Statement Date: November 17, 2014

S000214
JAMES F. THOMPSON
112 MAXINE DR
PEARL MS 39208-6344

AT&T Benefits Center Website
resources.hewitt.com/att

AT&T Benefits Center
1-877-722-0020
7 a.m. to 7 p.m. Central Time, Monday through Friday.

Certificate of Group Health Coverage - 2015

Important-Keep This Certificate

This certificate is evidence of your coverage under the AT&T Inc. Group Health Plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

If you become covered under another group health plan, check with the plan administrator to see whether you need to provide this certificate. You may also need this certificate to buy an insurance policy for yourself or your family that does not exclude coverage for medical conditions that are present before you enroll. **Please keep this notice for your records.**

Coverage History for JAMES F. THOMPSON, **12-26**

Group Health Plan	Coverage		Begin Date	End Date
Retiree Medical - Non-Medicare	Covered	Individual	09-01-2010	11-30-2011
	Covered	Individual + 1	08-01-2010	08-31-2010
	Covered	Individual + 2 or More	01-01-2007	07-31-2010

Retiree Medical - Medicare	Covered	Individual	12-01-2011	12-31-2014
	Covered	Individual + 2 or More	12-31-2004	12-31-2006

Medicare Prescription Drug Coverage

Since your prescription drug coverage with AT&T Inc. has ended, you or your Medicare-eligible family members should consider enrolling in a Medicare prescription drug plan or other creditable coverage soon to avoid higher costs. If you haven't already enrolled in a Medicare prescription drug plan or other creditable coverage, you have 63 days from the day your AT&T Inc. coverage ends to enroll or you'll pay a higher premium. The Medicare prescription drug premium will go up 1% for every month you delay enrolling after the 63-day deadline. For example, if you wait 10 months after the deadline to enroll, your premium will be 10% higher as long as you have Medicare prescription drug coverage.

Pre-existing Condition Exclusions

Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date."Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), coverage through high-risk pools, and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break. Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right To Get Special Enrollment In Another Plan

Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Other special enrollment rights with a 30-day notice period are triggered by marriage, birth, adoption, and placement for adoption. Additionally, if you or your dependents gain or lose eligibility for premium assistance under Medicaid or the Children’s Health Insurance Program (CHIP), you may request special enrollment in another group health plan within 60 days.

Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request enrollment as soon as possible.

Prohibition Against Discrimination Based On A Health Factor

Under HIPAA, a group health plan may not keep you (or your dependents) out of the Plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right To Individual Health Coverage

Under HIPAA, if you are an "eligible individual", you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job. Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

Special Information For People On FMLA Leave

If you are taking leave under the Family and Medical Leave Act (FMLA) and you drop health coverage during your leave, any days without health coverage while on FMLA leave will not count towards a 63-day break in coverage. In addition, if you do not return from leave, the 30-day period to request special enrollment in another plan will not start before your FMLA leave ends.

Therefore, when you apply for other health coverage, you should tell your plan administrator or health insurer about any prior FMLA leave.

State Flexibility

This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

Questions?

If you have any questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications, ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: **www.dol.gov/ebsa**, the DOL's interactive Web pages-Health *E* laws, or **www.cms.hhs.gov/HIPAAGenInfo**.

For More Information

If you need additional information, call the AT&T Benefits Center toll-free at **1-877-722-0020** (domestic) or **1-847-883-0866** (international). Service Associates are available 7 a.m. to 7 p.m. Central Time, Monday through Friday.

AT&T Benefits Center is responding to inquiries on behalf of the plan administrator, AT&T Inc.. Please address any written correspondence to:

AT&T Benefits Center
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