouth for the taxes due on the imputed income on a quarterly basis. You will receive a bill each quarter for the amount of the taxes that are due. The taxes paid and the imputed income will be reflected on a W-2 or Form 1099-R that will be sent to you in January each year.

Child Eligibility Rules

Definition of an Eligible Child

Your eligible children include the unmarried children you claim as dependents for federal income tax purposes. The definition of an eligible child includes:

- Your natural-born child.
- Stepchildren or children for whom you or your spouse or domestic partner are court-appointed, permanent legal guardians and the child(ren) live with you full time.
- Your domestic partner's child(ren) if they reside with you and your domestic partner, and your partner is responsible for providing medical coverage.
- Your adopted child or a child placed with you for adoption. Placement of a child for adoption means your assumption and retention of a legal obligation for total or partial support of such child in anticipation of adopting the child. Appropriate documentation will need to be provided.
- Children of a divorced employee, whether or not they live with the employee.

Note: Other court-appointed or approved relationships may qualify after existing for a 12-month period.

Wards of the state, foster children, or custodial appointments are **not** eligible to be covered under your benefits.

If your children are not covered immediately prior to your retirement, you may add coverage for them after retirement. You will, however, pay the full cost of this coverage.

Age Requirements

You can cover your unmarried children under the Health and Insurance Plans until the end of the year in which they reach age 19. You can cover your children beyond age 19 in these situations:

- You can cover a child who is a full-time student until the end of the year he or she reaches age 25.
- You can cover a disabled child for as long as he or she remains eligible for coverage.

Rules for Full-Time Students

If your eligible child is a full-time student according to the school's definition of full time, you can continue your child's benefits coverage after age 19. Schools include an accredited high school, college, university, or other bona fide educational institution, such as nursing school or trade school that has a curriculum for full-time students. Correspondence schools, night schools, or schools requiring less than full-time attendance are not acceptable. Typically, the courses generate the following credits for full-time students:

- Four-Year Institution—12 hours/quarter or 12 hours/semester.
- Junior College—12 hours/quarter.
- Some educational institutions, etc., may require more or fewer hours to qualify for full-time student status. The student must satisfy the eligibility requirements for full-time student status of the educational institution that he or she is attending to be eligible for coverage.
- In some cases, computer and Internet classes qualify as long as they meet the school's full-time student requirements.

Students in a co-op intern program do not qualify during their work periods unless they maintain full-time academic status.

You'll receive a message on the ***Benefits@Your Fingertips*** Web site, as well as a letter mailed to your home, asking you to verify your child's full-time student status.

As long as the certification is accepted, you can continue the coverage until the end of the year your child reaches age 25 as long as he or she is a full-time student.

If a dependent does not meet the eligibility guidelines, his or her coverage will terminate at the end of the month in which he or she is no longer a full-time student or marries. Should your child lose eligibility, it is your responsibility to notify the BellSouth Benefits Service Center so that the appropriate correction can be made to your file.

Note: Your dependent child is allowed 1 term out of school per school year (and summer counts as 1 term) while still maintaining full-time status.

Rules for Disabled Children

An unmarried disabled child age 19 or older is eligible for benefits if he or she became disabled before age 19 (or age 25 if a full-time student). You must certify your dependent as disabled prior to his or her losing Class I dependent eligibility status.

For your child's coverage to continue, you must notify the BellSouth Benefits Service Center and request information on how to certify your dependent as disabled.

Qualified Medical Child Support Order

Certain judgments or court orders could require BellSouth's health plans to cover your child. This is known as a Medical Child Support Order. The company determines whether the court order is a Qualified Medical Child Support Order (QMCSO). If it is, the child gains eligibility for coverage.

The child can also gain eligibility for coverage if the company receives a National Medical Support Notice and determines it to be a QMCSO. In these situations, the company can take deductions from your paychecks for the child's coverage.

The plans cover the child from the date the order is approved until the date or age stated in the order, but **not** beyond the normal eligibility age. The child is added to whatever coverage you're enrolled in. If you're not already enrolled, you'll be assigned coverage.

If a QMCSO requires someone other than you—for example, your ex-spouse—to provide health coverage for your child, you can drop coverage for that child if he or she actually becomes covered under the other person's plans. See “If Your Child Loses Eligibility Under the Company's Plans”.

Contact the BellSouth Benefits Service Center as soon as you're aware of any court proceedings that may affect your child's eligibility for coverage under the company's plans.

You can request, without charge, a copy of the procedures used to determine the qualified status of a Medical Child Support Order from the plan administrator.

Participants Within the Same Family

If Both Are Retired

If you and your spouse/partner are both BellSouth retirees:

- Either of you may waive individual retiree medical and/or dental coverage and be covered as a dependent under the other's retiree coverage; or
- Both of you may elect individual coverage.

If you have eligible children, only 1 of you may cover the children under your retiree coverage.

If 1 is Active and 1 is Retired

Regardless of whether contributions for coverage are required, a BellSouth retiree married to an active BellSouth employee may waive retiree medical and/or dental coverage and be covered as a dependent under the active employee's coverage. The active employee may not, however, waive his or her coverage and be covered under the retiree's plans.

Enrollment

Initial Enrollment for Retiree Coverage

When you are eligible to retire on a service or disability pension and you go to ***Benefits@Your Fingertips*** or call the BellSouth Benefits Service Center to initiate an application to retire, a retiree Health & Insurance package will be generated and mailed to you. You can then review the coverages assigned to you and the dependents you have covered under your BellSouth benefits at the time you decide to retire. If you decide to change your coverages, you can indicate your enrollment decisions on the ***Benefits@Your Fingertips*** Web site or by calling the BellSouth Benefits Service Center.

If you don't change your assigned coverages within 31 days of your retirement date, those coverages will go into effect when your retirement becomes effective. This coverage stays in effect until the next annual enrollment period, unless you have a change in status that allows you to change your coverage.

Note: If you are a represented long-term disability-only participant, you should call the BellSouth Benefits Service Center at 1-800-528-1232 to enroll.

Annual Enrollment for Retiree Coverage

Each fall, you can review your coverage and makes changes for the next plan year. You'll receive a message when it's time to enroll, and you can enroll on the ***Benefits@Your Fingertips*** Web site.

If you don't enroll, your current options, if available, are carried over to the next plan year.

You must enroll during the annual enrollment period if:

- You want to change any of your or your dependents' current coverage.
- You want to enroll a new dependent for coverage.
- You're enrolled in a plan option that won't be offered next year and don't want to be assigned coverage.

When Becoming Eligible for Medicare

About 90 days before your or your spouse's or same-sex domestic partner's 65th birthday, you'll be notified and may choose a new Retiree Medical Plan option.

Note: When you become eligible for Medicare, BellSouth will only pay secondary benefits. However, you must enroll in both Medicare Part A and B to receive these secondary benefits.

If you don't enroll by the 1st of the month in which your Medicare coverage would take effect, you'll be assigned BellSouth coverage. You must notify the BellSouth Benefits Center when you or your spouse or same-sex domestic partner becomes eligible for Medicare. COBRA coverage will end for you or your dependent that becomes eligible for Medicare effective the 1st of the month in which you turn age 65.

Other Enrollment Opportunities for Retiree Coverage

There are other times when you can enroll yourself or your eligible dependents for coverage. For example, if you get married, you can change your coverage level and add your spouse to your coverage.

Initial Enrollment for COBRA Coverage

You have 60 days from the date on your COBRA Enrollment Notice to enroll for COBRA coverage. You may only enroll in those plans that you or your dependents were covered under on the day prior to your COBRA qualifying event and are allowed to be continued through COBRA. See page 29 for more information on COBRA.

Assigned Coverage

At Initial Retirement

If you have applied to retire and do not change the assigned coverages before your retirement becomes effective, these assigned coverages go into effect for you:

- Medical Insurance: Your active medical option, if available. If it is not available and you do not choose another available option, you will be assigned default coverage based on your home address.

- Dental Insurance: Retiree dental coverage if you are currently covered under active dental coverage. If you don't have active dental coverage, you will be assigned the "No Coverage" option.

- Supplemental Transplant Assistance Plan (STAP):

    — If you are a retiring management employee, you will be assigned Individual coverage under this plan.

    — If you are a retiring represented employee and you are currently enrolled for STAP coverage, your current coverage will continue. If you are not currently enrolled for STAP, you are not eligible to enroll for coverage at this time unless you are a Utility Operations employee or certain ND/CA employees.

- Retiree Life Insurance:

    — If you are a retiring management employee, your retiree life insurance will initially be equal to the amount of company-paid Basic Life Insurance you had as of your retirement date. Your coverage decreases 10% per year from ages 66 through 70. See page 121 for more information. Your retiree life insurance does not include accidental death and dismemberment coverage.

    — If you are a retiring represented employee, your company-paid Basic Life Insurance will be in the amount of $15,000. Your retiree life insurance does not include accidental death and dismemberment coverage. Special rules may apply for represented employees who retire before January 1, 1992, See page 119 for more information.

    — If you are a retiring represented employee, you may apply for Optional Retiree Coverage under the BellSouth Group Life Plan. This employee-paid coverage provides an amount of insurance equal to the difference between the amount of coverage you had on your last day of active employment and $15,000, rounded up to the next higher $5,000.

    — Any retiring employee who has optional life coverage in the BellSouth Group Life Plan on their last day of active work may elect to continue their coverage as an individual policy by applying for it and paying the appropriate rates.

At Annual Enrollment for Retiree Coverage

If you don't make new coverage choices during annual enrollment, all of your current coverages, if available, are carried over for the next plan year.

If your current retiree medical option is no longer offered, you'll be assigned coverage under another retiree medical option. If you don't want coverage under the assigned option, you must enroll in a different option during your annual enrollment period.

When Becoming Eligible for Medicare

You're assigned current coverage, if available, or you'll be assigned coverage under another retiree medical option. You'll receive enrollment materials.

Note: BellSouth's medical plan will not pay any benefits unless you are enrolled in both Medicare Parts A and B.

{The following paragraph was added to the printed booklet by an addendum dated 7/2006:}

You must notify the BellSouth Benefits Service Center when you or a covered dependent first becomes eligible for Medicare.

Coverage Categories

When you apply to retire, your covered dependents will remain covered under your retiree benefits. They can include your spouse or domestic partner and/or any eligible children.

At your initial enrollment as a retiree or during any subsequent annual enrollment, you can choose which dependents to cover under each plan. A category is assigned based on your choices:

- Individual
- 2 Party
- Family

If you and 1 or more family members are eligible BellSouth retirees, special rules apply. See the section "Participants Within the Same Family" for more information.

Annual Enrollment for COBRA Participants

Special enrollment rules apply for COBRA participants. See page 29 for more information.

When Eligibility Ends

Your Eligibility

Your eligibility for coverage ends when:

- You no longer meet the eligibility requirements.
- You belong to a group that becomes ineligible.
- You die.
- The plans are discontinued or amended.
- You are no longer eligible for Long-Term Disability.
- You stop paying for your coverage.

Your Spouse's/Partner's Eligibility

Your spouse's/partner's eligibility ends—and he or she loses coverage—when:

- Your eligibility ends.
- You and your spouse divorce, become legally separated, or have your marriage annulled.
- Your domestic partnership ends.
- Your spouse or domestic partner dies.

Your divorce, legal separation, or annulment or the dissolution of your domestic partnership qualifies as a change in status, so you can change your coverage. The coverage change must be consistent with the qualified status change.

Your Child's Eligibility

Your child's eligibility ends—and he or she loses coverage—when:

- Your eligibility ends.
- Adoption proceedings for that child end.
- Your child turns age 19, if he or she is neither a full-time student nor disabled. (Eligibility ends at the end of the year.)
- Your child turns age 25, if he or she is a full-time student. (Eligibility ends at the end of the year.)
- Your child stops being a full-time student, if he or she is past the year he or she reached age 19. (Eligibility ends at the end of the month.}
- Your child gets married.
- Your child loses disabled dependent status.
- Your child dies.

Your child's loss of eligibility qualifies as a change in status, so you can change your coverage. The coverage change must be consistent with the qualified status change.

Your Class II Dependent's Eligibility

Your Class II dependent's eligibility ends—and he or she loses coverage—when:

- Your eligibility ends.
- Your Class II dependent’s income exceeds the annual income limit

- Your Class II dependent gets married.
- Your Class II dependent dies.

Your Sponsored Child's Eligibility

Your sponsored child's eligibility ends—and he or she loses coverage—when:

- Your eligibility ends.
- Your sponsored child turns age 23. (Eligibility ends at the end of the year.)
- Your sponsored child gets married.
- Your sponsored child dies.

Your Survivors' Eligibility

{The following paragraph replaced language in the print booklet by an addendum dated 7/2006:}

If you have BellSouth retiree healthcare coverage when you die, your surviving dependents' eligibility continues for as long as they would otherwise be eligible. As the survivor of a retiree, your dependents are eligible for free medical coverage for 6 months; after 6 months they can continue medical coverage by paying 100% of the premium cost. However, if coverage lapses for non-payment, it cannot be restarted. Your survivors will also be eligible for COBRA coverage and will receive COBRA enrollment materials. If your dependents elect to continue coverage under COBRA, they will not be entitled to the 6-month period of free coverage and their COBRA continuation coverage will end after 36 months.

When Coverage Ends

Timing (for Retiree Coverage)

Your retiree medical, dental, and life coverage ends on the **last day of the month** in which you lose eligibility for coverage. Your STAP coverage ends—for you and your dependents—on the first day of the month in which you reach age 65. If a covered dependent reaches age 65 before you do, his or her coverage will end on the first day of the month in which the dependent attains age 65.

However, if you're being billed directly for your coverage and you fail to make a payment, your coverage ends retroactive to the date coverage was paid through.

Retiree Coverage You Can Continue If Your Coverage Ends

You may be able to continue medical, dental, and STAP coverage through COBRA.

You may be able to convert your retiree insurance coverage to an individual policy.

Timing (for Survivor Coverage)

Your survivors' medical coverage ends on the **last day of the month** in which they lose eligibility for coverage.

However, if they're being billed directly for coverage and fail to make a payment, their coverage ends retroactive to the date coverage was paid through.

Coverage Your Survivors Can Continue

{The following paragraph replaced language in the print booklet by an addendum dated 7/2006:}

If you have BellSouth retiree healthcare coverage when you die, your surviving dependents may continue coverage for as long as they would otherwise be eligible. As the survivor of a retiree, your dependents are eligible for free medical coverage for 6 months; after 6 months they can continue medical coverage by paying 100% of the premium cost. However, if coverage lapses for non-payment, it cannot be restarted. Your survivors will also be eligible for COBRA coverage and will receive COBRA enrollment materials. If your dependents elect to continue medical coverage under COBRA, they will not be entitled to the 6-month period of free coverage and their COBRA continuation coverage will end after 36 months. They also may be able to convert their medical insurance coverage to individual policies.

Information You or Your Dependents Receive

When coverage ends, you and/or your dependents may receive:

- COBRA Enrollment Notice, with information about continuing your healthcare coverage
- Certificate of Group Health Coverage, to show how long you and/or your dependents were covered under the Medical Plan
- Coverage Termination Notice, with information about converting your insurance coverage into individual policies

Conversion and Portability Rules

Conversion Rules

Employees who lose eligibility for coverage can convert their basic and optional group life insurance coverage to individual coverage if they choose to port coverage. Children can convert when they reach the limiting age or are otherwise no longer eligible.

Generally, you can buy conversion coverage equal to the amount of the coverage you lost. If you convert coverage, you'll pay the insurance company's usual rate for that coverage.

When you lose coverage, you'll receive a conversion notice in the mail with information on how to convert your coverage. You'll have 31 days from the date you lost coverage to make the conversion.

When you convert coverage, you'll receive a new policy from the claims administrator. A converted policy is no longer part of the BellSouth Group Life Plan.

Please direct any questions about converting your coverage to the claims administrator.

If you are a former represented employee who has or will retire after January 1, 1992, your company-paid retiree life insurance coverage is set at $15,000. You will have a 1-time opportunity to purchase additional coverage to replace any lost amounts of coverage on yourself through the Optional Retiree Coverage under the BellSouth Group Life Plan. The coverage amount is equal to the difference between your benefits pay and $15,000, rounded up to the nearest $5,000. You must apply for this coverage within 75 days of your retirement date by contacting the insurance company.

Portability Rules for the BellSouth Group Life Plan

Employees and covered eligible dependents may elect to continue Optional Life Insurance coverage through The Prudential Insurance Company of America's (Prudential) portable pool which may provide better rates and coverage than a converted policy. Portability is available without providing evidence of insurability (EOI) although you can submit EOI to apply for preferred portability rates. Dependent coverage cannot be ported unless you also port your coverage, except your spouse may port in the event of divorce or your death.

You can port the full amount of your terminated coverage or decrease coverage, but your ported coverage cannot be less than $10,000 or more than the lesser of 5 times your annual pay amount or $1,000,000. At the time you port, you may increase your amount of coverage by at least $20,000 but not more than 1 times annual pay, provided you submit EOI to Prudential and are approved. A ported policy is no longer part of the BellSouth Group Life Plan.

You may not port coverage if you were not actively at work on the day prior to your coverage termination, or if you are disabled at the time of coverage termination. You cannot port coverage if you are age 80 or older. Ported coverage reduces to 60% at age 65, and then reduces to 50% of the original ported amount at age 70. Ported coverage terminates at age 80.

You must apply for portability within the time limits determined by the insurance carrier, based on the actual date of your coverage termination and the date that the insurance carrier notifies you of your coverage termination, but in no event can you apply to port your coverage after the 91st day following your coverage termination date.

Additional portability rules may apply. Contact the insurance company for complete information.

Certificate of Group Health Coverage

When your BellSouth medical coverage ends, a federal law known as HIPAA (the Health Insurance Portability and Accountability Act) requires the company to provide you with a Certificate of Group Health Coverage (sometimes called "Proof of Continuous Coverage"). The certificate shows the length of time that you were "continuously covered" under the company's medical plan.

The certificate is intended to reduce or eliminate the waiting period that another plan may have regarding the payment of claims for preexisting conditions.

For example, if you enroll in another employer's medical plan before having a break in coverage of 63 days, your continuous coverage under the Health and Insurance Plan would reduce or eliminate the new plan's preexisting condition waiting period.

You should keep the certificate for your records.

COBRA

Continuing Coverage

Special rules apply when you or your dependents lose coverage under BellSouth's health plans due to a COBRA qualifying event. A federal law known as COBRA (the Consolidated Omnibus Budget Reconciliation Act) contains provisions relating to continuation of healthcare coverage for you, your dependents, and certain former employees whose coverage ends under the company's healthcare plans due to certain situations. There are also situations where your coverage is not lost, but the price you pay for coverage increases because of a change in status or work hours. This is also considered a COBRA qualifying event.

For the purposes of COBRA continuation coverage, health plans include:

- Medical Insurance—The BellSouth Retiree Medical Assistance Plan
- Dental Insurance—The BellSouth Retiree Dental Assistance Plan
- STAP—The BellSouth Supplemental Transplant Assistance Plan

Notification of a Qualifying Event

BellSouth will notify you or your covered dependents when a qualifying event occurs for 1 of the following reasons:

- You lose eligibility for benefits.
- Your cost of coverage changes due to a change in status.

You or your covered dependents must notify the BellSouth Benefits Center by telephone within 60 days of the date a qualifying event occurs for 1 of the following reasons:

- You get divorced or become legally separated.
- Your child is no longer eligible for coverage.
- You are determined to be disabled.
- You experience a second qualifying event.
- You die.

If you or your dependents don't provide the required notice by telephone, you or your dependents won't be eligible for COBRA. The BellSouth Benefits Service Center does not accept written notification. All unsolicited mail is returned to the sender.

COBRA Enrollment Notice

When you or your covered dependents lose coverage due to a COBRA qualifying event, a COBRA Enrollment Notice is sent to your home mailing address, even if you have an alternate address on file.

The notice includes information on available coverage and cost. It also includes instructions on how to elect COBRA coverage.

Electing COBRA Coverage

Each qualified beneficiary has the right to elect coverage independently.

You or your covered dependents must call the BellSouth Benefits Service Center to make your COBRA elections within 60 days of the date you lose coverage on account of the qualifying event or the date the COBRA Enrollment Notice is sent, whichever is later. COBRA coverage is retroactive to the date your active coverage ends.

If you or your covered dependents don't elect COBRA coverage within 60 days, you lose the opportunity to continue coverage under COBRA.

Paying for COBRA Coverage

If you or your covered dependents elect COBRA coverage, you or they are required to pay monthly premiums for that coverage.

The BellSouth Benefits Service Center must receive the first premium payment within 60 days of the date COBRA coverage is elected.

After that, payments are due on the 1st of each month.

You or your dependents are responsible for paying the full cost of the elected coverage (the total of what you and the company were paying for your coverage), plus a 2% administration fee, as allowed by law.

If you or 1 of your dependents is disabled while covered under COBRA, you pay:

- 102% of the COBRA premium for the first 18 months of coverage
- 150% of the premium for month 19 and beyond

Costs vary, depending on the coverage elected and the number of dependents covered. When you or your dependents become eligible for COBRA, you'll be notified of what the monthly premium will be. The cost for coverage may change at the beginning of a new plan year.

Changing Your COBRA Coverage

As COBRA coverage participants, you and other qualified beneficiaries have the same rights and restrictions as other plan participants to change your coverage during the year and at annual enrollment. You may need to demonstrate a qualified change in status to change your coverage during the year.

When COBRA Coverage Ends

Your COBRA coverage continues through the end of the 18-, 29-, or 36-month period you're entitled to, based on the qualifying event.

However, the plan can end your COBRA coverage earlier if:

- You or your covered dependents fail to make the first premium payment within 60 days of its due date.

- You or your covered dependents fail to make 1 of the ongoing premium payments within 60 days of its due date.

- The person receiving COBRA benefits becomes covered under another group plan (not maintained by the company) that has no preexisting condition, exclusion, or limitation affecting him or her.

- The person receiving COBRA benefits becomes entitled to Medicare.

- The company ends the plan.

COBRA coverage will **not** continue for more than 36 months, even if multiple qualifying events occur.

COBRA Qualifying Events

Definition of a Qualifying Event

You or your dependents have a qualifying event if you lose healthcare coverage for 1 of these reasons:

- You voluntarily or involuntarily leave BellSouth, including for retirement.
- Your work hours are reduced.
- Your cost of coverage increases due to a change in status or work hours.
- You become entitled to Medicare.

Your covered dependents can also have a qualifying event if:

- You get divorced or become legally separated.
- Your child is no longer eligible for coverage.
- Your covered dependent becomes entitled to Medicare.
- You die.

Continuation Period

The length of time you or your covered dependents can continue coverage under COBRA depends on the qualifying event:

Qualifying Event	Qualified Beneficiaries	Length of Coverage
Your work hours are reduced, or you leave the company.	You, your spouse/partner, and/or your child(ren)	18 months
You or your dependent is determined to be disabled (as defined by the Social Security Act) on or before the COBRA-qualifying event or within the first 60 days of COBRA coverage.*	You, your spouse/partner, and/or your child(ren)	29 months
You divorce or become legally separated from your spouse, or your domestic partnership ends.	Your ex-spouse or former domestic partner and/or your child(ren)	36 months
Your child(ren) lose(s) eligibility.	Your child(ren)	36 months
You become entitled to Medicare.	Your spouse/partner and/or your child(ren)	36 months

*The disability extension (29 months of total coverage) applies if you've lost coverage due to leaving the company or a reduction in work hours. You must notify the BellSouth Benefits Service Center by telephone of a Social Security award or appeal notice within 60 days of the Social Security disability determination and before the end of the 18th month of COBRA coverage.

Qualifying Event	Qualified Beneficiaries	Length of Coverage
You die.	Your spouse and/or your child(ren)	36 months

Second Qualifying Event

If your dependents are covered under COBRA because you leave the company or your work hours are reduced, and a second qualifying event occurs during their initial 18 or 29 months of COBRA coverage, they can elect up to a total of 36 months of COBRA coverage.

For example, assume that your dependent child has COBRA coverage due to your loss of coverage. If that child isn't a full-time student at the end of the year in which he or she turns age 19, he or she is eligible for up to a total of 36 months of COBRA coverage.

To qualify for an extension of coverage, you or your dependents must notify the BellSouth Benefits Service Center by telephone within 60 days of the second qualifying event.

The Trade Act of 2002 provides an additional COBRA election period for certain eligible Trade Adjustment Assistance (TAA) recipients. According to the provision, if you did not elect continuation coverage during the regular COBRA election period, you may elect continuation coverage within the 60 day period that starts on the first day of the month when you are determined to have met the definition of an eligible TAA recipient. However, such election may not be made later than six (6) months after the date you lost coverage as a result of your separation from employment that resulted in you becoming an eligible TAA recipient. If you become TAA-eligible, you may be entitled to a second opportunity to enroll for continuation healthcare coverage through COBRA. A copy of your TAA certification is required for enrollment.

The Trade Act of 2002 also created a new tax credit for individuals who become eligible for trade adjustment assistance (TAA) and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC-eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of premiums paid for qualified health insurance, including continuation coverage. If you have questions about the new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. More information about the Trade Act is available on the Department of Labor Web site: **www.dol.gov**.

Qualified COBRA Beneficiaries

Definition of a Qualified Beneficiary

A qualified beneficiary is an individual who, **on the day before** the qualifying event, has BellSouth medical or dental coverage.

A qualified beneficiary can be:

- The covered employee or retiree;
- The covered spouse or same-sex domestic partner of a covered employee or retiree;
- The covered dependent of a covered employee or retiree;
- The covered same-sex domestic partner's child of a covered employee or retiree; or
- A newborn or newly adopted child or a child placed for adoption who is added to a covered employee's or retiree's COBRA coverage within 30 days of birth, adoption, or placement for adoption.

Each qualified beneficiary can make COBRA elections independent of any other qualified beneficiary's elections.

Nonqualified Beneficiaries

A qualified beneficiary can also add certain nonqualified beneficiaries to his or her COBRA coverage.

Nonqualified beneficiaries are family members who were eligible for coverage under the company's plans but weren't covered on the day before the qualifying event.

Nonqualified beneficiaries also include individuals covered under the company's plans on the day before the qualifying event but not in 1 of the groups of qualified beneficiaries listed above.

Nonqualified beneficiaries receive the same coverage that the qualified beneficiary elects. They don't have independent coverage election rights under COBRA.

If You Die

Health Plan Coverage

If you die after you've separated from the company, your surviving covered dependents may be eligible to continue their coverage through the Retiree Medical Plan if:

- You're enrolled in the Retiree Medical Plan when you die.
- Your surviving dependents are covered by the Retiree Medical Plan when you die.

Your dependents will have a choice between COBRA and BellSouth-provided coverage. See page 29 for more information.

Life Insurance

Retiree life insurance coverage ends when you die.

Medical Plan

Coverage Categories

When you enroll in the plan, you need to choose the dependents you want to cover. You'll then be assigned a coverage category.

Medical Plan Options

For Retirees Not Yet Eligible for Medicare

Until you or any of your dependents become eligible for Medicare, you can choose coverage under any of these pre-Medicare Retiree Medical Plan options if they are available in your home ZIP code:

- No coverage
- Preferred Provider Organization (PPO) (including the ValueCare option)
- Point of Service (POS) Plan (including the ValueCare option)
- Indemnity Basic Plan
- Exclusive Provider Organization (EPO)
- Health Maintenance Organization (HMO)

For Retirees or Any Dependents Eligible for Medicare

While you are active, BellSouth will continue as the primary plan for you and your dependents.

As a retiree, when you or your eligible dependents become eligible for Medicare, the eligible person must enroll in both Parts A and B of Medicare in order to have secondary coverage under a BellSouth medical option.

If Medicare eligible, you and your dependents also have the option to enroll in Medicare Part D. See the Medicare Overview section for more information.

If you, as the BellSouth retired employee, become eligible for Medicare before any of your other dependents, you will have an opportunity to choose your coverage from among these Medical Plan options:

- No coverage
- Indemnity Basic Plan When Medicare Is Primary
- Exclusive Provider Organization (EPO)
- Health Maintenance Organization (HMO)

The options available to you, based on your ZIP code, will be shown on an enrollment worksheet that will be sent to your home address approximately 3 months before you become Medicare eligible.

Your dependents, whether they are eligible for Medicare or not, must be enrolled in the same medical option that you choose for yourself.

If 1 of your dependents becomes eligible for Medicare before you do, he or she will continue participating in your current medical option. Medicare coverage will be primary for your dependent, and the BellSouth medical option will pay the difference between the benefits paid by Medicare and the benefits that would have been paid by the BellSouth medical option had it been primary.

For retirees whose retirement date is prior to January 1, 1998: Spouses who have to pay for Medicare coverage due to an insufficient work history will not be excluded from Retiree Medical Plan primary coverage. BellSouth will continue to provide primary coverage until the spouse is eligible for Medicare coverage based on the retiree's work history. Then, the Retiree Medical Plan will provide secondary coverage.

For retirees whose retirement date is on or after January 1, 1998: Spouses/partners who have to pay for Medicare coverage will be excluded from Retiree Medical Plan primary coverage. Only secondary benefits will be provided, even though the spouse/partner has to pay for Medicare coverage due to an insufficient work history. Remember, the eligible dependent must have primary coverage through Medicare Parts A and B for BellSouth to pay secondary benefits for medical claims.

Retiree Medical Plan primary coverage is not available to any Class II dependents that become eligible for Medicare, regardless of their work history or the retiree's retirement date.

The company reserves the right to modify coverage, including the reduction or elimination of coverage or the requirement of payments for dependent coverage, at its discretion.

How the Options Vary

The options vary in these ways:

- The need to use an in-network provider or a primary care physician
- The deductible
- Coinsurance and copayment amounts
- Precertification procedures
- Out-of-pocket maximum amount
- The coverage provided for specific services, including emergency care
- The manner in which they coordinate benefits with your other coverage
- The process for filing benefit claims

Cost of Coverage: Retired Employees

In General

You and the company may share in the cost of coverage. Your cost varies based on a variety of factors which include:

- The participating BellSouth company from which you retire
- The date you were hired and the date you retire
- Your years of service with BellSouth at retirement
- The eligible dependents you have elected to cover

- The plan option you choose
- The state in which you reside as a retiree

Depending on the above factors, you may share in the cost of coverage by paying 1 or more of the following premiums:

- Capped Excess Premium
- Prorated Premium
- HMO Premium
- Class II/Sponsored Dependent Premium

These premiums are explained below. Some groups are required to pay the full cost of coverage. See the tables below to determine whether you are required to make these premium payments.

CAP and Capped Excess Premium

The CAP amount (CAP) is the maximum aggregate dollar amount the company will pay for all retiree medical coverage. The CAP was set initially at 11.4% above the actual 1990 cost; however, the company has elected to increase the CAP above the initial amount on occasion. The company reserves the right to increase or decrease the CAP in subsequent years.

The Capped Excess Premium amount is calculated by determining the excess of aggregate actual cost for the medical plan 2 years prior to the current year over the CAP. For example, the Capped Excess Premium for 2006 is based on the excess of 2004 actual cost over the CAP. The excess, as a percentage of total actual cost, is then applied to the per capita cost, 2 years prior, of the following 4 categories to determine the dollar premium amount:

- Single—before Medicare eligibility, single coverage
- Family—before Medicare eligibility, single and dependent(s) coverage
- Single—Medicare eligible, single coverage
- Family—Medicare eligible, single and dependent(s) coverage

In the event you cover a dependent who is not in the same category above—for instance, you are not yet eligible for Medicare but your dependent is—the Capped Excess Premium will be further adjusted to reflect the different costs of medical coverage for you and your dependent.

Prorated Premium

This premium determines how much (in addition to any Capped Excess Premium) of the total cost of medical coverage you pay in retirement, based on the length of your service with the company and your retirement date. The Prorated Premium is determined as follows:

If you have this many years of service (net credited service):	**You pay this percentage of the prorated premium:**
30 or more	0%
20-29	10%
15-19	20%
Less than 15	30%

If you are required to pay both a Prorated Premium and a Capped Excess Premium, the total premium will be offset by the Capped Excess Premium before the prorate percentage is applied. The Prorated Premium may not be required if you retire under an early retirement program or severance program or formal surplus reduction program that waives the premium (you will have to pay for Class I dependents, other than your spouse/partner, who are added after the effective date of your retirement). Prorated Premiums depend on your state of residence.

Applying the Capped Excess Premium and Prorated Premium to Your Dependents

As noted, the application of the Capped Excess Premium depends on the company you retire from and your retirement date. How the premiums apply to your dependents also depends on when you retire and when their coverage was effective.

Additional Premium for HMO or EPO Coverage

The Capped Excess Premium and Prorated Premium are calculated each year for the PPO, POS, Indemnity Basic Plan, or Indemnity Basic Plan When Medicare is Primary medical options. If you enroll in an HMO or EPO medical option and its total cost of coverage is greater than the cost of coverage for those options, you will pay the difference in cost in addition to any Capped Excess Premium and Prorated Premium that may apply.

Management Employees Who Were Hired after December 31, 2000

If you were hired by BellSouth on or after January 1, 2001, when you retire on a service or disability pension, you will be eligible for post-retirement medical and dental coverage but you will pay 100% of its cost, based on the retiree group rates. In effect, you will have "access only" to BellSouth's retiree healthcare coverages.

This access-only provision applies to:

- New management employees hired on or after January 1, 2001.
- An employee hired on or after January 1, 2001, who is covered by the Mandatory Portability Agreement. (The Mandatory Portability Agreement preserves previous service for use in determining pension eligibility but it does not apply to eligibility for post-retirement healthcare benefits).
- An employee with previous BellSouth service who is rehired on or after January 1, 2001, but who was **not** eligible for post-retirement healthcare coverage when he or she terminated from BellSouth's employment. Although the employee's service may bridge and result in an NCS (Net Credited Service) date prior to January 1, 2001, for purposes of post-retirement healthcare coverage, he or she will be considered to have access-only coverage.
- A represented employee hired on or after January 1, 2001, who is later promoted to management will have access-only coverage when he or she retires.

The access-only provision will **not** apply to you if:

- You are a management employee rehired on or after January 1, 2001, but you were eligible for company-subsidized post-retirement healthcare coverage when you previously terminated employment with BellSouth. When you work long enough to retire again, you will be treated as an employee who was hired before January 1, 2001 and you will receive credit for the additional service.

- You are a management employee hired prior to January 1, 2001, and your subsequently transfer to another BellSouth company after January 1, 2001 maintaining continuous employment with BellSouth.

- You are a management employee hired before January 1, 2001, who subsequently returns from a leave of absence that may result in an adjustment to your NCS date so that it is on or after January 1, 2001, but your service has been continuous.

- You are a represented employee hired before January 1, 2001, who is subsequently promoted to management after January 1, 2001, but who has maintained continuous employment with BellSouth.

{The following tables replaced the tables in the printed booklet by an addendum dated 7/2006:}

For Management Retirees

Effective date:	**How the cost of medical coverage is paid:**
Hired after December 21, 2000	Retiree and all Class I dependents: Retiree pays 100%
Retired after December 31, 1991 but were hired before January 1, 2001	Retiree and spouse or domestic partner: Retiree pays Capped Excess Premium and Prorated Premium Other Class I dependents: **If coverage began before retirement—**Retiree pays Capped Excess Premium and Prorated Premium **If coverage began after retirement—**Retiree pays 100% HMO Premiums and Class II/Sponsored Dependent Premiums apply.
Retired after December 31, 1987 and before January 1, 1992	Retiree and spouse or domestic partner: Retiree pays Prorated Premium Other Class I dependents: **If coverage began before retirement—**Retiree pays Prorated Premium **If coverage began after retirement—**Retiree pays 100% HMO Premiums and Class II/Sponsored Dependent Premiums apply.
Retired before January 1, 1988	Retiree and spouse or domestic partner: BellSouth pays 100% Other Class I dependents: **If coverage began before January 1, 1988—**BellSouth pays 100% **If coverage began after December 31, 1987—**Retiree pays 100% HMO Premiums and Class II/Sponsored Dependent Premiums apply.

For Nonmanagement Retirees (excluding retirees of Stevens Graphics and L.M. Berry)

Effective date:	**How the cost of medical coverage is paid:**
Retired after December 31, 1991	Retiree and spouse or domestic partner: Retiree pays the Prorated Premium. Retiree is subject to the Capped Excess Premium; however, the earliest this premium will be required is January 1, 2010. Other Class I dependents: **If coverage began before retirement** Retiree pays the Prorated Premium and the Capped Excess Premium; however, the earliest this premium will be required is January 1, 2010. **If coverage began after retirement—**Retiree pays 100% HMO Premiums and Class II/Sponsored Dependent Premiums apply.
Retired after December 31, 1987 and before January 1, 1992	Retiree and spouse or domestic partner: Retiree pays Prorated Premium Other Class I dependents: **If coverage began before retirement—**Retiree pays Prorated Premium **If coverage began after retirement—**Retiree pays 100% HMO Premiums and Class II/Sponsored Dependent Premiums apply.
Retired before January 1, 1988	Retiree and spouse or domestic partner: BellSouth pays 100% Other Class I dependents: **If coverage began before January 1, 1988—**BellSouth pays 100% **If coverage began after December 31, 1987—**Retiree pays 100% HMO Premiums and Class II/Sponsored Dependent Premiums apply.

For L.M. Berry Retirees

Effective date:	**How the cost of medical coverage is paid:**
Hired after December 21, 2000	Retiree and all Class I dependents: Retiree pays 100%
Management employees who retired after March 31, 2001 but were hired before January 1, 2001	Retiree and spouse or domestic partner: Retiree pays Capped Excess Premium and Prorated Premium Other Class I dependents: **If coverage began before retirement—**Retiree pays Capped Excess Premium and Prorated Premium **If coverage began after retirement—**Retiree pays 100% HMO Premiums and Class II/Sponsored Dependent Premiums apply.
Non-management employees who retired after March 31, 2001	Retiree and spouse or domestic partner: Retiree pays Capped Excess Premium and Prorated Premium. However, the Capped Excess Premium for this category of retirees is reduced by a premium adjustment. Other Class I dependents: **If coverage began before retirement—**Retiree pays Capped Excess Premium and Prorated Premium **If coverage began after retirement—**Retiree pays 100% HMO Premiums and Class II/Sponsored Dependent Premiums apply.
Retired before April 1, 2001	Retiree and spouse or domestic partner: Retiree pays active rates charged to L.M. Berry employees. The premium is adjusted once you or your covered dependents become eligible for Medicare. Other Class I dependents: **If coverage began before retirement—**Retiree pays active rates charged to L.M. Berry employees **If coverage began after retirement—**Retiree pays 100% Class II/Sponsored Dependent Premiums apply.

For Stevens Graphics Retirees

Effective date:	How the cost of medical coverage is paid:
Hired after December 21, 2000	Retiree and all Class I dependents: Retiree pays 100%
Management employees who retired after March 31, 1998 but were hired before January 1, 2001	Retiree and spouse or domestic partner: Retiree pays Capped Excess Premium and Prorated Premium Other Class I dependents: **If coverage began before retirement —**Capped Excess Premium and Prorated Premium **If coverage began after retirement—**Retiree pays 100% HMO Premiums and Class II/Sponsored Dependent Premiums apply.
Management employees who retired before April 1, 1998 and all non-management employees not identified below	Retiree and spouse or domestic partner: Retiree pays 100% of the cost of coverage* for Stevens Graphics active employees Other Class I dependents: **If coverage began before retirement—**Retiree pays 100% of the cost of coverage* for Stevens Graphics active employees **If coverage began after retirement—**Retiree pays 100% *The cost of coverage is adjusted when the retiree becomes Medicare-eligible. HMO Premiums and Class II/Sponsored Dependent Premiums apply.
Non-management employees who retired from Local No. 121C (including employees formerly represented by 540M) after April 1, 1998 with 35 or more years of service	Retiree and spouse or domestic partner: Retiree pays 90% of the cost of coverage* for Stevens Graphics active employees Other Class I dependents: **If coverage began before retirement—**Retiree pays 90% of the cost of coverage* for Stevens Graphics active employees **If coverage began after retirement—**Retiree pays 100% *The cost of coverage is adjusted when the retiree becomes Medicare-eligible. HMO Premiums and Class II/Sponsored Dependent Premiums apply.

How Retirees Pay for Coverage

If you pay for coverage as a retiree, you may pay for your coverage monthly through direct billing, by deduction from your pension checks, or by direct debit from a checking or savings account at your bank. When you retire, you will automatically be direct billed. If you wish to pay your contributions by deduction from your pension check or by direct debit, you may do so through ***Benefits@Your Fingertips*** or by calling the BellSouth Benefits Service Center.

Reimbursement of Medicare Part B Premiums

If you enroll for Medicare Part B after becoming eligible for Medicare, the company may reimburse a portion of the premiums you pay for that coverage if you're eligible. The company currently reimburses Part B premiums, up to the 1990 premium amount ($28.60) for you and your eligible Class I dependents that were covered under BellSouth medical coverage **on your last day on the active payroll**. You must be pension-eligible to receive Part B reimbursement. However, the following do not qualify for Medicare Part B premium reimbursement:

- LTD-only participants;
- L.M. Berry retirees who retired prior to April 1, 2001;
- Stevens Graphics retirees, including:
  - All non-management retirees;
  - All management retirees who retired prior to January 1, 2002;
- All Class II dependents;
- Retiree's spouse/partner and dependents added after retirement; and
- Employees who retire under the Rule of 65.

To apply for reimbursement, contact the BellSouth Benefits Service Center. If Retiree MAP provides primary coverage, Part B premiums are not reimbursed.

It is your responsibility to notify the BellSouth Benefits Service Center of any change in Medicare eligibility for you and your dependents within 31 days of that change.

Changing Your Medical Plan Option

After enrolling, you can only change your option:

- If you move and your current option is no longer available;
- If your eligibility for the medical plan changes;
- During annual enrollment;
- If the option is no longer offered; or
- If the contract between the company and the plan insurer ends.

Related Benefits

When you enroll for medical coverage under an Indemnity, PPO, or POS plan, you also receive this coverage:

- Prescription Drug Program
- Mental Health and Substance Abuse Treatment

If you enroll in an HMO or EPO, contact the HMO or EPO directly to learn about its prescription drug and mental health and substance abuse benefits. The provider of these benefits—and the benefits themselves—may be different than those who provide service under the Indemnity, PPO, and POS plans.

Coverage Under the Women's Health and Cancer Rights Act

The Health and Insurance Plan provides benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). For details about the mastectomy-related services available under your health plan, contact the plan directly.

Terms You Should Know

The following is an alphabetical listing of some terms you should know. Each term gives a brief definition or refers to another page that provides additional detail.

- **Administrator**—A third party, your medical vendor, who administers the medical option in which you are enrolled.
- **Claim**—Expenses that are considered under the plan for benefits by the claims administrator. These expenses must be incurred after the effective date of the plan and prior to its termination, and for which the date of service (or treatment-incurred date) is prior to the date of termination of the plan.
- **Claims administrator**—An organization that processes medical claims at the request of the company.
- **Claims report**—A statement provided to the participant about a claim. The statement includes information such as what expenses the plan covers, what applies to the deductible, and what is paid or excluded. Many medical plans refer to this report as an explanation of benefits (EOB).
- **COBRA—**See page 29.
- **Coordination of Benefits (COB)**—See page 54.
- **Coinsurance—**See page 60.
- **Copayment—**See page 60.
- **Deductible—**See page 59.
- **Dependent—**See page 9.
- **Domestic partner (Partner)**—See page 13.
- **Employee Retirement Income Security Act of 1974 (ERISA)—**This is an act that governs operation and administration of employee benefit plans.
- **Exclusion—**A service, supply, treatment, circumstance, etc., that is not covered by the plan.
- **Health Insurance Portability and Accountability Act of 1996 (HIPAA)—**This is a federal law that limits preexisting condition exclusions by placing restrictions on their use and requiring employers to provide certification of healthcare coverage to employees, permits special enrollment periods that provide individuals with an opportunity to enroll in healthcare coverage, and creates more access to health plan coverage by eliminating discrimination based on an individual's health status and guaranteeing availability and renewability of healthcare coverage.
- **Internal Revenue Code of 1986 (IRC)**—This is the federal tax law.
- **Medicare—**See page 84.

- **Out-of-pocket maximum**—See page 62.

- **Participant—**An individual covered by a participating company under the terms of the plan. Participants include:

  — Former employees who retire with a service or disability pension and their enrolled dependents.

  — Former eligible represented employees who are receiving benefits through the BellSouth Long-Term Disability Plan for Non-Salaried Employees and not eligible for a disability or service pension and their enrolled dependents.

  — Former eligible employees who were granted certain benefits through a separation plan.

  — Surviving spouses of deceased retirees and their enrolled dependents.

  — COBRA-covered individuals and their enrolled dependents.

  Participants may not participate in all plans.

- **Precertification**—See page 61.

- **Primary care physician (PCP)**—See page 57.

- **Reasonable and customary (R&C)**—See page 63.

- **Retiree**—See page 2.

- **Subrogation**—See page 152.

- **Summary plan description (SPD)**—This is a detailed, but easily understood, summary that describes a pension or welfare plan's provisions and that is provided to participants and beneficiaries.

Exclusive Provider Organization (EPO) Overview

How an EPO Works

In general, an EPO provides prepaid benefits for most healthcare needs, with no bills or claim forms. An EPO provides services through a select group of doctors, hospitals, and other providers who are under contract to the EPO.

If you live in an EPO's service area, as defined by your home ZIP code, you're eligible to join that EPO if enrolled in an EPO. You may need to choose a primary care physician (PCP) or facility from a list of providers in the service area when you enroll. See the information from your specific plan.

If you receive medical services outside your PCP's office without being referred by your PCP, you usually won't receive any benefits coverage. Contact the EPO directly about the benefits it may provide for out-of-network services, including emergency care.

Your EPO Options

To learn how the EPO covers specific medical services or to request a summary plan description, contact the EPO directly. The telephone number is on your medical ID card.

For Dependents Not Living With You

If you have a covered dependent that doesn't live with you but does live in the EPO service area, he or she should choose a PCP and have that PCP coordinate all care.

If your covered dependent lives outside the EPO service area, call the EPO directly to find out what benefits, if any, are available.

If You're Traveling

If you need medical care while traveling outside the network service area:

- Contact your PCP or EPO as soon as possible after you receive emergency care.
- Contact your EPO before you receive any non-emergency care.

For More About Your EPO

The benefits paid by the EPO option in which you have enrolled are described more specifically in the summary plan description or certificate of coverage issued by the EPO option administrator. To access this information, from the home page of ***Benefits@Your Fingertips*** select “Health Care,” then select “Medical,” and on the medical page, under “Learn About Your Medical Benefits,” select “View and Print Your Summary Plan Description.”

Indemnity Option Overview (Indemnity Basic Plan and Indemnity Basic Plan When Medicare Is Primary)

How an Indemnity Option Works

Under the Indemnity Plan, your healthcare provider will submit claims on your behalf.

In an indemnity plan, you can seek care from any licensed doctor, provider, or hospital and receive benefits. Hospital precertification is required for some services to receive the highest level of benefits.

Here's a look at how the plan works:

- You must pay a deductible each plan year.
- The plan then pays a percentage of covered reasonable and customary expenses.
- You pay the remaining portion of charges, called coinsurance, up to the out-of-pocket maximum.
- You pay any amounts above reasonable and customary. Amounts above reasonable and customary do not count toward the out-of-pocket maximum.
- Once you reach the annual out-of-pocket maximum, the plan pays 100% of most covered expenses for the rest of the plan year.

Note: The Indemnity Basic Plan is only available to employees who live in selected ZIP codes, and to certain employees and retirees who have grandfathered eligibility for this option. The Indemnity Basic Plan When Medicare Is Primary is available to retirees who are eligible for Medicare.

For More About Your Indemnity Medical Option

The benefits paid by the Indemnity Basic Plan and Indemnity Basic Plan When Medicare is Primary medical options are described more specifically in the summary plan descriptions issued by the Basic Plan administrator. To access this information, from the home page of ***Benefits@Your Fingertips*** select “Health Care,” then select “Medical,” and on the medical page, under “Learn About Your Medical Benefits,” select “View and Print Your Summary Plan Description.”

Preferred Provider Organization (PPO) Overview (including ValueCare option)

How a PPO Works

Preferred Provider Organizations (PPOs) have networks of participating doctors and hospitals that provide medical care at negotiated rates.

To choose a PPO option, you must live in an area that the PPO network supports, as defined by your home ZIP code.

Unlike some other medical plans, PPOs don't require you to use a primary care physician (PCP) to coordinate your care.

How to Locate a Network Provider

You can request a list of network providers by:

- Calling the plan directly (the telephone number is on your plan ID card)
- Using the online directory that's available on the ***Benefits@Your Fingertips*** Web site
- Visiting the plan's Web site (the Web site address is on your plan ID card or may be accessed from the ***Benefits@Your Fingertips*** Web site)

There is no charge to receive provider lists or directories.

To learn how the PPO covers specific medical services, contact the plan directly. The telephone number is on your plan ID card.

For Dependents Not Living With You

If you have a covered dependent that doesn't live with you but does live in another network area, he or she should use in-network providers to receive the highest level of benefits.

If your covered dependent lives outside a network area, the PPO usually pays benefits at a reduced level. Call the PPO administrator directly to find out what benefits, if any, are available. The telephone number is on your medical ID card.

If You're Traveling

If you need care while traveling outside the network service area:

- Contact the PPO as soon as possible after you receive emergency care.
- Contact the PPO before you receive any non-emergency care.

For More About Your PPO Option

The benefits paid by the PPO option are described more specifically in the summary plan description issued by the PPO administrator. To access this information, from the home page of ***Benefits@Your Fingertips***, select "Health Care," then select "Medical," and on the medical page, under "Learn About Your Medical Benefits," select "View and Print Your Summary Plan Description."

Point of Service (POS) Plan Overview (Including ValueCare option)

How a POS Plan Works

Point of Service (POS) plans have networks of participating doctors and hospitals that provide medical care at negotiated rates.

To choose a POS option, you must live in an area supported by the POS network, as defined by your home ZIP code. Retirees over the age of 65 are not eligible to participate in a POS Plan.

When you enroll in a POS option, you may need to choose a primary care physician (PCP). See the information from your specific plan.

How the POS option pays benefits depends on whether your care is coordinated by your PCP and whether you use in-network or out-of-network providers.

In-Network Providers

To receive the POS option's highest level of benefits, you need to receive care from your PCP or get a referral from your PCP to another in-network provider. You may need to file claims for any services your PCP doesn't coordinate.

Out-of-Network Providers

The POS option provides a lower benefit if your PCP does not render your medical services or fails to provide a referral for services rendered by an in-network provider. You may need to pay the full amount for services up front and file your own claims for reimbursement. You must pay a deductible each plan year. The POS option then pays a percentage of covered reasonable and customary expenses. You pay the remaining portion of charges, called coinsurance, up to the out-of-pocket maximum.

How to Locate a Network Provider

You can request a list of network providers by:

- Calling the POS administrator directly (the telephone number is on your medical ID card)
- Using the online directory that's available on the ***Benefits@Your Fingertips*** Web site
- Visiting the POS option's Web site (the Web site address is on your medical ID card or you may access it from the ***Benefits@Your Fingertips*** Web site)

There is no charge to receive provider lists or directories.

For Dependents Not Living With You

If you have a covered dependent that doesn't live with you but does live in the POS network area, he or she should choose a PCP and have that PCP coordinate all care.

If your covered dependent lives outside the POS network area, out-of-network benefits may be available with proper advance notification of your health plan. Call the POS administrator directly to find out what benefits, if any, are available. The telephone number is on your medical ID card.

If You're Traveling

If you need medical care while traveling outside the network service area:

- Contact your PCP or the POS plan insurer as soon as possible after you receive emergency care.
- Contact the POS plan insurer before you receive any non-emergency care.

For More About Your POS Option

The benefits paid by the POS option in which you are enrolled are described more specifically in the summary plan description issued by the POS administrator. To access this information, from the home page of ***Benefits@Your Fingertips*** select "Health Care," then select "Medical," and on the medical page, under "Learn About Your Medical Benefits," select "View and Print Your Summary Plan Description."

Health Maintenance Organization (HMO) Overview

How an HMO Works

In general, an HMO provides prepaid benefits for most healthcare needs, with no bills or claim forms. An HMO provides services through a select group of doctors, hospitals, and other providers who are under contract to the HMO. Benefit provisions of HMOs may vary; in particular, benefits provided by fully-insured HMOs may be subject to restrictions and other requirements by the laws of the state in which they are registered.

If you live in an HMO's service area, as defined by your home ZIP code, you're eligible to join that HMO. You need to choose a primary care physician (PCP) or facility from a list of providers in the service area when you enroll.

If you receive medical services outside your PCP's office without being referred by your PCP, you usually won't receive any benefits coverage. Contact the HMO directly about the benefits it may provide for out-of-network services, including emergency care.

Your HMO Options

You may have 1 or more HMO options available to you. You'll be able to compare the available options, including their costs and benefits, when you enroll or when you're eligible to make midyear changes to your coverage.

To learn how the HMO covers specific medical services or to request a summary plan description, contact the HMO directly. The telephone number is on your plan ID card.

For Dependents Not Living With You

If you have a covered dependent that doesn't live with you but does live in the HMO service area, he or she should choose a PCP and have that PCP coordinate all care.

If your covered dependent lives outside the HMO service area, call the HMO directly to find out what benefits, if any, are available.

If You're Traveling

If you need medical care while traveling outside the network service area:

- Contact your PCP or HMO as soon as possible after you receive emergency care.
- Contact your HMO before you receive any non-emergency care.

For More About Your HMO Option

The benefits paid by the HMO option in which you are enrolled are described more specifically in the summary plan description issued by the HMO administrator. To access this information, from the home page of ***Benefits@Your Fingertips*** select “Health Care,” then select “Medical,” and on the medical page, under “Learn About Your Medical Benefits,” select “View and Print Your Summary Plan Description.”

Coordination of Benefits

{An addendum dated July 2006 replaced the entire Coordination of Benefits section in the printed booklet with the following material:}

With the growing number of medical plans and the increasing number of two-income families, many people are covered—or have the opportunity to be covered—under more than one group plan. For this reason, the BellSouth medical plan contains a Coordination of Benefits (COB) provision which is designed to ensure that you receive benefits up to your medical option's benefit levels on each claim while preventing duplication of payment.

When Coordination of Benefits Applies

COB applies when a retiree, LTD-only participant, surviving spouse, or dependent is covered, or in certain circumstances is eligible for coverage, by more than one group plan or by Medicare. Under the BellSouth plan, a group plan is a medical plan offered by an employer (business, partnership, individual owner, etc.) to its employees at no cost or at a cost subsidized by the employer. For example, multiple-choice flexible benefit plans, ERISA-type plans, federal/state/local government plans, and certain church plans are considered group plans. However, if an employer simply offers a plan for the convenience of its employees by collecting the premiums but does not contribute to its cost, the plan is not considered a group plan.

Keep in mind, the provisions of your medical option apply even if the BellSouth plan is the secondary plan. That is, any in-network/out-of-network differences in benefits apply, and no secondary benefits are paid for expenses that the BellSouth plan would not cover if it were primary.

It is your responsibility to notify the BellSouth Benefits Service Center of any additions/changes in your and your dependents' eligibility for other insurance coverage within 31 days of the change.

When Coordination of Benefits Does Not Apply

COB rules do not apply:

- Between two medical options both provided by BellSouth; or
- To any individual or personal policies of insurance.

Primary/Secondary Coverage

The plan that considers expenses first is the primary plan. The plan that waits for the primary plan to consider expenses is the secondary plan.

When the BellSouth medical option is the secondary plan, combined benefits from both the primary and secondary plans may not total more than the amount the BellSouth medical option would have paid alone. In other words, a BellSouth medical option will coordinate benefits up to its benefit levels.

Effective January 1, 1999, in order for BellSouth to pay secondary on a medical claim, the covered person for whom the claim is filed must:

- Have other primary coverage available and be enrolled in that coverage; and
- If eligible for Medicare, be enrolled in both Medicare Parts A and B; and
- Apply for primary benefits from the primary carrier; and

- Provide proof (in the form of an Explanation of Benefits from the primary carrier) that primary benefits have been paid.

A BellSouth medical option coordinates with other group health plans according to the following rules:

- A plan that has no rules for coordinating benefits with other plans is primary.
- A plan that has a secondary-only rule for its employees when other coverage is available will be primary.
- A plan that covers a person as an employee or in some capacity other than as a dependent is primary.
- The plan of the parent or sponsor whose birthday comes first in the year will be the primary plan for children and other dependents. This is the "birthday rule." If a plan has not adopted the birthday rule, that plan's rules will determine which plan is primary. However, if your spouse works and declines dependent coverage because contributions are required, the BellSouth plan will provide full plan benefits for your dependent children.

Special rules apply for children whose parents are divorced or separated:

- If there is a court order establishing which parent has financial responsibility for the child's health care expenses, that parent's plan will be primary. (However, if that parent fails to provide coverage, the children will continue to be eligible for coverage on a primary basis as a dependent of the employee or retiree until the parent responsible for health care assumes legal responsibility. The employee or retiree must provide the BellSouth Benefits Service Center documentation that legal action has been taken to force the former spouse to abide by the court order.)
- If there is no court order and the parent with custody has not remarried, that parent's plan is primary.
- If there is no court order and the parent with custody has remarried, plans covering the child will pay benefits in the following order:
  - The plan of the parent with custody;
  - The plan of the step-parent with custody;
  - The plan of the parent without custody.

- If none of the rules listed above establish an order of payment, the plan which has covered the person the longest will be primary.

COB Rules: When Your Spouse/Partner is Employed

If Your Spouse/Partner Declines His/Her Employer's Group Plan

If you retired prior to January 1, 1988, and your spouse declines his/her current or former employer's coverage because employee contributions are required, your BellSouth medical option will provide full plan benefits. If you retired on or after January 1, 1988, and your spouse is employed, the COB rules described below apply.

BellSouth's medical option will be the secondary plan if your spouse/partner works and declines his/her employer's group plan coverage when the employer contributes:

- All or any part of the cost of the coverage for its employees (if your spouse/partner works 30 or more hours per week);

- The full cost of coverage for its employees, even when your spouse/partner works less than 30 hours per week; or
- The full cost of dependent coverage if it would be primary according to COB rules.

COB still applies if your working spouse/partner has a waiting period during which he or she has to pay 100% of the cost for his or her employer's medical coverage. Your spouse/partner is not eligible for primary coverage under your BellSouth plan during that time unless you purchase primary spouse/partner medical coverage.

Should the COB rules apply to your working spouse/partner, you may purchase working spouse/partner primary coverage, unless your spouse/partner works more than 30 hours weekly and his/her employer pays the full cost of coverage. In that case, you cannot purchase BellSouth medical coverage for your spouse/partner.

If Your Spouse/Partner is Self-Employed

Special COB rules apply if your spouse or partner:

- Is eligible for group medical coverage through a professional association but declines it, or
- Has employees and provides group medical coverage to them.

If either situation above applies, your BellSouth medical option will not pay any benefits since a covered person must have primary coverage in order for BellSouth to pay any secondary benefits.

As an alternative, you may purchase working spouse/partner primary coverage for your self-employed spouse/partner. Please contact the BellSouth Benefits Service Center at 1-800-528-1232 for more information.

COB Rules: When Your Spouse/Partner is Retired

COB rules also affect you if your spouse/partner is retired and:

- His or her former employer does not require a premium for post retirement medical coverage—in this case, a BellSouth medical option will ***only*** provide secondary coverage if the spouse/partner is enrolled in his/her employer's medical coverage.
- His or her former employer ***does*** require a premium for post-retirement medical coverage—in this case, your spouse/partner may decline coverage from his/her employer and your BellSouth plan will provide primary benefits. If your spouse/partner chooses to purchase primary coverage from his or her former employer, your BellSouth plan will provide secondary coverage.

COB Rules for Surviving Spouses/Partners

A surviving spouse/partner who becomes employed is not required to select coverage paid for in part or in full by his/her employer. If the surviving spouse elects coverage through his/her employer, however, coverage through BellSouth will be secondary.

The surviving spouse/partner may choose to continue primary coverage for any eligible dependents through BellSouth if they are not covered under any other group plan, regardless of whether the surviving spouse/partner chooses to be secondary under BellSouth's coverage.

Special Rules for Certain Former Management Employees

If you are a former management employee who retired on or after January 1, 1992, the company plan will pay secondary benefits in the following circumstances:

- You become employed at another company and your new employer offers a group medical plan; ***and***
- Your new employer pays all or any part of the cost of coverage for an employee working 30 or more hours weekly (or 50% of the cost of coverage for an employee working less than 30 hours weekly); ***and***
- Your new employer pays 25% or more of the cost of coverage for dependents, including children.

Note: If your new employer offers group medical coverage and you do not enroll yourself and any eligible dependents, the BellSouth plan will not pay any secondary benefits.

If you retire and subsequently become employed at a company offering group medical coverage, you may waive retiree medical coverage through BellSouth. If you waive coverage, coverage under the BellSouth plan will end for you and all your eligible dependents. During the period you waive coverage, you will not pay any premium for BellSouth retiree medical coverage.

If you waive coverage as the result of other employment after retirement, your BellSouth retiree medical coverage may be reinstated at any time. To reinstate your coverage, call the BellSouth Benefits Service Center.

In-Network Providers

Definition of an In-Network Provider

An in-network provider is under contract to a medical plan to provide services. In-network providers can include doctors, hospitals, optometrists, pharmacies, and other designated service providers.

In-Network Providers for PPOs

If you enroll in a Preferred Provider Organization (PPO):

- You'll receive the highest level of benefits if you use in-network providers.
- You don't need to choose a primary care physician.

If you use an out-of-network provider:

- The deductible and coinsurance you pay will be higher.
- Your out-of-pocket maximum will be higher.

In-Network Providers for POS Options

If you enroll in a Point of Service (POS) option:

- You must choose a primary care physician (PCP), who will coordinate all your care.
- You'll receive the highest level of benefits when your PCP refers you to in-network providers.

If your PCP doesn't coordinate your care or you use an out-of-network provider:

- The deductible and coinsurance you pay will be higher.
- Your out-of-pocket maximum will be higher.

Finding an In-Network Provider

To determine whether a doctor or facility is in your medical option's network, you can:

- Use the online directory that's available on the ***Benefits@Your Fingertips*** Web site.
- Visit the medical option's Web site, if it has 1, to see if it has an online directory.
- Call the medical option administrator directly (the telephone number is on your medical ID card).
- Call your doctor, hospital, or other facility directly.

Primary Care Physicians (PCPs)

Definition of a Primary Care Physician

A primary care physician (PCP) is an in-network provider who is usually trained in the areas of general practice, family practice, internal medicine, or pediatrics.

A PCP coordinates all of your and/or your family's medical care and makes referrals to specialists for any specialized care needs. Each covered member of your family can choose his or her own PCP.

You may need to choose a PCP if you enroll in a:

- Point of Service (POS) Option
- HMO
- EPO

If you don't select a PCP, 1 may be assigned to you, or the medical option may consider all of your claims for services at the out-of-network level.

PCPs for POS Options

If you enroll in a Point of Service (POS) option:

- Your PCP should be your first contact whenever you need medical care. He or she should coordinate all your care in his or her office, with any hospitals and specialists, and with any other in-network providers you need to see.

- You'll receive the highest level of benefits if your PCP coordinates all your care and if all the providers you use are in the POS network.

You can see any provider without a referral from your PCP and still receive benefits. But:

- The deductible and coinsurance you pay will be higher.
- Your out-of-pocket maximum will be higher.
- Some medical procedures may require precertification.

PCPs for HMOs and EPOs

If you enroll in an HMO or EPO, you may need to choose a PCP or facility from a list of network providers in your area. See the information from your specific plan. If your plan requires it and your don’t select a PCP, 1 will be assigned to you.

If you are required to choose a PCP:

- You must receive care from your PCP or a specialist to whom your PCP refers you.
- If you receive medical services outside your PCP's office without being referred, you generally won't receive any benefit coverage, even if the service provider is in the HMO or EPO network.

Finding a PCP

To find a PCP who's in your medical option's network, you can:

- Use the online directory that's available on the ***Benefits@Your Fingertips*** Web site.
- Visit the medical option administrator's Web site, if it has 1, to see if it has an online directory.
- Call the medical option directly (the telephone number is on your medical ID card).
- Call your doctor, hospital, or other facility directly.

Changing Your PCP

The first time you enroll yourself and/or your dependents in a medical option that requires you to choose a PCP, you'll choose your PCP as part of the enrollment process. If you want to change your PCP after you've enrolled, contact the plan directly. The telephone number is on your plan ID card.

Deductible

Definition of a Deductible

A deductible is the portion of your healthcare expenses you pay out-of-pocket each year before any benefits are paid. The amount of your deductible depends on the medical option you choose.

A deductible is different from coinsurance and copayments.

How the Family Deductible Works

No family member pays more than the amount of the individual deductible in any year.

Each covered person pays toward his or her individual deductible until the family deductible is met. When the combined amount of expenses applied to the deductibles for all individuals equal the family deductible amount, no further deductible is due.

For example, assume you have 5 family members, and your medical plan has an individual deductible of $750 and a family deductible of $1,500. If each of the 5 of you has paid $300 of deductible expenses in a year, the family deductible has been met.

Plans with Deductibles

You're required to pay a deductible before you'll be reimbursed for many kinds of covered services under the:

- Preferred Provider Organization (PPO)
- Point of Service (POS) Plan
- Indemnity Basic Plan and Indemnity Basic Plan When Medicare is Primary

Generally, you don't pay a deductible under any of the HMOs or EPOs.

For the specific deductibles that apply in your medical option, refer to the summary plan description or certificate of coverage issued by the medical option administrator. To access this information, from the home page of ***Benefits@Your Fingertips*** select “Health Care,” then select “Medical,” and on the medical page, under “Learn About Your Medical Benefits,” select “View and Print Your Summary Plan Description.”

Coinsurance and Copayments

For most medical services, you pay either a copayment or coinsurance. For some services, you may pay both.

Definition of Coinsurance

Coinsurance is the percentage of charges you pay for covered services, in addition to any applicable deductible.

Depending on the plan option you choose and your doctor's or hospital's policy:

- If you access in-network providers, claims will be filed with your medical plan by the provider.
- You may need to pay the full amount at the doctor's office or hospital and then be reimbursed for everything except the percentage you pay as coinsurance.
- Your doctor or hospital may bill the medical plan first and then bill you for the amount remaining.

Definition of a Copayment

A copayment is a flat dollar amount you pay directly to the doctor or hospital when you receive certain covered services from an in-network provider, out-of-network provider, or a primary care physician (PCP).

For the specific coinsurance or copayments that apply in your medical option, refer to the summary plan description or certificate of coverage issued by your medical option administrator. To access this information, from the home page of ***Benefits@Your Fingertips*** select "Health Care," then select "Medical," and on the medical page, under "Learn About Your Medical Benefits," select "View and Print Your Summary Plan Description."

Precertification Requirements

Definition of Precertification

Before you or your covered dependent is admitted to a hospital on an elective (non-emergency) basis, precertification—or authorization—of medical necessity from your medical plan may be required.

The purpose of this review is to ensure that service you are to receive meets specific medical criteria for coverage.

When You Must Precertify

Typically, to receive the highest level of benefits, you or your medical care provider must precertify any non-emergency hospital admission, surgical procedure, or service, regardless of the medical plan option you choose. An advantage of enrolling in a HMO, EPO, or POS plan is your primary care physician (PCP) will precertify your care.

Your medical option may also require you to precertify non-emergency procedures delivered out of network or not coordinated by your primary care physician (PCP).

Precertification is **not** required for emergency care. However, most plans require you to contact them as soon as possible (usually within 24 hours) after you've received emergency care.

To determine the precertification requirements for your medical option, call your medical option administrator at the phone number on your medical ID card or review the medical option's summary plan description on ***Benefits@Your Fingertips***. To access this information, from the home page of ***Benefits@Your Fingertips*** select “Health Care,” then select “Medical,” and on the medical page, under “Learn About Your Medical Benefits,” select “View and Print Your Summary Plan Description.”

Out-of-Pocket Maximum

Definition of an Out-of-Pocket Maximum

An out-of-pocket maximum is a limit you pay for your share of certain covered expenses in a given year.

Once you reach an annual out-of-pocket maximum, the medical option typically pays 100% of any subsequent covered expenses for the rest of the year.

Prescription Drug Out-of-Pocket Maximum

If you are enrolled in the PPO, POS, Indemnity Basic Plan, or Indemnity Basic Plan When Medicare is Primary medical options, your prescription drug coverage is provided through Medco. Your prescription drug benefits have an out-of-pocket maximum for the copayments you pay for each prescription. Once you reach the out-of-pocket maximum, you pay a smaller copayment on each prescription for the remainder of the year.

How Out-of-Pocket Maximums Work

Coinsurance payments you make count toward your annual out-of-pocket maximums.

Some expenses you pay, however, may not apply toward your annual out-of-pocket maximum, such as:

- Any mental health and substance abuse treatment charges
- Any additional charges you pay for not following precertification requirements
- Any charges not covered by your medical option or exceeding reasonable and customary or other limits

Your Option's Maximums

To see the out-of-pocket maximum, if any, for your medical option, call the medical option administrator at the phone number on your medical ID card or review the option's summary plan description on ***Benefits@Your Fingertips***. To access this information, from the home page of ***Benefits@Your Fingertips*** select “Health Care,” then select “Medical,” and on the medical page, under “Learn About Your Medical Benefits,” select “View and Print Your Summary Plan Description.”

Reasonable and Customary (R&C) Limits

Some medical options limit the amount of a medical charge that will be considered for benefits up to reasonable and customary limits. R&C limits are determined as the fair and reasonable value of a medical procedure or service, based on historical data. A charge is “reasonable and customary” when:

- The fee is that which an individual physician or provider of medical service most frequently charges to the majority of patients for a similar service or medical procedure and which falls within the range of usual fees charged for that service by physicians or other medical providers with similar training and experience for the performance of similar services or medical procedures within the same locality; or

- The medical option administrator determines a fee is justified because of special circumstances, or medical complications requiring additional time, skill, and experience in connection with a particular service or procedure.

R&C limits apply for services under these plans:

- Preferred Provider Organization (PPO), if you don't use a network provider

- Point of Service (POS) Plan, if you live in a network area but go outside the network for care or don't get a referral

- Indemnity Basic Plan and Indemnity Basic Plan When Medicare is Primary

Typically, you pay for all charges **over** the R&C limit. In addition, amounts over the R&C limit typically don't count toward the deductible or the out-of-pocket maximums.

Filing Medical Plan Claims

Preferred Provider Organization (PPO)

You don't need to file a claim if you go to an in-network provider. Your doctor will submit the expenses directly to the PPO. All expenses, however, must be submitted within 1 year after you incur the charges.

If your out-of-network provider does not file your claim for you, you can get a claim form and filing instructions by calling the option administrator directly. The telephone number and address are on your medical ID card. Claims for out-of-network expenses must be filed within 1 year of the incurred date.

The instructions on the claim form should be followed carefully. Be sure all questions are answered fully and any required statements and bills are submitted with the claim form.

Point of Service (POS) Option

You don't need to file a claim for any medical expenses coordinated by your primary care physician (PCP) and received from an in-network provider. Your doctor will submit the expenses directly to the POS option. All expenses, however, must be submitted within 1 year after you incur the charges.

To receive maximum payment for services from someone other than your PCP, you must have a referral from your PCP.

If your out-of-network provider does not file your claim for you, you can get a claim form and filing instructions by calling the option administrator directly. The telephone number and address are on your medical ID card. Claims for out-of-network expenses must be filed within 1 year of the incurred date.

The instructions on the claim form should be followed carefully. Be sure all questions are answered fully and any required statements and bills are submitted with the claim form.

Indemnity Basic Plan and Indemnity Basic Plan When Medicare is Primary

Most providers are aware of claim filing requirements and will file claims for you. If your provider does not file your claim for you, you can get a claim form and filing instructions by calling the option administrator directly. The telephone number and address are on your medical ID card. Claims for medical expenses must be filed within 1 year of the incurred date.

The instructions on the claim form should be followed carefully. Be sure all questions are answered fully and any required statements and bills are submitted with the claim form.

Health Maintenance Organization (HMO)

You don't need to file claim forms. If you use an out-of-network provider, the services will not be covered.

Exclusive Provider Organization (EPO)

You don't need to file claim forms. If you use an out-of-network provider, the services will not be covered.

How to Appeal Denied Claims

If a claim for benefits is denied, you have the right to appeal the claim's denial. The process for appealing a denied claim, and the address to which appeals should be sent, will vary depending on the type of claim and the reason for the denial:

Eligibility:

If a claim is denied on the basis that you or a dependent is not eligible for coverage under a medical option, your appeal should be directed to the Benefits Director c/o the BellSouth Benefits Service Center, which has final authority over all issues of eligibility.

Benefits payable:

If a claim is denied on the basis that an expense or service is not a covered expense, or you do not agree with how a benefit was calculated for an expense, your appeal should be directed to the medical option administrator. BellSouth has delegated complete discretionary authority to each option administrator to make all benefits determinations, to interpret the terms and provisions of the medical option they administer, and to provide a review procedure for denied claims. Their decisions and interpretations are final and conclusive. To find the appeal procedures for your medical option, refer to the summary plan description issued by the medical option administrator. To access this information, from the home page of ***Benefits@Your Fingertips*** select "Health Care," then select "Medical," and on the medical page, under "Learn About Your Medical Benefits," select "View and Print Your Summary Plan Description."

Subrogation and Right of Recovery

If you recover any charges for covered expenses from a third party, BellSouth has the right to recover any benefits it has paid you already. This also applies if any claim or benefit is overpaid. For more information, refer to "Situations Affecting Your Benefits" on page 152.

Prescription Drug Program

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 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. In these cases, your doctor may need to provide more information to determine if your prescription meets the recommended guidelines.

If you are filling a short-term prescription, your participating pharmacy will let you know if additional information is required by your plan. You or the pharmacy can then ask your doctor to call a special toll-free number. This call will initiate a review that typically takes 1 to 2 business days. Once the review is complete, we will notify you and your doctor of the decision. If the review approves coverage for your prescription, the letter will tell you the length of your coverage approval. If the review is denied, the letter will include the reason for coverage denial and instructions on how to submit an appeal if you choose.

If you are filling a prescription by mail, the mail order service will let you know if additional information is required and a similar process is followed.

If you enroll in an HMO or EPO, prescription drug coverage is provided through the HMO or EPO. Contact your plan administrator for details.

How the Program Works

For Short-Term Prescriptions

You can fill short-term prescriptions (up to a 60-day supply) at a participating retail pharmacy.

A few weeks after you enroll for medical coverage, you'll receive a prescription drug ID card in the mail. You must present this card when filling a prescription at a retail pharmacy to receive the highest level of benefits and avoid having to file a claim.

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.” In addition, you can call Medco Health at the phone number on the back of your prescription drug ID card.

If you use a pharmacy that does not participate in the Medco Health network, no benefits are payable. You will pay the full cost of your prescription.

For Maintenance Medications

You'll use the program's mail-order service to fill prescriptions for any medications you or your covered dependents use on an ongoing basis. You can order up to a 90-day supply through the mail-order service.

When your doctor prescribes a new maintenance medication, you may want to ask for a second prescription for a 14-day supply of that drug, in addition to the ongoing prescription. The short-term prescription, filled at your local retail pharmacy, will serve your needs while you're waiting for your mail-order prescription to arrive.

You can fill your mail-order prescriptions 3 ways:

- By mail—send in the completed order form with your prescription and copayment.
- By phone—ask your doctor to call Medco at 1-888-327-9791. 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: from the home page of ***Benefits@Your Fingertips,*** select "Health Care" then select "Medical," and on the medical page select the link under "Prescription Drug benefits." Once you are logged in, visit the "Order center" and click on "Request a new prescription from your doctor" and follow the on-screen instructions.

Replacement/Early Refill Policy

Under certain conditions, BellSouth will authorize Medco to cover the expense of replacing medications (copayments will apply). The conditions are outlined below:

- When medications are stolen or destroyed due to fire and a police report is filed; and
- In the case of a natural disaster and the medication is destroyed.

Early refills are authorized in cases when members are traveling outside the United States where refills would not be available. Please note this procedure will not apply to certain controlled substances. Contact Medco Health and its representatives will advise you of the procedures.

Program Benefits

Generic versus Brand Name

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.

If your doctor allows a generic drug but you choose the brand name drug, you will pay the

difference between the brand name drug price and the generic drug price ***plus*** the generic copayment.

You pay these copayments for prescription drugs:

Represented Retirees Who Retired before January 1, 1992 and Management Retirees

Drug Type	Short-Term Prescription, to a 30-Day Supply	Short-Term Prescription, 31- to 60-Day Supply	Maintenance Medication Via Mail Order
Generic	$7 copayment	$10 copayment	$8 copayment per 90-day supply
Brand name	$13 copayment	$16 copayment	$15 copayment per 90-day supply

{An addendum dated July 2006 revised the sentence below to read as follows:}

Once your out-of-pocket copayments reach $450, your copayment is reduced to $5 per prescription.

Represented Retirees Who Retired on or after January 1, 1992

Drug Type	Short-Term Prescription, to a 30-Day Supply	Short-Term Prescription, 31- to 60-Day Supply	Maintenance Medication Via Mail Order
Generic Effective January 1, 2006	$10	$12.50	$15
Brand name Effective January 1, 2006	$35	$42.50	$50

{An addendum dated July 2006 revised the sentence below to read as follows:}

Once your out-of-pocket copayments reach $650 in 2006 and $700 in 2007, your copayment is reduced to $7 in 2006 and $8 in 2007 per prescription.

Drugs Not Covered

Certain drugs and medicines aren't covered by the plan. See page 73 for more information. Your payments for excluded medications can't be used to satisfy your deductible.

Drugs Requiring Preauthorization

Some prescription drugs are covered only when supported by documentation of medical necessity. Drugs costs are paid at 100% of covered charges after the copayment or coinsurance. Contact Medco Health at 1-877-797-7472 to receive more information about the information which is required from your prescribing physician. These drugs include, but are not limited to:

- Growth hormones
- Birth control (oral forms only) drugs for dependents
- Enteral supplies (covered only if administered by nasogastric or gastrostomy tubes)
- Food/dietary supplies (covered only if administered by nasogastric or gastrostomy tubes)
- Crinone
- Depo-Provera (covered if for non-birth control purposes only)
- Avita (member must have approved if over the age of 23)
- Retin-A (member must have approved if over the age of 23)

To ensure quality and safety, the Pharmacy Benefit Manager also administers drug utilization programs based on FDA-approved prescribing and safety information.

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. The BellSouth benefit will be 90% of covered charges (or 100% of covered charges after you reach the annual out-of-pocket maximum) ***minus*** the payment by the primary coverage for both generic drugs or for brand name drugs when required by your physician.

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

With respect to the payment of pharmacy benefits by the Basic Indemnity Plan, PPO, and POS, medical options, BellSouth has delegated to the Pharmacy Benefit Manager (PBM), Medco Health Solutions of Irving, the duty to administer all claims for pharmacy benefits. The PBM governs the operation of the pharmacy benefits for the medical option for which they administer pharmacy benefits at all times. The PBM is designated as the claims administrator and has complete discretionary authority to make all benefits determinations for pharmacy benefits under the plan, to interpret the terms and provisions of the plan, and to provide a review procedure for denied claims. Its decisions and interpretations are final and conclusive.

Medco Health has established the following claims review and appeal procedures:

Appeal/Review of Pharmacy Benefit Denial

For all claims other than member-submitted paper claims:

In the event you receive an adverse determination following a request for coverage of a prescription benefit claim, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician), must provide in writing, your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, and any additional information that may be relevant to your appeal. This information should be mailed to:

Medco Health Solutions of Irving
8111 Royal Ridge Parkway
Irving, TX 75063

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. The notice will include the specific reasons for the decision and the plan provisions on which the decision is based. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second-level appeal. To initiate a second-level appeal, you or your authorized representative (such as your physician), must provide in writing, your name, member ID, phone number, the prescription drug for which benefit coverage has been denied and any additional information that may be relevant to your appeal. This information should be mailed to:

Medco Health Solutions of Irving
8111 Royal Ridge Parkway
Irving, TX 75063

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for appeal. You have the right to receive, upon request and at no charge, the information used to review your second-level appeal. The decision made on your second-level appeal is final and binding.

If you are not satisfied with the decision of the second-level appeal, you also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if your second-level appeal is denied.

If you are not satisfied with the decision of the second-level appeal, you have the right to submit a voluntary appeal to:

Medco Health Solutions of Irving
8111 Royal Ridge Parkway
Irving, TX 75063

In that case, the decision of the voluntary appeal will become final and binding.

If you are not satisfied with the decision of the voluntary appeal, you also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if your voluntary appeal is denied.

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. An urgent care claim is any claim for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim, of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information.

You have the right to request an urgent appeal of an adverse determination if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or your physician may call 1-877-797-7472 or send a written request to:

Medco Health Solutions of Irving
8111 Royal Ridge Parkway
Irving, TX 75063

In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review your appeal. You also have the right to bring a civil action under section 502(a) of ERISA if your final appeal is denied.

For member submitted paper claims:

Your plan provides for reimbursement of prescriptions when you pay 100% of the prescription price at the time of purchase. This claim will be processed based on your plan benefit. You will receive an explanation of benefits within 30 days of receipt of your claim. If you are not satisfied with the decision regarding your benefit coverage, you have the right to appeal this decision in writing within 180 days of receipt of notice of the initial decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician), must provide in writing, your name, member ID, phone number, the prescription drug for which benefit coverage has been reduced or denied, and any additional information that may be relevant to your appeal. This information should be mailed to:

Medco Health Solutions of Irving
8111 Royal Ridge Parkway
Irving, TX 75063

A decision regarding your appeal will be sent to you within 30 days of receipt of your written request. The notice will include the specific reasons for the decision and the plan provision on which the decision is based. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second-level appeal. To initiate a second-level appeal, you or your authorized representative (such as your physician), must provide in writing, your name, member ID, phone number, the prescription drug for which benefit coverage has been reduced or denied and any additional information that may be relevant to your appeal. This information should be mailed to:

Medco Health Solutions of Irving
8111 Royal Ridge Parkway
Irving, TX 75063

A decision regarding your request will be sent to you in writing within 30 days of receipt of your written request for appeal. The decision made on your second-level appeal is final and binding.

If you are not satisfied with the decision of the second-level appeal, you also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if your second-level appeal is denied.

If you are not satisfied with the decision of the second-level appeal, you have the right to submit a voluntary appeal to:

Medco Health Solutions of Irving
8111 Royal Ridge Parkway
Irving, TX 75063

In that case, the decision of the voluntary appeal will become final and binding.

If you are not satisfied with the decision of the voluntary appeal, you also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) if your voluntary appeal is denied.

Drugs Not Covered

Here are examples of drugs and medicines **not** covered by the prescription drug program if you are enrolled in the PPO, POS, Indemnity Basic, or Indemnity Basic When Medicare is Primary medical options. This list isn't exhaustive.

- Investigational drugs*
- Infertility drugs
- Nicorette/Nicoderm or any smoking cessation drug/supply
- Vitamins (except prenatal)
- Medicare Part B drugs
- Drugs for the purpose of weight loss
- Cosmetic drugs
- Non-oral forms of contraceptives (e.g., Norplant, etc.)
- Dietary supplements (except those administered by nasogastric or gastrostomy tubes)
- Dermatologicals, hair growth stimulants
- Therapeutic devices or appliances, including support garments, and other non-medicinal substances, regardless of intended use
- Non-legend drugs (over the counter)
- Taxes—Some state or municipalities (or parishes) impose a sales or use tax on prescription medications. **Tax is not a covered expense under the medical options and is your responsibility.** Tax is in addition to the required copayment and is not applied to your out-of-pocket maximums.

If you have any questions about whether a medication is covered, contact the plan directly. The telephone number is listed on your plan ID card.

Your payments for excluded medications can't be used to satisfy your deductible.

* Any drug or biological product not generally regarded as safe and effective for use in humans because it has not received final approval for marketing by the United States Food and Drug Administration (FDA) for a particular condition or diagnosis.

Mental Health and Substance Abuse Treatment

Eligibility for Coverage

Your mental health and substance abuse treatment benefits are shown here if you enroll in the:

- Preferred Provider Organization (PPO)
- Point of Service (POS) Plan
- Indemnity Basic Plan or Indemnity Basic Plan When Medicare Primary

The coverage described here doesn't apply to you if you enroll in an HMO or EPO. Contact your medical option directly for information about its mental health and substance abuse benefits.

Benefits Provided

When Mental Health Managed Care (MHMC) is used to precertify mental health and substance abuse treatment, you receive the highest level of benefits. You may receive a lower level of benefits by using non-MHMC providers and facilities.

For some services, the MHMC must still precertify care before there is any coverage, and non-MHMC providers must meet certain requirements. Unless specified, an annual deductible of $200 must be satisfied before any mental health or substance abuse treatment benefits will be paid.

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

Service	In Network (MHMC)	Out of Network (Non-MHMC)
Inpatient mental health treatment (These 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.	The plan pays 90% of R&C charges after the deductible, up to $85 per visit. Maximum of 52 visits per year (limited to 2 visits a week).

Service	In Network (MHMC)	Out of Network (Non-MHMC)
Outpatient mental health treatment	You pay a $15 copayment per visit. No deductible 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 2 visits per week).
Inpatient detoxification (no more than 2 in a 5-year period). (These services must be precertified before benefits can be paid.) The second admission must start at least 180 days after the first 1 ended to be considered separate and not part of the previous admission.	The plan pays 100% of covered charges after you pay the deductible. Physician fees must be included in the facility charge.	The plan pays 90% of the payment allowance after you pay the deductible. Physician fees must be included in the facility charge.
Inpatient substance abuse rehabilitation (limit 2 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.* **Note:** Class II and sponsored dependents are **not** eligible. (These services must be precertified before benefits can be paid.)	The plan pays 100% of covered charges after you pay the deductible. Physician fees must be included in the facility charge.	The plan pays 90% of the payment allowance after you pay the deductible. Physician fees must be included in the facility charge.

*The mental health and substance abuse benefit pays for 3 substance treatments per lifetime for up to 30 days each. Up to 2 of the admissions may be inpatient. An alternate benefit may be substituted for 1 or both inpatient admissions if appropriate and precertified.

Service	In Network (MHMC)	Out of Network (Non-MHMC)
Alternate benefits (mental health and substance abuse) If for substance abuse, limited to 2 benefits per lifetime for up to 30 days each. Includes partial hospitalization, residential treatment, and intensive structured outpatient treatment. **Note:** Class II and sponsored dependents are **not** eligible. (These services must be precertified before benefits can be paid.)	The plan pays 100% of covered charges after you pay the deductible. Physician fees must be included in the facility charge.	The plan pays 90% of the payment allowance after you pay the deductible. Physician fees must be included in the facility charge.

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

Claim Review/Appeal Process

With respect to the payment of mental health and substance abuse benefits by the Indemnity Basic Plan, PPO, and POS medical options, BellSouth has delegated to the Mental Health Managed Care Manager (MHMCM), Magellan Health Services, the duty to administer all claims for mental health and substance abuse benefits. The MHMCM governs the operation of the mental health and substance abuse benefits for the medical options for which they administer mental health and substance abuse benefits at all times. The MHMCM is designated as the claims administrator and has complete discretionary authority to make all benefits determinations for mental health and substance abuse benefits under the plan, to interpret the terms and provisions of the plan and to provide a review procedure for denied claims. Its decisions and interpretations are final and conclusive.

Magellan Behavioral Health has established the following claims review and appeal procedures:

Appeal/Review of Denied Claims

Claims for mental health and substance abuse 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 pre-certification of inpatient admissions or alternate benefits) or concurrent (services that require periodic medical necessity review and re-certification such as an ongoing hospitalization or services such as medication management or psychotherapy). This summary explains how we process these different types of claims and how you can appeal a partial or complete denial of a

claim. The following claims and appeal procedures for mental health and substance abuse benefits are designed to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this summary. An authorized representative is someone you designate **in writing** to act on your behalf. 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 summary. 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 (i.e., after the service has been rendered)

What Constitutes a Claim

For you to obtain benefits after services have been rendered (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 the dedicated BellSouth Customer Service Department and ask for a claim form. Tell us the type of service for which you wish to file a claim (for example, hospital or physician), 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:

Magellan Health Services
PO Box 1099
Maryland Heights, MO 63043

Claims must be submitted and received by us within 365 days of the date of service 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, 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 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 15 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.**

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 the

same 30-day period. If we do not receive the information, your claim will be decided based on the available information. This may result in a denial of your claim.

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 (i.e., before the services have been rendered)

A pre-service claim is 1 in which you are required to obtain approval from Magellan before services are rendered. For example, you may be required to obtain pre-certification of inpatient hospital benefits or for Alternate Benefits. Or you may be required to obtain a pre-procedure review of other medical services in order to obtain coverage under the plan. Pre-service claims pertain only to the medical necessity of a service. If we grant a pre-service claim, we are not telling you that the service is or will be, covered; we are only telling you that the service or supply meets our medical necessity guidelines. For example, we might pre-certify your inpatient hospital admission but later deny your claim because the admission was related to a pre-existing condition or was for a service that is excluded under the BellSouth plan.

In order to file a pre-service claim you or your provider must call Magellan Health Services (Magellan) at 1-800-984-9135 (toll-free). You must tell us your contract number, the name of the facility in which you are being admitted (if applicable), the name of a person we 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:

Magellan Behavioral Health
PO Box 1099
Maryland Heights, MO 63043

Non-urgent pre-service claims (for example, those relating to routine services) 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 us within 48 hours of the admission and we certify the admission as both medically necessary and as an emergency admission.

If you fail to properly file a pre-service claim, we will notify you of the failure within 24 hours (for urgent pre-service claims) or 5 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:

- 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

- 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 tell you what further information we need within 24 hours of your claim. 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. If we do not receive the information, your claim will be decided based on the available information. This may result in a denial of your claim. Our response may be oral; if it is, we will follow it up in writing within 3 days.

Non-Urgent Pre-Service Claims

If your claim is not urgent, we will notify you of our decision within 5 business days. If we need more information, we will tell you what further information we need before the 5-day period expires. You will then have 15 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 5 days after we receive the requested information. If we do not receive the information, your claim will be decided based on the available information at the end of the 15-day period. This may result in a denial of your claim.

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, you can ask us to determine beforehand whether the procedure is excluded. 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 dedicated BellSouth Customer Service Department.

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. Call Magellan at 1-800-984-9135 (toll-free) in order to request an extension of care. 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 healthcare 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 1 or more of the following:

- You may call or write the dedicated BellSouth Customer Service Department. 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 everything we can to maintain it.

Reviews

Prior to January 1, 2003, you or your authorized representative could request a review of a post-service claim by calling or writing the BellSouth dedicated Customer Service Department at Magellan. This initial review was not considered a formal ERISA appeal. If you disagreed with the results of the review, you could still exercise your appeal rights under ERISA. As a result of the new Department of Labor rules, effective January 1, 2003, a written request for a review must be considered exercising your ERISA appeal rights (subject to proper submission of information as outlined below). You may still request a review of your claims by phone. If we

are unable to answer your questions at the time of your call, we will respond to your request by return phone call.

Appeals

In General

The rules in this section of the summary allow you or your authorized representative to appeal any adverse benefit determination. An adverse benefit determination includes any 1 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 deductibles, coinsurance and/or copayments 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, you must send us a letter, containing 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:

Magellan Health Services
PO Box 1619
Alpharetta, GA 30009
Attention: BellSouth Appeals Coordinator

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 Magellan at 1-800-984-9135 (toll-free). If in writing, you should send your letter to the following address:

Magellan Health Services
PO Box 1619
Alpharetta, GA 30009
Attention: BellSouth Appeals Coordinator

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 1 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 are medically necessary), we will consult a healthcare professional who has appropriate expertise. If we consulted a healthcare 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 30 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 1 business day or, if during a long weekend, 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 it will be 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 1 business day or 72 hours if over a long weekend (in urgent pre-service cases), 30 days (in non-urgent pre-service cases or 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

If you have filed an appeal and are dissatisfied with our response, you may do 1 or more of the following:

- You may ask the dedicated BellSouth Customer Service Department at Magellan 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 Magellan at 1-800-984-9135 (toll-free). If in writing, you should send your letter to the following address:

Magellan Health Services
PO Box 1619
Alpharetta, GA 30009
Attention: BellSouth Appeals Coordinator

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

Magellan Health Services
PO Box 1619
Alpharetta, GA 30009
Attention: BellSouth Appeals Coordinator

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.

Medicare Overview

Eligibility

Medicare provides medical benefits if you meet any of these criteria:

- You're age 65 or older and eligible for Social Security or railroad retirement benefits.
- You're entitled to Social Security disability benefits after being totally disabled for 24 months.
- You have end-stage renal disease requiring dialysis and/or kidney transplant.

If you're not eligible for Social Security benefits, you're not eligible for Medicare. However, you can "buy in" to Medicare when you reach age 65. You can apply by contacting the Social Security Administration.

When Coverage Begins

Your Medicare coverage begins **either**:

- The 1st of the month in which you turn age 65 (or, if you turn 65 on the 1st of the month, on the 1st of the month preceding your birthday)
- If you're entitled to end-stage renal disease benefits, 3 months after your dialysis starts or the month you enter a hospital for a transplant

How Medicare Coverage Works

There are 3 components to traditional Medicare benefits:

- **Part A—**Hospital insurance benefits
- **Part B—**Supplemental medical benefits
- **Part D—**Prescription drugs

You must be enrolled in both Medicare Parts A and B to receive any benefits from the BellSouth Plan. The government charges a monthly premium for Medicare Parts B and D.

There is a monthly premium for Medicare Part B and the premium amount may change each year. Your monthly premium is deducted from your monthly Social Security payment. In addition to your monthly premiums, you may be required to pay for other services.

Medicare Part D is Medicare's prescription drug program that is effective January 1, 2006. It's important to understand that BellSouth will continue to offer prescription drug coverage during 2006 to you as part of your health benefits. **For the vast majority of BellSouth participants who are covered by Medicare, the prescription drug benefit provided to you by BellSouth is equal to or better than the coverage offered by Medicare Part D.** Medicare Part D simply offers you another opportunity to consider for your prescription drug coverage.

You should either stay in BellSouth's prescription drug benefit by staying in your current medical option or enroll in the Medicare Part D prescription drug plan, **but not both.**

If you enroll in a Medicare prescription drug plan, you will pay a monthly premium for coverage,

based on the plan you select. Each year, the premium cost will be adjusted to reflect Medicare Part D costs and inflation.

If You're Age 65 or Older

The Social Security Administration automatically files your application for Medicare Part A and Part B coverage when you apply for monthly Social Security retirement benefits.

Your Medicare coverage begins on the 1st day of the month in which you turn 65. If your birthday falls on the 1st of the month, your coverage begins on the 1st of the preceding month.

You can waive Social Security retirement benefits and Medicare Part B if you're still working and covered under the company's medical plan. You have the option of enrolling in Medicare Part D at a later date during a Special Enrollment Period. Most people who sign up during the Special Enrollment Period don't pay the higher premium associated with a late enrollment. Contact your local Social Security office or visit **www.medicare.gov** for more details on the Special Enrollment Period.

Social Security Disability

Medicare benefits begin in the 25th month after you're entitled to receive Social Security disability benefits.

You're no longer eligible to receive Medicare benefits due to a disability at the **earlier** of:

- Your 65th birthday
- The end of the month after the month in which notice of termination of disability status is mailed, if you're no longer considered disabled.

End-Stage Renal Disease

Medicare benefits begin either:

- 3 months after dialysis starts. or
- The month you enter a hospital for a transplant.

Benefits end:

- 12 months after dialysis ends; or
- 36 months after a transplant.

For More Information

For more information, visit the Medicare Web site at **www.medicare.gov**.

Dental Plan

Coverage Categories

When you enroll in the plan, you must choose the dependents you want to cover. You'll then be assigned a coverage category.

Dental Plan Options

For Retirees

BellSouth offers these options:

- No coverage
- Retiree Dental Assistance Plan

Cost of Coverage: Retired Employees

In General

You and the company may share in the cost of coverage. Your cost varies based on a variety of factors which include:

- The participating BellSouth company you retire from
- The date you were hired and the date you retire
- The eligible dependents you have elected to cover

Depending on the above factors, you may share in the cost of coverage by paying the Capped Excess Premium. Some groups are required to pay some or all of the cost of coverage. See the tables below to determine what premium payments you are required to pay, if any.

CAP & Capped Excess Premium

The CAP amount (CAP) is the maximum aggregate dollar amount the company will pay for all retiree dental coverage. The CAP was set initially at 11.4% above the actual 1990 cost; however, the company has elected to increase the CAP above the initial amount on occasion. The company reserves the right to increase or decrease the CAP in subsequent years.

The Capped Excess Premium amount is calculated by determining the excess of the aggregate actual cost for the dental plan 2 years prior to the current year over the CAP. For example, the Capped Excess Premium for 2006 is based on the excess of 2004 actual cost over the CAP.

Applying the Capped Excess Premium to Your Dependents

As noted, the application of the capped excess premium depends on the company you retire from and your retirement date. How the premiums apply to your dependents also depends on when you retire and when their coverage was effective.

Management Employees Who Were Hired after December 31, 2000

If you were hired by BellSouth on or after January 1, 2001, when you retire on a service or disability pension, you will be eligible for post-retirement medical and dental coverage but you will pay 100% of its cost, based on the retiree group rates. In effect, you will have "access only" to BellSouth's retiree healthcare coverages.

This access-only provision applies to:

- New management employees hired on or after January 1, 2001.

- An employee hired on or after January 1, 2001, who is covered by the Mandatory Portability Agreement. (The Mandatory Portability Agreement preserves previous service for use in determining pension eligibility but it does not apply to eligibility for post-retirement healthcare benefits).

- An employee with previous BellSouth service who is rehired on or after January 1, 2001, but who was **not** eligible for post-retirement healthcare coverage when he or she terminated from BellSouth's employment. Although the employee's service may bridge and result in an NCS (Net Credited Service) date prior to January 1, 2001, for purposes of post-retirement healthcare coverage, he or she will be considered to have access-only coverage.

- A represented employee hired on or after January 1, 2001, who is later promoted to management will have access-only coverage when he or she retires.

The access-only provision will **not** apply to you if:

- You are a management employee rehired on or after January 1, 2001, but you were eligible for company-subsidized post-retirement healthcare coverage when you previously terminated employment with BellSouth. When you work long enough to retire again, you will be treated as an employee who was hired before January 1, 2001 and you will receive credit for the additional service.

- You are a management employee hired prior to January 1, 2001, and your subsequently transfer to another BellSouth company after January 1, 2001 maintaining continuous employment with BellSouth.

- You are a management employee hired before January 1, 2001, who subsequently returns from a leave of absence that may result in an adjustment to your NCS date so that it is on or after January 1, 2001, but your service has been continuous.

- You are a represented employee hired before January 1, 2001, who is subsequently promoted to management after January 1, 2001, but who has maintained continuous employment with BellSouth.

{The following tables replaced the tables in the printed booklet by an addendum dated 7/2006:}

For Management Retirees

Effective date:	How the cost of dental coverage is paid:
Hired after December 31, 2000	Retiree and all Class I dependents: Retiree pays 100%
Retired after December 31, 1991 but were hired before January 1, 2001	Retiree and spouse or domestic partner: Retiree pays Capped Excess Premium Other Class I dependents: **If coverage began before retirement—**Retiree pays Capped Excess Premium **If coverage began after retirement—**Retiree pays 100%
Retired after December 31, 1987 and before January 1, 1992	Retiree and spouse or domestic partner: BellSouth pays 100% Other Class I dependents: **If coverage began before retirement—**BellSouth pays 100% **If coverage began after retirement—**Retiree pays 100%
Retired before January 1, 1988	Retiree and spouse or domestic partner: BellSouth pays 100% Other Class I dependents: **If coverage began before January 1, 1988—**BellSouth pays 100% **If coverage began after December 31, 1987—**Retiree pays 100%

For Nonmanagement Retirees (excluding retirees of Stevens Graphics and L.M. Berry)

Effective date:	How the cost of dental coverage is paid:
Retired after December 31, 1991	Retiree and spouse or domestic partner: Retiree pays Capped Excess Premium; however, the earliest this premium will be required is January 1, 2010. Other Class I dependents: **If coverage began before retirement—**Retiree pays Capped Excess Premium however, the earliest this premium will be required is January 1, 2010. **If coverage began after retirement—**Retiree pays 100%
Retired after December 31, 1987 and before January 1, 1992	Retiree and spouse or domestic partner: BellSouth pays 100% Other Class I dependents: **If coverage began before retirement—**BellSouth pays 100% **If coverage began after retirement—**Retiree pays 100%
Retired before January 1, 1988	Retiree and spouse or domestic partner: BellSouth pays 100% Other Class I dependents: **If coverage began before January 1, 1988—**BellSouth pays 100% **If coverage began after December 31, 1987—**Retiree pays 100%

For L.M. Berry Retirees

Effective date:	How the cost of dental coverage is paid:
Hired after December 31, 2000	Retiree and all Class I dependents: Retiree pays 100%
Management employees hired before January 1, 2001 who retire after March 31, 2001	Retiree and spouse or domestic partner: Retiree pays Capped Excess Premium Other Class I dependents: **If coverage began before retirement—**Retiree pays Capped Excess Premium **If coverage began after retirement—**Retiree pays 100%
Non-management employees who retired after March 31, 2001	Retiree and spouse or domestic partner: Retiree pays Capped Excess Premium. Other Class I dependents: **If coverage began before retirement—**Retiree pays Capped Excess Premium **If coverage began after retirement—**Retiree pays 100%
Retired before April 1, 2001	Retiree and spouse or domestic partner: Retiree pays active rates charged to L.M. Berry employees. Other Class I dependents: **If coverage began before retirement—**Retiree pays active rates charged to L.M. Berry employees **If coverage began after retirement—**Retiree pays 100%

For Stevens Graphics Retirees

Effective date:	How the cost of dental coverage is paid:
Hired after December 31, 2000	Retiree and all Class I dependents: Retiree pays 100%
Management employees hired before January 1, 2001 who retired after March 31, 1998	Retiree and spouse or domestic partner: Retiree pays 50% of the premium rate for Steven's Graphics active employees. However, once the premium amount is equal to the premium amount required of a BellSouth Corporate retiree, the premium requirement will be maintained at the same level as that of a BellSouth Corporate retiree. Other Class I dependents: **If coverage began before retirement —**Capped Excess Premium **If coverage began after retirement—**Retiree pays 100%
Management employees who retired before April 1, 1998 and all non-management employees not identified below	Retiree and spouse or domestic partner: Retiree pays 100% of the cost of coverage for Stevens Graphics active employees Other Class I dependents: **If coverage began before retirement—**Retiree pays 100% of the cost of coverage for Stevens Graphics active employees **If coverage began after retirement—**Retiree pays 100%

Effective date:	How the cost of dental coverage is paid:
Non-management employees who retired from Local No. 121C (including employees formerly represented by 540M) after April 1, 1998 with 35 or more years of service	Retiree and spouse or domestic partner: Retiree pays 90% of the cost of coverage for Stevens Graphics active employees Other Class I dependents: **If coverage began before retirement—**Retiree pays 90% of the cost of coverage for Stevens Graphics active employees **If coverage began after retirement—**Retiree pays 100%

How Retirees Pay for Coverage

If you pay for coverage as a retiree, you may pay for your coverage monthly through direct billing, by deduction from your pension checks, or by direct debit from a checking or savings account at your bank. When you retire, you will automatically be direct billed. If you wish to pay your contributions by deduction from your pension check or by direct debit, you may do so through ***Benefits@Your Fingertips*** or by calling the BellSouth Benefits Service Center.

Changing Your Dental Plan Option

After you enroll, you can change your option only:

- During annual enrollment
- If the option is no longer offered
- If the contract between BellSouth and the Dental Plan ends
- If you experience a qualified change of status

Dental Plan

You can arrange for a pretreatment estimate of benefits through your dentist to learn ahead of time how the plan might cover your need.

Benefits for Covered Services

If you enroll in the Retiree Dental Assistance Plan, here's how the plan's benefits are determined:

Annual deductible	$25 per person, $75 per family for Type B Services (such as inlays, onlays, crowns, and root canals) and orthodontic services. This is waived if 1 preventive treatment is done within 12 months of the day you incur Type B services.
Annual maximum coverage	$1,400 per person for Type A and Type B services
Lifetime orthodontia maximum benefit	$1,650 per person for those under age 20 $1,250 per person for those age 20 and over

The Retiree Dental Assistance Plan includes a “passive PPO” network.

The network is a group of participating dentists that provide dental care at negotiated rates. Unlike a traditional PPO in which you receive a lower benefit level if you use an out-of-network provider, you receive the same level of benefits in a passive PPO for both in-network and out-of-network providers. Your benefit will be 100% of reasonable & customary (R&C) charges for Type A services.

Even though the benefit levels are the same for in-network and out-of-network providers, you’ll save money when you use a network provider. For instance, when you use a network provider for Type A services, there won’t be any amounts you have to pay because the charges are over the R&C levels.

Alternate Procedures

There is often more than 1 way to treat a particular dental problem. For example, sometimes either a crown or a filling could be used to restore a tooth. Also, dentists make choices regarding materials to be used, such as choosing between precious metals and plastic for restorations.

If you and/or the dentist decide on the more costly treatment, you are responsible for charges beyond those for the less costly alternate treatment paid by Connecticut General Life Insurance Company.

Connecticut General Life Insurance Company will pay the lower schedule amount, provided the treatment meets acceptable dental standards. Whenever the alternate procedures provision is applied, Connecticut General Life Insurance Company's dental consultant reviews the claim.

Coordination of Benefits

If you or any of your eligible dependents are covered by more than 1 dental plan, benefits will be coordinated by the 2 plans.

What's Not Covered

Certain dental services and supplies aren't covered by the plan. Your payments for excluded expenses can't be used to satisfy your deductible.

Dental Deductible

Definition of a Deductible

A deductible is the portion of your dental expenses that you pay out-of-pocket each year for some kinds of services before any benefits can be paid by the plan.

A deductible is different from coinsurance and copayments.

How the Family Deductible Works

No family member pays more than the individual deductible in any plan year.

If you cover eligible dependents, the maximum amount you will pay in deductibles for a year is 3 individual deductibles. That is, after 3 covered persons each satisfy an individual deductible, no other covered person has to pay any deductible for that year.

Reasonable and Customary (R&C) Limits

Benefits for Type A services are based on a percentage of reasonable and customary (R&C) charges. R&C is the fair and usual value of a dental procedure or service. A charge is "reasonable and customary" when the fee:

- Is that which an individual dentist or provider of dental services most frequently charges to the majority of participants for a similar service or dental procedure;
- Falls within the range of usual fees charged for that service by dentists with similar training and experience for the performance of similar services or dental procedures within the same locality;
- Is justifiable, as determined by CIGNA, in consideration of special circumstances or dental complications requiring additional time, skill, and experience in connection with a particular service or procedure.

If your dentist charges more than the R&C rates for a service in your area, you are responsible for paying all amounts over the R&C level, in addition to your coinsurance, if any, for the type of service provided. An advantage of using a dentist in the passive PPO is that his or her rates will not exceed the R&C rates for your area.

Type A Services

This plan pays 100% of reasonable and customary charges for certain preventive and diagnostic care, called "Type A" services. Connecticut General Life Insurance Company, the claims administrator, determines what fee is reasonable. In making that judgment, Connecticut General considers the following:

- The usual fee which the individual dentist most frequently charges the majority of patients for a service rendered or supply furnished;
- The prevailing range of fees charged in the same area by dentists of similar training and experience for the service rendered or supply furnished; and
- Unusual circumstances or complications requiring additional time, skill and experience in connection with particular dental services or procedures.

Type A services, for which the retiree Dental Assistance Plan pays 100% of the reasonable and customary charges, are:

- Routine oral examination, but no more than 2 examinations in a calendar year. These exams are for diagnosing your oral health and determining what dental care you need. Charges for oral exams other than routine exams will be handled on a per case basis. Additional benefit payments may be allowed when there is a confirmed disease or injury requiring a specific exam for treatment. However, if you have an emergency exam and a Type B service performed on the same day, only the Type B service will be considered for payment.
- Prophylaxis (cleaning and scaling your teeth), but not more than twice in a calendar year, when performed by a dentist or a dental hygienist. **Please note that root planing and scaling (an intensive cleaning of gums and teeth) is considered a Type B service.**
- Fluoride treatments, excluding prophylaxis, when performed by a dentist or dental hygienist, including:
  - Topical (local) application of sodium fluoride, but not more than 4 treatments in a calendar year; or
  - Topical application of stannous fluoride, but not more than 1 treatment in a calendar year; or
  - Topical application of acid fluoride phosphate, but not more than 1 treatment in a calendar year.
- Space maintainers (for dependent children under age 19 only), including installation of fixed or removable appliances designed only to maintain existing space created by the premature loss of teeth.
- Dental X-rays or radiographs, including:
  - Full-mouth panorex X-rays, but not more than once in 5 consecutive calendar years;
  - Supplementary bitewing X-rays but not more than twice in a calendar year; and
  - Any dental X-ray required to diagnose a specific condition that needs treatment, except X-rays in conjunction with orthodontia and TMJ.

Note: X-rays may be required in order to determine appropriate payment levels for impacted wisdom teeth extractions, gold restorations, crowns, dentures and bridgework. If Connecticut General Life Insurance Company has a need for X-rays, a request will be made to your dental provider.

Type B Services

Benefit amounts for Type B services are paid on a fixed-fee benefit schedule. Dollar amounts in the schedule are the maximum amount the plan will pay for a particular procedure. Before Type B benefits can be paid, you must meet the $25 deductible for you and each eligible dependent. A family limit applies after the deductible has been paid for 3 covered family members during a 12-month period. When this happens, the deductible for your entire family has been satisfied for that year.

The $25 deductible is waived when 1 preventive treatment is done within 12 months prior to the date you incur Type B services. This waiver applies separately to each covered person once each calendar year. Preventive treatment means routine cleaning and scaling of teeth, dental X-rays, and fluoride treatments that qualify as Type A services.

In addition, the $25 deductible will be waived for participants who have complete (upper and lower) dentures.

Type B services include:

- Restorations, including fillings, inlays, onlays, and crowns: treatment necessary to restore the structure of a tooth or teeth which have major decay or fracture. Inlays, onlays, and crowns are covered only when a less costly restoration would not restore the teeth (see Alternate Procedures for more information).

- Oral surgery: surgical procedures in and about the mouth. Surgery as a result of an accident is not covered; however, it may be covered by your medical plan.

- Endodontics, such as root canal work: procedures used for the prevention and treatment of diseases of the dental pulp (or root), excluding sedative bases or liners and implants.

- Periodontics: non-surgical and surgical procedures for treatment of the supporting area around the teeth. Root planing and scaling is an intensive cleaning of gums and teeth after periodontal treatment. Payment is based on how many quadrants are treated on the same day.

- Prosthodontics: services to replace 1 or more teeth except third molars (wisdom teeth), extracted while the patient is covered under the plan. This includes:

    — Initial installation of fixed bridge work, including inlays and crowns to form supports (abutments).

    — Initial installation of removable partial or full dentures, including adjustments during the 6-month period after they are installed.

    — Adding teeth to an existing removable partial denture or to bridge work because of additional extractions.

    — Installing a permanent full denture that replaces the teeth and is installed within 12 months of a temporary denture.

— Replacing an existing removable partial denture, full denture, or fixed bridge work, with a prosthesis of the same kind, provided the existing denture or bridge is at least 5 years old and cannot be made serviceable. The 5-year limitation is waived if additional extractions require replacement.

— Repairing or re-cementing inlays, crowns, bridge work, or dentures, or re-lining of dentures.

- Orthodontics: Services for the prevention and correction of malocclusion of teeth (crooked teeth).

- The maximum lifetime benefit payable for orthodontia is $1,250 for each covered person age 20 or over, or $1,650 for each covered person under age 20. This maximum is in addition to and separate and distinct from the plan's $1,400 per calendar-year maximum for regular dental benefits.

- Oral splints for non-surgical treatment of temporomandibular joint dysfunction (TMJ). The annual maximum benefit for oral splints for a covered person is $300 with a lifetime maximum benefit of $1,200.

- General anesthesia, when medically necessary and administered in connection with oral surgery. Anesthesia agents and local anesthesia are not covered expenses.

- Sealant coverage: 1 treatment per lifetime for participants age 13 and under. Benefits are limited to 1 application per tooth or per quadrant during the lifetime of the patient.

Location List

To find out what your scheduled allowances are for Type B services, follow these steps:

- Consult the location list to find out which schedule applies to you. It is keyed to the dentist's location.

- Refer to the Schedule of Payment for Services to determine benefits payable.

Dentist's location	**Use Schedule Number:**
Alabama	
Birmingham (ZIP codes beginning 352 only)	**2**
Decatur (ZIP codes beginning 356 only)	**2**
Northern Alabama (ZIP codes beginning 357 and 358 only)	**2**
City of Montgomery (ZIP codes beginning 361 only)	**2**
City of Mobile (ZIP codes beginning 366 only)	**2**
Remainder of state	**1**

Dentist's location	Use Schedule Number:
Alaska	**2**
Arizona	**2**
Arkansas	
City of Little Rock (ZIP codes beginning 722 only)	**2**
Remainder of state	**1**
California	
Greater Los Angeles (ZIP codes beginning 900–918 & 926–931 only)	**4**
Greater San Francisco (ZIP codes beginning 940–951 only)	**4**
Remainder of state	**3**
Colorado	
Greater Denver (ZIP codes beginning 800–803 only)	**3**
Remainder of state	**2**
Connecticut	
New London (ZIP codes beginning 063 only)	**2**
Waterbury area (ZIP codes beginning 067 only)	**2**
Remainder of state	**3**
Delaware	
City of Wilmington (ZIP codes beginning 198 only)	**3**
Remainder of state	**2**
District of Columbia	**3**
Florida	
Pensacola area (ZIP codes beginning 324–325 only)	**2**
Orlando area (ZIP codes beginning 327–329 only)	**2**
ZIP codes beginning with 332 only	**4**
Tampa/St. Petersburg (ZIP codes beginning 335–337 and 346 only)	**2**
Remainder of state (including ZIP code 349)	**3**
Georgia	
City of Atlanta (ZIP codes beginning 300, 302, and 303 only)	**3**

Dentist's location	Use Schedule Number:
Swainsboro, Augusta, Macon (ZIP codes beginning 304, 308, 310, 311)	**1**
Columbus (ZIP codes beginning 318, 319)	**1**
Remainder of state	**2**
Hawaii	**3**
Idaho	**2**
Illinois	
Chicago and area (ZIP codes beginning 600–606 only)	**3**
Remainder of state	**2**
Indiana	
Indianapolis area (ZIP codes beginning 460–462 only)	**2**
Gary, South Bend, Ft. Wayne, and surrounding areas (ZIP codes beginning 463–469, 471, and 473 only)	**2**
Remainder of state	**1**
Iowa	**1**
Kansas	**2**
Kentucky	
ZIP codes beginning 405, 406, 415, and 423 only	**2**
Remainder of state	**1**
Louisiana	
City of Baton Rouge (ZIP codes beginning 708 only)	**3**
Remainder of state	**2**
Maine	**1**
Maryland	**3**
Massachusetts	**2**
Michigan	
Detroit area (ZIP codes beginning 480–483 only)	**4**
Flint (ZIP codes beginning 485 only)	**3**
Lansing (ZIP codes beginning 489 only)	**3**
Grand Rapids (ZIP codes beginning 495 only)	**3**

Dentist's location	Use Schedule Number:
Remainder of state	**2**
Minnesota	
Minneapolis-St. Paul (ZIP codes beginning 551–554 only)	**2**
Remainder of state	**1**
Mississippi	
Northwest Mississippi (ZIP codes beginning 386)	**2**
Greenville area (ZIP codes beginning 387)	**2**
City of Jackson (ZIP codes beginning 391 and 392 only)	**2**
Southeast Mississippi (ZIP codes beginning 394 and 395 only)	**2**
Remainder of state	**1**
Missouri	
Greater St. Louis (ZIP codes beginning 630–633 only)	**2**
Greater Kansas City (ZIP codes beginning 640–641 only)	**2**
Remainder of state	**1**
Montana	**2**
Nebraska	
City of Omaha (ZIP codes beginning 681 only)	**2**
Remainder of state	**1**
Nevada	**4**
New Hampshire	**2**
New Jersey	
Southern New Jersey (ZIP codes beginning 080–084 only)	**2**
Remainder of state	**3**
New Mexico	**2**
New York	
Westchester & Putnam Counties (ZIP codes beginning 105–108 only)	**3**
Northern NY state (ZIP codes beginning 128, 129, and 136 only)	**1**
Southern NY state (ZIP codes beginning 127, 137–139, 147, 148, and 149 only)	**1**

Dentist's location	Use Schedule Number:
Remainder of state	**2**
North Carolina	
ZIP codes beginning 277, 278, 280, 282	**3**
Remainder of state	**2**
North Dakota	**1**
Ohio	
Greater Cleveland (ZIP codes beginning 440–441 only)	**3**
Greater Cincinnati (ZIP codes beginning 450–452 only)	**1**
Remainder of state	**2**
Oklahoma	
Oklahoma City area (ZIP codes beginning 730–731 only)	**2**
Tulsa area (ZIP codes beginning 740–741 only)	**2**
Remainder of state	**1**
Oregon	**2**
Pennsylvania	
City of Pittsburgh (ZIP codes beginning 152 only)	**3**
Remainder of state	**2**
Rhode Island	**2**
South Carolina	
Spartanburg area (ZIP codes beginning 293)	**1**
Florence/Myrtle Beach area (ZIP codes beginning 295)	**1**
Aiken area (ZIP codes beginning 298)	**1**
Remainder of state	**2**
South Dakota	**1**
Tennessee	
City of Nashville (ZIP codes beginning 370-372, 374, 376, 379 only)	**2**
City of Memphis (ZIP codes beginning 381 only)	**2**
Remainder of state	**1**

Dentist's location	Use Schedule Number:
Texas	
City of Houston (ZIP codes beginning 770–772 only)	**4**
Houston area, including Beaumont (ZIP codes beginning 773–777 only)	**3**
Dallas, Fort Worth, Waco (ZIP codes beginning 750–752, 760–761, 766–767 only)	**3**
Corpus Christi area (ZIP codes beginning 783–785 only)	**3**
City of Austin (ZIP codes beginning 787 only)	**3**
Lubbock area (ZIP codes beginning 793–794 only)	**3**
Remainder of state	**2**
Utah	**1**
Vermont	**1**
Virginia	
Washington, D.C., area (ZIP codes beginning 220–223 only)	**3**
Remainder of state	**2**
Washington	
Seattle, Tacoma (ZIP codes beginning 980–984 only)	**3**
Remainder of state	**2**
West Virginia	
Charleston area (ZIP codes beginning 250–253 only)	**2**
Wheeling area (ZIP codes beginning 260 only)	**2**
Remainder of state	**1**
Wisconsin	**2**
Wyoming	**2**
Outside U.S.A.	**2**
Note: Schedules reflect differences in dental benefits by geographic area.	

Type B Payment Schedule

Partial listing of schedules of allowances for Type B services most commonly performed. This list is not all-inclusive, so it's important to contact CIGNA directly to see how specific services are covered.

Services	**Schedules**			
Restorations	**1**	**2**	**3**	**4**
Sealant per tooth	12	14	17	21
Amalgam 1 surface primary or permanent	32	37	41	45
Amalgam 2 surfaces primary or permanent	43	48	57	63
Amalgam 3 surfaces primary or permanent	52	62	69	77
Amalgam 4 surfaces primary or permanent	62	70	83	91
Composite resin—1 surface	37	43	48	52
Composite resin—2 surfaces	48	57	63	70
Composite resin—3 surfaces	62	70	83	91
Inlay, metallic—1 surface	303	345	391	438
Inlay, metallic—2 surfaces	305	350	398	443
Inlay, metallic—3 surfaces	317	364	411	460
Onlay, metallic—4 surfaces	371	428	486	542
Crowns	**1**	**2**	**3**	**4**
Resin with noble metal	338	389	443	494
Porcelain/ceramic substrate	391	450	509	568
Porcelain fused to predominantly base metal	360	414	469	524
Porcelain fused to noble metal	363	420	471	528
Full cast high noble metal	371	427	482	537
Full cast noble metal	337	385	437	487
Prefab stainless steel crown primary	81	94	107	118
Pulp cap—direct (excluding final restoration)	19	23	26	29

Services	Schedules			
Root Canal Therapy	**1**	**2**	**3**	**4**
Anterior (excluding final restoration)	226	257	294	328
Bicuspid (excluding final restoration)	298	345	388	435
Apicoectomy/periradicular surgery—anterior	161	189	213	238
Apicoectomy/periradicular surgery—bicuspid first root	244	279	321	358
Periodontics	**1**	**2**	**3**	**4**
Gingivectomy or gingivoplasty—4 or more teeth per quadrant	145	165	189	210
Gingivectomy or gingivoplasty—1 to 3 teeth per quadrant	43	48	53	62
Osseous surgery—including flap entry and closure 4 or more contiguous teeth per quadrant)	358	411	464	518
Periodontal scaling and root planing (4 or more contiguous teeth or bounded teeth spaced per quadrant)	55	64	75	81
Prosthodontics	**1**	**2**	**3**	**4**
Complete dentures including 6 months' post-delivery care				
Complete upper	495	572	646	723
Complete lower	481	553	627	700
Immediate upper	520	600	678	758
Immediate lower	481	553	627	700
Partial dentures including 6 months' post-delivery care				
Upper—resin base (including any conventional clasps, rests, and teeth)	536	616	700	779
Lower—resin base (including any conventional clasps, rests, and teeth)	536	616	700	779
Upper—cast metal framework with resin denture bases including any conventional clasps, rests, and teeth	518	596	675	755
Lower—cast metal framework with resin denture bases including any conventional clasps, rests, and teeth	504	582	660	735
Removable unilateral partial denture—1 piece cast metal (including clasps and teeth)	311	361	411	457

Services	Schedules			
Bridge pontics	**1**	**2**	**3**	**4**
Cast high noble metal	354	408	462	516
Porcelain fused to noble metal	353	407	460	515
Porcelain fused to high noble metal	371	427	483	542
Resin with noble metal	349	399	452	504
Oral surgery	**1**	**2**	**3**	**4**
Extraction—erupted tooth or exposed root (elevation and/or forceps removal)	32	39	43	48
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	58	67	76	84
Removal of impacted tooth (soft tissue)	96	110	124	141
Removal of impacted tooth (partially bony)	130	149	171	189
Removal of impacted tooth (completely bony)	156	177	202	226
General anesthesia (first 30 minutes)	118	134	149	171
Orthodontics (maximum lifetime benefit $1,250 for covered persons age 20 or over, and $1,650 for covered persons under age 20)	**1**	**2**	**3**	**4**
Appliances for tooth guidance fixed or removable	202	234	264	294
Comprehensive orthodontic treatment Preliminary study, including X-rays, etc., and treatment plan	122	140	160	177
Initial placement of full banded braces	624	718	811	906
Active full banded treatment per month after initial placement of braces	77	89	101	111

Dental Terms

Abutment: Terminal tooth or root that retains or supports a bridge or a fixed or removable prosthesis.

Anesthesia:

Local: The condition produced by the administration of specific agents to achieve the loss of conscious pain response in a specific location or area of the body.

General: The condition produced by the administration of specific agents to render the patient completely unconscious and completely without conscious pain response.

Anterior Teeth: Front 8 teeth on upper or lower jaw. Includes incisors and cuspids (canines).

Appliance: A device used to provide function or therapeutic (healing) effect.

Fixed: 1 that is cemented to the teeth or attached by adhesive materials.

Prosthetic: 1 used to provide replacement for a missing tooth.

Bitewing: Dental X-ray showing approximately the coronal (crown) halves of the upper and lower jaw.

Bridgework:

Fixed: Partial denture retained with crowns or inlays cemented to the natural teeth, which are used as abutments.

Fixed-removable: 1 which the dentist can remove but the patient cannot.

Removable: A partial denture retained by attachments which permit removal of the denture, normally held by clasps.

Crown: Placed over tooth when large portion of a tooth is lost to decay or has broken off and cannot be repaired by a filing.

Dental hygienist: A person who has been trained and licensed to remove calcareous deposits and stains from the surfaces of the teeth (clean your teeth), and to provide additional services and information on the prevention of oral disease.

Dentist: A person duly licensed to practice dentistry by the governmental authorities having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered. As used in this dental expense plan, the term “dentist” also includes a licensed physician authorized by his license to perform the particular dental service he or she has rendered.

Denture: A device replacing missing teeth.

Fixed bridge: A prosthesis which replaces 1 or several teeth and which is cemented in place in the mouth. It consists of 1 or more pontics held in place by 1 or more retainers on the abutment teeth.

Fluoride: A solution of fluorine which is applied topically to the teeth for the purpose of preventing dental decay.

Impression: A negative reproduction of a given area. Example: In bridge work, an impression of a tooth (abutment) is used to prepare it for an inlay or a crown.

Inlay: A restoration made to fit a prepared tooth cavity and then cemented onto place.

Malocclusion: An abnormal relation of the opposing teeth when brought into habitual opposition (commonly thought of as crooked teeth or an abnormal bite).

Onlay: An occlusal rest or restoration that is extended to cover the entire surface of the tooth. It often is used to restore lost tooth structure and increase height of tooth.

Orthodontics: The branch of dentistry primarily concerned with the detection, prevention, and correction of skeletal or dental malocclusions. Commonly, straightening teeth.

Partial denture: A prosthesis that replaces 1 or more, but less than all, of the natural teeth and associated structures and that is supported by the teeth and/or the gums; may be removable or fixed, 1 side or 2 sides.

Periapical: Enclosing or surrounding the tissues and bony sockets of the teeth.

Posterior Teeth: Back teeth in the mouth behind the canines (bicuspids and molars).

Pontic: The part of a fixed bridge which is suspended between the abutments and which replaces a missing tooth or teeth.

Prophylaxis: The removal of tartar and stains from the teeth; cleaning of teeth by a dentist or dental hygienist.

Prosthesis: An artificial replacement of 1 or more natural teeth and/or associated structures.

Restoration: A broad term applied to any inlay, crown, bridge, partial denture, or complete denture that restores or replaces loss of tooth structure, teeth or oral tissue; the term applies to the end result of repairing and restoring or reforming the shape, form and function of part or all of a tooth or teeth.

Root canal therapy (endodontic therapy): Treatment of a tooth having a damaged pulp or root; usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with sealing material.

Scale: To remove calculus (tartar) and stains from teeth with special instruments.

Topical: Painting the surface of teeth, as in fluoride treatment, or application of a cream-like anesthetic formula to the surface of the gum.

What's Not Covered

Here are examples of expenses that the plan does **not** cover. This list isn't exhaustive.

- Work done primarily for appearance or cosmetic purposes, including facings on crowns and bridges farther back than the second bicuspid.
- Work done while you were not covered under this plan, except as provided under an extension of benefits provision.
- Replacement of teeth removed before coverage is effective. Fees for services that are in excess of reasonable and customary charges.
- Appliances, restorations, and procedures to alter vertical dimension and restore occlusion, including temporomandibular joint dysfunction or TMJ, except oral splints.
- Replacing lost or stolen appliances.
- Extra sets of dentures or other appliances.
- Work that is otherwise free of charge to patients.
- Work that is furnished or payable to the armed forces of any government.
- Services or supplies not necessary for proper dental care.
- Broken appointments.
- Completion of claim forms or filing claims.
- Educational training programs, dietary instructions, or plaque control programs.
- Implantology (implants).
- Hospitalization for dental treatment, either inpatient or outpatient.
- Additional charges beyond those for a comparable less costly alternate treatment.
- Treatment resulting from declared or undeclared war, insurrection, participation in a riot, or service in the armed forces of any government.
- Work that is payable under Workers' Compensation or similar laws.
- Services covered by any other health plan of this company.
- Anesthesia, except general anesthesia, when medically necessary in connection with oral surgery.
- Drugs or their administration.

- Experimental procedures.
- Services received as a result of accidental injury to teeth. (Accidental injury expenses may be covered under the Medical Assistance Plan.)

Your payments for excluded expenses can't be used to satisfy your deductible.

If you have any questions about whether an expense is covered, contact the plan directly.

Pretreatment Estimate of Benefits

Definition of a Pretreatment Estimate

A pretreatment—or predetermination—estimate allows you to find out, before you incur any expenses:

- Estimated cost for treatment
- Estimated benefit payment
- Possible alternative treatments that may be more cost-effective

A pretreatment estimate doesn't guarantee benefits from the plan. However, it can help you understand more about how the plan works for your specific need so you can make an informed decision about treatment.

When to Request an Estimate

You should request a pretreatment estimate in either of these situations:

- A procedure is expected to cost more than $200.
- You don't know if the procedure is covered under the plan.

How to Get an Estimate

To request a pretreatment estimate, you and your dentist need to complete a claim form and submit it to your plan. It's the same form with the same instructions that you use to file a claim after receiving services.

You can print a claim form from ***Benefits@Your Fingertips*** or request 1 by calling the plan administrator.

Filing Dental Plan Claims

How to File a Claim

You need to file a claim for all dental expenses. You can print a claim form from ***Benefits@Your Fingertips*** or request 1 by calling CIGNA, the plan administrator.

If you request a pretreatment estimate of benefits, the form you fill out for the estimate also serves as your claim form. Just add the itemized bill to it after you receive treatment.

The instructions on the claim form should be followed carefully. Be sure all questions are answered fully and any required statements and bills are submitted with the claim form.

Claims should be filed within 90 days after you have the dental services performed. Claims received 1 year after the date of service will not be accepted, nor will benefits be paid.

If you use 1 of the network providers in the passive PPO, you don't have to file a claim. The provider will file the claim for you.

Medical Necessity

To be an eligible expense under the plan, every treatment, service, or supply must be a medical necessity as determined by the plan. A treatment, service, or supply is usually a medical necessity if it's:

- Consistent with and appropriate for the condition
- Of proven value and not redundant with other procedures
- Not experimental or investigational
- Approved by the U.S. government, if required

Dental Claims Review/Appeal Process

This summary explains how CIGNA processes dental claims and how you can appeal a partial or complete denial of a claim.

The following claims and appeal procedures are designed to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

You must act on your own behalf or through an authorized representative if you wish to exercise your rights under this summary. An authorized representative is someone you designate in writing to act on your behalf. CIGNA has developed a form that you must use if you wish to designate an authorized representative. You can get the form by calling CIGNA at 1-800-251-6401. If a person is not properly designated as your authorized representative, CIGNA will not be able to deal with him or her in connection with the exercise of your rights under this summary.

Dental Claims

What Constitutes a Claim

For you to obtain benefits after dental services have been rendered, CIGNA must receive a properly completed and filed claim from you or your provider.

In order to treat a submission by you or your provider as a claim, it must be submitted on a properly completed standardized claim form or, in the case of electronically filed claims, it must be provided with the data elements that CIGNA specifies in advance. Most providers are aware of CIGNA claim filing requirements and some will file claims for you. If your provider does not file your claim for you, you should call CIGNA and ask for a dental claim form. When you receive the form, complete it, attach an itemized bill, and send it to:

CIGNA
P.O. Box 188037
Chattanooga, TN 37422-8037

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

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

Processing of Claims

Even if CIGNA has received all of the information that is needed in order to treat a submission as a claim, from time to time additional information may be needed in order to determine whether the claim is payable. The most common example of this is x-rays. If CIGNA needs this sort of additional information, they will ask you to furnish it to them, and they will suspend further processing of your claim until the information is received. You will have 90 days to provide the information to CIGNA. In order to expedite their receipt of the information, they may request it directly from your provider. If they do this, you will receive you a copy of their request. However, you will remain responsible for seeing that CIGNA get the information on time.

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

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

Who Gets Paid

Some of the contracts CIGNA has with providers of services require them to pay benefits directly to the providers. With other claims CIGNA may choose whether to pay you or the provider. If you or the provider owes CIGNA money they may deduct the amount owed from the

benefit paid. When they pay or deduct the amount owed from you or the provider, this completes their obligation to you under the plan. CIGNA need not honor an assignment of your claim to anyone. Upon your death or incompetence, or if you are a minor, they may pay your estate, your guardian or any relative they believe is due to be paid. This, too, completes our plan obligation to you.

Courtesy Pre-Determinations of Treatment Plans

CIGNA encourages, but does not require, you or your provider to submit a treatment plan to them for a courtesy pre-determination of benefits. In either case, courtesy pre-determinations are not claims under the plan. When CIGNA processes requests for courtesy pre-determinations, they are not bound by the time frames and standards that apply to claims.

Your Right to Information

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

Member Satisfaction

If you are dissatisfied with CIGNA's handling of a claim or have any questions or complaints, you may do 1 or more of the following:

- You may call or write the CIGNA Dental Appeals Division. They 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.

Reviews

Prior to January 1, 2003, you or your authorized representative could request a review of a post-service claim by calling or writing to CIGNA. This initial review was not considered a formal ERISA appeal. If you disagreed with the results of the review, you could still exercise your appeal rights under ERISA. As a result of the new Department of Labor rules, effective January 1, 2003, a written request for a review must be considered exercising your ERISA appeal rights (subject to proper submission of information as outlined below). You may still call to inquire about your post-service claims by phone. If CIGNA is unable to answer your questions at the time of your call, they will respond to your request by return phone call.

Appeals

In General

The rules in this section of the summary allow you or your authorized representative to appeal any adverse benefit determination. An adverse benefit determination means any determination CIGNA makes with respect to a claim that results in your owing any money to your provider other than copayments you make, or are required to make, to your provider.

You have 180 days following their adverse benefit determination within which to submit an appeal.

How to File an Appeal

Your appeal must be in writing and your written documentation must clearly indicate that you are submitting an appeal. Make sure you use the word "appeal" in your letter. Send written requests for review of any denied claim or any other disputed matters as follows:

CIGNA Dental Appeals Division
P.O. Box 188044
Chattanooga, TN 37422-8044

The person sending a request has the right to:

- Review pertinent plan documents. You may get these documents by following the procedure outlined in the "Plan Documents" section.

- Send the claims administrator a written statement and any other documents in support of your claim for benefits or other matters under review.

The claims administrator will provide you a written response to the appeal within 90 days after it is received. If your claim is again denied, you may have further rights under ERISA; see the "Your Rights Under ERISA" section for more information.

Conduct of the Appeal

CIGNA will assign your appeal to 1 or more persons within their organization who are neither the persons who made the initial determination nor subordinates of those persons. If resolution of your appeal requires them to make a medical judgment (such as whether services are dentally necessary), they will consult a healthcare professional who has appropriate expertise. If CIGNA consulted a healthcare professional during their initial decision, they will not consult that same person or a subordinate of that person during their consideration of your appeal.

If CIGNA needs more information, they will ask you to provide it to them. In some cases they may ask your provider to furnish that information directly to them. If they do this, they will send you a copy of their request. **However, you will remain responsible for seeing that CIGNA receives the information.** If they do not receive the information, it may be necessary for them to deny your appeal.

CIGNA will consider your appeal fully and fairly.

Time Limits for Consideration of Your Appeal

CIGNA will notify you of their decision within 60 days of the date on which you filed your appeal.

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

If You Are Dissatisfied

If you have filed an appeal and are dissatisfied with our response, you may do 1 or more of the following:

- You may ask CIGNA 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 CIGNA has given you their appeal decision and you are still dissatisfied, you may file a second appeal (called a voluntary appeal). Voluntary appeals must be in writing, and must be submitted to the following address:

CIGNA Dental Appeals Division
P.O. Box 188044
Chattanooga, TN 37422-8044

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

If you file a voluntary appeal, CIGNA will not assert in court a failure to exhaust administrative remedies if you fail to exhaust the voluntary appeal. CIGNA 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, CIGNA will not impose any fees or costs on you as part of your voluntary appeal.

You may ask CIGNA 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.

Subrogation and Right of Recovery

If you recover any charges for covered expenses from a third party, BellSouth has the right to recover any benefits it has paid you already. This also applies if any claim or benefit is overpaid. For more information, refer to “Situations Affecting Your Benefits” on page 152.

Supplemental Transplant Assistance Plan (STAP)

IMPORTANT NOTE

The Supplemental Transplant Assistance Plan was terminated as of December 31, 2006, and any assets remaining in the STAP trust (once all claims have been processed) will be merged into the trusts that support BellSouth's medical plans. Effective January 1, 2007, transplants formerly covered under STAP will be covered by the PPO, POS, and Basic Indemnity medical options. HMOs/EPOs may cover the same or similar transplants. In addition, most medical options (except the HMOs/EPOs) have expanded their transplant coverage to include limited transplant-related travel benefits. Check with your medical option administrator for a complete list of covered transplants.

If you had a transplant prior to December 31, 2006, that was covered by STAP, you will be eligible for covered services related to your transplant. Participants who were on the waiting list for a transplant under STAP as of December 31, 2006, will be eligible for the same covered services through the PPO, POS, or Basic Indemnity medical options.

All provisions of your medical option will apply to transplant services, including but not limited to eligibility, enrollment, deductibles, copayments, coinsurance, and the claims/appeal process.

Special Rules for Participating in STAP

For Former Represented Employees

If you were enrolled in STAP as an active employee, you may continue your STAP coverage during retirement until the first day of the month in which you reach age 65. Utility Operations employees were not eligible as active employees but will have the opportunity to enroll in STAP as a retiree. ND/CA employees were not eligible as active employees but may have the opportunity to enroll in STAP as a retiree.

For Former Management Employees

As a management employee, when you retire with a service pension from a company that offers post-retirement medical benefits, you will automatically be enrolled in STAP if you are under age 65 at the time you retire. If you do not wish to participate in STAP, you may decline coverage. If you do decline coverage, you will not be able to enroll for coverage at a later date.

How Long Coverage May Continue

If you have STAP coverage as a retiree, your coverage will continue until the first day of the month in which you reach age 65. At that time, STAP coverage for you and your eligible dependents will end. If an eligible dependent attains age 65 before you do, his or her coverage will end on the first day of the month in which age 65 is attained. You may pay your premiums for coverage through deductions from a monthly pension check or by direct billing.

How the Plan Works

The Supplemental Transplant Assistance Plan (STAP) provides coverage for specific human organ and tissue transplants not covered under your medical option's standard benefits. If your medical option does not cover specific human organ and tissue transplants through its standard benefits, your medical option will cover STAP-covered transplants and transplant-related procedures and services through STAP.

Benefits apply to STAP-covered transplants and transplant-related procedures and services, including all medical expenses directly associated with any procedures related to transplant protocols.

Under STAP, covered charges include medical expenses for treatment directly associated with illness or injuries that require the following tissue or organ transplants:

- Heart/lung combined procedure
- Liver
- Lung
- Pancreas
- Autologous bone marrow transplants for the treatment of breast cancer, testicular cancer, colon cancer, solid brain tumor malignancies, lung cancer, lymphoma, neuroblastoma, multiple myeloma, and ovarian cancer
- Peripheral stem cell transplants (not covered under MAP) for the treatment of breast cancer, testicular cancer, colon cancer, solid brain tumor malignancies, lung cancer, lymphoma, neuroblastoma, multiple myeloma, and ovarian cancer

The tissue and organ transplants listed above will be covered by STAP if the following requirements are met:

- The patient must be faced with a life-threatening illness. All conventional therapies must have been performed but did not cure or lessen the medical situation.
- The transplant must have a reasonable probability of success, which will lead to a higher quality of life.
- There must be no pre-disposing factors that would affect the probability of success (i.e., history of chronic alcoholism without having successfully completed rehabilitation and being substance free for at least 1 year for recipients of a liver transplant).

Precertification

Precertification is required in order to take full advantage of the benefits available under the plan. Call your medical option to have your procedure precertified.

If you are enrolled in an HMO, EPO, POS, PPO, or Indemnity Basic Plan When Medicare is Primary option, you must be precertified for a transplant procedure. To the extent that benefits for a covered transplant are not paid by your medical plan option, they will be paid by STAP.

If your hospital admission for the transplant surgery or treatments is not precertified by your medical option, any STAP benefits that are payable will be reduced by the $250 precertification penalty for non-compliance and reimbursement will be made at 80% of covered charges for facility and 80% R&C for all other services.

Remember, your health plan member services department is available to assist you and your covered dependents in securing maximum STAP benefits. Your decisions regarding your medical care are to be made by you and your physicians.

Benefits for Covered Services Under STAP

Inpatient Hospital Services

STAP-covered inpatient hospital services include:

- Room and board.
- Use of the operating, delivery, and recovery rooms plus special equipment.
- General nursing care.
- Laboratory tests and X-rays.
- Special diets.
- Physician and rehabilitative therapy.
- Administration of blood.

Outpatient Hospital Services

Charges for services associated with covered transplant procedures provided by an ambulatory surgical facility or hospital outpatient department must be precertified if an invasive procedure is involved.

How Benefits Are Paid for Facility Charges

Benefits for in-network facility charges are covered at 100% of covered charges. Benefits for out-of-network facility charges are paid at 80% of covered charges.

Services not precertified will result in the $250 precertification penalty for non-compliance and payment at 80% of covered charges for facilities and 80% of R&C charges for all other services.

Remember, the decisions concerning treatment and location of treatment are always up to you and your physician.

Physician/Surgeon Care Benefits

Covered services provided by physicians will be reimbursed as follows—up to STAP benefit period and lifetime maximums:

In-Network Physicians	100% of covered charges
Out-of-Network Physicians	80% of R&C charges

Mental and Nervous Care Benefits

Any pre- and post-transplant psychiatric evaluation and/or treatment of either the patient or the family will be applied toward the lifetime maximum under STAP. **These benefits apply only to therapy required as part of the transplant procedure.**

All expenses related to "mental and nervous care" must be precertified by your case manager. If the therapy is not precertified, the expenses are **not covered** under STAP and may not be eligible for reimbursement under any other BellSouth plan. All "mental and nervous" services will be reviewed to determine if the care is related to the transplant.

Remember, all decisions relating to the treatment of mental or nervous conditions are up to you and your physician.

Prescription Drug Benefits

Prescription drug expenses will be provided under your current medical plan drug program (retail pharmacy or mail order program).

STAP reimburses 100 percent of reasonable and customary charges for covered prescription drugs purchased from any pharmacy.

Plan Exclusions

Although STAP covers a broad range of services and supplies, there are items that are excluded and not covered. These exclusions include, but are not limited to:

- Expenses due to a pre-existing condition.
- Charges for any services received prior to STAP's effective date.
- Expenses covered under another BellSouth medical option.
- Charges paid or payable under the laws of any country or for which you have no legal obligation to pay.
- Over-the-counter drugs, even if prescribed.
- Charges in excess of those considered reasonable and customary.
- Charges for any surgery or medical treatment, including drugs, which are not directly related to the transplantation process covered under STAP.
- Charges for in-hospital personal services (i.e., radio and television rentals, barber, etc.).
- Charges for custodial care, respite care, or rest cures.
- Charges above STAP limits.
- Any penalty applied for non-compliance; such as failure to precertify a procedure.

- Charges related to a transplant procedure not specifically listed in "How the Plan Works" above.

STAP is intended to reimburse you for medically necessary expenses incurred in the treatment of covered transplants. Any charges for care, treatment, services or supplies that are not determined to be medically necessary for the treatment of the transplants covered under the plan, or which are provided solely for your convenience, are considered exclusions.

Coordination of Benefits

STAP coordinates its benefits with a company-paid plan that provides the primary coverage for a STAP transplant. The STAP plan will provide secondary benefits up to 100 percent of the cost of covered procedures and charges up to plan limits and maximums.

Note: There is coordination of benefits between BellSouth sponsored plans.

Benefit Periods and Maximum

STAP benefits apply only to STAP-covered transplants and transplant-related procedures and services, including all medical expenses directly associated with any procedures related to transplant protocol (i.e., candidacy screening).

For example, a benefit period for a covered bone marrow transplant generally begins on the date of the first Myelo Ablative Therapy. Some expenses, such as therapy prior to harvesting, may be covered under another BellSouth medical option. Such payments under another medical option do not apply toward STAP limits.

The STAP benefit maximum is $500,000 per lifetime, per participant.

How to File a Claim

Once coverage begins, you can apply for benefits as soon as you incur covered expenses.

Claims must be filed by you or your provider within 12 months of receiving services.

Claims should be filed through your medical option.

Claims Review/Appeal Process

How to Appeal Denied Claims

If a claim for benefits is denied, you have the right to appeal the claim's denial. The process for appealing a denied claim, and the address to which appeals should be sent, will vary depending on the type of claim and the reason for the denial.

Eligibility

If a claim is denied on the basis that you or a dependent is not eligible for coverage, your appeal should be directed to the Director Benefits c/o the BellSouth Benefits Service Center.

Please see the section entitled "Other Plan Matters" in the Administrative section for more information.

Benefits Payable

If a claim is denied on the basis that an expense or service is not a covered expense, or you do not agree with how a benefit was calculated for an expense, your appeal should be directed to the medical option administrator. BellSouth has delegated complete discretionary authority to each option administrator to make all benefits determinations, to interpret the terms and provisions of the medical option they administer, and to provide a review procedure for denied claims. Their decisions and interpretations are final and conclusive. To find the appeal procedures for your medical option, refer to the summary plan description issued by the medical option administrator. To access this information, from the home page of ***Benefits@Your Fingertips*** select "Health Care," then select "Medical," and on the medical page, under "Learn about Your Medical Benefits," select "View and Print Your Summary Plan Description."

BellSouth Group Life Plan for Retirees

How the Plan Works

The BellSouth Group Life Plan for Retirees pays benefits to your beneficiary if you die and are covered by the plan. Your beneficiary will need to file a claim. Stevens Graphics represented employees, Utility Operations, and some National Directory Assistance retirees are not eligible for company-paid life insurance during retirement.

Your retiree benefit under the Group Life Insurance Plan is determined by:

- Your employee status
- Your type of pension benefit
- Your retirement date

Your Basic (Company-Provided) Life Insurance

For Retired Represented Employees who Retired Before January 1, 1992 and Retired Management Employees

If you retired with a service pension, BellSouth provides you with the amount of basic life insurance coverage you had as of your retirement date. If you continue working after age 65, your coverage at retirement will be equal to 1 times your benefits pay at age 65.

The company pays the full cost for coverage.

Your benefit will be reduced after you reach age 66 and each year on your birthday through age 70, as described on page 121.

For Retired Represented Employees Who Retired After December 31, 1991

If you retired with a service pension, BellSouth provides you with life insurance coverage of $15,000 during your retirement. The company pays the full cost for coverage.

One-Time Opportunity to Purchase Additional Coverage

Through the Optional Retiree Coverage, you will have a 1-time opportunity to purchase coverage equal to the difference between your active coverage and $15,000 rounded up to the nearest $5,000 but not more than $50,000 without having to provide evidence of insurability. For example, if you had $52,000 of life insurance as an active employee, you could purchase an amount equal to $52,000 minus $15,000 ($37,000) rounded up to the nearest $5,000, which is $40,000. You must enroll for this coverage within 75 days of your retirement date.

You may also be able to purchase additional coverage by providing evidence of insurability. The amount you may be able purchase by providing evidence of insurability is $50,000 minus the amount you can purchase without insurability. For example, if you can purchase $40,000 of optional retiree coverage without evidence of insurability, you may apply for up to $10,000 ($50,000–$40,000) of coverage by providing evidence of insurability.

This additional coverage is not part of the BellSouth Group Life Plan.

Your Optional (Employee-Paid) Life Insurance

For Retired Management and Represented Employees Who Retired After December 31, 2005

If you were purchasing optional employee life insurance coverage through the BellSouth Group Life Plan on your last day of active employment, you will be able to keep (port) this optional coverage when you retire. You must apply for this coverage within 31 days of your retirement date. Cost is based on the insurance company's portability rates and your age. Coverage reduces at age 65 to 60% of the original amount, and again reduces at age 70 to 50% of the original amount. Coverage terminates automatically at age 80. Ported coverage is not part of the BellSouth Group Life Plan.

If you were purchasing optional employee life insurance coverage as well as spouse or child coverage, you will be able to port these coverages if you also port your optional employee life coverage. See page 27 for portability rules for the BellSouth Group Life Plan.

Assignment of Benefits

You can make an absolute assignment of your life insurance benefits, as described on page 122. When you do, you give the named person or entity (such as a trust) the authority to make all decisions relating to your life insurance benefits.

You may also enter into an agreement with a viatical company to pay a portion of your death benefit in advance of your death.

Accelerated Death Benefit

If you have a life expectancy of 12 months or less and your retiree life insurance coverage is $10,000 or more, you can request an accelerated benefit from the BellSouth Group Life Plan, as described on page 123.

- You'll receive up to 75% of your life insurance coverage benefit, up to $500,000.
- Once you receive the accelerated benefit, your total benefit is reduced by the amount you receive.

Payment is made directly to you. The benefit is paid in a lump sum.

When you die, your beneficiary will receive the remaining balance of the life insurance benefit.

This feature isn't available if you assign your benefits.

For more information or application forms, contact the insurance company.

Reductions

Your retiree life insurance coverage decreases 10% per year from ages 66 through 70. (No reductions apply to the $15,000 benefit for Represented employees who retired on or after January 1, 1992.)

Each reduction takes effect on your birthday.

If you're over age 66 at the time of your retirement, your coverage amount is reduced at your next birthday after you retire to catch up the reductions. Reductions are calculated using your benefits pay at the time you retired or at age 65 if you worked past age 65.

Your coverage is reduced as follows:

When You Reach Age:	**Your Original Coverage Amount is Reduced by this Amount:**
66	10%
67	20%
68	30%
69	40%
70	50%

For example, if your 1 times pay coverage is $50,000 at age 65:

- At age 66, your coverage will reduce to $45,000.
- At age 67, your coverage will reduce to $40,000.
- At age 68, your coverage will reduce to $35,000.
- At age 69, your coverage will reduce to $30,000.
- At age 70, your coverage will reduce to $25,000.

Naming Life Insurance Beneficiaries

Your Beneficiaries

You'll need to name 1 or more primary beneficiaries for your BellSouth life insurance benefits.

You also can name 1 or more secondary beneficiaries who'll receive plan benefits if all primary beneficiaries die before you.

Your beneficiary choices for the Group Life Insurance Plan take effect when you submit them on ***Benefits@Your Fingertips*** or call the BellSouth Benefits Service Center.

Beneficiary elections made prior to July 1, 2003 will be cancelled after February 28, 2006 and you will be considered as not having a beneficiary on file unless you make or have made a designation since July 1, 2003.

You can add or change your beneficiary for the Group Life Insurance Plan at any time on ***Benefits@Your Fingertips*** or call the BellSouth Benefits Service Center.

If you die and don't have a beneficiary on file, or if your primary and secondary beneficiaries have died before you, the benefit will be paid according to the plan's rules. See page 124 for more information.

Absolute Assignment

You can make an absolute assignment for your retiree life insurance benefit.

When you make an absolute assignment, you are making an irrevocable gift assignment of your life insurance benefit. This means you are naming someone else as the owner of your life insurance coverage even though it's your life that is covered.

By making an assignment, you give up all incidents of ownership, including but not limited to, all rights of coverage, title, claim, interest, and benefit, both present and future, with respect to your coverage and all other coverage under the plan

After you make an absolute assignment, you cannot revoke the assignment at a later date nor can you change your coverage options or beneficiaries. The person to whom you assign your coverage has the absolute and continuing right to name beneficiaries or to exercise any other privileges which otherwise would have been available to you. You are responsible for continued payment of any required premiums.

Because of the legal and tax implications, you may wish to contact your tax or estate planning advisor before making an assignment.

You can request an absolute assignment form by calling the BellSouth Benefits Service Center.

Accelerated Death Benefit

If you become terminally ill while covered under this plan, you may request the insurance company to pay an accelerated benefit. Upon the insurance company's approval of your request, it may pay you up to 75% of your life insurance coverage amount, up to $500,000.

For the purposes of this provision, a person is considered terminally ill if the person:

- Suffers from an incurable, progressive and medically recognized disease or condition; and
- To a reasonable medical probability and based on a generally accepted prognostic protocol, will not survive more than the 12 months beyond the date of the request for an accelerated benefit.

Requesting an Accelerated Benefit

You may request an accelerated benefit at any time by contacting the BellSouth Benefits Service Center. You will be provided with the necessary forms to complete. An accelerated benefit can only be granted once, but there is no limit on the number of times you may re-apply if denied. Benefits cannot be accelerated if coverage has been assigned.

Your written request must include the statement of a currently licensed United States physician that you are terminally ill.

Your request for an accelerated benefit may be denied if:

- Prior to the insurance company's approval of your request, the life insurance plan is terminated for your eligible class of employees (even though all or part of your life insurance coverage continues for any reason); or
- The entire amount of life insurance ceases under the life insurance plan for any reason; or
- Prior to payment of the accelerated benefit, you die.

Upon approval by the insurance company, the amount of the accelerated benefit will be paid to you in a lump sum.

To the extent allowed by law:

- Any accelerated benefit paid to you is exempt from any legal or equitable process for your debts or the debts of your spouse/partner; and
- You will not be required to request an accelerated benefit in order to satisfy claims of creditors.

Your Life Insurance Amount after an Accelerated Benefit Has Been Paid

When your request for an accelerated benefit has been approved, the amount of life insurance then in force will be reduced by the accelerated benefit amount. Once the life insurance has been so reduced, you will not be entitled to convert the amount of life insurance that ceases because of the reduction by the accelerated benefit amount.

If your life insurance amount is subject to a scheduled reduction under the retirement rules

within the life expectancy of 12 months, your accelerated death benefit is based on the life insurance amount your coverage will be reduced to.

For example, suppose your original coverage amount is $50,000. If a 10% reduction would apply within 12 months of your accelerated death benefit application date, your accelerated death benefit would be 75% of $45,000 ($50,000 minus the 10% reduction amount of $5,000).

Seek Legal or Tax Advice

While the life insurance company cannot provide legal or tax advice to you or BellSouth, you should carefully consider the tax consequences of requesting an accelerated benefit. The amount of an accelerated benefit may be subject to income tax upon receipt. (Effective January 1, 1997, federal law excludes from taxable gross income the amount of any accelerated benefits that are paid on account of terminal illness.) You should consult your legal counsel or tax advisor before you request an accelerated benefit.

How Benefits Are Paid

Life insurance benefits will be paid as soon as the necessary written proof to support a claim is received.

Any life insurance benefit in the event of your death will be paid in accordance with your beneficiary designation. Payment will be made in 1 lump sum unless your beneficiary elects an installment method which has been agreed to by the insurance company. The methods of settlement allowed will be those offered by The Prudential Insurance Company of America (Prudential) under the individual life insurance policies Prudential is issuing when the payment election is made.

If a named beneficiary dies before you, his or her share will be payable in equal shares to any other named beneficiaries who survive you.

If there is no living beneficiary named at the date of your death, the insurance company will pay the death claim proceeds to the first of the following survivors of the insured person:

- Your surviving spouse, if any;
- Your surviving children equally, if there is no surviving spouse;
- Your surviving parents equally, if there is no surviving spouse or child;
- Your surviving brothers or sisters equally, if there is no surviving spouse, child, or parent; or
- Your estate.

Filing Life Insurance Claims

Life Insurance Claims

If you die, your next of kin or beneficiary should notify the BellSouth Benefits Service Center of your death.

Once the BellSouth Benefits Service Center has been contacted, your insurer will be notified. The insurer will outline the steps to take to claim benefits, including providing a certified copy of the death certificate. You or your beneficiary must submit a claim within 90 days of the death.

Accelerated Death Benefit Claims

Contact the BellSouth Benefits Service Center to initiate a claim.

Claim Review/Appeal Process

Appeal Procedures

If a claim for benefits is denied, in whole or in part, you, your beneficiary or beneficiaries will receive written notification from The Prudential Life Insurance Company of America (Prudential). This written notification will include:

- The specific reason for the denial;
- Specific reference to pertinent provisions (plan or law) on which the denial is based;
- A description of any additional material or information necessary for further review of the claim and an explanation of why such material or information is necessary; and
- Appropriate information on the steps to take if you, your beneficiary or beneficiaries or a duly authorized person representing you or your beneficiary or beneficiaries wish to submit the claim for review.

Prudential shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and the date by which the plan expects to decide your claim shall be furnished to you within the initial 45-day period. This 30-day extension may be extended by an additional 30-day period if necessary.

If a claim for benefits is denied or you or your beneficiary(ies) feel you have been treated unfairly with respect to the plan, you, your beneficiary(ies) or other duly authorized person may appeal the denial or other action in writing within 180 days of the date of the denial.

Written request for review of any denied claim or other disputed matter should be sent directly to Prudential.

The person sending the request has the right to:

- Review pertinent plan documents which may be obtained by following the procedures described in the Plan Documents section; and

- Send to Prudential a written statement of the issues and any other documents in support of the claim for benefits or other matters under review.

Prudential will provide a written response to the appeal within 60 days of receipt with the option to take a 45-day extension to review the appeal. However, Prudential has the exclusive right to interpret the provisions of the plan, so its decision is conclusive and binding. In any case, as a participant or a beneficiary(ies) of a participant in the plan, you may have further rights under the Employee Retiree Income Security Act of 1974 (ERISA). (See “Your Rights under ERISA”.)

Changing Your Coverage

Rules for Changing Coverage

Federal laws set specific rules about the types of coverage changes employees can make in most benefit plans during the year.

After you enroll in (or decline) coverage, your choices generally stay in effect for the rest of the plan year (January 1 through December 31).

However, in special circumstances called qualified changes in status, you can enroll in coverage or change your choices in most plans during the plan year.

Qualified Changes in Status

During the plan year, you can change your benefit coverage if a qualified change in status affects your or your dependents' eligibility under the BellSouth plans or another employer's plans.

If you're eligible to make coverage changes, your changes must be consistent with the change in status. They must also match any changes your spouse/partner or child makes to his or her coverage under another employer's plans.

These situations qualify as a change in status:

- Your legal marital status changes.
    - — You get married.
    - — You get divorced, or legally separated, or have your marriage annulled.
    - — Your spouse dies.
- The number of your eligible children changes.
    - — You have or adopt a child.
    - — Your child gains or loses eligibility for coverage under the Health and Insurance Plans (including gains or loses caused by a change in legal custody)
    - — Your child dies
- Your dependent care cost changes significantly.
- You move to a new address.
- Your family member's benefits eligibility changes because of a change in his or her eligibility or coverage under another employer's plans:
    - — He or she gains or loses eligibility as a result of a change in work schedule or status.
    - — He or she loses coverage.

— His or her cost for coverage changes.

— He or she makes new coverage choices during his or her employer's annual enrollment.

- You or your family member becomes entitled to or loses Medicare or Medicaid.
- Your or your family member's COBRA coverage from another employer expires.
- You gain or lose eligibility for another employer's group health plan.

You can also make midyear changes to your coverage if:

- Your domestic partner becomes eligible for coverage.
- Your domestic partnership ends.
- Your domestic partner dies.

Timing of 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 generally will be effective the date of the event. Notification beyond 31 days may result in a delayed benefits effective date.

Additional Rules for Changing Retiree Coverage

You can add dependents that are eligible for coverage even if they were not covered when you retired. However, an additional cost may apply. You can add coverage for any newly eligible dependents—for example, if you get married after you retire.

If You Get Married

During the plan year, you can change your benefits coverage if you get married.

If you're eligible to make coverage changes, your changes must be consistent with the qualified change in status. They must also correspond to any changes your spouse/partner or child makes to his or her coverage under another employer's plans.

This table details the changes you can make to your benefits:

Coverage	**You can make the following coverage changes:**
Medical and Dental	
Medical and Dental	Enroll yourself if you're not already covered.
	Add coverage for your spouse/partner.
	Add coverage for any eligible children.
	Drop coverage for yourself if you become covered under your spouse's/partner's plan.
	Drop coverage for any eligible children if they become covered under your spouse's/partner's plan.
	Change option (e.g., PPO to HMO) if affected dependents are added to coverage.

If Your Domestic Partner Is Eligible for Coverage

During the plan year, you can change your benefits coverage if your same-sex domestic partner becomes eligible for coverage.

If you're eligible to make coverage changes, your changes must be consistent with the qualified change in status. They must also correspond to any changes your same-sex domestic partner or child makes to his or her coverage under another employer's plans.

The following table details the changes you can make to your benefits. Not all retired employees are eligible for domestic partner coverage. If you were eligible for domestic partner coverage as an employee, you're eligible as a retiree.

Changes can only be made after the domestic partner affidavit has been received and approved.

Coverage	**You can make the following coverage changes:**
Medical and Dental	
Medical and Dental	Enroll yourself if you're not already covered.
	Add coverage for your same-sex domestic partner.
	Add coverage for any eligible children.
	Drop coverage for yourself if you become covered under your same-sex domestic partner's plan.
	Drop coverage for any eligible children if they become covered under your same-sex domestic partner's plan.
	Note: The following change is allowed only if the dependent is an IRS Section 152-eligible dependent, Change option (e.g., PPO to HMO) if affected dependents are added to coverage.

If You Get Divorced or Legally Separated

During the plan year, you can change your benefits coverage if you get divorced or legally separated.

If you're eligible to make coverage changes, your changes must be consistent with the qualified change in status. They must also correspond to any changes your spouse or child makes to his or her coverage under another employer's plans.

The following table details the changes you can make to your benefits:

Coverage	**You can make the following coverage changes:**
Medical and Dental	
Medical and Dental	Enroll yourself if you're not already covered.
	Drop your ex-spouse.
	Add coverage for any eligible children.
	Drop coverage for any eligible children if they become covered under your ex-spouse's plan.
	Change option (e.g., PPO to HMO) if affected dependents are added to coverage.

If You End a Domestic Partnership

During the plan year, you can change your benefits coverage if you end your domestic partnership.

If you're eligible to make coverage changes, your changes must be consistent with the qualified change in status. They must also correspond to any changes your domestic partner or child makes to his or her coverage under another employer's plans.

Changes to your benefits can't be made until your Termination of Domestic Partnership Form is returned. This form can be found on the Request Materials section of the ***Benefits@Your Fingertips*** Web site.

The following table details the changes you can make to your benefits:

Coverage	**You can make the following coverage changes:**
Medical and Dental	
Medical and Dental	Enroll yourself if you're not already covered.
	Drop your same-sex domestic partner.
	Drop coverage for any eligible children if they become covered under your former domestic partner's plan.
	Add coverage for any eligible children.
	Change option (e.g., PPO to HMO) if affected dependents are added to coverage.

If Your Spouse/Partner Dies

During the plan year, you can change your benefits coverage if a qualified change in status affects your, your spouse/partner's, or your child's eligibility under the BellSouth plans or another employer's plans.

If you're eligible to make coverage changes, your changes must be consistent with the qualified change in status.

This table details the changes you can make to your benefits:

Coverage	**You can make the following coverage changes:**
Medical and Dental	
Medical and Dental	You must drop coverage for your spouse/partner.
	Enroll yourself if not currently enrolled.
	Add affected dependents
	Drop dependent(s) no longer eligible.
	Your coverage category may change as a result.

If You Have or Adopt a Child

During the plan year, you can change your benefits coverage if you have or adopt a child.

If you're eligible to make coverage changes, your changes must be consistent with the qualified change in status. They must also correspond to any changes your spouse/partner or child makes to his or her coverage under another employer's plans.

If you're adding a child due to adoption or wish to cover a child in anticipation of adoption, your dependent child may not be added until the appropriate paperwork is submitted and approved. Instructions for returning documentation can be found on the Request Materials section of the ***Benefits@Your Fingertips*** Web site.

This table details the changes you can make to your benefits:

Coverage	**You can make the following coverage changes:**
Medical and Dental	
Medical and Dental	Enroll yourself if you're not already covered.
	Add coverage for your spouse/partner.
	Add coverage for any eligible children.
	Drop coverage for yourself if you become covered under your spouse's/partner's plan.
	Drop coverage for any eligible children if they become covered under your spouse's/partner's plan.
	Change option (e.g., PPO to HMO) if affected dependents are added to coverage.

If you add a dependent child after retirement, you'll be required to pay an additional amount.

If Your Child Gains Eligibility Under the Health and Insurance Plans

During the plan year, you can change your benefits coverage if a qualifying change in status affects your child's eligibility under the BellSouth plans or another employer's plans.

If you're eligible to make coverage changes, your changes must be consistent with the qualified change in status. They must also correspond to any changes your spouse/ or child makes to his or her coverage under another employer's plans.

The following table details the changes you can make to your benefits:

Coverage	**You can make the following coverage changes:**
Medical and Dental	
Medical and Dental	Enroll yourself if you're not already covered.
	Add coverage for any eligible children.

If Your Child Loses Eligibility Under the Health and Insurance Plan (including a change in legal custody)

During the plan year, you can change your benefits coverage if a qualified change in status affects your child's eligibility under the BellSouth plans or another employer's plans.

If you're eligible to make coverage changes, your changes must be consistent with the qualified change in status. They must also correspond to any changes your spouse/partner or child makes to his or her coverage under another employer's plans.

The following table details the changes you can make to your benefits:

Coverage	**You can make the following coverage changes:**
Medical and Dental	
Medical and Dental	Drop the affected dependent.

If Your Child Dies

During the plan year, you can change your benefits coverage if a qualified change in status affects your, your spouse's/partner's, or your child's eligibility under the BellSouth plans or another employer's plans.

If you're eligible to make coverage changes, your changes must be consistent with the qualified change in status.

The following table details the changes you can make to your benefits:

Coverage	**You can make the following coverage changes:**
Medical and Dental	
Medical and Dental	You must drop coverage for the child who has died.
	You can't change your own or any other family member's coverage.
	Your coverage category may change as a result.

If You Move to a New Address

During the plan year, you can change your benefits coverage if a qualified change in status affects your, your spouse's/partner's, or your child's eligibility under the BellSouth plans or another employer's plans.

If you're eligible to make coverage changes, your changes must be consistent with the qualified change in status. They must also correspond to any changes your spouse/partner or child makes to his or her coverage under another employer's plans.

If you move to a new ZIP code and your medical option is no longer available, you'll be allowed to elect a new medical option.

If Your Family Member Gains Benefits Eligibility

Work Situation Changes That May Affect Eligibility

Your spouse/partner or child may gain eligibility for benefits under another employer's plans when he or she:

- Starts a job
- Has a change in work schedule (for example, from part time to full time)
- Has a qualified change in status (for example, from hourly to salaried)
- Is transferred to a different work site
- Returns from an unpaid leave of absence

Allowable Changes

During the plan year, you can change your benefits coverage if a qualified change in status affects your, your spouse's/partner's, or your child's eligibility under the BellSouth plans or another employer's plans.

If you're eligible to make coverage changes, the changes must be consistent with the qualified change in status. They must also correspond to any changes your spouse/partner or child makes to his or her coverage under another employer's plans.

This table details the changes you can make to your benefits:

Coverage	**You can make the following coverage changes:**
Medical and Dental	
Medical and Dental	Drop coverage for yourself.
	Drop coverage for your spouse/partner.
	Drop coverage for any eligible children.

If Your Family Member Loses Benefits Eligibility

Work Situation Changes That May Affect Eligibility

Your spouse/partner or child may lose eligibility for benefits under another employer's plans when he or she:

- Leaves a job
- Has a change in work schedule (for example, from full time to part time)
- Has a qualified change in status (for example, from salaried to hourly)
- Is transferred to a different work site
- Begins an unpaid leave of absence

Allowable Changes

During the plan year, you can change your benefits coverage if a qualified change in status affects your, your spouse's/partner's, or your child's eligibility under the BellSouth plans or another employer's plans.

If you're eligible to make coverage changes, your changes must be consistent with the qualified change in status. They must also correspond to any changes your spouse/partner or child makes to his or her coverage under another employer's plans.

This table details the changes you can make to your benefits:

Coverage	**You can make the following coverage changes:**
Medical and Dental	
Medical and Dental	Enroll yourself if you're not already covered.
	Add coverage for your spouse/partner.
	Add coverage for any eligible children.

If Your Family Member's Cost for Coverage Changes

During the plan year, you can change your benefits coverage if a family member's cost for coverage changes under another employer's plan.

If you're eligible to make coverage changes, your changes must be consistent with the qualified change in status. They must also correspond to any changes your spouse/partner or child makes to his or her coverage under another employer's plans.

The following table details the changes you can make to your benefits:

Coverage	You can make the following coverage changes:
Medical and Dental	
Medical and Dental	Add coverage for yourself.
	Add coverage for your spouse/partner.
	Add coverage for any eligible children.

If Your Family Member Makes New Coverage Choices During Another Employer's Annual Enrollment

During the plan year, you can change your benefits coverage if a family member makes new coverage choices during another employer's annual enrollment period.

If you're eligible to make coverage changes, your changes must be consistent with the qualified change in status. They must also correspond to any changes your spouse/partner or child makes to his or her coverage under another employer's plans.

This table details the changes you can make to your benefits:

Coverage	You can make the following coverage changes:
Medical and Dental	
Medical and Dental	Enroll yourself if you're not already covered.
	Add coverage for your spouse/partner.
	Add coverage for any eligible children.
	Drop coverage for yourself if you become covered under your spouse's/partner's plan.
	Drop coverage for any eligible children if they become covered under your spouse's/partner's plan.

If Your Family Member Loses Coverage Under Another Employer's Plan

Definition of a Loss of Coverage

These situations are examples of what's considered a loss of coverage:

- Your spouse's/partner's or child's employer discontinues a benefit plan.
- You or your family member loses coverage because you've reached the annual or lifetime limit on benefits under a plan.
- The HMO you or your family members are enrolled in is no longer available where you live.
- The plan significantly reduces the benefits related to a specific medical condition that you or a family member is being treated for.

Allowable Changes

During the plan year, you can change your benefits coverage if a qualifying change in status affects your, your spouse's/partner's, or your child's eligibility under the BellSouth plans or another employer's plans.

If your family member has a loss of coverage in his or her employer's plan and similar coverage isn't available in his or her plan, then you may be able to change your coverage. If your family member has a loss of coverage but similar coverage **is** available, you can't change your coverage.

If you're eligible to make coverage changes, your changes must be consistent with the qualified change in status. They must also correspond to any changes your spouse/partner or child makes to his or her coverage under another employer's plans.

This table details the changes you can make to your benefits:

Coverage	**You can make the following coverage changes:**
Medical and Dental	
Medical and Dental	Enroll yourself if you're not already covered.
	Add coverage for your spouse/partner.
	Add coverage for any eligible children.

If You or Your Family Member Becomes Entitled to or Loses Medicare or Medicaid

During the plan year, you can change your benefits coverage if a qualified change in status affects your, your spouse's/partner's, or your child's eligibility under the BellSouth plans or another employer's plans.

If you're a BellSouth retiree, you're only allowed to make changes in certain benefits if you or your dependent gains or loses eligibility to Medicare or Medicaid.

Note: When you or any covered dependent becomes eligible for Medicare, the eligible person must enroll in both Part A and Part B of Medicare in order to continue coverage under a BellSouth medical option.

The following table details the changes you can make to your benefits:

Coverage	**You can make the following coverage changes:**
Medical and Dental **If You or Your Family Member Becomes Entitled to Medicare or Medicaid**	
Medical and Dental	Drop coverage only for the person who becomes entitled to Medicare or Medicaid.
	Change medical options.
Medical and Dental **If You or Your Family Member Loses Medicare or Medicaid**	
Medical and Dental	Enroll yourself if you're not already covered.
	Add coverage for the eligible dependent that loses Medicare or Medicaid coverage (your spouse/partner or child).
	Change medical options.

If COBRA Coverage From Another Employer Expires

COBRA coverage through another employer is considered to have expired when the 18-, 29-, or 36-month coverage continuation period you or your dependent was entitled to expires. At that time, you can make changes to your BellSouth benefits coverage.

The following table details the changes you can make to your benefits:

Coverage	**You can make the following coverage changes:**
Medical and Dental **If your or your family members' COBRA coverage expires.**	
Medical and Dental	Enroll yourself if you're not already covered.
	Add coverage for your spouse/partner.
	Add coverage for any eligible children.

If You Gain Eligibility for Another Employer's Group Health Plan

During the plan year, you can change your benefits coverage if you gain eligibility for benefits under another employer's group health plan.

If you're eligible to make coverage changes, your changes must be consistent with the qualified change in status. They must also correspond to any changes your spouse/partner or child makes to his or her coverage under another employer's plans.

The following table details the changes you can make to your benefits:

Coverage	**You can make the following coverage changes:**
Medical and Dental	
Medical and Dental	Drop coverage for yourself and your covered dependents.

If You Lose Eligibility for Another Employer's Group Health Plan

During the plan year, you can change your benefits coverage if you lose eligibility for benefits under another employer's group health plan.

If you're eligible to make coverage changes, your changes must be consistent with the qualified change in status. They must also correspond to any changes your spouse/partner or child makes to his or her coverage under another employer's plans.

The following table details the changes you can make to your benefits:

Coverage	**You can make the following coverage changes:**
Medical and Dental	
Medical and Dental	Enroll yourself if you're not already covered.
	Add coverage for your spouse/partner.
	Add coverage for any eligible children.

Benefit Plans' Sponsor and Administrator

The plans' sponsor is BellSouth Corporation.

The plans' administrator is BellSouth Corporation.

You may direct any questions about your rights under the plans to the plan administrator at any time by calling the BellSouth Benefits Service Center at 1-800-528-1232 or writing to this address:

BellSouth Corporation
Room 13C09
1155 Peachtree Street NE
Atlanta, GA 30309

You and your beneficiary may obtain an updated list of the employers participating in a plan by sending a written request to the above address. The list of sponsoring employers is also available for inspection at the above address.

The plan administrator has been delegated full and final authority and discretion to:

- Make all final determinations or allow changes under the plans, including eligibility for benefits.
- Interpret and construe all of the terms and provisions of the plans.

The plan administrator also authorizes or performs the day-to-day operations of the plan, such as authorizing benefit payments, considering appeals, resolving questions, maintaining records, filing reports, and distributing information to plan participants and beneficiaries.

For some plans, BellSouth has delegated fiduciary responsibility for claims to the Employees' Benefit Claim Review Committee (EBCRC), claims administrators or insurance companies. In addition, BellSouth may delegate 1 or more of its duties to its agents.

Important Plan Information

Plan Identification

The BellSouth Corporation Employer Identification Number (EIN) is 58-1533433. The plan names, plan numbers, and plan types are shown below:

Plan Name	Plan Number	Plan Type
BellSouth Retiree Medical Assistance Plan	528	Welfare plan
BellSouth Retiree Dental Assistance Plan	529	Welfare plan
BellSouth Supplemental Transplant Assistance Plan	544	Welfare plan
BellSouth Group Life Plan	541	Welfare plan providing death benefits

Plan Year

Records for each plan are maintained on a calendar-year basis, starting each January 1 and ending each December 31.

Service of Legal Process

Legal process for any plan (use official plan name) may be served on:

Corporation Service Company (CSC)
40 Technology Parkway South # 300
Norcross, GA 30092

In addition, legal process may be served on the plan administrator.

Plan Funding

Your company currently provides for the payment of the retiree medical and dental benefits through 1 of 2 established trusts: 1 for management retirees (BellSouth Corporation Health Care Trust—Retirees) and 1 for represented retirees (BellSouth Corporation Representable Employees' Health Care Trust—Retirees).

{The following sentence was added to the printed booklet by an addendum dated 7/2006:}

Payment of benefits for represented employees on LTD benefits is made through the BellSouth Corporation Representable Employees' Health Care Trust – Employees.

All participating BellSouth companies make periodic contributions to the trusts, which are actuarially determined to meet the plans' obligations. The trusts also accept participant contributions for medical and dental coverage. In addition, to meet the Plan's obligations, the participating companies make periodic contributions.

For company-paid life insurance, premiums for retired employees (except for key managers as defined under appropriate Internal Revenue Code provisions) are paid to the insurer from 1 of 2 trusts: 1 for management retirees (BellSouth Corporation RFA VEBA Trust for Non-Representable Employees) and 1 for represented retirees (BellSouth Corporation RFA VEBA Trust). Premiums for optional coverage are funded by participating retirees.

A separate trust (BellSouth Corporation Supplemental Transplant Assistance Trust) accepts participant contributions for STAP and funds the benefits under that plan.

The trustee for all trusts is:

State Street Bank & Trust Company
Institutional Investor Services
Post Office Box 5501
Boston, MA 02206

With respect to medical, dental, and STAP, benefit payment checks are distributed by the respective claims administrators or insurers who are reimbursed by the respective trusts. Benefit payment checks that are not cashed within 120 days after the date of the check will be considered null and void, and the benefit so paid will be forfeited. All forfeited amounts will be redeposited into the Trust. Any benefit so forfeited may be reinstated by filing a claim for the forfeited amount within 12 months of the date the check was originally issued and satisfactorily demonstrating entitlement to the payment.

Health and Insurance Claims Administrators and Insurance Companies

The following are the claims administrators and insurance companies for the health and insurance plans.

BellSouth Medical Plan

Medical Benefit Claims

With respect to the payment of benefits by a medical plan option, BellSouth has delegated to the various medical carriers, Pharmacy Benefit Manager (PBM) and Mental Health Managed Care Manager (MHMC) the duty to administer all claims for plan benefits for all participating companies. The medical plans, PBM and MHMC, govern the operation of the plan with respect to benefit claims at all times. Each medical carrier, PBM and MHMC is designated as the claims administrator, and each has complete discretionary authority to make all benefits determinations under the plan, to interpret the terms and provisions of the plan and to provide a review procedure for denied claims. Their decisions and interpretations are final and conclusive.

For the address of each medical plan option administrator, please refer to the Summary Plan Description provided by each medical plan option. 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." Or, refer to the printed Summary Plan Description you received from your medical plan option administrator. You may request an individual copy of the medical option's Summary Plan Description by calling the BellSouth Benefits Service Center.

The address for the Pharmacy Benefit Manager for employees participating in the Basic Plan PPO, POS, and Basic Indemnity medical options is:

Medco Health Solutions of Irving
8111 Royal Ridge Parkway
Irving, TX 75063
1-877-797-7472

For participants in the HMO and EPO medical plan options, the medical option administrator is also the Pharmacy Benefit Manager.

The address for the Mental Health Managed Care Manager (MHMC) for employees participating in the Indemnity Basic Plan, PPO, and POS medical options is:

Magellan Health Services
P.O. Box 1099
Maryland Heights, MO 63043
1-800-984-9135

Other Plan Matters

See "Claims and Appeal Procedures for Other Plan Matters" on page 150.

BellSouth Dental Plan
Dental Benefit Claims

With respect to the payment of benefits by the dental plan, BellSouth has delegated to Connecticut General Life Insurance Company (CIGNA) the duty to administer all claims for plan benefits for all participating companies. CIGNA governs the operation of the plan at all times. CIGNA is designated as the claims administrator and has complete discretionary authority to make all benefits determinations under the plan, to interpret the terms and provisions of the plan and to provide a review procedure for denied claims. Their decisions and interpretations are final and conclusive.

CIGNA can be reached at 1-800-251-6401 or by writing to:

CIGNA
P.O. Box 188044
Chattanooga, TN 37422-8044

Other Plan Matters

See "Claims and Appeal Procedures for Other Plan Matters" on page 150.

BellSouth Group Life Plan

The BellSouth Group Life Plan is underwritten by The Prudential Insurance Company of America:

BellSouth has delegated to Prudential the duty to administer all claims for plan benefits for all participating companies. Prudential is the named fiduciary under the plan with complete authority to review all denied claims for benefits in exercising such fiduciary responsibilities.

Prudential shall have discretionary authority to determine whether or to what extent participants and beneficiaries are entitled to benefits and to construe disputed or doubtful plan terms. Any such decision of Prudential is final and not subject to further review.

The master group life contract, Group Life Insurance Contract Number G-44425-GA between BellSouth and Prudential governs the operation of the plan at all times. Prudential is the investment manager for the plan.

Supplemental Transplant Assistance Plan

STAP Benefit Claims

With respect to the payment of benefits by STAP, BellSouth has delegated to the various medical carriers the duty to administer all claims for plan benefits for all participating companies. Each medical carrier is designated as the claims administrator and each has complete discretionary authority to make all benefits determinations under the plan, to interpret the terms and provisions of the plan and to provide a review procedure for denied claims. Their decisions are final and conclusive.

For the address of each medical plan option administrator, please refer to the Summary Plan Description provided by each medical plan option. To view these SPDs, go to ***Benefits@Your Fingertips.*** From there, select "Health Care," then "Medical," and then "Access your medical option's Summary Plan Description." Or, refer to the printed Summary Plan Description you received from your medical plan option administrator. You may request an individual copy of the medical option's Summary Plan Description by calling the BellSouth Benefits Service Center.

Other Plan Matters

See "Claims and Appeal Procedures for Other Plan Matters" on page 150.

Claims and Appeal Procedures for Other Plan Matters

Review Procedures

In addition of the Review/Appeal procedures described above with regard to medical, pharmacy (PBM), and mental health (MHMC) matters, plan participants also have a right to file a written claim regarding any other matter of the administration of the plan (eligibility, premium payments, etc.). Claims regarding such matters must be submitted in writing within 180 days of the date of the occurrence giving rise to the claim. Claims should be sent to the following address:

Director Benefits
c/o BellSouth Benefits Service Center
P.O. Box 785038
Orlando, FL 32878-5038

Telephone: 1-800-528-1232

If the Director Benefits or its designee denies a claim in whole or in part, it will send a written notice of its decision to the claimant within 90 days of the date the claim request was received. The notice will include the specific reason for the decision.

In some cases, the Director Benefits or its designee may need more than 90 days in which to make a decision. In such cases, the Director Benefits or its designee will notify the claimant in writing within the initial 90 day waiting period and explain why it needs more time. An additional 90 days to make its decision may be taken if such notice will show the date by which the Director Benefits or its designee will send its decision.

If the Director Benefits or its designee does not render a decision within the 90 days or the extended time period, the claim is deemed denied.

Appeal Procedures

If you do not agree in whole or in part with the decision of the Director Benefits, you may appeal that decision (or deemed decision) in whole or in part in accordance with this appeal procedure. In considering whether to appeal, you may request in writing to receive copies, free of charge, of all documents relied upon by the Director Benefits in reviewing your claim.

You may use the appeal procedure if:

- You receive a written denial of your claim within the proper time limit and you wish to appeal the written denial;
- You do receive a reply after 90 days;
- The Director Benefits or its designee or the Employees' Benefit Claim Review Committee (EBCRC) designee has extended the time an additional 90 days, and you do not receive a reply after the additional 90 days
- You receive a written denial of your claim within the proper time limit and you wish to appeal the written denial.

If your claim is denied in whole or part, you may appeal this denial in writing within 60 days after you receive the denial (or within 60 days of a deemed denial). Your appeal must be sent in writing to the following address:

Employees' Benefit Claim Review Committee
c/o BellSouth Benefits Service Center
P.O. Box 785038
Orlando, FL 32878-5038

Telephone: 1-800-528-1232

You may include with your appeal any written comments, documents, records, or other information relating to your claim.

The EBCRC will conduct a review and decide on the appeal of your denied claim. It will make its decision within 60 days after receiving the written request for review. In some cases, the EBCRC may need more than 60 days to make a decision. In such cases, the EBCRC will notify you in writing, within the initial 60-day waiting period, and explain why it needs more time. The EBCRC may then have 60 days more, or a total of 120 days, to make its decision.

The EBCRC has been delegated exclusive, discretionary authority by BellSouth to interpret finally and conclusively and to administer the provisions of the plan with respect to claims administration for all plan matters not otherwise delegated to a claims administrator. Its decisions are final and are not subject to further administrative review.

Situations Affecting Your Benefits

Here are a few situations that may affect your benefits from the plans:

- No benefits are paid for services or supplies received before coverage begins or after coverage ends.
- You, your provider, or your beneficiary must file a claim before benefits are paid.
- If you, your provider, or your beneficiary file a claim for benefits but do not complete all of the necessary information, benefits could be delayed or denied.
- Benefits may be delayed or denied if you don't keep your most current address on file and the company can't locate you or your beneficiary.

Subrogation

Right of Subrogation

If we pay or provide any benefits for you under these plans, 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 must 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.

Non-Assignment of Rights to Pursue Claims for Plan Benefits

The right to pursue a claim for benefits under the plans may be pursued only by a plan participant or covered dependent or his or her legal guardian. No participant or covered dependent may assign to any third party his or her legal rights under a plan, including the right to pursue the review/appeal procedures of the plans as well as the right to pursue a civil action.

Time Limit for Filing Civil Action for Denied Claims

As a participant or a covered dependent of a participant in the plans, you have the right under ERISA to file a civil action in court after exhausting the review/appeal procedures of a plan. However, no legal action may be commenced or maintained against a plan or its administrators (including the medical carriers) more than 120 days after the date that the applicable claims administrator issues its final written response to your appeal. Note, however, that if you properly and timely file a voluntary appeal, this 120-day time limit will be suspended (tolled) for so long as your voluntary appeal is pending in accordance with the applicable plan's claims and appeal procedures.

Plan Continuance

While the plan sponsor expects to continue the plans indefinitely, it reserves the right to amend, modify, suspend, or terminate the plans at any time and for any reason, subject to any applicable collective bargaining agreements. Copies of these collective bargaining agreements are distributed or made available to employees covered by them upon request.

The plan sponsor also reserves the right to change the amount of required employee contributions for coverages under the plans at any time and for any reason.

Important: An amendment or termination of the plan(s) may affect not only the coverage of active employees (and their covered dependents) but also of COBRA participants and former employees who retired, died, or otherwise terminated employment.

A plan change may transfer plan assets and debt to another plan or split the plan into 2 or more parts. If the plan sponsor changes or ends a plan, it may decide to set up a different plan.

Benefit Payments If a Plan Ends

If a plan ends, coverage for all affected participants ends on the date of plan termination.

Privacy Notice

This section describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice gives you information required by law about the duties and privacy practices of the BellSouth Medical Assistance Plan, the BellSouth Dental Assistance Plan, and the BellSouth Supplemental Transplant Assistance Plan (the "Plans") to protect the privacy of your medical information. The Plans provide health and/or dental benefits to you to the extent you participate in such plan(s) as described in your summary plan description(s). The Plans receive and maintain your health information in the course of providing these health benefits to you. The Plans hire business associates to help provide these benefits to you. These business associates also receive and maintain your health information in the course of assisting the Plans. The Plans are sponsored by BellSouth Corporation (the "Plans' Sponsor").

The Plans are required to follow the terms of this notice until it is replaced. The Plans reserve the right to change the terms of this notice at any time. If the Plans make changes to this notice, the Plans will revise it and send a new notice to all subscribers covered by the Plans at that time. The Plans reserve the right to make the new changes apply to all your health information maintained by the Plans before and after the effective date of the new notice.

Purposes for which the Plans May Use or Disclose Your Health Information without Your Consent or Authorization

The Plans may use and disclose your health information for the following purposes:

- **Healthcare Providers' Treatment Purposes.** For example, the Plans may disclose your health information to your doctor, at the doctor's request, for your treatment by him.

- **Payment.** For example, the Plans may use or disclose your health information to pay claims for covered healthcare services or to provide eligibility information to your doctor when you receive treatment.

- **Healthcare Operations.** For example, the Plans may use or disclose your health information (i) to conduct quality assessment and improvement activities, (ii) for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of a contract of health insurance, (iii) to authorize business associates to perform data aggregation services, (iv) to engage in care coordination or case management, and (v) to manage, plan or develop the Plans' business.

- **Health Services.** The Plans may use your health information to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plans may disclose your health information to the Plans' business associates to assist the Plans in these activities.

- **As required by law.** For example, the Plans must allow the U.S. Department of Health and Human Services to audit the Plans' records. The Plans may also disclose your health information as authorized by and to the extent necessary to comply with workers' compensation or other similar laws.

- **To Business Associates.** The Plans may disclose your health information to the Plans' business associates that the Plans hire to assist the Plans. Each business associate of the Plans must agree in writing to ensure the continuing confidentiality and security of your health information.

- **To Plan Sponsor.** The Plans may disclose to the Plans' Sponsor, in summary form, claims history and other similar information. Such summary information does not disclose your name or other distinguishing characteristics. The Plans may also disclose to the Plans' Sponsor the fact that you are enrolled in, or disenrolled from the Plans. The Plans may disclose your health information to the Plans' Sponsor for the Plans' administrative functions that the Plans' Sponsor provides to the Plans if the Plans' Sponsor agrees in writing to ensure the continuing confidentiality and security of your health information. The Plans' Sponsor must also agree not to use or disclose your health information for employment-related activities or for any other benefit or benefit plans of the Plans' Sponsor.

The Plans may also use and disclose your health information as follows:

- To comply with legal proceedings, such as a court or administrative order or subpoena.

- To law enforcement officials for limited law enforcement purposes.

- To a family member, friend or other person, for the purpose of helping you with your healthcare or with payment for your healthcare, if you are in a situation such as a medical emergency and you cannot give your agreement to the Plans to do this.

- To your personal representatives appointed by you or designated by applicable law.

- For research purposes in limited circumstances.

- To a coroner, medical examiner, or funeral director about a deceased person.

- To an organ procurement organization in limited circumstances.

- To avert a serious threat to your health or safety or the health or safety of others.

- To a governmental agency authorized to oversee the healthcare system or government programs.

- To federal officials for lawful intelligence, counterintelligence and other national security purposes.

- To public health authorities for public health purposes.

- To appropriate military authorities, if you are a member of the armed forces.

Uses and Disclosures with Your Permission

The Plans will not use or disclose your health information for any other purposes unless you give the Plans your written authorization to do so. If you give the Plans written authorization to use or disclose your medical information for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your health information the Plans maintain, unless the Plans have taken action in reliance on your authorization.

Your Rights

You may make a written request to the Plans to do 1 or more of the following concerning your health information that the Plans maintain:

- To put additional restrictions on the Plans' use and disclosure of your health information. The Plans do not have to agree to your request.

- To communicate with you in confidence about your health information by a different means or at a different location than the Plans are currently doing. The Plans do not have to agree to your request unless such confidential communications are necessary to avoid endangering you and your request continues to allow the Plans to collect premiums and pay claims. Your request must specify the alternative means or location to communicate with you in confidence. Even though you requested that we communicate with you in confidence, the Plans may give subscribers cost information.

- To see and get copies of your health information. In limited cases, the Plans do not have to agree to your request.

- To correct your health information. In some cases, the Plans do not have to agree to your request.

- To receive a list of disclosures of your health information that the Plans and the Plans' business associates made for certain purposes for the last 6 years (but not for disclosures before April 14, 2003).

- To send you a paper copy of this notice if you received this notice by e-mail or on the Internet.

If you want to exercise any of these rights described in this notice, please contact the Contact Office (below). The Plans will give you the necessary information and forms for you to complete and return to the Contact Office. In some cases, the Plans may charge you a nominal, cost-based fee to carry out your request.

Complaints

If you believe your privacy rights have been violated by the Plans, you have the right to complain to the particular Plan or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with the pertinent Plan at our Contact Office (below). We will not retaliate against you if you choose to file a complaint with that Plan or with the U.S. Department of Health and Human Services.

Contact Office

To request additional copies of this notice or to receive more information about our privacy practices or your rights, please contact us at the following Contact Office:

BellSouth Benefits Service Center
P.O. Box 785038
Orlando, FL 32878-5038
Telephone: 1-800-528-1232

Your Rights Under ERISA

As a participant in the Health and Insurance Plans, you're entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), which are listed below.

Receive Information about Your Plan and Benefits

As a plan participant, you're entitled to:

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

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plans, including insurance contracts and collective bargaining agreements, and copies of the latest annual reports (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plans' 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

As a plan participant, you're entitled to continue healthcare coverage for yourself, your spouse, or your dependents if there's a loss of coverage under a 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.

If you have creditable coverage from another plan, any exclusionary periods of coverage for preexisting conditions under your group health plan may be reduced or eliminated. You should be provided a Certificate of Group Health 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 ends, if you request the certificate before losing coverage
- If you request the certificate up to 24 months after losing coverage

Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after the enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that's denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a Medical Child Support Order, you may file suit in federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you're 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're 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:

U.S. Department of Labor
Employee Benefits Security Administration
Division of Technical Assistance and Inquiries
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.