Summary Plan Description

IMPORTANT BENEFITS INFORMATION

AT&T Medicare-Eligible Health Reimbursement Account Program

This summary plan description (SPD) is a guide for using the AT&T Medicare-Eligible Health Reimbursement Account Program (Program), a component program under the AT&T Umbrella Benefit Plan No. 1.

Please keep this SPD for future reference.

DISTRIBUTION: Distributed to Medicare-Eligible Former Employees, individuals on Long-Term Disability and survivors of Eligible Former Employees of AT&T Companies listed in Appendix A, "Participating Companies and Applicable Bargaining Agreements".

NIN: 78-32350

IMPORTANT INFORMATION

In all cases, the official documents for the Plan govern and are the final authority on the terms of the Plan. AT&T reserves the right to terminate or amend any and all of its employee benefit plans or programs. Participation in the plans and programs is neither a contract nor a guarantee of future employment.

What Is This Document?

This is a summary plan description (SPD) for the AT&T Medicare-Eligible Health Reimbursement Account Program (Program) under the AT&T Umbrella Benefit Plan No. 1 (Plan) and together constitute the Plan document.

This booklet contains a summary in English of your rights and benefits under the Program. If you have difficulty understanding any part of this booklet, please contact the Claims Administrator at **800-928-8027,** between 7 a.m. and 10 p.m. CST, Monday through Friday.

Este document contiene un resumen, en ingles, al AT&T Medicare-Eligible Health Reimbursement Account Program. Si usted tiene dificultad en entender este documento, entre en contacto por favor con el Claims Administrator en **800-928-8027,** entre 7 a.m. y 10 p.m. CST, Lunes a Viernes.

What Action Do I Need to Take?

You should review this SPD and keep it for future reference.

Why Did I Receive This Document?

You are receiving this SPD because the Program's records indicate that you and/or your dependent(s) are Medicare-Eligible, over the age of 65 and may be eligible to participate in the Program. Please see the "Eligibility and Participation" section of this SPD to determine your eligibility for Benefits under this Program.

How Do I Use This Document?

As you read this SPD, pay special attention to the key points at the beginning of most major sections and shaded boxes that contain helpful examples and important notes. While AT&T has provided these tools to help you better understand the Program, it is important that you read the SPD in its entirety, so that you can understand the details of the Program. Also, throughout this SPD, there are cross-references to other sections in the SPD. Please consult the Table of Contents to help you locate these cross-referenced sections.

Keep your SPD for your future reference. It is your primary resource for your questions about the Program.

Questions?

If you have questions regarding information in this SPD, contact the applicable Administrators. Contact information is provided in the "Contact Information" section.

CONTENTS

USING THIS SUMMARY PLAN DESCRIPTION

KEY POINTS

- *The AT&T Umbrella Benefit Plan No. 1 (Plan) is a welfare benefit plan providing health and welfare benefits through component programs.*
- *This is a summary plan description (SPD) for the Plan and the AT&T Medicare-Eligible Health Reimbursement Account Program (Program) under the Plan.*
- *This SPD is a legal document that provides comprehensive information about the Program.*

Use this SPD to answer your questions about Program benefits. This SPD is effective Jan. 1, 2015.

Keep this SPD with your important papers.

Section References

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

Terms Used in This SPD

Certain terms used in this SPD have specific meanings when applied to your participation. The "Definitions" section defines capitalized terms. Recognizing the defined terms will help you to better understand the information provided in this SPD.

Company Labels and Employee Group Acronyms Used in This SPD

Not all information in this SPD applies to every Eligible Former Employee. Some Program provisions regarding eligibility and provisions of the Program benefits may differ based on your bargained classification, if applicable, the Participating Company you worked for, your status as a Former Employee, and other factors. This SPD notes these differences. In the interest of brevity, any time an exception pertaining to a particular Participating Company or eligible Employee Group covered by a bargained contract, if applicable, exists, the SPD may refer to the Participating Company or eligible Employee Group by an acronym rather than an official Participating Company or eligible Employee Group name.

A complete list of the Participating Company names, acronyms and eligible Employee Groups covered by collective bargaining agreements is located in *Appendix A,* Participating Companies and Applicable Collective Bargaining Agreements. If you are not sure what information applies to you, contact the applicable Administrator. See the "Contact Information" section for contact information.

OVERVIEW

KEY POINTS

- *The Program is established effective Jan. 1, 2015.*
- *The Program provides Eligible Former Employees of Participating Companies with reimbursements of eligible out-of-pocket health care costs, such as premiums for coverage and eligible health care expenses.*
- *Participation in the Program is contingent on you and your dependent(s), if applicable, enrolling in Qualifying Insurance Coverage.*
- *Only those Eligible Expenses incurred by individuals eligible for the Program and enrolled in Qualifying Insurance Coverage are reimbursable under the Program.*

The Program establishes and maintains a Health Reimbursement Account (HRA) in the name of each Eligible Former Employee. Company funds are used to credit the HRA. No Former Employee contributions or salary deferrals are permitted.

The Program is intended to qualify as an employer-provided medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended (Code) and as a health reimbursement arrangement as defined in IRS Notice 2002-45, and will be interpreted to accomplish that objective. Reimbursements under the Program are intended to be eligible for exclusion from a Participant's income under Code Section 105(b).

Eligible Former Employees and/or Eligible Dependents can use amounts credited to their HRA for reimbursement of premiums for Qualifying Insurance Coverage as well as Eligible Expenses. HRA reimbursements are not subject to federal income tax.

Eligible Former Employees and/or Eligible Dependents must substantiate their Eligible Expenses before receiving reimbursement from their HRA.

Unused amounts in an HRA roll over from year to year as long as there are funds remaining. The funds may only be used to reimburse those Eligible Expenses incurred by an Eligible Former Employee or Eligible Dependent. The Former Employee or Eligible Dependent must attest to this fact when submitting a Claim for reimbursement.

ELIGIBILITY AND PARTICIPATION

KEY POINTS

- *Only Eligible Former Employees and their Eligible Dependents who enroll in Qualifying Insurance Coverage can participate in the Program.*
- *Eligible Former Employees include certain Former Employees who are Medicare-Eligible.*

This section summarizes the Program's eligibility provisions. If you have questions or want to confirm eligibility after reading this information, contact the Claims Administrator. See the "Contact Information" section for contact information.

Eligible Former Employees

You must be an Eligible Former Employee to participate in the Program. An Eligible Former Employee is a Former Employees who, as of the HRA Crediting Date, terminates employment with a Participating Company listed in *Appendix A*, is Medicare-Eligible and at least 65 years of age, and purchases Qualifying Insurance Coverage. You are not eligible to participate in the Program if you are an Active Employee or an "Eligible Retired Employee" as defined in a collective bargaining agreement.

> **IMPORTANT:** Former Employees and their dependents living outside the United State are not eligible for the Program. In addition, Former Employees and their dependents living in U.S. Territories (e.g., Puerto Rico, Guam and the USVI) or in foreign countries are not eligible for an HRA; however, eligibility may be extended at the Company's discretion.

See *Appendix A*, "Participating Companies and Applicable Collective Bargaining Agreements" for specific information.

Eligible Dependents

Your Eligible Dependent(s), as identified for federal income tax purposes in the "Eligible Expenses" section below, may only participate in the Program if the following conditions are met:

You are a Former Employee and enrolled in Qualifying Insurance Coverage

- your dependent is Medicare-Eligible and at least 65 years of age;
- your dependent(s) enrolls in Qualifying Insurance Coverage.

You would be eligible to participate in the Program except that you have not reached 65 years of age

- you enroll in coverage under an AT&T Medical Program;
- your dependent is Medicare-Eligible and at least 65 years of age; and
- your dependent purchases Qualifying Insurance Coverage.

> **IMPORTANT:** Former Employees and their dependents living outside the United State are not eligible for the Program. In addition, Former Employees and their dependents living in U.S. Territories (e.g., Puerto Rico, Guam and the USVI) or in foreign countries are not eligible for an HRA; however, eligibility may be extended at the Company's discretion.

A dependent of either an Active Employee or an "Eligible Retired Employee" as defined in a collective bargaining agreement, is not eligible to participate in the Program.

Record Keeper(s)

A Participant, or Record Keeper, is the individual in whose name the HRA is established and may be an Eligible Former Employee, a surviving spouse, or a divorced spouse or dependent participating through COBRA who has available funds credited to an HRA under the Program or who had and will have additional funds credited to an HRA under the Program. The funds credited to the HRA may only be used to reimburse Eligible Expenses incurred by Eligible Former Employees and/or Eligible Dependents.

When Participation Ends

Participation in the Program ends on the earlier of the date:

- The Program terminates;
- You or your Eligible Dependent(s) are no longer enrolled in Qualifying Insurance Coverage;
- You or your Eligible Dependent(s) cease to fulfill the eligibility requirements of the Program;
- You or your Eligible Dependent(s) die (See the "Impact on Program Benefits in the Event of A Death" section for Information);
- You or your Eligible Dependent(s) are no longer enrolled in Medicare; or
- Your HRA Account Balance has been completely used and you are no longer eligible to receive an additional HRA Crediting Amount.

Rehired Retirees

If you become an Active Employee, any funds remaining in your HRA may only be used to reimburse Eligible Expenses incurred by Program participants prior to your becoming an Active Employee. Expenses incurred by you or your Eligible Dependents while you are an Active Employee are not eligible for reimbursement under the Program. Any funds remaining in your HRA when you become an Active Employee will continue to roll forward and may be used at a later date, provided you meet all the requirements of the Program.

Modifications Required by the Plan Administrator

The Plan Administrator may modify your HRA or seek reimbursement from you for mistakes made

- as to your eligibility or participation,
- the credits made to your HRA, or
- the amount of HRA reimbursement paid to you.

If the Plan Administrator determines a modification is appropriate, administratively possible, and otherwise permissible under the Code and other applicable law, the Plan Administrator may allocate, withhold, accelerate or otherwise adjust such amounts as will, in its judgment, accord the credits to your HRA or reimbursements from your HRA to which you are properly entitled under the Program.

HRA CREDITING

KEY POINT

- *Eligible Former Employees and each of their Eligible Dependents will receive HRA Crediting Amounts of $2,700 and $1,500 for 2015, respectively.*

- *Your HRA will be credited on Jan. 1, 2015 unless you become an Eligible Former Employee later in the year either because you terminate employment with an AT&T Controlled Group Company later in the year or you become eligible for Medicare due to reaching age 65 later in the year, in which case your HRA will be credited after your employment is terminated or you become eligible for Medicare, as applicable, and the HRA Crediting Amount will be pro-rated based on that date.*
- *If you are an eligible Former Employee and/or have dependents who are Eligible Dependents, the Company will credit your HRA with an HRA Crediting Amount. An eligible Former Employee's HRA, or that of the dependent of an eligible Former Employee, will be established in the name of the eligible Former Employee. If, however, one of the Eligible Dependents is also an eligible Former Employee, the HRA will be established in the names of both eligible Former Employees. The HRA Crediting Date may occur within a reasonable time period after the Claims Administrator determines that you are enrolled in Qualifying Insurance Coverage. See the table below for HRA Crediting Amounts effective Jan. 1, 2015.*

Eligible Participant	HRA Crediting Amount
Former Employee	$2,700
Dependent	$1,500

Full allocation of the HRA Crediting Amount(s) will be available to eligible Former Employees and their Eligible Dependents for crediting on Jan. 1, 2015 in an HRA in the name of the Former Employee. If, however, the Former Employee and/or their dependent(s) become eligible for the Program later in the year, allocation of the HRA Crediting Amount will be prorated based on the effective date of enrollment in Qualifying Insurance Coverage.

Here are examples of how this works:

- **Example 1:** An eligible Former Employee becomes eligible for Medicare on Aug. 1, 2015 and enrolls in Qualifying Insurance Coverage effective Aug. 1, 2015. The Former Employee will receive $1,125 to use for reimbursement of Eligible Expenses incurred on or after Aug. 1, 2015.
- **Example 2:** An eligible Former Employee becomes eligible for Medicare on Aug. 1, 2015 and enrolls in Qualifying Insurance Coverage effective Sept. 1, 2015. The Former Employee will receive $900 to use for reimbursement of Eligible Expenses incurred on or after Sept. 1, 2015.

You or your Eligible Dependent(s) may be eligible for additional HRA Crediting Amount(s) under the Catastrophic Prescription Drug Benefit if the amount you or your Eligible Dependent actually pay out-of-pocket for qualifying prescription drugs during 2015 totals more than $5,000. See the "Catastrophic Prescription Drug Benefit" section for information.

HOW THE HRA WORKS

KEY POINTS

- *Your HRA is a tax-effective way for the Company to reimburse Eligible Expenses for you and your Eligible Dependents.*
- *When you have Eligible Expenses, you first pay the bills and then submit a Claim for reimbursement. If you are enrolled in automatic reimbursement of your premiums, however, you will not need to submit a Claim for reimbursement.*
- *The tax benefits of Program participation do not extend to reimbursement of Eligible Expenses incurred by or on behalf of a Legally Recognized Partner (LRP) or Domestic Partner (DP) and their children unless the LRP, DP or their children are Eligible Dependents within the meaning of the Code.*
- *Federal tax law and the Program place restrictions on HRA usage because of the HRA's tax-free nature.*

You may use your HRA as a tax-effective way to pay for Eligible Expenses. The Program's purpose is to reimburse Eligible Expenses, up to the amount of your HRA Account Balance, for you and your Eligible Dependents. The Program will maintain an HRA in your name, or if your Eligible Dependent is also an eligible Former Employee, in both your names and keep records of the amounts credited, used and available for reimbursement.

Using Your HRA

Your HRA is a recordkeeping account. **No** cash or other property is set aside by the Company. If you have an HRA Account Balance, all reimbursements will be paid from the general assets of the Company when you submit an HRA reimbursement request that is approved.

When you have Eligible Expenses, you first pay the bills as you normally do, then submit your receipt and a Claim form for reimbursement. You then use the balance in your HRA to seek reimbursement from the Program for Eligible Expenses. You do not pay taxes on the amount in your HRA or the amount that is distributed from your HRA.

Eligible Expenses incurred while you are not a Participant in the Program are **not** eligible for reimbursement.

You must have a positive HRA Account Balance to submit a Claim for reimbursement of Eligible Expenses. If you submit your Claim when your HRA Account Balance is zero, your Claim will be denied and no reimbursement will be made. However, if you receive additional crediting under the Catastrophic Prescription Drug Benefit, you may use that incremental HRA Crediting Amount for reimbursement of Eligible Expenses incurred during 2015.

Your HRA will be debited for any reimbursements of Eligible Expenses paid to you. Any unused HRA Crediting Amount left in your account will be used to reimburse you for future Eligible Expenses incurred as long as you remain a Program Participant. Upon loss of eligibility, your participation in the Program stops, and the Program will not reimburse Eligible Expenses incurred after this time unless you continue your participation by electing COBRA continuation coverage, as described below.

The Program offers tax advantages such as not requiring payment of federal, state (in most states), and local income tax (if applicable) and Social Security taxes on the amounts credited to

your HRA or the amounts you receive as reimbursements for Eligible Expenses. These tax advantages may increase the amount of your take home pay. In no event will this Program provide any benefits in the form of cash or any other taxable or nontaxable benefit, other than reimbursement for Eligible Expenses.

Any unused HRA Crediting Amount at the end of the calendar year will carry over into the next year so long as you remain a Participant in the Program. You can use the HRA Account Balance for reimbursement of Eligible Expenses incurred during the new calendar year.

Limitations on an HRA

Federal law and the Program place some restrictions on the use of HRAs because of their tax advantages. You should understand the rules that govern their use.

- To be eligible for reimbursement from an HRA, you must first receive the service and incur the Eligible Expense after your first HRA Crediting Date.
- You have a three-month grace period to submit all requests for reimbursement of Eligible Expenses incurred during the calendar year. This means you must submit a Claim for reimbursement to the Claims Administrator for receipt by March 31, 2015. If a participant in the Program dies, the grace period will be extended to six months. In this case, a Claim for reimbursement must be sent to the Claims Administrator for receipt by June 30 of the calendar year immediately after the calendar year in which the participant incurred the Eligible Expense and subsequently died. After the end of the grace period, the account will be closed unless there is a claim or appeal pending or unless a Former Employee or surviving Eligible Dependent is eligible to utilize the remaining amounts for expenses they incur.
- The amount available for reimbursement from your HRA Account Balance at any time is limited to the total amount the Company has credited to your HRA (HRA Crediting Amount), less all reimbursements paid from your HRA. The maximum reimbursement from your HRA at any point in time is limited to your HRA Account Balance.
- Any HRA Account Balance at the end of the Plan Year will remain in your HRA in the following year. You may continue to use these funds until they run out, without regard to whether you are enrolled in Qualifying Insurance Coverage. If you are no longer enrolled in Qualifying Insurance Coverage, however, no new HRA Credit Amounts will be added to your HRA.
- You do not receive interest on your HRA Account Balance or on any HRA Crediting Amounts.
- The tax benefits of participation in the Program do **not** extend to Eligible Expenses incurred by or on behalf of your Legally Recognized Partner LRP) or Domestic Partner (DP) or their children unless those individuals also qualify as your dependents within the meaning of federal tax laws.

Impact on Program Benefits in the Event of A Death

The following table illustrates how Program Benefits are impacted in the event you or your dependent die while one or both of you are a Participant in the Program.

Impact on Program Benefits in the Event of A Death			
Former Employee Coverage	**Dependent Coverage**	**Former Employee dies in 2015**	**Eligible Dependent dies in 2015**
Enrolled in Qualifying Insurance Coverage	Enrolled in Qualifying Insurance Coverage	If the Former Employee dies in 2015, the Claims Administrator will create a new account for the Eligible Dependent with their name as the Record Keeper and any funds remaining in the Former Employee's HRA at that time will be transferred to the surviving Eligible Dependent's account. The surviving Eligible Dependent may submit Claims for reimbursement of Eligible Expenses the Former Employee incurred prior to death, through June 30, 2016. The surviving Eligible Dependent also may submit Claims for reimbursement of Eligible Expenses the surviving Eligible Dependent incurs as long as funds remain available in the HRA. Upon timely notice of the Former Employee's death, the surviving Eligible Dependent's HRA will be credited with a $1,500 HRA Crediting Amount. See the "Extension of Coverage – COBRA" section for about the potential availability of COBRA. *If the surviving Eligible Dependent is a Former Employee, see note below.	If your Eligible Dependent dies in 2015, you retain the funds in your HRA at the time of your Eligible Dependent's death. You may submit Claims for reimbursement of Eligible Expenses incurred by your Eligible Dependent prior to their death, through June 30, 2016. Any amounts remaining in the account are also available for reimbursement of your Eligible Expenses.
	Enrolled in AT&T Medical Program	If the Former Employee dies in 2015, the surviving dependent may submit Claims for reimbursement for Eligible Expenses the Former Employee incurred prior to death may be submitted through June 30, 2016. Any funds remaining available under the HRA after all Claims submitted by June 30, 2016 are processed will be forfeited. **If the surviving dependent is a Former Employee, see note below.	Your dependent was not enrolled in Qualifying Insurance Coverage prior to death so there is no impact on your HRA.

Impact on Program Benefits in the Event of A Death			
Former Employee Coverage	**Dependent Coverage**	**Former Employee dies in 2015**	**Eligible Dependent dies in 2015**
	None	If the Former Employee dies in 2015, the estate may submit Claims for reimbursement for Eligible Expenses the Former Employee incurred prior to death through June 30, 2016. Any funds remaining available under the HRA after June 30, 2016 will be forfeited.	N/A
Enrolled in AT&T Medical Program	Enrolled in Qualifying Insurance Coverage	If the Former Employee dies in 2015, the Claims Administrator will create a new account for the Eligible Dependent with their name as the Record Keeper and any funds remaining in the account previously held in the Former Employee's name, will be transferred to the surviving Eligible Dependent's account. The surviving Eligible Dependent may continue to submit Claims for reimbursement for Eligible Expenses. Upon timely notice of the Former Employee's death, the surviving Eligible Dependent's account will be credited with a $1,500 HRA Crediting Amount. See the "Extension of Coverage – COBRA" section for about the potential availability of COBRA.	If your Eligible Dependent dies in 2015, you may submit Claims for reimbursement for Eligible Expenses incurred by your Eligible Dependent prior to death, through June 30, 2016. Any funds available after June 30, 2016 will remain dormant in the HRA in your name. When you become Medicare-Eligible and enroll in Qualifying Insurance Coverage, you will have access to the decedent's suspended HRA and may submit Claims for reimbursement of your Eligible Expenses.

*Note: *If both you and your Spouse are Former Employees and enrolled in Qualifying Insurance Coverage as of Jan. 1, 2015, you will each receive an HRA Crediting Amount of $2,700 in an HRA in your respective names. If you or your Spouse dies in 2015, the remaining balance from the decedent's account will be transferred to the surviving Spouse's account. The surviving Spouse must submit Claims for reimbursement for Eligible Expenses the Former Employee incurred prior to death by June 30, 2016.*

***If the surviving Spouse is not yet 65 years of age, and so not enrolled in Qualifying Insurance Coverage, the Claims Administrator will create a new account in the surviving Spouse's name as the Record Keeper. Any HRA funds available after June 30, 2016 will be unavailable until the surviving Spouse becomes Medicare-Eligible and enrolls in Qualifying Insurance Coverage. At that time, the surviving Spouse will have access to any remaining balance in the decedent's suspended HRA.*

ELIGIBLE EXPENSES

KEY POINT

- *Eligible Expenses reimbursable from your HRA include expenses incurred for "medical care" within the meaning of Section 213(d) of the Code.*

For Eligible Expenses to be reimbursed, they must have been incurred while you were an active Participant in the Program. You incur an expense when the service causing the expense is provided, not when you pay the expense. If you have paid the expense but the services have not yet been rendered, then the expense has not been incurred and cannot be reimbursed until after the service is rendered.

If you elected to continue to maintain an HRA through COBRA, claims for Eligible Expenses incurred during your COBRA period are reimbursable.

Expenses reimbursed by another plan or insurance may not be reimbursed from your HRA. For example, the HRA may reimburse co-payments, deductibles, and medical expenses not covered by a medical plan or insurance. Contributions or premiums for coverage are reimbursable from your HRA if they were paid on a post-tax basis.

Eligible Expenses – Examples

A *partial* list of eligible medical care expenses reimbursable from your HRA includes the following:

- Premiums for Qualifying Insurance Coverage, but only if paid on a post-tax basis;
- Fees for services performed by licensed physicians, dentists, chiropractors, podiatrists, optometrists, opticians, psychologists, osteopaths, therapists, nurses and technicians;
- Health care and dental deductibles, coinsurance and copayments;
- Vision care, such as contact lenses (including saline solution and enzyme cleaner), eyeglasses, laser eye surgery and eye examinations;
- Hearing care, such as hearing aids and hearing examinations;
- Prescription drugs, including insulin and birth control pills or other prescribed contraceptives;
- Vitamins and tonics prescribed by a doctor based on medical necessity if not taken as a food supplement or to preserve general health;
- Expenses resulting from treatment in hospitals, clinics and other licensed medical facilities;
- Prosthetic devices, including artificial limbs, artificial teeth, crutches, dentures, eyeglasses and hearing aids;
- Over-the-counter medicines purchased with a prescription. The Participant must submit a copy of the prescription and the receipt for the purchase to the Claims Administrator in order to receive reimbursement. Insulin is eligible even if purchased without a prescription.
- Expenses resulting from illness and procedures including the following:
    - Acupuncture

- Ambulance
- Braces
- Braille-books and magazines
- Christian Science practitioners' fees
- Developmentally disabled persons' cost for special home
- Handicapped persons' special schools, care and special equipment
- Immunizations
- In-vitro fertilization
- Lamaze classes
- Orthopedic shoes
- Oxygen
- Routine physical exams
- Seeing-eye dog and upkeep
- Wheelchair

For more information, refer to IRS Publication 502, which may be available at your local IRS office or online at **irs.gov/pub/irs-pdf/p502.pdf.** However, you should use this IRS publication with caution because it was prepared for purposes of describing medical expenses that are deductible for federal income tax purposes, not for the purpose of determining which expenses are reimbursable from an HRA.

Ineligible Expenses

A *partial* list of health care expenses that are **not** eligible for reimbursement from your HRA includes the following:

- Any expenses paid by any health care plan or reimbursed by insurance;
- Cosmetic surgery that is not related to an accident or congenital defect;
- Medical treatment, services or medicine that is illegal in the location where you receive it;
- Nonprescription drugs (other than insulin);
- Nicotine gum and patches that can be purchased without a prescription for smoking cessation programs;
- Over-the-counter medicines purchased without a prescription, except insulin which is an eligible expense without a prescription;
- Weight reduction programs that are not for the purpose of curing any specific ailment or disease, but are for the purpose of improving the individual's appearance, health and sense of well-being;

- Equipment and supplies:
    - Air conditioner, even if prescribed by a physician, if it is permanently attached to your home
    - Bottled water bought to avoid drinking fluoridated city water
    - Cosmetics
    - Sundries, such as toothpaste and other toiletries
    - Installation of power steering in an automobile
    - Mobile telephones
- Miscellaneous expenses:
    - Expenses you incurred before or after you participate in the Program or expenses for which you were reimbursed by another plan
    - Antiseptic diaper services
    - Athletic club expenses to keep physically fit
    - Babysitting expenses to enable you to see your physician
    - Boarding school fees for a healthy child to enable you to recuperate from an illness or injury, even if prescribed by a physician
    - Change-of-environment trips to boost the morale of an ailing person, even if recommended by a physician
    - Dance lessons, even if recommended by a physician
    - Domestic help, even if recommended by a physician, although the cost for nursing duties of domestic help may be claimed
    - Funeral, cremation, burial, cemetery plot, monument or mausoleum expenses
    - Health programs offered by resort hotels, health clubs and gyms
    - Health care expenses of your former spouse
    - Premiums/contributions for life insurance policies, disability income policies or for double indemnity or waiver of premium for disability or hospital income policies
    - Premiums/contributions for health care coverage paid on a before-tax basis
    - Scientology fees
    - Transportation costs of a disabled person to and from work
    - Traveling costs to look for a new place to work, even if recommended by a physician
    - Tuition and travel expenses to send a problem child to a special school for a beneficial change in environment
    - Veterinary fees

- Vitamins, unless prescribed by a physician based on medical necessity
- Psychoanalysis undertaken to satisfy curriculum requirements for students
- Expenses of divorce, even when a doctor of psychiatry recommends divorce
- Contributions to state disability funds
- Electrolysis
- Wigs, unless medically necessary for mental health of a patient who has lost all hair due to disease
- Maternity clothes
- Hair transplants
- Mechanical exercise device not specifically prescribed by a doctor
- Religious cult deprogramming
- Cost of illegal drugs or nonprescription drugs
- Marriage counseling provided by clergymen
- Tattoos and ear piercing
- Chauffeur services
- Cosmetic dental work (for example, teeth whitening and caps)

Note: If you receive reimbursement for an ineligible expense from your HRA, you are responsible for repaying the money.

For more information, refer to IRS Publication 502, which may be available at your local IRS office or online at **irs.gov/pub/irs-pdf/p502.pdf.**

Eligible Dependents

Eligible Expenses incurred by you, on your behalf or on behalf of your Eligible Dependents may be reimbursed from your HRA. For this purpose, your Eligible Dependents enrolled in Qualifying Insurance Coverage are:

- Your spouse;
- A “qualifying child” as defined in the Code; or
- A “qualifying relative” as defined in the Code.

A “qualifying child” is an individual who:

- Is your child, brother, sister, stepbrother or stepsister or the descendant of any of these individuals;
- Is younger than you, unless the child is permanently and totally disabled;
- Lives in your home for more than half of the year;
- Is a citizen, national or resident of the U.S. or a resident of Canada or Mexico;

- Is younger than age 19 at the end of the year or is a full-time student younger than age 24 at the end of the year, but there is no age limitation if the individual is totally and permanently disabled;
- Has not provided over half of his or her own support during the year; and
- Has not filed a joint tax return (other than only for claim of refund) with his or her spouse for the year.

A "qualifying child" is also an individual younger than 27 at the end of the calendar year, who is:

- Your child, stepson or stepdaughter;
- A child whom you have legally adopted or who is placed with you for legal adoption; and
- A child who is placed with you by an authorized placement agency, or by judgment, decree, or other order of any court of competent jurisdiction.

A *qualifying relative* is an individual who:

- Is your child (or your child's descendant), brother, sister, stepbrother, stepsister, mother or father (or an ancestor of your mother or father), stepmother, stepfather, niece, nephew, aunt, uncle, son-in-law, daughter-in-law, mother-in-law, father-in-law, sister-in-law, brother-in-law, or any other individual who, for the calendar year, has your same principal place of abode in a manner that is not prohibited by local law;
- Receives more than half of his or her support from you; and
- Is not your or anyone else's "qualifying child."

You may receive reimbursement of otherwise Eligible Expenses that you incur on behalf of your Legally Recognized Partner (LRP) or Domestic Partner (DP) and their dependent(s) only if your LRP or DP and their dependent(s) are a "qualifying child" or a "qualifying relative" for federal income tax purposes.

REIMBURSEMENTS FROM YOUR HRA

KEY POINTS

- *You may submit Claims for reimbursement online, by mobile device, by fax, or by mail to receive reimbursement from your HRA. See the "Contact Information" table for more information.*
- *Your HRA Account Balance is the amount available for reimbursement from your HRA at any time while you are participating in the Program or during COBRA continuation coverage.*
- *This section describes how to obtain reimbursement for Eligible Expenses from your HRA.*
- *For additional information on how to file Claims and/or Appeals, see the "Claims and Appeals Procedures" section.*

How to File HRA Claims for Reimbursement

You may submit Claims for reimbursement online, by mobile device, by fax, or by mail. Approved claims can be reimbursed by check or direct deposit.

Follow these steps to file a HRA Claim:

1. Pay the expense by its due date. You may not receive reimbursement from your HRA Account Balance until after you pay the expense. Do not wait to pay the expense.

2. Obtain a HRA Claim Reimbursement Claim Form electronically or by contacting the Claims Administrator directly. See the "Contact Information" table for contact information.

3. For reimbursement of Eligible Expenses, you must submit your HRA Claim Reimbursement Claim Form and itemized receipts containing the following:

    a. Service provider's name;

    b. Date of service;

    c. Description of service;

    d. Who the service was for; and

    e. The out-of-pocket amount you are claiming for reimbursement.

    Explanation of Benefit (EOB) statements from your carrier are also acceptable forms of documentation for out-of-pocket expenses.

4. Complete and submit your signed HRA Claim Reimbursement Claim Form and receipt(s) in one of three ways:

    a. **Online** - Go to **aon.retiree.com/att** and follow this path:

    Account Summary -> *Get Reimbursed* from the right side of the screen.

    b. **Mobile Application** - Search for the "Reimburse Me" application (for Apple or Android devices) in the App Store. After you have downloaded the App, use your Record Keeper Aon Retiree Exchange ID to log in and select "Submit Claim" on the bottom of the Accounts screen.

    c. **Paper** - You can also enter your information on a paper HRA Claim Reimbursement Claim Form. Paper forms are available by calling the Claims Administrator. Completed forms can be faxed or mailed, along with appropriate receipts or documentation. See the "Contact Information" table for contact information.

5. When mailing your claim form, be sure to keep a copy of the receipt and your claim form in case you need to provide more information about your Claim.

6. You must mail or fax your claim form and receipt(s), or submit a claim electronically (including uploading images of your receipts), any time before March 31 of the calendar year after the calendar year that you incurred the Eligible Expense. The Claims Administrator must receive all prior year Claims by March 31 for the Claims to be reimbursable. If a Participant in the Program dies, however, the grace period to file a Claim for reimbursement for Eligible Expenses attributable to the deceased participant will be extended by three months to June 30 of the calendar year immediately after the

calendar year in which the participant incurred the Eligible Expense and subsequently died. See the "Impact on Program Benefits in the Event of A Death" section for information.

IMPORTANT: The HRA can only be used to reimburse Eligible Expenses incurred by an eligible Former Employee or Eligible Dependent enrolled in Qualifying Insurance Coverage. When submitting each Claim, the Record Keeper will be required to attest that each Claim only includes expenses that meet this requirement.

Reimbursement From Your HRA

Available Reimbursement Amounts

The amount available for reimbursement from your HRA at any time while you are participating in the Program, including periods for which you elected and paid for COBRA continuation, is your HRA Account Balance.

You can log onto your account at any time through **aon.retiree.com/att** to view your available balance and claim activity. In addition, each time a claim is processed, you will receive a notification on the status of your claim, including any amounts paid. Also, if you have a balance in your HRA, you will receive a statement from the Claims Administrator in the fourth quarter of each year as a reminder to file claims for unused funds. Regular statements, such as monthly statements, are not provided.

Any unused amounts in your HRA will carry over to the next Plan Year, without regard to whether you are enrolled in Qualifying Insurance Coverage. If you cease to be enrolled in Qualifying Insurance Coverage, however, no further HRA Crediting Amounts will be added to your HRA.

Explanation of Benefits (EOB)

Each time a Claim is processed, you will receive either a paper or email Explanation of Benefits (EOB) showing the outcome of your Claim (i.e., approved, partially approved, or denied). If you have an email address on file, you will receive an electronic copy of the EOB unless you specify otherwise. If you are due a reimbursement, it will be issued to you via a check or direct deposit based on your preference.

Reimbursement by Check

After your Claim is processed, and if approved, the Claims Administrator will send you a reimbursement check for Eligible Expenses that you paid up to the amount of your HRA Account Balance. Your reimbursement check is generally mailed seven to ten business days after your Claim is processed. Your reimbursement check will accompany an Explanation of Benefits (EOB) detailing the Claim payment.

Reimbursement by Direct Deposit

You can also have your reimbursement amount electronically deposited directly into your checking or savings account. With direct deposit, you can begin receiving reimbursements within two business days after your Claim is processed. You may sign-up for direct deposit online or by contacting the Claims Administrator. See the "Contact Information" table for contact information.

You may set up direct deposit online or by contacting the Claims Administrator. Once initiated, direct deposit will continue without further action by you. If for any reason, you stop paying the premiums, then you must notify the Claims Administrator and any over-payments must be returned. See the "Contact Information" table for contact information.

Premium Auto-reimbursement

You may also choose to participate in "premium auto-reimbursement," a service that automatically reimburses you each month after you have paid your premium for Qualifying Insurance Coverage. The premium auto-reimbursement service is only available for Qualifying Insurance Coverage and, generally, the Claims Administrator will not require that you submit documentation as this is provided by the insurer. For those insurance carriers that do not participate in premium auto-reimbursement, however, you will be required to submit documentation verifying the following:

1. The premium amounts paid;
2. The date coverage began; and
3. Proof of payment.

Auto-reimbursement is also available for reimbursement of your Medicare Part B premium (if applicable) after you have paid.

CATASTROPHIC PRESCRIPTION DRUG BENEFIT

KEY POINT

- *If you are enrolled in Medicare Part D Plan and your actual out-of-pocket expenses for prescription drugs total more than $5,000 during 2015, you will be eligible for additional HRA Crediting Amount(s) under the Program.*
- *To determine eligibility for additional HRA Crediting Amount(s) under the Program, a Former Employee, their Eligible Dependent or, if applicable, the surviving spouse of a Former Employee must provide a Monthly Prescription Drug Summary and a credit request form to the Claims Administrator for approval.*
- *If approved, additional HRA Crediting Amount(s) equal to your actual out-of-pocket expenses for prescription drugs incurred during 2015 will be added to your HRA less the threshold amount of $5,000, and not exceeding $100,000 per eligible Former Employee or Eligible Dependent.*

You or your Eligible Dependent(s) will be eligible for additional HRA Crediting Amount(s) under the Program if the amount you or your Eligible Dependent actually paid out-of-pocket for qualifying prescription drugs during 2015 totals more than $5,000.

You will receive a Monthly Prescription Drug Summary from the provider of your Medicare Part D prescription drug plan detailing your actual out-of-pocket prescription drug expenses. You must send the Monthly Prescription Drug Summary, along with a credit request form to the Claims Administrator. The Claims Administrator determines eligibility for additional HRA Crediting Amount(s) under the Program. Requests must be submitted by March 31, 2016. Credit request forms are available upon request from the Claims Administrator. See the "Contact Information" table for contact information.

Only those prescription drugs included in the approved Formulary List of the Medicare Part D Plan in which you are enrolled are Eligible Expenses under the Catastrophic Prescription Drug Benefit. If you are not enrolled in a Medicare Part D Plan, you are not eligible for the Catastrophic Prescription Drug Benefit.

Once the Monthly Prescription Drug Summary and credit request form are received, the Claims Administrator will determine, at its discretion, if you or your Eligible Dependents are eligible for an additional HRA Crediting. If so, an HRA Crediting Amount equal to the costs exceeding $5,000 incurred for out-of-pocket prescription drug expenses will be added to your HRA. Additional HRA Crediting Amount(s) under the Program will not exceed $100,000 per eligible Former Employee or Eligible Dependent. Any unused amount at the end of the calendar year will carry over into the next year. You can use the HRA Account Balance for reimbursement of Eligible Expenses incurred during the new calendar year.

MEDICARE ELIGIBILITY

KEY POINT

- *Medicare eligibility affects your ability to participate in the Program and to receive HRA Crediting Amount(s).*

You must be eligible for Medicare as your primary coverage and actually enrolled in Qualifying Insurance Coverage to be eligible for an account to be established and to receive an HRA Crediting Amount under the Program. An individual who is not enrolled in Medicare coverage which is their primary coverage, will not be eligible for an HRA Crediting Amount under the Program. If an account is established and an HRA Crediting Amount is credited, you may continue to receive reimbursement of the Eligible Expenses of you and your Eligible Dependent(s), provided you are not an Active Employee.

CLAIM FOR ELIGIBILITY

If you try to participate in the Program but are told you are not eligible, you may call the Claims Administrator to try to resolve the issue, See the "Contact Information" table for information. If the issue is not resolved to your satisfaction, you may file a written Claim for Eligibility.

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

How to File a Claim for Eligibility

To file a Claim for Eligibility, you must submit your written Claim for Eligibility to the YSA Benefit Determination Review Team, along with any documentation that supports your Claim for Eligibility, to the address in the "Contact Information" section. You may obtain an Eligibility Claim Form from the Claims Administrator on request.

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

If the YSA Benefit Determination Review Team requires additional information from you to determine your Claim for Eligibility, you will receive notification and will have 45 days from the date you receive the notification to provide the information. The YSA Benefit Determination Review Team's decision time period will be suspended until you provide the requested information, up to 45 days.

Upon receiving the information, the YSA Benefit Determination Review Team will decide your Claim within the time remaining in the initial 30-day or extended 45-day review period, whichever applies.

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

What Happens If Your Claim for Eligibility Is Denied

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

- Specific reasons for the denial
- Specific references to the Program provisions on which the denial is based
- If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination, and that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request
- If applicable, a description of any additional information needed to make your Claim for Eligibility acceptable and the reason the information is needed
- A description of the Program's Appeal procedures, and
- A statement of your right to file a civil action under ERISA after you have exhausted all opportunities to Appeal under the Program.

How to Appeal a Denied Claim for Eligibility

If your Claim for Eligibility is denied and you disagree with the decision, you may appeal by filing a written request for review. To appeal the claim, you or your authorized representative must file a written Appeal with the Eligibility and Enrollment Appeals Committee within 180 days from receiving the denial notice. Although a special form is not required, you may contact the Claims Administrator and obtain an Appeal form. A service representative also can provide the appropriate address to direct your Appeal. Your Appeal should be sent to:

YSA Service Center
Eligibility and Enrollment Appeals Committee
P.O. Box 1407
Lincolnshire, IL 60069-1407

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

- Send a written statement of the issues and any other comments. Be sure to clearly state any facts and/or reasons you believe should be considered and include any documents, records, or other information relating to your Appeal
- Include any new or additional evidence or materials that support your Appeal. This information must be provided with your written statement when you file your Appeal

- Request and receive, free of charge, documents relevant to your Claim for Eligibility, such as any internal rule, guideline, protocol or other similar criterion relied on in denying your Claim for Eligibility, and
- Reasonable access to and copies of all documents, records and other information relevant to your Claim for Eligibility.

Appeals Process

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

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

The EEAC's decision on your Appeal will be in writing and will include the specific reasons and references to Program provisions relied on to make the decision. The EEAC's decision will include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your Claim for Eligibility. The EEAC has been delegated the exclusive right to interpret and administer applicable provisions of the Program, and its decisions are conclusive and binding and are not subject to further review under the Program. If your Appeal is denied, it is final and is not subject to further review. However, you may have further rights under ERISA, as described in the "ERISA Rights of Participants and Beneficiaries" section.

APPEALS OF A DENIAL OF A CLAIM FOR REIMBURSEMENT

KEY POINTS

- *You may file an Appeal of a denial of a Claim for reimbursement.*
- *Initial Claims for reimbursement made and appealed under the Program are Level I Appeals and may be escalated to Level II Appeals.*
- *Level I and Level II Appeals must be filed with the YSA Benefit Determination Review Team.*
- *A denied Level 1 Appeal for reimbursement may be appealed to a Level II Appeal within 180 days after receipt of the denial notice.*
- *You must pursue all of your Appeal rights under the Program before filing a lawsuit in a court of law.*

You or a duly authorized person has the right under ERISA and the Program to file a written Level I Appeal for Reimbursement.

The following sections describe the procedures used by the Program to process an Appeal for a denial of Claim for reimbursement, along with your rights and responsibilities. These procedures were designed to comply with the rules of the United States Department of Labor (DOL) concerning such Claims. It is important that you follow these procedures to make sure you receive the full extent of your Benefits under the Program. You may file suit in federal court if your Claim

for reimbursement is denied under the Program. However, you must complete all available processes offered under the Program before filing suit.

> **IMPORTANT:** All of the facts and circumstances of your case will be thoroughly reviewed. If you have completed all of the procedures explained in the following sections and your Appeal is denied, you have the right to file suit in federal court if your Claim for reimbursement is denied.

APPEALS FOR REIMBURSEMENT

If your Claim for reimbursement is denied, you may contact YSA to try to resolve the issue. See the "Contact Information" table for contact information. If the issue is not resolved to your satisfaction, you may file a written Level I Appeal for reimbursement.

You are responsible for initiating the Level I Appeal process. The process does not begin until you have provided a written Claim, as outlined in the following section.

How to File a Level I Appeal for Reimbursement

To file a Level I Appeal for reimbursement, you must submit your written Level I Appeal for reimbursement, along with any documentation that supports your Level I Appeal for reimbursement, to the YSA Benefit Determination Review Team at the address listed in the "Contact Information" table. To submit a Level I Appeal for denied reimbursement you must file a completed Appeal Initiation Form (AIF) or other written document asserting your Level I Appeal along with any supporting documentation, with YSA. An AIF is available from YSA on request.

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

If the YSA Benefit Determination Review Team requires additional information from you in order to determine your Level I Appeal for reimbursement, you will receive notification and you will have 45 days from the date you receive the notification to provide the information. The YSA Benefit Determination Review Team's decision time period will be suspended until you provide the requested information, up to 45 days.

Once the information is received, the YSA Benefit Determination Team will decide your Level I Appeal within the time remaining in the initial 30-day or extended 45-day review period, whichever applies.

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

The following table summarizes the Program's Level I Appeal decision time frame:

Activity	Number of Days Allowed	
The YSA Benefit Determination Review Team decision on Claim	30 days	From the date the YSA Benefit Determination Review Team received your initial Claim
Time period is extended if the YSA Benefit Determination Review Team determines special circumstances require more time	Up to 15 additional days	After the initial 30-day period
You must provide additional information requested by the YSA Benefit Determination Review Team	45 days	From the date you receive notice from the YSA Benefit Determination Review Team stating that additional information is needed

What Happens If Your Level 1 Appeal for Reimbursement is Denied

Your Level I Appeal for reimbursement is denied when the YSA Benefit Determination Review Team sends written notice that denies your Level I Appeal for reimbursement in whole or in part or if you do not receive notice of the denial within the time periods described above. A written denial notice will contain:

- Specific reasons for the denial.
- Specific references to the Program provisions upon which the denial is based.
- If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in making the determination and that a copy of the rule, guideline, protocol or criterion will be provided free of charge upon request.
- If applicable, a description of any additional information needed to make your Level I appeal for reimbursement acceptable and the reason the information is needed.
- A description of the Program's Level II Appeal procedures.
- A statement of your right to file a civil action under ERISA after you have exhausted all opportunities to appeal under the Program.

How to Appeal a Denied Level 1 Appeal for Reimbursement

If your Level I Appeal for reimbursement is denied and you disagree with the decision, you may appeal the decision by filing a written request for review. To appeal the Level 1 Appeal, you or your authorized representative must file a written Level II Appeal with the YSA Benefit Determination Review Team within 180 days of receipt of the denial notice. A special form is not required; however, you may contact the Claims Administrator and obtain a Level II Appeal form. A service representative also can provide the appropriate address to direct your Level II Appeal. See the "Contact Information" table for contact information.

If you or your authorized representative submits a Level II Appeal of a denied Level I Appeal for reimbursement, you or your representative has the right to:

- Send a written statement of the issues and any other comments. Be sure to clearly state any facts and/or reasons you believe should be considered and include any documents, records or other information relating to your Level II Appeal.

- Include any new or additional evidence or materials that support your Level II Appeal. This information must be provided with your written statement when you file your Level II Appeal.
- Request and receive, free of charge, documents relevant to your appeal for reimbursement, such as any internal rule, guideline, protocol or other similar criterion relied on in denying your Level I Appeal for reimbursement.
- Reasonable access to and copies of all documents, records and other information relevant to your Level I Appeal for reimbursement.

Level II Appeals Process

The YSA Benefit Determination Review Team will review and decide your Level II Appeal. In the review of your Level II Appeal, the YSA Benefit Determination Review Team will not afford deference to the denied Level I Appeal.

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

The YSA Benefit Determination Review Team's decision on your Level II Appeal will be in writing and will include the specific reasons and references to Program provisions relied on to make the decision. The YSA Benefit Determination Review Team's decision will include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your appeal for reimbursement. The YSA Benefit Determination Review Team has been delegated the exclusive right to interpret and administer applicable provisions of the Program, and its decisions are conclusive and binding and are not subject to further review under the Program. If your Level II Appeal is denied, it is final and is not subject to further review. However, you may have further rights under ERISA, as described in the "ERISA Rights of Participants and Beneficiaries" section.

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

Activity	Number of Days
You request a review of a denied Level I Appeal for reimbursement	180 days From receipt of a denial notice
The YSA Benefit Determination Review Team decides on Level II Appeal	60 days From the date the YSA Benefit Determination Review Team receives your Level II Appeal
Time period is extended if the YSA Benefit Determination Review Team determines special circumstances require more time	Up to 60 days After the initial 60-day period

External Review Process for Certain Eligibility Claims

If your Level II Appeal of a denied appeal for reimbursement is denied by the YSA Benefit Determination Review Team, there is an opportunity for external review but only in situations that involve rescission of Program coverage. Generally, rescission of Program coverage is the cancellation or discontinuance of your coverage that has retroactive effect, except to the extent it

is attributable to failure to timely pay required contributions or due to an act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact.

PLAN ADMINISTRATION

Plan Administrator

The Plan Administrator is the named fiduciary of the Program with the power and duty to do all things necessary to carry out the Program's terms. The Plan Administrator has the sole and absolute discretion to interpret the Program's provisions, make findings of fact, determine the rights and status of Participants and others under the Program, decide disputes under the Program and delegate all or a part of this discretion to third parties. To the extent permitted by law, such interpretations, findings, determinations and decisions shall be final and conclusive on all people for all Program purposes.

Administration

The Plan Administrator has contracted with third parties for certain functions including, but not limited to, the processing of related benefits and Claims. In carrying out these functions, these third-party administrators have been delegated responsibility and discretion for interpreting the Program's provisions, making findings of fact, determining the rights and status of Participants and others under the Program and deciding disputes under the Program. The *Other Plan Information* table indicates the functions performed by a third-party administrator for the Program as well as the name, address and telephone number of each contractor.

The Program will be interpreted and administered in a manner consistent with applicable provisions of the Code and ERISA, and to the extent not preempted by federal law and the laws of the state of Texas.

Amendment or Termination of the Program

AT&T Inc. intends to continue the Program described within this SPD but reserves the right to amend or terminate the Program or to amend or eliminate Program Benefits at any time. In addition, your Participating Company reserves the right to end its participation in the Program. In any such event, you and other Participants may not be eligible to receive Benefits as described in this SPD, and you may lose participation in the Program. However, no Program amendment or termination will diminish or eliminate any Claim for any Benefit to which you may have become entitled before such amendment or termination, unless the termination or amendment is necessary for the Program to comply with the law.

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

Limitation of Rights

Except as otherwise required by law or as allowed under the provision of the Program, Program Benefits may not be assigned or alienated. This means that you may not sell, assign, pledge or otherwise transfer Program Benefits before the Benefits are paid to you, nor are your Program benefits subject to attachments, garnishment, execution or encumbrance of any kind before payment to you.

Legal Action Against the Program

If you wish to bring legal action concerning your right to participate in the Program or your right to receive Program Benefits, you must first exhaust the Claim and Appeals process described in this SPD. During the final level of that Appeal process, you must raise all issues and state all reasons that provide a basis for your Appeal. Legal action involving the Program should be filed directly against the Program. Process in legal actions concerning the provision of Program Benefits should be served on the Plan Administrator as provided in the following *Other Plan Information* table. In order to bring an action against the Plan for Benefits, you must bring the action no later than five years following the date your Claim was denied.

Indemnification

AT&T Inc. agrees to indemnify and hold harmless any present or former employee of AT&T Inc. or any of its affiliates or subsidiaries to whom fiduciary or plan administration responsibilities are delegated, including but not limited to, members of any committees and their delegates responsible for Program administration and related responsibilities. This right of indemnification includes any and all claims, demands, rights, liabilities, damages, causes of actions, costs and expenses of whatsoever kind and nature (including Plan Administrator-approved attorneys' fees and amounts paid in settlement of any claims) occasioned by any act or omission to act in connection with the Program, if such act or omission is in good faith. This right to indemnification will be in addition to such other rights as such employees may enjoy as a matter of law or by reason of insurance coverage of any kind. Rights granted hereunder shall be in addition to and not in lieu of any rights to indemnification to which such employee may be entitled pursuant to the by-laws of AT&T Inc. or any of its affiliates or subsidiaries.

PLAN INFORMATION

Other Plan Information	
Plan Name	AT&T Umbrella Benefit Plan No. 1
Program Name	AT&T Medicare-Eligible Health Reimbursement Account Program
Plan Number	600
Plan Sponsor/Employer Identification Number (EIN)	AT&T Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333** EIN 43-1301883
Plan Administrator	AT&T Services, Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333**
Name and Address of Employer	Affiliates of AT&T Inc. P.O. Box 132160 Dallas, TX 75313-2160 **210-351-3333**

Other Plan Information	
Type of Administration	Plan administration is retained by the Plan Administrator. However, the Plan Administrator has contracted with third parties for certain functions associated with the Program as follows • The Plan Administrator administers Claims and Appeals for Benefits on a contract basis with the Claims Administrator, see the "Contact Information" section for more information. The Claims Administrator has full discretionary authority to interpret Plan provisions as they apply to entitlement for Benefits. • The Plan Administrator administers enrollment and eligibility under the Plan provisions, including the determination of initial Claims for Eligibility and initial appeals for Claims for Benefits involving eligibility, on a contract basis with the Claims Administrator, see the "Contact Information" section for more information. • The Plan Administrator administers COBRA under the Plan provisions on a contract basis with the Eligibility and Enrollment Vendor, see the "Contact Information" section for more information. • The Benefit Determination Review Team (BDRT) determines Level II Appeals from a denial of Claim for Benefits. The BDRT has full discretionary authority to interpret Plan provisions as they apply to a Claim for Benefits. See the "Contact Information" section for the address to write to. • The AT&T Eligibility and Enrollment Appeals Committee (EEAC) determines final Appeals from the denial of eligibility. The EEAC has full discretionary authority to interpret Plan provisions as they apply to eligibility for Benefits. See the "Contact Information" section for the address to write to.
Agent for Service of Legal Process	Process in legal actions in which the Plan is a party should be served on the Plan at the following Address CT Corporation 350 N. St. Paul St. Dallas, TX 75201
Type of Plan	This Program is intended to qualify as an employer-provided medical reimbursement plan under Code Sections 105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Eligible Expenses reimbursed under the Program are intended to be eligible for exclusion from Participants' gross income under Code Section 105(b).
Plan Year	Jan. 1 - Dec. 31
Plan Funding and Contributions	The Program is funded by Company contributions. Nothing herein will be construed to require the Company or the Claims Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Company from which any payments under this Plan may be made.
Plan Records	All Program records are kept on a calendar year basis beginning Jan. 1 and ending Dec. 31.

ERISA RIGHTS OF PARTICIPANTS

KEY POINTS

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

Your ERISA Rights

The HRA is subject to the Employee Retirement Income Security Act of 1974 (ERISA). As a Participant in the HRA, you are entitled to certain rights and protections under ERISA, including:

- To receive information about the Program and the benefits it provides.
- To examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Program, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan Administrator with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration. See the “How to Obtain Information” section.
- To obtain copies of documents governing the operation of the Program, including collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated SPD or SMM (the Plan Administrator may make a reasonable charge for the copies), provided you send a written request to the following address:

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

- Receive a summary of the Program's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
- Have the Company continue to credit your HRA if there is a loss of coverage under the Program as a result of a Qualifying Event (see the “Extension of Coverage — COBRA” section). You or your Eligible Dependents may have to pay for such coverage. Review this SPD and the other documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants, ERISA imposes duties upon the people responsible for operating the Program. The people who operate the Program, called "fiduciaries," have a duty to act prudently and in the interest of you and other Participants. No one, including a Participating Company, any union or any other person, may discriminate against you to prevent you from obtaining any Program benefit or exercising your rights under ERISA.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of the Program documents or the latest annual report, and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the requested materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a Claim for Benefits under the Program that 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. See the "How to File a Claim and Appeal Under the Plan" section for more information. In addition, if you disagree with the Plan Administrator's final decision, you may file suit in a state or federal court.

If it should happen that plan fiduciaries misuse the Program's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have questions about the Program, you should contact the Claims Administrator for assistance. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or at

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

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

EXTENSION OF COVERAGE — COBRA

KEY POINTS

- *COBRA continuation coverage is a temporary extension of your Program participation when participation would otherwise end due to a Qualifying Event.*
- *You may elect and pay for Program COBRA continuation coverage to avoid forfeiting your HRA Account Balance and to continue receiving any HRA Crediting Amounts due to Participants.*

- *You must notify the Eligibility and Enrollment Vendor of a Qualifying Event within 60 days of the later of the date on which the Qualifying Event occurs or loss of coverage resulting from the Qualifying Event. If you, or your Qualified Beneficiary, do not elect Program COBRA continuation coverage within the 65-day election period using the procedure described in this section, you will lose your right to elect COBRA continuation coverage.*
- *If you fail to make the required COBRA premium payments within the allowable time period, your COBRA continuation coverage will end and you will not be able to reenroll.*

COBRA Continuation Coverage

If your participation in the Program ends due to a Qualifying Event, you may elect to continue Program participation and receive the same coverage you had under the Program on the day before the Qualifying Event for the periods prescribed by the Consolidated Omnibus Budget Reconciliation Act (COBRA). This would allow you and each Qualified Beneficiary to avoid forfeiting the funds remaining in your account if funds would otherwise be forfeited under the Program. This also would allow you to continue receiving any future HRA Crediting Amounts due to similarly situated Eligible Former Employees and their Eligible Dependents. If you do not elect to extend coverage under the Program, you have until March 31 of the calendar year following the last year during which you were a Program Participant to submit HRA Claims for expenses incurred while you were a Participant.

Federal law requires most employers to offer Eligible Former Employees and their Eligible Dependents the right to elect a temporary extension of Program coverage (referred to as "continuation coverage" or "COBRA continuation coverage") in certain instances when Program coverage would otherwise end.

This section generally explains COBRA continuation coverage for the Program when it may become available to you and your Eligible Dependents, and what you need to do to protect your right to receive it.

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

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a temporary extension of your HRA participation when participation would otherwise end due to a Qualifying Event. Qualifying Events are listed later in this section. After a Qualifying Event occurs, and any required notice is provided to the COBRA Administrator, HRA COBRA continuation coverage must be offered to a Qualified Beneficiary. A Qualified Beneficiary can choose to elect and pay for Program COBRA continuation coverage to receive future HRA Crediting Amounts and to avoid forfeiting any unused HRA Account Balance that exists at the time participation or coverage would otherwise end.

You are a Qualified Beneficiary if you lose coverage under the Program due to a Qualifying Event. Your spouse and dependents whose medical expenses are reimbursable under the Program are each a Qualified Beneficiary if, due to a Qualifying Event, you lose coverage or their medical expenses are no longer reimbursable under the Program. Only a Qualified Beneficiary may elect

to continue Program coverage under COBRA. A Qualified Beneficiary who elects Program COBRA continuation coverage must pay for continuation coverage.

Ordinarily, the Program COBRA continuation coverage is the same coverage that the Qualified Beneficiary had on the day before the Qualifying Event occurred.

COBRA Qualifying Events: When Is COBRA Coverage Available?

Spouse

Your Spouse or LRP will become a Qualified Beneficiary and have the right to elect continuation coverage if your Spouse or LRP loses Program coverage due to any of the following Qualifying Events:

1. You die.
2. You and your Spouse or LRP divorce or legally separate.

Note: If you eliminate coverage for your Spouse or LRP in anticipation of a divorce or legal separation and the divorce or legal separation occurs, then the actual divorce or legal separation will be considered a Qualifying Event, even though your former Spouse or LRP lost coverage earlier. If your former Spouse or LRP notifies the Eligibility and Enrollment Vendor within 60 days after the later of the divorce or legal separation or the date coverage ends and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.

Children

Your dependent child will become a Qualified Beneficiary and have the right to elect continuation coverage if you lose Program eligibility or the dependent stops being an Eligible Dependent because any of the following four Qualifying Events occurs:

1. You die.
2. You and your Spouse or LRP divorce or legally separate.
3. The child ceases to be an Eligible Dependent child under the Program.

Important Notice Obligations

The Program will offer Program COBRA continuation coverage to you or a Qualified Beneficiary only after timely notification of a Qualifying Event to the Eligibility and Enrollment Vendor.

Your Notice Obligations

For a Qualifying Event, you or the Qualified Beneficiary are responsible for notifying the Eligibility and Enrollment Vendor. You or the Qualified Beneficiary must provide this notice within 60 days after the date the Qualifying Event occurs using the procedures specified in the "COBRA Notice and Election Procedures" section.

If you or a Qualified Beneficiary fail to provide this notice to the Eligibility and Enrollment Vendor during this 60-day notice period (using the procedures specified), you, your Spouse or LRP or your dependent children will not have the option to elect continuation coverage.

Once the Eligibility and Enrollment Vendor receives timely notice of a Qualifying Event, COBRA continuation coverage will be offered to you and/or the Qualified Beneficiary. If you or the Qualified Beneficiary timely elects COBRA continuation coverage, the coverage will begin on the date that the Program coverage would otherwise end.

COBRA Notice and Election Procedures

A COBRA election notification must be provided to the Eligibility and Enrollment Vendor within the following time frames.

IMPORTANT: COBRA Notice and Election Procedures

You must provide all required notification or make your COBRA election by the last day of the required notification period by calling the Eligibility and Enrollment Vendor at the telephone number provided in the "Contact Information" section or in subsequent SMMs. You must speak to a service associate at the time of the call. Written or electronic communications or calls to other telephone numbers will not meet your obligation to provide this notice. See the *Eligibility and Enrollment Vendor* table in the "Contact Information" section for contact information.

When you call to provide notice or elect coverage, you must provide the name and address and last four digits of the Social Security number of the Eligible Former Employee covered under the Program and the name(s) and address(es) and last four digits of the Social Security number of the Qualified Beneficiary(ies) affected. If your notice concerns a Qualifying Event, you also must identify the Qualifying Event as well as the date on which the Qualifying Event(s) occurred.

If desired, you and/or your Qualified Beneficiary must elect continuation coverage, using the election procedures described in the "COBRA Notice and Election Procedures" section above within 65 days after Program coverage ends or, if later, 65 days after the date the Eligibility and Enrollment Vendor mails a notice of the right to elect continuation coverage to your last known address**. If you or your Qualified Beneficiary do not elect continuation coverage within this 65-day election period by using the procedure described in the "COBRA Notice and Election Procedures" section above, you will lose your right to elect continuation coverage.**

If you or a Qualified Beneficiary rejects continuation coverage, he or she may change his or her mind and enroll anytime during the 65-day election period by using the required election procedure.

Each Qualified Beneficiary may elect continuation coverage individually under the Program. For example, your Spouse or LRP may elect continuation coverage even if you do not elect it. Parents may elect to continue coverage on behalf of their dependent children only.

Paying for COBRA Continuation Coverage

Generally, each Qualified Beneficiary may be required to pay the entire cost of COBRA continuation coverage. This amount may not exceed 102 percent of the "applicable premium." The applicable premium is a reasonable estimate of the cost of providing Program coverage for a similarly situated Participant who has not experienced a Qualifying Event, taking into account an actuarially determined percentage of the total amount available for reimbursement from all Program Participants, which is based, in part, on the total amount available for reimbursement.

Your election notice from the Eligibility and Enrollment Vendor will include the cost of COBRA continuation coverage. When you elect COBRA coverage, you will receive an initial bill from the Eligibility and Enrollment Vendor. You must make your first payment for COBRA coverage within 60 days of the date of your election. Your required first payment amount will be stated on your initial bill and will include the cost of COBRA coverage from the date COBRA coverage begins through the end of the month after the month in which the bill is issued. Claims for

reimbursement may not be processed and reimbursed until you have elected COBRA coverage and have made the first payment. Any amounts reimbursed from your HRA during this period will be canceled retroactively if you do not elect COBRA coverage or coverage is canceled because you do not make timely payments. Bills for subsequent coverage will be issued monthly. Payment is due on the first day of each month for that month's coverage, subject to a 60-day grace period. If you don't make the full premium payment by the due date or within the 60-day grace period, your COBRA coverage will be canceled retroactively for all COBRA coverage included in the bill to the last day of the month for which the full premium has been paid, with no possibility of reinstatement.

All COBRA coverage payments must be made by direct debit from your bank account or check and mailed to the address on your bill. Payment will **not** be accepted at any other location or through any other means. Your payment is made on the date that it is postmarked. If your check is returned for insufficient funds or otherwise, that payment will be considered unpaid. For questions about direct debit, contact the Eligibility and Enrollment Vendor. Contact information can be found in the "Contact Information" section.

How Long Does COBRA Continuation Coverage Last?

COBRA continuation coverage is a temporary continuation of coverage. If the Qualifying Event is termination of employment, Program COBRA continuation coverage will continue for a period of 18 months following the date that regular coverage ended. If another Qualifying Event occurs during the initial 18-month period, Program COBRA continuation coverage may be extended to 36 months. You are responsible for notifying the Eligibility and Enrollment Vendor of the second Qualifying Event within 60 days of the second Qualifying Event occurring. Program COBRA continuation coverage may also be extended to 29 months when an individual is disabled within 60 days after the date the entitlement to Program COBRA continuation coverage initially arose, and continues to be disabled at the end of the 18-month period. In all other cases to which COBRA secondary events apply, Program COBRA continuation coverage will be for a period of 36 months.

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

COBRA continuation coverage will automatically terminate when any one of the following events occurs before the end of the calendar year:

1. The premium for your COBRA coverage is not paid in full within the allowable grace period.
2. If, for any reason other than a Qualifying Event, the Program would terminate coverage of a Participant **not** receiving continuation coverage (such as fraud).
3. AT&T Inc. terminates the Program or a Participating Company terminates its participation in the Program with respect to all similarly situated Eligible Former Employees.

OTHER PLAN INFORMATION

This section describes some additional information about the Program and various laws that may impact your right to Program benefits.

Qualified Medical Child Support Orders

The Program will provide benefits by any qualified medical child support order (QMCSO), as defined by ERISA Section 609(a). Generally, a QMCSO is an administrative agency or court-ordered judgment, decree, order or settlement agreement in connection with a state domestic relations law (including a community property law) that either:

- Creates or extends the rights of an "alternate recipient" to participate in a program that provides group health benefits.
- Enforces certain laws relating to medical child support.

An alternate recipient is any child of an Eligible Person who is recognized by a medical child support order as having a right to enrollment under an Eligible Person's group health benefits.

A medical child support order has to satisfy certain specific conditions to be qualified. The Eligibility and Enrollment Vendor will notify you if the Company receives a medical child support order that applies to you and will provide you with a copy of the Program's procedures used for determining whether the medical child support order is qualified. You also may contact the Eligibility and Enrollment Vendor directly at any time to receive a copy of these procedures free of charge.

If the Eligibility and Enrollment Vendor determines the order to be qualified, the Program will comply with the QMSCO provisions. If a QMCSO is issued for your child with respect to the Program and you are eligible but not participating in the Program at that time, you and your child will be enrolled in the applicable provisions of the Program in accordance with its terms.

Newborns' and Mothers' Health Protection Act of 1996

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

HIPAA Provisions

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides you with certain rights regarding the privacy of your health information. You have received a summary of those rights from the Program. You may also view or print a copy of the Program's summary of those rights from the Eligibility and Enrollment Vendor's website. Additionally, you may receive a free copy of the Claims Administrator's privacy of health information at any time by contacting the Claims Administrator identified in the "Contact Information" section.

A limited number of Company Employees have access to a Program Participant's individually identifiable health information for administering the Program. This individually identifiable health

information is Protected Health Information under HIPAA. HIPAA and its implementing regulations restrict the Company's ability to use and disclose Protected Health Information.

Protected Health Information (PHI) means information created or received by the Program that relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for providing health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information for persons living or deceased.

The Company shall have access to PHI relating to the Program only as permitted under the Program or as otherwise required or permitted by HIPAA.

- The Eligibility and Enrollment Vendor may disclose to the Company information on whether an individual is participating in the Program.
- The Claims Administrator may disclose Summary Health Information to the Company, provided the Company requests the Summary Health Information for the purpose of modifying, amending, or terminating the Program. "Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR Section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.
- Unless otherwise permitted by law, and subject to the conditions of disclosure described below and obtaining written certification as provided in the Program, the Claims Administrator may disclose PHI to the Company, for Program administration purposes only. "Program administration purposes" means administrative functions performed by the Company on behalf of the Program, such as quality assurance, claims processing, auditing, and monitoring. Program administrative functions do not include any other benefit or benefit plan functions of the Company, and they do not include any employment-related functions. In no event shall the Company be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR Section 164.504(f).

The Company agrees that for any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Claims Administrator, the Company shall:

- Not use or further disclose the PHI other than as permitted or required by the Program or as required by law;
- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Program, agrees to the same restrictions and conditions that apply to the Company with respect to PHI;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;
- Report to the Program any use or disclosure of information that is inconsistent with these uses or disclosures of which it becomes aware;

- Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR Section 164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Program available to the Secretary of Health and Human Services to determine compliance by the Program with HIPAA's privacy requirements;
- If feasible, return or destroy all PHI received from the HRA that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that the adequate separation between the Program and the Company (i.e., the "firewall"), required in 45 CFR Section 504(f)(2)(iii), is satisfied.

The Company further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Program, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI. Further, it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Company will report to the Plan Administrator any security incident of which it becomes aware.

The Company may provide PHI to Employees of the Company whose employment responsibilities include administration of the Program (and their superiors, who have a need to know such information), including payroll staff performing Program functions, members of the EEAC, and any other employee who needs access to PHI in order to perform Program administration functions that the Company performs for the Program (such as quality assurance, claims processing, auditing, monitoring, payroll, and appeals). No other Employees shall have access to PHI. These specified Employees (or classes of Employees) shall only have access to and use PHI to the extent necessary to perform the Program administration functions that the Company performs for the Program. If any of these specified Employees does not comply with the provisions of this Program section, that Employee shall be subject to disciplinary action by the Company for noncompliance pursuant to the Company's Employee discipline and termination procedures.

The Company will ensure that these HIPAA provisions are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

CONTACT INFORMATION

Review the tables in this section for contact information for the various Plan Administrators and vendors.

Contact Information	
Vendor	
Name	Your Spending Account (YSA)
Type	Eligibility and Enrollment
Services Provided	To determine eligibility for the Program, including eligibility for the Catastrophic Prescription Drug Benefit, or request reimbursements for Eligible Expenses
Vendor Contact Numbers	
Contact Numbers Information	Contact the YSA Service Center at:
Domestic Telephone Number	**800-928-8027 (TTY use 711 Relay)**
Vendor Hours of Operation	
Hours of Operation	**YSA Service Center:** Monday through Friday from 7 a.m. to 10p.m. Central time.
Vendor Website	
Website Access Information	**Important:** To access the Your Spending Account (YSA) website you will need the Aon Retiree Health Exchange ID assigned to the Record Keeper.
Website	**aon.retiree.com/att**
Mailing Address Information	General questions about the Program Benefits may be sent to:
Domestic	Your Spending Account PO Box 1407 Lincolnshire, IL 60069-1407

Contact Information	
Claims Information	**Claims for Benefits** Written Claims for Benefits, including reimbursement requests under the Program may be mailed or faxed to the address below: Your Spending Account PO Box 1407 Lincolnshire, IL 60069-1407 Fax Number: **888-211-9900** Claims may also be submitted electronically: 1. Online - Go to the YSA Service Center web page through **aon.retiree.com/att.** 2. Mobile Application - You may also access the Mobile Application by searching for the "Reimburse Me" application (for Apple or Android devices) in the App store. Note: You will need the Aon Retiree Exchange ID assigned to the Record Keeper to log-in. To determine eligibility for incremental credits for the Catastrophic Prescription Drug Benefit, you must complete and send the Catastrophic Drug Credit Request Form to the YSA Service Center per the instructions on the form. You may access the form in two ways: 1. On the YSA Service Center web page through **aon.retiree.com/att** or 2. By calling the Aon Retiree Health Exchange at **800-928-8027 (TTY use 711 Relay)** **Claims for Eligibility** Written Claims for Eligibility must be sent to: Your Spending Account Benefit Determination Review Team PO Box 1407 Lincolnshire, IL 60069-1407 Fax: **847-554-1397**
Appeals Information	Written Level I and Level II Appeals of a denied Claim for Reimbursement under the Program **must** be sent to: Your Spending Account Benefit Determination Review Team PO Box 1407 Lincolnshire, IL 60069-1407 Fax: **847-554-1397** Written Appeals of a Denied Claim for Eligibility **must** be sent to: Your Spending Account Eligibility and Enrollment Appeals Committee PO Box 1407 Lincolnshire, IL 60069-1407

Contact Information	
Vendor	
Name	Aon Hewitt
Type	Eligibility and Enrollment Vendor, operating as the AT&T Benefits Center
Services Provided	COBRA Administration
Vendor Contact Numbers	
Contact Numbers Information	Contact the AT&T Benefits Center at:
Domestic Telephone Number	**877-722-0020**
International Telephone Number	**847-883-0866**
Vendor Hours of Operation	
Hours of Operation	**Service Center:** Monday through Friday from 7 a.m. to 7p.m. Central time. To speak to the AT&T Benefits Center by phone, you will need to provide the last four digits of your Social Security number, your date of birth and your AT&T Benefits Center password. **IVR System:** The interactive voice response system is available 24 hours a day, seven days a week (except Sundays from 1 a.m. to noon Central time and periodically during the week for one hour between midnight and 5 a.m. for maintenance and updates).
Vendor Website	
Website Access Information	**Important:** To access the website you will need your AT&T Benefits Center ID and password.
Website	**resources.hewitt.com/att**

INFORMATION CHANGES AND OTHER COMMON RESOURCES

It's important to keep your home address current because the majority of information about your benefits or similar information is sent to this address.

Eligible Former Employee Home Address Changes
Call the YSA Service Center to change your address. **Telephone numbers and dialing instructions:** **800-928-8027** **Hours of operation:** Monday through Friday from 7:30 a.m. to 11 p.m. Central Time **IMPORTANT:** These instructions are for recipients of long-term disability benefits as well as COBRA participants, alternate payees and survivors who have a pension benefit (including a retiree death benefit) or savings plan benefit that has yet to be paid to you. If you are not eligible to receive a pension or savings plan benefit or have already received your entire pension and savings plan benefits in a lump sum and are not eligible for a retiree death benefit from your pension plan, call the AT&T Benefits Center at **877-722-0020** to update your home address.

AT&T Benefits Intranet and Internet Access
Your Benefits section of access.att.com Go to the Your Benefits section of **access.att.com** (AT&T's secure Internet site) for Benefits information at home.

DEFINITIONS

The definitions in this section apply to the terms used in this SPD. These terms are capitalized when they appear in the text.

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

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

Aon Retiree Health Exchange. A service provider the Company contracted with to provide assistance to Medicare-Eligible, Former Employees and Eligible Dependents in selecting and enrolling in individual insurance policies. Aon Retiree Health Exchange offers this service with respect to the following types of individual insurance policies:

- Medicare medical – Medicare Advantage, and Medigap (Medicare supplement);

- Medicare prescription drug (may be offered through Medicare Advantage or a stand-alone plan);
- Dental; and
- Vision.

Appeal. A written request for the Program to review an Adverse Benefit Determination under the formal process outlined in the Program for a Claim for Eligibility or Claim for Benefits. See the "Claims Procedure" section for more information.

Applicable Collective Bargaining Agreement. An agreement between a Participating Company and a union that is listed in *Appendix A,* "Participating Companies and Applicable Collective Bargaining Agreements".

AT&T Medical Program. Any option available to an Eligible Former Employee under the AT&T Umbrella Benefit Plan No. 1 that provides comprehensive medical care benefits.

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

Base Medical Program. The group health benefits program sponsored by your Company for which you are eligible to enroll for comprehensive medical benefits.

Benefit Determination Review Team (BDRT). The team designated by the Company to make the final determination on an Appeal of a denial of a Claim for Reimbursement.

Benefits. Reimbursements for covered services or supplies that are available under the Program. The availability of Benefits is subject to the terms, conditions, limitations and exclusions of the Program.

Child(ren). See the "Eligible Dependents" section for the definition of Child(ren).

Claim. A Claim is a request, submitted electronically or written, for reimbursement for Eligible Expenses under the Program.

Claims Administrator. The third-party administrator the Company has delegated the duty to make the initial determination of eligibility for the Program and to process and review Claims for reimbursements under the Program.

COBRA. COBRA is the Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272) as enacted April 7, 1986, and as subsequently amended from time to time. See the "Extension of Coverage – COBRA" section for more information.

Code. Code is the Internal Revenue Code of 1986, as amended from time to time. Any reference to any section of the Code shall be deemed to include any applicable regulations and rulings.

Company Self-Funded Option. Company Self-Funded Option means a comprehensive medical care coverage option under an AT&T Medical Program, the benefits under which are funded through the Company and not through a third-party insurer.

Eligibility and Enrollment Appeals Committee (EEAC). The Eligibility and Enrollment Appeals Committee (EEAC) is the committee appointed by the Company to make the final determination on eligibility Appeals.

Eligibility and Enrollment Vendor. The Eligibility and Enrollment Vendor (currently operating as the AT&T Benefits Center) is the third-party vendor to which the Plan Administrator has delegated Program responsibility for COBRA administration.

Eligible Dependent. See the "Eligible Dependent" section for an explanation as to who qualifies as an Eligible Dependent.

Eligible Expenses. Eligible Expenses are expenditures actually incurred by an Eligible Former Employee or an Eligible Dependent for "medical care," within the meaning of Section 213(d) of the Code, such as out-of-pocket expenses that count toward your deductibles, copayments and coinsurance, as well as monthly premiums for individual insurance coverage, including Qualifying Insurance Coverage.

Employee. Any individual, other than a leased employee or nonresident alien employed outside the United States, who is carried on the Payroll records of a Participating Company as a common law employee and who receives a regular and stated compensation, other than a pension or retainer, from that Participating Company, in exchange for services rendered to that AT&T Participating Company.

Employee Group. An Employee Group as provided in Appendix A.

ERISA. The Employee Retirement Income Security Act of 1974, as amended from time to time. Any reference to any section of ERISA shall be deemed to include any applicable regulations and rulings.

Exchange. See the definition of Aon Retiree Health Exchange.

Explanation of Benefits (EOB). A statement you receive after the Claims Administrator has processed your Claim for reimbursement, showing the expenses submitted for reimbursement and the amount that is reimbursed.

FMLA. The Family and Medical Leave Act of 1993, as amended from time to time. Reference to any section or subsection of the FMLA includes references to any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

Former Employee. A Former Employee is an individual who was carried on the Payroll records of a Participating Company as an Employee, who received a regular and stated compensation, other than a pension or retainer, from that Participating Company, in exchange for services rendered to that Participating Company, and is eligible for Post-Employment Benefits under their Base Medical Program that the individual was eligible to participate in on termination of employment or would have been eligible but for the transition from the Base Medical Program to eligibility to purchase individual insurance coverage through the Exchange. See the "Eligibility and Participation" section for information.

HIPAA. HIPAA is the Health Income Portability and Accountability Act (HIPAA) of 1996, as amended from time to time including any applicable regulations and rulings.

HRA. HRA is an acronym for the "Health Reimbursement Account," which is a bookkeeping account created by the Company for Eligible Former Employees and receives HRA Crediting Amounts on the HRA Crediting Date(s).

HRA Account Balance. HRA Account Balance is the amount available for reimbursement from each Participant's HRA and is equal to the aggregate value of HRA Crediting Amounts, less reimbursements.

HRA Crediting Date. HRA Crediting Date is the date that an HRA is credited by the Company.

HRA Crediting Amount. HRA Crediting Amount is the amount that the Company credits to a Participant's HRA.

Legally Recognized Partner (LRP). Any individual:

- Who is a Registered Domestic Partner (RDP) or
- With whom an Eligible Former Employee has entered into a same-gender relationship pursuant to and in accordance with state or local law, such as civil union or other legally recognized arrangement that provides legal benefits, protections and responsibilities under state law to those afforded to a Spouse.

Management Employee. An Employee who is classified as management on the records of the Company.

Medicare. Medicare is the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq., and as later amended.

Medicare-Eligible. A Former Employee or Eligible Dependent who is eligible for Medicare by reason of age.

Monthly Prescription Drug Summary. An accounting, sent monthly from the carrier on a participant's Medicare Part D prescription drug plan detailing participant's out-of-pocket expenses for prescription drugs.

Nonmanagement Nonunion Employee. An Employee who is not covered by a collective bargaining agreement and who is not classified as a Management Employee.

Participant. A Participant is an Eligible Former Employee or surviving Eligible Dependent who has an HRA Account Balance but does not include an individual who previously had an account but the account is suspended.

Participating Company. Participating Company means the Company and/or affiliate or business unit of the Company that has elected to participate in the Program, subject to approval provided in accordance with the AT&T Schedule of Authorizations. See *Appendix A*, "Participating Companies and Applicable Collective Bargaining Agreements" for a list of the Participating Companies.

Payroll. Payroll is the system used by a Participating Company to pay those individuals it considers Employees and to withhold employment taxes from the compensation it pays those Employees. "Payroll" does not include any system that an entity uses to pay individuals whom it does not consider its Employees and for whom it does not actually withhold employment taxes (including individuals regarded as independent contractors).

Plan. Plan means the AT&T Umbrella Benefit Plan No. 1.

Plan Administrator or Company. AT&T Services, Inc.

Plan Year. Plan Year refers to the 12-month period beginning Jan. 1 and ending Dec. 31.

Post-Employment Benefits. Post-Employment Benefits is AT&T Medical Program coverage (excluding COBRA) made available to a Former Employee who meets eligibility requirements for continued coverage in a Company Self-Funded Option under an AT&T Medical Program after the Employee terminates employment.

Program. Program means the AT&T Medicare-Eligible Health Reimbursement Account Program.

Qualified Beneficiary. A Qualified Beneficiary is an individual who satisfies the conditions for COBRA continuation coverage described in the "Extension of Coverage — COBRA" section.

Qualifying Event. A Qualifying Event is an event that gives a Qualified Beneficiary the right to retain coverage under the Program in accordance with COBRA.

Qualifying Insurance Coverage. Medical or prescription drug individual insurance coverage purchased by a Former Employee or their Eligible Dependents through the Aon Retiree Health Exchange.

Registered Domestic Partner (RDP). Any individual with whom an Eligible Former Employee has entered into a domestic partnership that has been registered with a governmental body pursuant to state or local law authorizing such registration and such relationship has not terminated. You may be asked to provide a copy of the domestic partner registration and other evidence that you continue to meet the requirements of the applicable registry and that the registered domestic partnership has not ended. See the "Dependent Eligibility Verification" section for information for dependent enrollment and verification of dependent eligibility.

Regular Employee. A Regular Employee is an Active Employee who is classified as a "Regular Employee," whether full time or part time, by a Participating Company.

Regular Limited Term or Regular Term Employee. A Regular Limited Term Employee or Regular Term Employee is an Active Employee who is classified as a "Regular Limited Term Employee" or "Regular Term Employee," respectively, by a Participating Company.

Spouse. The person to whom you are legally married, including through common law marriage.

SSP or Success Sharing Plan. SSP or Success Sharing Plan means an arrangement governed by the terms and conditions of a collective bargaining agreement which provides HRA credits based on AT&T stock attributes.

SSP HRA Participant. An SSP HRA Participant is an Eligible Person who satisfies the SSP HRA eligibility terms and conditions as described in the "Eligible Persons" subsection of the "Eligibility and Participation" section.

Temporary (Temp) Employee. A Temporary Employee is an Employee who is classified as a "Temporary Employee" by a Participating Company.

Term Employee. A Term Employee is an Active Employee who is classified as a "Term Employee" by a Participating Company.

USERRA. USERRA is the Uniformed Services Employment and Reemployment Rights Act of 1994.

APPENDIX A: PARTICIPATING COMPANIES AND APPLICABLE COLLECTIVE BARGAINING AGREEMENTS

This section identifies Participating Companies and applicable collective bargaining agreements and employee groups. These include Companies that no longer participate, but certain former Employees of these Companies remain eligible to participate in the Program.

This section also provides general information regarding which groups of Eligible Former Employees within a Participating Company are eligible to participate in the Program.

This table must be used with the "Eligibility and Participation" section to determine eligibility to participate in the Program. See the "Eligibility and Participation" section for more information on eligibility to participate in the Program.

Note: In addition, with prior approval of the AT&T Inc. board of directors (or its delegate), other Companies may hereafter become Participating Companies in the Program. A complete updated list of all the Participating Companies for the Program may be obtained from the Plan Administrator. The list also may be examined at the Plan Administrator's office or at other Participating Company locations in your area.

	Participating Company Name and Acronym	**Employee Group**	**Bargaining Unit**
Population Abbreviation			
ACP - CWA District 4	AT&T Teleholdings, Inc. ACP	Bargained No Employees as of Jan. 1, 1999.	AT&T Midwest Core Contract - CWA District 4
ACP - IBEW Local 21	AT&T Teleholdings, Inc. ACP	Bargained No Employees as of Jan. 1, 1999.	IBEW System Counsel T-3 (AT&T Midwest Contract)
ACP - M	AT&T Teleholdings, Inc. ACP	Management No Employees as of Jan. 1, 1999.	N/A
AIS - CWA District 9	SBC Global Services, Inc. AIS	Bargained	SBC Global Services, Inc. - CWA District 9 (Appendix D to the AT&T West Core Contract - CWA District 9)
AIS - IBEW Local 134	SBC Global Services, Inc. AIS	Bargained	SBC Global Services, Inc. - IBEW Local 134 (Appendix F to the AT&T Midwest Core Contract - IBEW Local 21)
AIS - IBEW Local 21	SBC Global Services, Inc. AIS	Bargained	SBC Global Services, Inc. - IBEW Local 21 (Appendix D to the AT&T Midwest Core Contract - IBEW Local 21)

	Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
AIS - IBEW Local 494	SBC Global Services, Inc. AIS	Bargained	SBC Global Services, Inc. - IBEW Local 494 (Appendix G to the AT&T Midwest Core Contract - IBEW Local 21)
AIS - IBEW Local 58	SBC Global Services, Inc. AIS	Bargained	SBC Global Services, Inc. - IBEW Local 58 (Appendix E to the AT&T Midwest Core Contract - IBEW Local 21)
AIS - M	SBC Global Services, Inc. AIS	Management	N/A
AIS - NMNU M	SBC Global Services, Inc. AIS	Nonmanagement Nonunion Follows Management level of benefits.	N/A
AIS COS - CWA District 4	SBC Global Services, Inc. AIS	Bargained	SBC Global Services, Inc., COS - CWA District 4
AIS CPE - CWA District 4	SBC Global Services, Inc. AIS	Bargained	SBC Global Services, Inc. (CPE) - CWA District 4 (Appendix G to the AT&T Midwest Core Contract - CWA District 4)
AKI - IBEW Local 1547	Alascom, Inc. AKI	Bargained	AT&T Alascom, Inc. - IBEW Local 1547
AKI - M	Alascom, Inc. AKI	Management	N/A
AKI - Teamsters Local 959	Alascom, Inc. AKI	Bargained	AT&T Alascom, Inc. - Teamsters Local 959
BBI - CWA District 3	AT&T Billing Southeast, LLC BBI	Bargained	AT&T Billing Southeast, LLC - CWA District 3
BBI - M	AT&T Billing Southeast, LLC BBI	Management	N/A

	Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
BCS - CWA District 3	BellSouth Communication Systems, LLC BCS	Bargained	AT&T Southeast Core Contract - CWA District 3
BCS - M	BellSouth Communication Systems, LLC BCS	Management	N/A
BCS - NMNU M	BellSouth Communication Systems, LLC BCS	Nonmanagement Nonunion Follows Management level of benefits.	N/A
BLD - CWA District 3	BellSouth Long Distance, Inc. BLD	Bargained All Active Employees moved to AT&T Services, Inc. June 16, 2012.	AT&T Southeast Core Contract - CWA District 3
BLD - M	BellSouth Long Distance, Inc. BLD	Management All Active Employees moved to AT&T Services, Inc. June 16, 2012.	N/A
BSC - CWA District 3	BellSouth Corporation BSC	Bargained All Active Employees moved to AT&T Services, Inc. June 16, 2012.	AT&T Southeast Core Contract - CWA District 3
BSC - M	BellSouth Corporation BSC	Management All Active Employees moved to AT&T Services, Inc. June 16, 2012.	N/A
BST - CWA District 3	BellSouth Telecommunications, LLC BST	Bargained	AT&T Southeast Core Contract - CWA District 3
BST - M	BellSouth Telecommunications, LLC BST	Management	N/A

	Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
BST - SE NMNUM	BellSouth Telecommunications, LLC BST	Nonmanagement Nonunion Effective Aug. 11, 2013, all BellSouth NMNUs were reclassified as Bargained Employees. All Active Employees now covered by AT&T Southeast Core Contract - CWA District 3. Eligible Former Employee Benefits follow the Benefits for similarly situated former Employees who were Management Employees at termination of employment.	N/A
BST (IS) - CWA District 3	BellSouth Telecommunications, LLC BST (IS)	Bargained Bargaining unit contract terminated Oct. 31, 2013. All Active Employees now covered by AT&T Southeast Core Contract - CWA District 3.	BellSouth Telecommunications, LLC (Internet Services) - CWA District 3
BST (ND & CA) - District 3	BellSouth Telecommunications, LLC BST (ND & CA)	Bargained	BellSouth Telecommunications, LLC (National Directory & Customer Assistance) - CWA District 3
BST (UO) - District 3	BellSouth Telecommunications, LLC BST (UO)	Bargained	BellSouth Telecommunications, LLC (Utility Operations) - CWA District 3
CINAIO - M	Cricket Wireless LLC CINAIO	Management Effective Dec. 9, 2013, Employees transferred to this entity.	N/A
CINSRV - CWA District 3	AT&T Mobility Puerto Rico Inc. CINSRV	Bargained	AT&T Mobility Puerto Rico Inc. - CWA District 3 (Green Contract)
CINSRV - M	AT&T Mobility Puerto Rico Inc. CINSRV	Management	N/A
CINW - CWA District 3	AT&T Mobility Services LLC CINW	Bargained	AT&T Mobility Services LLC - CWA District 3 (Black Contract)

	Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
CINW - CWA District 6	AT&T Mobility Services LLC CINW	Bargained	AT&T Mobility Services LLC - CWA District 6 (Purple Contract)
CINW - CWA Districts 1, 2, 4, 7, 9, 13	AT&T Mobility Services LLC CINW	Bargained	AT&T Mobility Services LLC - CWA Districts 1, 2, 4, 7, 9, 13 (Orange Contract)
CINW - IBEW Local 1547	AT&T Mobility Services LLC CINW	Bargained	AT&T Mobility Services LLC - IBEW Local 1547 (Blue Contract)
CINW - M	AT&T Mobility Services LLC CINW	Management	N/A
CRD - M	AT&T Capital Services, Inc. CRD	Management All Active Employees moved to AT&T Services, Inc. effective June 6, 2012.	N/A
ILB - CWA District 4	Illinois Bell Telephone Company ILB	Bargained	AT&T Midwest Core Contract - CWA District 4
ILB - IBEW Local 21	Illinois Bell Telephone Company ILB	Bargained	IBEW System Counsel T-3 (AT&T Midwest Contract)
ILB - M	Illinois Bell Telephone Company ILB	Management	N/A
ILB - NMNU IBEW	Illinois Bell Telephone Company ILB	Nonmanagement Nonunion Follows IBEW System Counsel T-3 (AT&T Midwest Contract) level of benefits.	N/A
INB - CWA District 4	Indiana Bell Telephone Company, Incorporated INB	Bargained	AT&T Midwest Core Contract - CWA District 4
INB - IBEW Local 21	Indiana Bell Telephone Company, Incorporated INB	Bargained	IBEW System Counsel T-3 (AT&T Midwest Contract)

	Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
INB - M	Indiana Bell Telephone Company, Incorporated INB	Management	N/A
INB - NMNU CWA	Indiana Bell Telephone Company, Incorporated INB	Nonmanagement Nonunion Follows AT&T Midwest Core Contract - CWA District 4 level of benefits.	N/A
MIB - CWA District 4	Michigan Bell Telephone Company MIB	Bargained	AT&T Midwest Core Contract - CWA District 4
MIB - M	Michigan Bell Telephone Company MIB	Management	N/A
MIB - NMNU CWA	Michigan Bell Telephone Company MIB	Nonmanagement Nonunion Follows AT&T Midwest Core Contract - CWA District 4 level of benefits.	N/A
NB - CWA District 9	Nevada Bell Telephone Company NB	Bargained	AT&T West Core Contract - CWA District 9
NB - M	Nevada Bell Telephone Company NB	Management	N/A
OHB - CWA District 4	The Ohio Bell Telephone Company OHB	Bargained	AT&T Midwest Core Contract - CWA District 4
OHB - M	The Ohio Bell Telephone Company OHB	Management	N/A
OHB - NMNU CWA	The Ohio Bell Telephone Company OHB	Nonmanagement Nonunion Follows AT&T Midwest Core Contract - CWA District 4 level of benefits.	N/A
PB - CWA District 9	Pacific Bell Telephone Company PB	Bargained	AT&T West Core Contract - CWA District 9

	Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
PB - IBEW Local 1269	Pacific Bell Telephone Company PB	Bargained	Pacific Bell Telephone Company - IBEW Local 1269
PB - M	Pacific Bell Telephone Company PB	Management	N/A
PB - NMNU CWA	Pacific Bell Telephone Company PB	Nonmanagement Nonunion Follows AT&T West Core Contract - CWA District 9 level of benefits.	N/A
PB - TIU Local 103	Pacific Bell Telephone Company PB	Bargained Bargaining unit contract terminated April 7, 2012. All Active Employees now covered under AT&T West Core Contract - CWA District 9.	Pacific Bell Telephone Company - TIU Local 103
SBCI - M	AT&T International, Inc. SBCI	Management No Employees as of Dec. 31, 2012.	N/A
SBCI-MSI - M	AT&T Mexico, LLC SBCI - MSI	Management	N/A
SBC-MSI - M	AT&T Management Services, L.P. SBC - MSI	Management	N/A
SBCSI - CWA	AT&T Services, Inc. SBCSI	Bargained	AT&T Corp. Core Contract - CWA
SBCSI - CWA District 1	AT&T Services, Inc. SBCSI	Bargained	AT&T East Core Contract - CWA District 1
SBCSI - CWA District 3	AT&T Services, Inc. SBCSI	Bargained	AT&T Southeast Core Contract - CWA District 3
SBCSI - CWA District 4	AT&T Services, Inc. SBCSI	Bargained	AT&T Midwest Core Contract - CWA District 4
SBCSI - CWA District 6	AT&T Services, Inc. SBCSI	Bargained	AT&T Southwest Core Contract - CWA District 6

	Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
SBCSI - CWA District 9	AT&T Services, Inc. SBCSI	Bargained	AT&T West Core Contract - CWA District 9
SBCSI - CWA District 9 (SBLD)	AT&T Services, Inc. SBCSI	Bargained	AT&T Services, Inc. - CWA District 9 (SBLD)
SBCSI - IBEW	AT&T Services, Inc. SBCSI	Bargained	IBEW System Counsel T-3 (AT&T Corp. National Contract)
SBCSI - IBEW Local 21 (Core)	AT&T Services, Inc. SBCSI	Bargained	IBEW System Counsel T-3 (AT&T Midwest Contract)
SBCSI - M	AT&T Services, Inc. SBCSI	Management	N/A
SBCSI - NMNU Legacy T CWA	AT&T Services, Inc. SBCSI	Nonmanagement Nonunion Hired before Aug. 8, 2009. Follows AT&T Corp. Core Contract - CWA (Legacy T) level of benefits.	N/A
SBCSI - NMNU Legacy T M	AT&T Services, Inc. SBCSI	Nonmanagement Nonunion Hired on or after Aug. 8, 2009. Follows Legacy T Management level of benefits.	N/A
SBCSI - NMNU MW CWA	AT&T Services, Inc. SBCSI	Nonmanagement Nonunion Benefits follow AT&T Midwest Core Contract - CWA District 4 level of benefits.	N/A
SBCSI - NMNU MW IBEW	AT&T Services, Inc. SBCSI	Nonmanagement Nonunion Follow IBEW System Counsel T-3 (AT&T Midwest Contract) level of benefits.	N/A
SBCSI - NMNU SW CWA	AT&T Services, Inc. SBCSI	Nonmanagement Nonunion Benefits follow AT&T Southwest Core Contract - CWA District 6 level of benefits.	N/A
SBCSI - NMNU West CWA	AT&T Services, Inc. SBCSI	Nonmanagement Nonunion Benefits follow AT&T West Core Contract - CWA District 9 level of benefits.	N/A

	Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
SBCSI Tier 1 - CWA	AT&T Services, Inc. SBCSI	Bargained	AT&T Services, Inc., National Internet Contract - Tier 1 - CWA
SBCSI Tier 2 - CWA	AT&T Services, Inc. SBCSI	Bargained	AT&T Services, Inc., National Internet Contract - Tier 2 - CWA
SBLD - IBEW Local 21	SBC Long Distance, LLC SBLD	Bargained All Active Employees moved to AT&T Services, Inc. June 16, 2012.	IBEW System Counsel T-3 (AT&T Midwest Contract)
SBLD - M	SBC Long Distance, LLC SBLD	Management All Active Employees moved to AT&T Services, Inc. June 16, 2012.	N/A
SBLD - NMNU IBEW	SBC Long Distance, LLC SBLD	Nonmanagement Nonunion All Active Employees moved to AT&T Services, Inc. June 16, 2012. Eligible Former Employee Benefits follow the Benefits for similarly situated former Employees who were IBEW System Counsel T-3 (AT&T Midwest Contract) at termination of employment.	N/A
SMSI - CWA District 6	AT&T Messaging, LLC SMSI	Bargained All Active Employees moved to AT&T Services, Inc. Sep. 18, 2011.	AT&T Messaging, LLC - CWA District 6
SMSI - M	AT&T Messaging, LLC SMSI	Management All Active Employees moved to AT&T Services, Inc. Sep. 18, 2011.	N/A
SNEAM - CWA District 1	SNET America, Inc. SNEAM	Bargained No Employees as of Jan. 1, 2010.	AT&T East Core Contract - CWA District 1
SNEAM - M	SNET America, Inc. SNEAM	Management No Employees as of Jan. 1, 2010.	N/A
SNET - CWA District 1	The Southern New England Telephone Company SNET	Bargained	AT&T East Core Contract - CWA District 1

	Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
SNET - M	The Southern New England Telephone Company SNET	Management	N/A
STG - Local 121C and Local 540M	Stevens Graphics, LLC STG	Bargained No Employees as of Jan. 1, 2011.	Stevens Graphics, LLC - Local 121C and Local 540M
STG - M	Stevens Graphics, LLC STG	Management No Employees as of Jan. 1, 2011.	N/A
SWBT - CWA District 6	Southwestern Bell Telephone Company SWBT	Bargained	AT&T Southwest Core Contract - CWA District 6
SWBT - M	Southwestern Bell Telephone Company SWBT	Management	N/A
SWBT - NMNU CWA	Southwestern Bell Telephone Company SWBT	Nonmanagement Nonunion Benefits follow AT&T Southwest Core Contract - CWA District 6 level of benefits.	N/A
TCORP - CWA	AT&T Corp. TCORP	Bargained	AT&T Corp. Core Contract - CWA
TCORP - CWA District 1 (SNEDG)	AT&T Corp. TCORP	Bargained	AT&T East Core Contract - CWA District 1 (SNEDG)
TCORP - IBEW	AT&T Corp. TCORP	Bargained	IBEW System Counsel T-3 (AT&T Corp. National Contract)
TCORP - M	AT&T Corp. TCORP	Management	N/A
TCORP - NMNU CWA	AT&T Corp. TCORP	Nonmanagement Nonunion Hired before Aug. 8, 2009. Benefits follow AT&T Corp. Core Contract - CWA (Legacy T) level of benefits.	N/A
TCORP - NMNU M	AT&T Corp. TCORP	Nonmanagement Nonunion Hired on or after Aug. 8, 2009. Benefits follow Legacy T Management level of benefits.	N/A

	Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
TGCS - M	AT&T Global Communication Services, Inc. TGCS	Management	N/A
TGCS - NMNU CWA	AT&T Global Communication Services, Inc. TGCS	Nonmanagement Nonunion Hired before Aug. 8, 2009. Benefits follow AT&T Corp. Core Contract - CWA (Legacy T) level of benefits.	N/A
TGCS - NMNU M	AT&T Global Communication Services, Inc. TGCS	Nonmanagement Nonunion Hired on or after Aug. 8, 2009. Benefits follow Legacy T Management level of benefits.	N/A
TGSI - M	AT&T Government Solutions, Inc. TGSI	Management	N/A
TNPM - M	AT&T Network Supply, LLC TNPM	Management No Employees as of Jan. 1, 2010.	N/A
TPR - CWA District 3	AT&T of Puerto Rico, Inc. TPR	Bargained	AT&T of Puerto Rico, Inc. - CWA District 3
TPR - M	AT&T of Puerto Rico, Inc. TPR	Management	N/A
TPR - NMNU CWA	AT&T of Puerto Rico, Inc. TPR	Nonmanagement Nonunion Benefits follow AT&T of Puerto Rico, Inc. - CWA District 3 level of benefits.	N/A
TSC - CWA	AT&T Support Services Company Inc. TSC	Bargained	AT&T Corp. Core Contract - CWA
TSC - IBEW	AT&T Support Services Company Inc. TSC	Bargained	IBEW System Counsel T-3 (AT&T Corp. National Contract)
TSC - M	AT&T Support Services Company Inc. TSC	Management	N/A

	Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
TSRVC - CWA	Teleport Communications America, LLC TSRVC	Bargained	AT&T Corp. Core Contract - CWA
TSRVC - IBEW	Teleport Communications America, LLC TSRVC	Bargained	IBEW System Counsel T-3 (AT&T Corp. National Contract)
TSRVC - M	Teleport Communications America, LLC TSRVC	Management	N/A
TSRVC - NMNU CWA	Teleport Communications America, LLC TSRVC	Nonmanagement Nonunion Hired before Aug. 8, 2009. Benefits follow AT&T Corp. Core Contract - CWA (Legacy T) level of benefits.	N/A
TSRVC - NMNU M	Teleport Communications America, LLC TSRVC	Nonmanagement Nonunion Hired on or after Aug. 8, 2009. Benefits follow Legacy T Management level of benefits.	N/A
TSYS - M	TC Systems, Inc. TSYS	Management No Employees as of Jan. 1, 2011.	N/A
TTSC - M	AT&T Technical Services Company, Inc. TTSC	Management	N/A
TVI - M	AT&T of the Virgin Islands, Inc. TVI	Management	N/A
TVI - NMNU CWA	AT&T of the Virgin Islands, Inc. TVI	Nonmanagement Nonunion Hired before Aug. 8, 2009. Benefits follow AT&T Corp. Core Contract - CWA (Legacy T) level of benefits.	N/A
TVI - NMNU M	AT&T of the Virgin Islands, Inc. TVI	Nonmanagement Nonunion Hired on or after Aug. 8, 2009. Benefits follow Legacy T Management level of benefits.	N/A

	Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
TWPS - M	AT&T World Personnel Services, Inc. TWPS	Management	N/A
WIB - CWA District 4	Wisconsin Bell, Inc. WIB	Bargained	AT&T Midwest Core Contract - CWA District 4
WIB - M	Wisconsin Bell, Inc. WIB	Management	N/A
WIB - NMNU CWA	Wisconsin Bell, Inc. WIB	Nonmanagement Nonunion Benefits follow AT&T Midwest Core Contract - CWA District 4 level of benefits.	N/A

APPENDIX A: FORMER PARTICIPATING COMPANIES

	Former Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
ACI - IBEW Local 21	Ameritech Communications, Inc. (Delaware) ACI	Bargained Company dissolved. Pre-2010 payroll entity closure.	IBEW System Counsel T-3 (AT&T Midwest Contract)
ACI - M	Ameritech Communications, Inc. (Delaware) ACI	Management Company dissolved. Pre-2010 payroll entity closure.	N/A
ADS-AIT - CWA District 4	Ameritech Advanced Data Services of Illinois, Inc. ADS-AIT	Bargained Merged into AT&T Corp on Dec. 31, 2008.	AT&T Midwest Core Contract - CWA District 4
ADS-AIT - IBEW Local 21	Ameritech Advanced Data Services of Illinois, Inc. ADS-AIT	Bargained Merged into AT&T Corp on Dec. 31, 2008.	IBEW System Counsel T-3 (AT&T Midwest Contract)
ADS-AIT - M	Ameritech Advanced Data Services of Illinois, Inc. ADS-AIT	Management Merged into AT&T Corp on Dec. 31, 2008.	N/A
ADV - CWA District 4	Ameritech Publishing, Inc. ADV	Bargained Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	Ameritech Publishing, Inc. - CWA District 4
ADV - M	Ameritech Publishing, Inc. ADV	Management Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
ADV - NMNU	Ameritech Publishing, Inc. ADV	Nonmanagement Nonunion Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
AIM - M	Ameritech Interactive Media Services, Inc. AIM	Management Company dissolved Dec. 31, 2004.	N/A
AMC - M	AMC Resources, LLC AMC	Management Sold Aug. 15, 2005.	N/A

	Former Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
AMI - M	SBC Asset Management Inc. AMI	Management Pre-2010 payroll entity closure.	N/A
AMP - M	Ameritech Mobile Phone Services (AMPS) of Illinois AMP	Management Company dissolved Oct. 8, 1999.	N/A
AMS - M	Ameritech Mobile Services, Inc. AMS	Management Sold Aug. 15, 2005.	N/A
APL - CWA District 4	APIL Partners Partnership APL	Bargained Company dissolved Aug. 31, 2004.	AT&T Midwest Core Contract - CWA District 4
APL - M	APIL Partners Partnership APL	Management Company dissolved Aug. 31, 2004.	N/A
ASI-AIT - CWA District 4	Ameritech Services, Inc. ASI - AIT	Bargained All Active Employees moved to AT&T Services, Inc. Dec. 18, 2011. Company dissolved Dec. 1, 2013.	AT&T Midwest Core Contract - CWA District 4
ASI-AIT - IBEW Local 21	Ameritech Services, Inc. ASI - AIT	Bargained All Active Employees moved to AT&T Services, Inc. Dec. 18, 2011. Company dissolved Dec. 1, 2013.	IBEW System Counsel T-3 (AT&T Midwest Contract)
ASI-AIT - M	Ameritech Services, Inc. ASI - AIT	Management All Active Employees moved to AT&T Services, Inc. Dec. 18, 2011. Company dissolved Dec. 1, 2013.	N/A
ASI-AIT - NMNU CWA	Ameritech Services, Inc. ASI - AIT	Nonmanagement Nonunion All Active Employees moved to AT&T Services, Inc. Dec. 18, 2011. Eligible Former Employee Benefits follow the Benefits for similarly situated former Employees covered by AT&T Midwest Core Contract - CWA District 4 at termination of employment. Company dissolved Dec. 1, 2013.	N/A

	Former Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
ASI-AIT - NMNU IBEW	Ameritech Services, Inc. ASI - AIT	Nonmanagement Nonunion All Active Employees moved to AT&T Services, Inc. Dec. 18, 2011. Eligible Former Employee Benefits follow the Benefits for similarly situated former Employees covered by AT&T Midwest Core Contract - CWA District 4 at termination of employment. Company dissolved Dec. 1, 2013.	N/A
ASI-SBC - CWA District 6	SBC Advanced Solutions, Inc. ASI-SBC	Bargained Merged into AT&T Corp. Pre-2010 payroll entity closure.	AT&T Southwest Core Contract - CWA District 6
ASI-SBC - CWA District 9	SBC Advanced Solutions, Inc. ASI-SBC	Bargained Merged into AT&T Corp. Pre-2010 payroll entity closure.	AT&T West Core Contract - CWA District 9
ASI-SBC - M	SBC Advanced Solutions, Inc. ASI-SBC	Management Merged into AT&T Corp. Pre-2010 payroll entity closure.	N/A
BAPCO - CWA District 3	BellSouth Advertising & Publishing Corporation BAPCO	Bargained Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	BellSouth Advertising & Publishing Corporation - CWA District 3
BAPCO - M	BellSouth Advertising & Publishing Corporation BAPCO	Management Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
BAPCO - NMNU	BellSouth Advertising & Publishing Corporation BAPCO	Nonmanagement Nonunion Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
BCO - M	L.M. Berry and Company BCO	Management Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
BCO - NMNU	L.M. Berry and Company BCO	Nonmanagement Nonunion Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
BCP - M	BellSouth Personal Comm Inc/PCI BCP	Management Company dissolved.	N/A

	Former Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
BDC - M	AT&T D.C. Services, Inc. BDC	Management Employees moved to AT&T Services, Inc. Dec. 31, 2011. Company dissolved.	N/A
BHN - M	Cooperative HealthCare Networks BHN	Management Sold Jan. 1, 1994.	N/A
BIPMAN - M	AT&T Intellectual Property Management, Inc. BIPMAN	Management Employees moved to AT&T Services, Inc. Dec. 31, 2011. Entity eliminated.	N/A
BIPMARK - M	AT&T Intellectual Property Marketing, Inc. BIPMARK	Management Employees moved to AT&T Services, Inc. Dec. 31, 2011.	N/A
BMD - M	BS Mobile Data, Inc. BMD	Management Employees transferred to Cingular Dec. 27, 2001.	N/A
BMI - CWA District 3	BellSouth Mobility a/k/a Cellular BMI	Bargained Employees transferred to Cingular Dec. 27, 2001.	AT&T Southeast Core Contract - CWA District 3
BMI - M	BellSouth Mobility a/k/a Cellular BMI	Management Employees transferred to Cingular Dec. 27, 2001.	N/A
BNI - M	Berry Network, LLC BNI	Management Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
BNI - NMNU	Berry Network, LLC BNI	Nonmanagement Nonunion Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
BRI - M	AT&T Resources, Inc. BRI	Management Employees transferred to AT&T Services, Inc. Payroll entity closed May 31, 2010.	N/A
BSN - CWA District 3	BellSouth Entertainment, LLC BSN	Bargained No Employees as of Jan. 1, 2009. Company eliminated Dec. 31, 2009.	AT&T Southeast Core Contract - CWA District 3

	Former Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
BSN - M	BellSouth Entertainment, LLC BSN	Management No Employees as of Jan. 1, 2009. Company eliminated Dec. 31, 2009.	N/A
BTG - M	BellSouth Technology Group, Inc. BTG	Management Employees moved to AT&T Services, Inc. Pre-2010 payroll entity closure.	N/A
CALI - M	AT&T Consulting Solutions, Inc. CALI	Management Effective June 16, 2013, all Active Employee and former Employee liabilities moved to AT&T Services, Inc. Entity merged into AT&T Corp. Dec. 31, 2013.	N/A
CCM - CWA District 3	BellSouth Credit and Collections Management, Inc. CCM	Bargained Employees moved to AT&T Services, Inc. Pre-2010 payroll entity closure.	AT&T Southeast Core Contract - CWA District 3
CCM - M	BellSouth Credit and Collections Management, Inc. CCM	Management Employees moved to AT&T Services, Inc. Pre-2010 payroll entity closure.	N/A
CELL1 - M	AWACS Resources LLC CELL1	Management No Employees as of Dec. 27, 2001.	N/A
CIN - CWA District 3	Westel Indianapolis Tel Co Indiana CIN	Bargained Employees transferred to Bellsouth Cellular Oct. 1, 2000.	AT&T Southeast Core Contract - CWA District 3
CSV - M	BellSouth Cellular Services LLC CSV	Management Transferred to Cingular Dec. 27, 2001.	N/A
DGA - IBEW Local 1269	PBD Holdings (dba AT&T Digital Graphics ADvantage) DGA	Bargained Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	AT&T Digital Graphics ADvantage - IBEW Local 1269
DGA - M	PBD Holdings (dba AT&T Digital Graphics ADvantage) DGA	Management Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A

	Former Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
DGA - NMNU	PBD Holdings (dba AT&T Digital Graphics ADvantage) DGA	Nonmanagement Nonunion Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
GNS-LLC - CWA	AT&T Global Network Services, LLC GNS-LLC	Bargained Effective Sept. 16, 2013, all Active Employees and former Employee liabilities moved to AT&T Services, Inc.	AT&T Corp. Core Contract - CWA
GNS-LLC - M	AT&T Global Network Services, LLC GNS-LLC	Management Effective Sept. 16, 2013, all Active Employees and former Employee liabilities moved to AT&T Services, Inc.	N/A
GNS-LLC - NMNU	AT&T Global Network Services, LLC GNS-LLC	Nonmanagement Nonunion Effective Sept. 16, 2013, all Active Employees and former Employee liabilities moved to AT&T Services, Inc.	N/A
HC - CWA District 9	Pacific Telesis Group HC	Bargained Merged into AT&T Teleholdings, Inc. Mar. 13, 2006.	AT&T West Core Contract - CWA District 9
HC - M	Pacific Telesis Group HC	Management Merged into AT&T Teleholdings, Inc. Mar. 13, 2006.	N/A
IMV - M	Intelligent Media Ventures, LLC IMV	Management Merged into Bellsouth Advertising & Publishing Corp. Dec. 29, 2009.	N/A
IYP - CWA District 4	Ameritech Interactive Media, Inc. IYP	Bargained Merged into Southwestern Bell Yellow Pages Dec. 28, 2000.	AT&T Midwest Core Contract - CWA District 4
IYP - M	Ameritech Interactive Media, Inc. IYP	Management Merged into Southwestern Bell Yellow Pages Dec. 28, 2000.	N/A
IYP - M (BLS)	IYP Employee Services, LLC IYP	Management Merged into Southwestern Bell Yellow Pages Dec. 28, 2000.	N/A

	Former Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
LMB - M	L. M. Berry Company LMB	Management Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
MSI-USA - M	SBC Management Services USA, Inc. MSI-USA	Management Company dissolved Dec. 31, 2004.	N/A
NME - IBEW Local 21	Ameritech New Media, LLC NME	Bargained Merged into Ameritech Wireless Holdings Inc. Jan. 29, 2010.	IBEW System Counsel T-3 (AT&T Midwest Contract)
NME - M	Ameritech New Media, LLC NME	Management Merged into Ameritech Wireless Holdings Inc. Jan. 29, 2010.	N/A
ORC - CWA District 4	SBC Datacomm, Inc. ORC	Bargained All Employees moved 2005. Name changed to AT&T Datacomm, LLC. Entity merged into AT&T Corp. Dec. 31, 2008.	AT&T Midwest Core Contract - CWA District 4
ORC - CWA District 6	SBC Datacomm, Inc. ORC	Bargained All Employees moved 2005. Name changed to AT&T Datacomm, LLC. Entity merged into AT&T Corp. Dec. 31, 2008.	AT&T Southwest Core Contract - CWA District 6
ORC - M	SBC Datacomm, Inc. ORC	Management All Employees moved 2005. Name changed to AT&T Datacomm, LLC. Entity merged into AT&T Corp. Dec. 31, 2008.	N/A
OWS - M	BellSouth International Wireless Services, Inc. OWS	Management Sold to Illuminent Sep. 28, 2001.	N/A
PBD - IBEW Local 1269	Pacific Bell Directory PBD	Bargained Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	Pacific Bell Directory (North) - IBEW Local 1269
PBD - IBEW Local 2139	Pacific Bell Directory PBD	Bargained Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	Pacific Bell Directory (South) - IBEW Local 2139
PBD - M	Pacific Bell Directory PBD	Management Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A

	Former Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
PBD N - NMNU	Pacific Bell Directory PBD	Nonmanagement Nonunion Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
PBD S - NMNU	Pacific Bell Directory PBD	Nonmanagement Nonunion Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
PBIS - CWA District 9	Pacific Bell Information Services PBIS	Bargained Employees moved to AT&T Services Sep. 16, 2011. Payroll entity closed Dec. 31, 2011.	AT&T West Core Contract - CWA District 9
PBIS - M	Pacific Bell Information Services PBIS	Management Employees moved to AT&T Services Sep. 16, 2011. Payroll entity closed Dec. 31, 2011.	N/A
PTF - M	PacTel Finance PTF	Management No Employees as of 2010.	N/A
PTSS - CWA District 9	Pacific Telesis Shared Services PTSS	Bargained Employees moved to AT&T Operations. Entity dissolved Dec. 31, 2003.	AT&T West Core Contract - CWA District 9
PTSS - M	Pacific Telesis Shared Services PTSS	Management Employees moved to AT&T Operations. Entity dissolved Dec. 31, 2003.	N/A
SBA - M	AT&T Advertising, L.P. SBA	Management Sold to Cerebrus May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
SBC-IA - M	SBC Interactive SBCIA	Management Employees moved to Southwestern Bell Yellow Pages Dec. 16, 2000. Entity dissolved Jan. 1, 2001.	N/A
SBC-OPS - CWA	AT&T Operations, Inc. SBC - OPS	Bargained Employees moved to AT&T Services Dec. 25, 2011. Entity merged into AT&T Services Dec. 31, 2011.	AT&T Corp. Core Contract - CWA
SBC-OPS - CWA District 1	AT&T Operations, Inc. SBC - OPS	Bargained Employees moved to AT&T Services Dec. 25, 2011. Entity merged into AT&T Services Dec. 31, 2011.	AT&T East Core Contract - CWA District 1

	Former Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
SBC-OPS - CWA District 3	AT&T Operations, Inc. SBC - OPS	Bargained Employees moved to AT&T Services Dec. 25, 2011. Entity merged into AT&T Services Dec. 31, 2011.	AT&T Southeast Core Contract - CWA District 3
SBC-OPS - CWA District 6	AT&T Operations, Inc. SBC - OPS	Bargained Employees moved to AT&T Services Dec. 25, 2011. Entity merged into AT&T Services Dec. 31, 2011.	AT&T Southwest Core Contract - CWA District 6
SBC-OPS - IBEW	AT&T Operations, Inc. SBC - OPS	Bargained Employees moved to AT&T Services Dec. 25, 2011. Entity merged into AT&T Services Dec. 31, 2011.	IBEW System Counsel T-3 (AT&T Corp. National Contract)
SBC-OPS - M	AT&T Operations, Inc. SBC - OPS	Management Employees moved to AT&T Services Dec. 25, 2011. Entity merged into AT&T Services Dec. 31, 2011.	N/A
SBCIS - CWA District 1	SBC Internet Services, LLC SBCIS	Bargained Effective Aug. 11, 2013 all Active Employees moved to BellSouth Telecommunications LLC and former Employee liabilities moved to AT&T Services, Inc. Payroll entity closed Dec. 31, 2013.	AT&T East Core Contract - CWA District 1
SBCIS - CWA District 4	SBC Internet Services, LLC SBCIS	Bargained Effective Aug. 11, 2013 all Active Employees moved to BellSouth Telecommunications LLC and former Employee liabilities moved to AT&T Services, Inc. Payroll entity closed Dec. 31, 2013.	AT&T Midwest Core Contract - CWA District 4
SBCIS - CWA District 6	SBC Internet Services, LLC SBCIS	Bargained Effective Aug. 11, 2013 all Active Employees moved to BellSouth Telecommunications LLC and former Employee liabilities moved to AT&T Services, Inc. Payroll entity closed Dec. 31, 2013.	AT&T Southwest Core Contract - CWA District 6

	Former Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
SBCIS - CWA District 9	SBC Internet Services, LLC SBCIS	Bargained Effective Aug. 11, 2013 all Active Employees moved to BellSouth Telecommunications LLC and former Employee liabilities moved to AT&T Services, Inc. Payroll entity closed Dec. 31, 2013.	AT&T West Core Contract - CWA District 9
SBCIS - M	SBC Internet Services, LLC SBCIS	Management Effective Aug. 11, 2013 all Active Employees moved to BellSouth Telecommunications LLC and former Employee liabilities moved to AT&T Services, Inc. Payroll entity closed Dec. 31, 2013.	N/A
SBCIS - SE NMNU	SBC Internet Services, LLC SBCIS	Nonmanagement Nonunion Effective Aug. 11, 2013 all Active Employees moved to BellSouth Telecommunications LLC and former Employee liabilities moved to AT&T Services, Inc. Payroll entity closed Dec. 31, 2013.	N/A
SBCIS Tier 1 - CWA	SBC Internet Services, LLC SBCIS	Bargained Effective Dec. 2012 all Active Employees moved to AT&T Services, Inc. Former Employee liabilities moved to AT&T Services effective Aug. 11, 2013. Payroll entity closed Dec. 31, 2013.	SBC Internet Services, LLC, National Internet Contract - Tier 1 - CWA
SBCIS Tier 2 - CWA	SBC Internet Services, LLC SBCIS	Bargained Effective Dec. 2012 all Active Employees moved to AT&T Services, Inc. Former Employee liabilities moved to AT&T Services effective Aug. 11, 2013. Payroll entity closed Dec. 31, 2013.	SBC Internet Services, LLC, National Internet Contract - Tier 2 - CWA
SBCTI - CWA District 6	SBC Telecom, Inc. SBCTI	Bargained Payroll entity closed Apr. 30, 2005.	AT&T Southwest Core Contract - CWA District 6
SBCTI - CWA District 9	SBC Telecom, Inc. SBCTI	Bargained Payroll entity closed Apr. 30, 2005.	AT&T West Core Contract - CWA District 9
SBCTI - M	SBC Telecom, Inc. SBCTI	Management Payroll entity closed Apr. 30, 2005.	N/A

	Former Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
SBCTRI - CWA District 3	AT&T Labs, Inc. SBCTRI	Bargained Employees moved to AT&T Services Jan. 1, 2011. Entity merged into AT&T Services Jan. 1, 2011.	AT&T Southeast Core Contract - CWA District 3
SBCTRI - M	AT&T Labs, Inc. SBCTRI	Management Employees moved to AT&T Services Jan. 1, 2011. Entity merged into AT&T Services Jan. 1, 2011.	N/A
SBCTRI - TCORP - CWA	AT&T Labs, Inc. SBCTRI	Bargained Employees moved to AT&T Services Jan. 1, 2011. Entity merged into AT&T Services Jan. 1, 2011.	AT&T Corp. Core Contract - CWA
SBIS - M	Southwestern Bell Internet Services, Inc. SBIS	Management Company dissolved Dec. 31, 2004.	N/A
SBMS - M	SBMS Resources, LLC SBMS	Management Employees transferred to Cingular Dec. 27, 2001.	N/A
SBT - CWA District 6	Southwestern Bell Telecommunications, Inc. SBT	Bargained Company dissolved Sep. 1, 2003.	AT&T Southwest Core Contract - CWA District 6
SBT - M	Southwestern Bell Telecommunications, Inc. SBT	Management Company dissolved Sep. 1, 2003.	N/A
SBVS - CWA District 6	AT&T Video Services, Inc. SBVS	Bargained Employees moved to AT&T Corp. Sep. 16, 2011. Entity merged into AT&T Corp. Sep. 30, 2011.	AT&T Southwest Contract - CWA District 6
SBVS - M	AT&T Video Services, Inc. SBVS	Management Employees moved to AT&T Corp. Sep. 16, 2011. Entity merged into AT&T Corp. Sep. 30, 2011.	N/A
SBYP - CWA District 6	Southwestern Bell Yellow Pages, Inc. SBYP	Bargained Sold to Cerebrus effective May 9, 2012. Payroll entity closed Mar. 31, 2013.	Southwestern Bell Yellow Pages, Inc. - CWA District 6

	Former Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
SBYP - M	Southwestern Bell Yellow Pages, Inc. SBYP	Management Sold to Cerebrus effective May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
SBYP - NMNU	Southwestern Bell Yellow Pages, Inc. SBYP	Nonmanagement Nonunion Sold to Cerebrus effective May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
SLC - M	Sunlink Corporation SLC	Management No Employees as of 2010.	N/A
SNECLP - M	Springwich Cellular Limited Partnership SNECLP	Management Company dissolved Jan. 31, 2001.	N/A
SNEDG - CWA District 1	SNET Diversified Group, Inc. SNEDG	Bargained Effective Dec. 1, 2013 all Active Employees moved to AT&T Corp. and former Employee liabilities moved to AT&T Services, Inc. Payroll entity closed Dec. 31, 2013.	AT&T East Core Contract - CWA District 1
SNEDG - M	SNET Diversified Group, Inc. SNEDG	Management Effective Dec. 1, 2013 all Active Employees moved to AT&T Corp. and former Employee liabilities moved to AT&T Services, Inc. Payroll entity closed Dec. 31, 2013.	N/A
SNEIS - CWA District 1	SNET Information Services, Inc. SNEIS	Bargained Sold to Cerebrus effective May 9, 2012. Payroll entity closed Mar. 31, 2013.	SNET Information Services, Inc. - CWA District 1
SNEIS - M	SNET Information Services, Inc. SNEIS	Management Sold to Cerebrus effective May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
SNEIS - NMNU	SNET Information Services, Inc. SNEIS	Nonmanagement Nonunion Sold to Cerebrus effective May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
SNEMOB - CWA District 1	SNET Mobility Resources, LLC SNEMOB	Bargained Employees transferred to Cingular Dec. 27, 2001.	AT&T East Core Contract - CWA District 1
SNEMOB - M	SNET Mobility Resources, LLC SNEMOB	Management Employees transferred to Cingular Dec. 27, 2001.	N/A

	Former Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
SNEPV - CWA District 1	SNET Personal Vision, Inc. SNEPV	Bargained Employees transferred to Southern New England Telecommunications Sep. 1, 2001.	AT&T East Core Contract - CWA District 1
SNEPV - M	SNET Personal Vision, Inc. SNEPV	Management Employees transferred to Southern New England Telecommunications Sep. 1, 2001.	N/A
SNETASI - M	SNET Advanced Services, Inc. SNETASI	Management Employees transferred to SNET America, Inc. 1999. Company dissolved.	N/A
SNEWT - CWA District 1	The Woodbury Telephone Company SNEWT	Bargained Payroll entity closed June 1, 2007. Employees transferred to Southern New England Telephone Company.	AT&T East Core Contract - CWA District 1
SNEWT - M	The Woodbury Telephone Company SNEWT	Management Payroll entity closed June 1, 2007. Management Employees transferred to AT&T Operations, Inc.	N/A
SSC - CWA District 3	BellSouth Affiliate Services Corporation SSC	Bargained Employees transferred to AT&T Services, Inc. and payroll entity closed. Pre-2010 payroll entity closure.	AT&T Southeast Core Contract - CWA District 3
SSC - M	BellSouth Affiliate Services Corporation SSC	Management Management Employees transferred to AT&T Operations, Inc. Pre-2010 payroll entity closure.	N/A
SWBAG - CWA District 7	Southwestern Bell Advertising Group, Inc. SWBAG	Bargained Sold to Cerebrus effective May 9, 2012. Payroll entity closed Mar. 31, 2013.	Southwestern Bell Advertising Group, Inc. - CWA District 7
SWBAG - M	Southwestern Bell Advertising Group, Inc. SWBAG	Management Sold to Cerebrus effective May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A
SWBAG - NMNU	Southwestern Bell Advertising Group, Inc. SWBAG	Nonmanagement Nonunion Sold to Cerebrus effective May 9, 2012. Payroll entity closed Mar. 31, 2013.	N/A

	Former Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
SWBW - M	Southwestern Bell Wireless Resources, LLC SWBW	Management Employees transferred to Cingular Dec. 27, 2001.	N/A
TCAR - M	TCG of The Carolinas, Inc. TCAR	Management Merged into TCG Services, Inc. on Dec. 29, 2009.	N/A
TCB - M	TELEPORT COMMUNICATIONS BOSTON, INC. TCB	Management Merged into TCG New Jersey, Inc. Feb. 29, 2008.	N/A
TDV - M	TCG Delaware Valley, Inc. TDV	Management Merged into TCG New Jersey, Inc. Feb. 29, 2008.	N/A
TIMC - M	AT&T Investment Management Corporation TIMC	Management Merged into AT&T Services, Inc. Dec. 29, 2009.	N/A
TNJ - M	TCG NEW JERSEY TNJ	Management Merged into TCG New Jersey, Inc. Dec. 29, 2009.	N/A
TNJ - TCORP - CWA	TCG NEW JERSEY TNJ	Bargained Merged into TCG New Jersey, Inc. Dec. 29, 2009.	AT&T Corp. Core Contract - CWA
TNJI - CWA	TCG New Jersey, Inc. TNJI	Bargained Employees transferred to Teleport Communications, Inc. and entity merged Dec. 31, 2012.	AT&T Corp. Core Contract - CWA
TNJI - IBEW	TCG New Jersey, Inc. TNJI	Bargained Employees transferred to Teleport Communications, Inc. and entity merged Dec. 31, 2012.	IBEW System Counsel T-3 (AT&T Corp. National Contract)
TNJI - M	TCG New Jersey, Inc. TNJI	Management Employees transferred to Teleport Communications, Inc. and entity merged Dec. 31, 2012.	N/A

	Former Participating Company Name and Acronym	Employee Group	Bargaining Unit
Population Abbreviation			
TNJI - NMNU	TCG New Jersey, Inc. TNJI	Nonmanagement Nonunion Employees transferred to Teleport Communications, Inc. and entity merged Dec. 31, 2012.	N/A
TNY - M	Teleport Communications New York TNY	Management No Employees as of Jan. 1, 2011. Merged into Teleport Communications, LLC Oct. 31, 2013.	N/A
TSI - CWA	AT&T Solutions, Inc. TSI	Bargained Effective Sept.16, 2013 all Active Employees and former Employee liabilities moved to AT&T Services, Inc.	AT&T Corp. Core Contract - CWA
TSI - IBEW	AT&T Solutions, Inc. TSI	Bargained Effective Sept. 16, 2013 all Active Employees and former Employee liabilities moved to AT&T Services, Inc.	IBEW System Counsel T-3 (AT&T Corp. National Contract)
TSI - M	AT&T Solutions, Inc. TSI	Management Effective Sept. 16, 2013 all Active Employees and former Employee liabilities moved to AT&T Services, Inc.	N/A
TSI - NMNU	AT&T Solutions, Inc. TSI	Nonmanagement Nonunion Effective Sept. 16, 2013 all Active Employees and former Employee liabilities moved to AT&T Services, Inc.	N/A
VG - M	AT&T Ventures Investment, Inc. VG	Management Employees transferred to AT&T Management Services, LLP. Payroll entity closed Jun. 30, 2010.	N/A
WDPS - CWA District 6	Worldwide Directory Products Sales, Inc. WDPS	Bargained No Employees as of Dec. 31, 1999.	Southwestern Bell Yellow Pages, Inc. - CWA District 6